Review of Interventions to Identify, Prevent, Reduce and Respond to Domestic Violence

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1. Executive Summary

1.1. Project Background

This review examines interventions to identify, prevent, reduce and respond to domestic violence between family members or between people who are (or who have been) intimate partners.

This following research questions are addressed:

> **Question 1:** What types of interventions or approaches are effective in preventing domestic violence from ever happening in the first place?
>
> **Question 2:** What types of interventions or approaches are effective in helping all those working in health and social care to safely identify and, where appropriate, intervene to prevent, domestic violence?
>
> **Question 3:** What types of interventions or approaches are effective in helping all those working in health and social care to respond to domestic violence?
>
> **Question 4:** What types of interventions and approaches are effective in identifying and responding to children who are exposed to domestic violence in the various settings identified?
>
> **Question 5:** What are the most effective types of partnership and partnership approaches for assessing and responding to domestic violence?

1.2. Methods

To locate evidence, a wide range of databases and websites indexing potentially relevant literature were searched.

The following inclusion criteria were applied:

- Does the study address one/more of the following populations:
  - Adults and young people/ teenagers in current or former intimate relationships who are experiencing or have experienced domestic violence;
  - Abuse of elders (65 years or older) or other adults by family members
  - Those who have been the victim of, or perpetrator/s of honour based violence or killings
  - Adults or children at risk of or experiencing forced marriage
  - Those who are perpetrating domestic violence;
  - Children who are exposed to domestic violence (i.e. The violence is not perpetrated on them directly, but they witness or experience it);
  - The general population;

- •Does the study evaluate an intervention/ approach to identify, prevent, reduce or respond to domestic violence between adults and young people who are, or have been, intimate partners, or the abuse of older people by a family member;

- Does the study focus on the following settings: health-care, social care and specialized domestic violence service settings;

- Was the study conducted in one of the following OECD countries: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom, United States;

- Was the study published in 2000 or later;

- Was the study published in English;

- Is the study a randomised controlled trials (RCT); a case-control study; interrupted time series; cohort study; cross sectional study; observational study; systematic review, or qualitative study, not already covered in an included systematic review?

The quality of included studies was assessed, and data were extracted, using the standard tools for National Institute for Health and Clinical Excellence (NICE) public health evidence reviews. Data were synthesised narratively.

Systematic reviews that included any of the study types listed above were collected. The individual studies covered by these systematic reviews were excluded from this review; a high level summary of reviews is provided prior to the main report of findings. Note that Q4 (Interventions for Children who are Exposed to Domestic Violence) was the first sub-section reviewed and the protocol was somewhat different; findings from one systematic review were included in the main report of findings, but the individual studies covered by the review were not individually reviewed/ rated.

1.3. Findings & Discussion

Q1: Prevention of Domestic Violence

A total of 14 articles were identified on interventions for preventing DV, informing 4 evidence statements related to: prevention approaches for young people; media campaigns; interventions implemented in health settings; and interventions in community settings for at-risk women.

Summary of findings

The majority of prevention approaches for young people were secondary prevention approaches, aimed at preventing violence among diverse sub-groups identified as high risk for IPV. Primary prevention programs that were school based and not linked with health, social care, or specialized DV services were outside of the scope of this review. While there is limited evidence on primary prevention programs for young people, there is modest evidence that prevention programs that target young people at risk for partner violence may improve knowledge, attitudinal (towards violence and gender roles) and interpersonal outcomes. Programs tended to focus on attitudinal changes, yet some studies conducted with young people at high risk for abuse also measured and reported modest reductions in violent behaviours.

Inconsistent evidence was found on the impact of media campaigns for improved recall, hypothetical bystander actions, and awareness of available resources, calls to hotlines and knowledge and perceptions of DV. Some studies reported improvements while others lacked reach to the intended audience, suggesting that media campaigns have the potential to raise awareness of DV and services but may be hindered by issues with implementation.

Only weak evidence was available for prevention interventions implemented in health care settings. Only two studies were located, both delivered in emergency departments, which demonstrated improvements in exposure to DV materials, or changes in knowledge and attitudes

related to DV. Further research is required to examine prevention interventions within or linked to health settings, and also to explore behavioural change following an intervention.

Finally, there was weak evidence related to prevention programs implemented in community settings for high-risk women, which included: women with learning disabilities and low income single African American mothers. While evidence was limited to two studies, findings suggest that engaging high risk groups may require tailored and innovative approaches to programme delivery.

Discussion

Overall, studies were primarily of moderate quality, with only one high quality study. Methodological limitations included the non-experimental nature of studies and lack of follow up beyond the end of the intervention. More robust studies are required to determine effective approaches to preventing DV among these groups.

While studies did not address all groups within the scope of our review (particularly 'honour based violence' and elder abuse prevention), the included studies did address diverse sub-populations of women and men or girls and boys, including: African American male adolescents, Hispanic youth, adolescent mothers and couples, women with learning disabilities, low income single African American mothers, as well as media campaigns with African Americans or within rural contexts. The range of diversity in these studies may reflect efforts to prevent DV among vulnerable sub-populations.

The contextual literature recommends the development of further tailored, community based approaches to violence prevention, along with interventions that address multiple levels of prevention. The need for longitudinal research to examine the effect of prevention programming on behaviour change has also been noted.

Q2: Identification of Domestic Violence

A total of 28 articles addressed the nature of the interventions and approaches used in health and social care settings for identifying DV, informing six evidence statements on: screening/ identification tools, screening formats, enhancing identification through additional protocols such as provider cueing, provider education that supports identification and intervention, organizational level supports for identification, and identification of violence with pregnant/ postpartum women.

Summary of findings

Moderate evidence revealed that the length of the tool used, the types of questions asked (e.g. frequency of abuse vs. yes/ no question) and screening tool used (tools captured by these studies include: WAST, CAS2, PVS, HITS) resulted in differences in identification (rates, types of violence and groups identified). However, the screening tools that were compared varied greatly between studies, so it is not possible to determine which particular tool or tools are most effective.

Moderate evidence also suggests that screening format (computer-assisted, face-to-face, self-report) impacts the disclosure of IPV, forms of violence reported, or may improve awareness of abuse. Again, it is not possible to determine which specific format is most effective due to variability between studies in the formats being compared. However, some moderately rated studies reported that women were more likely to disclose IPV in a self-report compared to a face-to-face format, while one poorly rated study reported the opposite.

Cueing refers to providing information about a patient prior to a clinical encounter that will "cue" or propel the provider to investigate issues of DV. There is moderate evidence that cueing improves discussion of, disclosure of and referrals or services provided for DV among some populations; all studies reported improvements in rates of identification and disclosure, with some differences noted between samples being compared (e.g. urban versus suburban participants).

The evidence on the effectiveness of provider education interventions for improving screening practices or clinical enquiry is inconsistent. Interventions were typically aimed at increasing health care providers' ability to raise the issue, screen for or detect DV among their patients. Some studies reported an increase in awareness, screening and documentation of DV; in other studies, improvements were modest or limited.

There is weak evidence that the implementation of policy or organizational changes to screening for DV improves screening rates, referral rates and/or provider comfort with and ability to screen. Only two studies examined this form of intervention, although both reported improvements in screening practices following the implementation of new procedures.

There is moderate evidence that universal screening or routine enquiry for DV in pregnancy, when supported by staff training and organizational support, improves screening practices and documentation of DV. Studies reported modest to substantial improvements screening rates in clinical settings, and improvements in women's privacy during screening and documentation of abuse during home visitation.

Discussion

Overall, the majority of studies were before and after studies and lacked follow-up. The majority of studies also focused on abuse of women by a male partner. Very few studies examined the impact of identification interventions or approaches for diverse sub-populations of women or screening for: perpetrators, children who witness violence, 'honour' based violence, and elders. The majority of studies also focused on the identification of DV in emergency department, antenatal care, or primary care settings. There is a lack of research examining the identification of DV in social care settings, or evaluating integrated approaches to identification across various health and social care settings.

While interventions and approaches examined do reveal some modest improvements in rates of identification or practices and knowledge related to the identification of DV, there appear to be significant challenges in achieving identification, referral and support goals. Although few studies examined interventions beyond the point of identification, some studies reported low rates of follow-up with women who had been identified as at risk. Further research is required to examine and address the barriers providers face in identifying and responding to DV. Furthermore, interventions are required that include a post-identification intervention and that measure health outcomes for participants. However, screening and routine enquiry interventions during pregnancy and postpartum appear to result in greater improvements in providers' inquiry or screening for DV, perhaps related to the relatively sustained and ongoing nature of the patient-provider relationship during pregnancy/ postpartum.

Q3: Responses to Domestic Violence

A total of 76 articles were identified on interventions and approaches used in health and social care settings for responding to violence among victims (33) (other than elders and couples, which are reported in the following section), perpetrators of violence (33), elders (3) and couples (7), informing 12 evidence statements on: advocacy interventions, skill-building interventions, counselling and brief interventions, and therapy interventions for victims; and individual interventions for abusers, short duration (16 weeks or less) group interventions measuring recidivism/ abuse outcomes, short duration group interventions measuring attitudinal, psychological and interpersonal outcomes, long duration (over 16 weeks) group interventions measuring recidivism/ abuse outcomes, long duration group interventions measuring attitudinal, interpersonal and psychological outcomes; couple interventions including substance use treatment and couples interventions not including substance use treatment; and interventions addressing elder abuse.

Summary of findings

Interventions for Victims of Domestic Violence

Advocacy interventions are those that inform, guide and help victims of DV to access a range of services and supports, and ensure their rights and entitlements are achieved. There is moderate evidence that advocacy services may improve women's access to community resources, reduce rates of IPV, improve safety, decrease depression, reduce various stressors, and improve parenting stress and children's well-being. While the majority of studies received a moderate quality rating, all studies reported improvements for women, suggesting that this may be a promising approach for responding to DV. Additional evidence for advocacy approaches will be included in the partnership section.

There is moderate evidence that skill building (teaching, training, experiential or group learning) on a range of topics with victims of partner violence has positive effects on victims' coping, well-being, decision-making abilities, safety and reduction of coercive and violent behaviour. While all studies reported improvements, interventions varied widely focusing on building skills such as: coping skills, safety planning and conflict resolution skills, knowledge of reproductive coercion and harm reduction in a reproductive context, decision-making and danger-assessment skills, economic education, and sleep training.

Counselling/ brief interventions promote a range of outcomes, such as reducing depression and increasing empowerment among those who have experienced DV, through interventions based on brief educational, cognitive-behavioural, and motivational interviewing approaches. There is moderate evidence that counselling interventions may improve: PTSD symptoms, depression, anxiety, self-esteem, stress management, independence, support, re-occurrence of violence, birth outcomes for pregnant women, motivational level, readiness to change, and/ or forgiveness. Diverse groups of women were included in these studies, such as: pregnant African American women, pregnant and postpartum women, women in shelters, Hispanic immigrant women and rural women. While the majority of interventions reported improvements on the various outcomes measured, some reported only modest improvements or improvements on some but not all measures.

Therapeutic interventions promote improvement in mental health impacts of violence, through more intensive treatments than counselling interventions such as group therapy. There is moderate evidence that therapy interventions may be effective for improving various PTSD symptoms, depression, trauma symptoms, psychological and social outcomes, parenting/ family-related outcomes and in some cases may reduce likelihood of future IPV or re-abuse. Several studies were conducted with low-income women, and the majority of women captured in these interventions were Caucasian. All studies reported improvements on the various outcomes measured; some studies that compared interventions reported differences in the type and level of effect.

Interventions for Perpetrators of Domestic Violence

For interventions for batterers, several studies included female batterers/ abusers, although the majority addressed interventions for male batterers. Studies varied in whether participants were court mandated, non-mandated, or both.

There is moderate evidence that individual interventions for abusers may improve: aggressive feelings towards partner, attitudinal change, understandings of violence and accountability, or short-term help seeking. Some interventions also reported improvements in violent behaviours or recidivism, while others demonstrated no effect. The types of individual interventions employed varied, including: case management, an individual level intervention combined with community outreach services, solution focused therapy, educational interventions, and motivational interviewing. Overall, interventions appeared to have a greater effect on attitudinal outcomes than recidivism/ violence outcomes (which, when measured improved in some but not all studies).

Short duration group approaches (16 weeks or less) included: family of origin group therapy, a solution and goal focused group treatment programme, CBT, unstructured supportive group therapy, group counselling, and group sessions based on the Duluth model. There is inconsistent evidence that these interventions reduce recidivism/ abuse outcomes. Multiple studies reported a reduction in recidivism or other abuse measures. In contrast, a few studies reported improvements in some, but not all abuse measures or no improvement at all, including a group treatment programme for female batterers and a cognitive behavioural group counselling intervention. However, there is moderate evidence that these short duration group interventions improve attitudinal, psychological and interpersonal outcomes among abusers. The majority of studies reported improvements on the various outcomes measured, although two studies examining a group treatment programme for female batterers, found improvements on some, but not all psychological measures.

Long duration approaches (over 16 weeks) included: CBT programs, psycho-educational components, abuser schema therapy, Duluth-based group therapy, and stages of change MI approach. There is inconsistent evidence regarding the effect of long duration group interventions for male abusers on recidivism or abuse outcomes. Evidence of effectiveness was inconsistent with some studies reporting a reduction in recidivism/ abuse outcomes, some reporting only temporary reductions or improvements in select measures of violence/ aggression (e.g. physical but not psychological aggression), and some studies demonstrating no impact on recidivism. The evidence of effectiveness for long duration group interventions on attitudinal, psychological and interpersonal outcomes is also inconsistent. Evidence of effectiveness was inconsistent, with most studies demonstrating improvements (on measures such as: communication, motivation to change, attitudes towards violence, conflict management skills, etc.), but some studies revealing little positive effect.

Interventions for Addressing Elder Abuse or Maltreatment

There were few studies examining elder abuse (either against elders or against caregivers), which used varying approaches and demonstrated mixed findings (related to effectiveness), and therefore evidence of effectiveness is weak.

Interventions for Couples

There is moderate evidence that behavioural couples therapy (BCT) included within substance use treatment is associated with improved abuse outcomes, and in some studies with improved substance use measures. While these show moderate effectiveness for perpetrators of violence struggling with substance use disorders, weaknesses of these approaches include a lack of grounding in a theoretical framework or acknowledgement of the gendered nature of violence. In addition, these studies were conducted with primarily White samples and therefore the effectiveness of these approaches for ethnically diverse couples and non-substance using couples has not been identified in this review. Only 3 studies examined couples interventions (which do not include treatment for substance users); these interventions were diverse in approach, samples used and outcomes measured, and therefore it is not possible to form overall conclusions on the effectiveness of couples-based approaches.

Discussion

Overall, there is a lack of research to address ‘honour’ based violence or forced marriage, and a lack of evidence on tailored approaches for diverse women and women at different levels of risk. Further research is required to address the need for a spectrum of services, and tailored and coordinated responses for those who have experienced DV. For abusers, most interventions were directed at heterosexual men who abuse their partners and no quality studies were found that evaluated family intervention responses to DV. There was also a lack of interventions delivered within or linked to the health sector.

For victims, there was moderate evidence for advocacy and various approaches to skill development, counselling and therapeutic approaches. However, many studies, particularly within the counselling/ brief intervention and therapeutic intervention approach sections, included small sample sizes. Many studies also reported high rates of attrition, and lacked follow-up beyond programme completion. Larger, more robust studies are required to determine effective approaches to responding to DV among victims.

Intervention approaches for abusers were generally quite uniform, often employing psycho-educational, broad skill development, or cognitive behavioural approaches, including the Duluth Model from the USA. However, there were variations in how programmes for abusers were implemented (setting, facilitator, duration, etc.). Larger, more robust studies and studies comparing different interventions and approaches (including those that compare varying intensities, durations, etc.) are required to respond to DV among batterers, couples and elders.

Q4: Interventions for Children Exposed to Domestic Violence

This review addressed the nature of the interventions and approaches used in health and social care settings for identifying and responding to children exposed to DV. Our review identified one systematic review article within which 25 articles were in the scope of this review, plus 13 additional articles. While the assessment method used in the review article is not precisely the same as the NICE method, the 25 articles were quality assessed for strengths and weaknesses and critically appraised by the review authors. However, the quality of these studies is reliant on what is reported by Rizo et al. (2011), and is therefore a limitation of this review.

Summary of findings

The Rizo et al. review identified four main approaches to responding to child witnesses of DV. They reported on approaches that are: counselling and therapeutic oriented; some that are crisis and outreach oriented; some that focus on parenting and the child-parent relationship, and some that are multi-component, involving more than one of the above in addition to approaches such as advocacy, social support and linkages between agencies. We reorganized all the findings, including the Rizo et al. studies, into new categories, reflecting factors such as whether or not the intervention was single or multi-component: therapy or psycho-education focused; aimed at children, or mothers and children; and recognizing the mix of aspects such as advocacy, therapy and parenting. An overview of these findings follows.

We found moderate to strong evidence that single component therapeutic interventions aimed at both mother and child are effective in improving child behaviour, mother-child attachment and stress and trauma-related symptoms in mothers and children. All studies included ethnically diverse samples of children and mothers. Intervention approaches varied, including: mother-child therapy, shelter-based parenting interventions, and play/ activity based therapies. In general, all studies reported improvements in the measured outcomes for children and their mothers. There is inconsistent evidence that single-component psycho-educational interventions aimed at mothers and children are effective in building coping skills, increasing knowledge of DV and improving children's behaviour and mothers' parenting skills. While the majority of studies reported improvements on the outcomes measured for children and mothers, in some studies improvements were not sustained at follow-up, while other studies had significant methodological weaknesses (small sample size, weak analysis, lack of information on intervention, etc.), limiting the formation of strong evidence of impact.

There is weak evidence regarding single component therapeutic interventions. Interventions varied widely, including: play therapy, expressive writing therapy, and equine assisted psychotherapy. Play therapy and equine therapy both demonstrated some improvements with diverse groups of children in behaviour, aggression and self-esteem, but there were only 3 studies in this area and these interventions are not comparable.

There is moderate evidence that single-component psycho-educational interventions (addressing skills such as: stress and conflict management, coping and relationship skills, understandings of violence, etc.) aimed at children are effective in improving children's coping skills, behaviour, emotional regulation, conflict resolution skills and knowledge about violence. While all studies reported improvements for children, these studies as a whole were moderate in quality (many lacked follow-up, included small sample sizes, etc.) limiting the formation of a strong evidence of impact.

There is moderate evidence that multi component interventions with a focus on advocacy are effective in reducing the trauma symptoms and stress in both children and families, and in improving child behaviours such as aggression. Interventions included: community-based service planning, nurse case management, and non-parental child care for disadvantaged families. Overall, these studies reported improvements in psychological and behavioural outcomes for children, with some indicating greater improvement with increased intensity. However, some studies were not very strong (lack of study details, incomplete data, etc.) and therefore only moderate evidence of impact is noted.

There is moderate evidence of effectiveness of multi component interventions including both therapy and advocacy among diverse populations of women and children, some with co occurring issues of substance use and mental health issues. All studies were conducted with ethnically diverse samples. These interventions increased knowledge and awareness about violence and safety planning, improved self-esteem and self-competence and improved interpersonal relationships. All studies reported improvements for children (with some noting variations between different age groups of children), but were moderate in quality.

There is moderate evidence of effectiveness of multi component interventions focused on therapy and parenting aimed at diverse populations of mothers and children. These interventions showed moderate improvement in children's behaviour and emotions, knowledge about violence and reductions in mothers' stress and ability to manage children. All studies reported improvements for both children and mothers, and several of the studies reviewed by Rizo were identified as rigorous. However, the majority of studies had significant methodological weaknesses, which limit the formation of strong conclusions regarding effectiveness.

Discussion

Overall, the majority of studies were before and after studies that did not have follow-up points. The diversity of the interventions and the lack of reporting of benefits specific to sub-components of multi-component interventions also make it difficult to compare and discuss the benefits of different modalities. However, in the case of single focus interventions, interventions aimed at mothers and children together appear to be more beneficial for improved outcomes for both, than for single focused interventions for children only. In addition, a number of multi-component studies reported improved outcomes for children tied to improved outcomes on the part of their mothers, confirming the benefits of a continuum oriented approach, with options for parents and children at different levels of risk, and with different preferences for support and treatment. General population interventions with children, or flexible, community based educational interventions that may reach more children and may offer broad prevention are lacking in the literature. Several grey literature reports that did not meet inclusion criteria also note the benefit of multi-system integrated interventions for children and adults (to be discussed in the following section).

Q5: Partnership Approaches to Domestic Violence

Twenty-one studies were included in the review and organized into four evidence statements: effectiveness for increasing referrals and addressing violence; interagency information sharing and policy development; enabling factors to partnership working; and barriers to partnership working. All studies received a moderate quality rating [+]. These studies included: collaborations among various service providers for handling cases of DV (including: DV agencies, child welfare,

police, mental health services), the impact of source of referral on outcomes, MARAC evaluations, evaluations of a community coordinating council, multi-agency approaches to elder abuse, a multi-agency service for gay, bisexual, transgender and heterosexual men who have experienced DV, and a partnership model to address children who witness violence.

Summary of findings

There is moderate that partnerships to address DV were effective at: increasing referrals, reducing further violence, or supporting victims of DV. The majority of studies found that partnership approaches were associated with improvements in various abuse-related measures including: family conflict, risk of mistreatment for elders, re-victimization or threat of violence, response to and safety for victims, and referrals to support services. However, one study found that a multi-agency approach was not effective in meeting the needs of vulnerable adults.

There is also moderate evidence that partnership approaches have been effective in improving relationships, practices and policies of partner agencies to address DV. Findings from these studies were typically based on stakeholder reports, revealing improvements in: relationships and collaboration between partners, training, knowledge and sharing of information and resources, the development of policies and protocols, involvement of key agencies/ stakeholders.

There is moderate evidence regarding both enabling factors and barriers to partnership working. These studies examined member/ stakeholder responses to identify factors associated with the perceived success of the partnership. Studies identified the following enabling factors as key to partnership working: strong leadership, management and coordination, active membership, community involvement, strong relationships and communication, training and resources, are associated with effective partnership working. However, the following barriers were reported: lack of resources (financial and human), differences in the culture of agencies/ organizations, leadership and management issues, lack of commitment, limited monitoring, and addressing diverse populations. Issues related to the inconsistent following of protocols or guidelines, and confidentiality issues among multi-disciplinary case review teams were commonly cited challenges. The lack of diverse representation in partnerships, and challenges in addressing DV among specific vulnerable groups including LGBT, Black and Minority Ethnic (BME) groups and women who experience sexual abuse was also noted in several studies.

Discussion

Overall, there were no high quality studies, and the majority of studies that were included were before or after or qualitative studies providing narrative reports of findings. There was a lack of research addressing ‘honour’-based violence, approaches for diverse sub-groups of women and men, or integrated DV and substance use services. However, many studies were conducted in the UK (nine out of twenty), so applicability of the available evidence is relatively high.

2. Background

Prevalence and Effects of Domestic Violence

Statistics from the 2009/ 2010 Home Office Statistical Bulletin reveals that 29.4%, or 4.8 million women in the UK (England and Wales) between the ages of 16 and 59 have been victims of DV (Flatley, Kershaw, Smith, Chaplin, & Moon, 2010). While DV is clearly gendered, with girls and women as the majority of targets, men are also victims. Findings from the same report reveal that 15.8%, or approximately 2.6 million men in the UK between the ages of 16 and 59 have been the victims of DV. Calculated within the last year, 7.5% of women (approximately 1, 207, 000 women) and 4.2% of men (approximately 677, 000 men) have experienced DV. However, women are more likely to have experienced physical injuries from abuse and repeated incidences of abuse. Single mothers, separated women, women living on a low income, and women with an illness or disability are at a greater risk to be victims of DV in the UK (Stanley, 2011). Multiple studies have also found that DV is often linked with, or occurs in a context, of alcohol use or substance abuse (Guille, 2004).

DV is associated with many health issues, including mental health issues, alcohol and substance use issues, trauma, unwanted pregnancy and sexual health issues (Taskforce on the health aspects of violence against women and children, 2010). A 2006 report from the UK Department of Health (Itzin, 2006) collected evidence on health effects of DV, including: evidence from one meta-analysis which revealed that 64% of women who experienced DV reported symptoms of post-traumatic stress disorder, 48% reported depression, and 18% had committed suicide. Another meta-analysis revealed that there is a higher risk of experiencing partner violence among women with mental disorders including depression and anxiety disorders, compared to women without mental disorders (Trevillion, Agnew-Davies, & Howard, 2011). Homelessness has also been found to be associated with DV, particularly for mothers and children who are leaving an abusive home (Stanley, 2011). Women who have separated from an abusive partner may also be at an increased risk of abuse during separation and in the context of contact with an ex-partner.

Connected to intimate partner violence, is the issue of children's exposure to DV. The second national survey conducted by the National Society for the Prevention of Cruelty to Children (NSPCC) on child maltreatment revealed that the rates for children or young people in the UK who had witnessed at least one incidence of violence in the past year was 3.3% for children under the age of 11, 2.9% for 11-17 year olds, and 12% for 18-24 year olds (Radford et al., 2011). Rates reported for witnessing at least one incidence of DV during the course of childhood were greater yet, with 12% reported by children under 11, 18.4% for young people 11-17 year olds and 24.8% for 18-24 year olds. This survey also revealed that children's exposure to DV was much higher for all age groups of children than direct forms of maltreatment or abuse. In the majority of cases where a child or young person had witnessed a parent physically abusing another parent, men were most often (96%) the perpetrators of violence. These statistics are similar to those reported from a study in Great Britain, which revealed that 4.3% of a 7, 865 sample of children had been exposed to DV (Meltzer, Doos, Vostanis, Ford, & Goodman, 2009). Findings from the British Crime Survey reveals that children exposed to violence may experience repeated exposure to violent incidents, as DV is the most commonly repeated crime reported in England and Wales (Walker & Smith, 2009).

Other forms of DV are also a significant issue within the UK. 'Honour' based violence includes acts of domestic abuse, forced marriage or 'honour' killings against those who are perceived to have brought shame or dishonour to their family or themselves (Home Office, 2012). Incidents of forced marriage in the UK reported by local and key national organizations are estimated at 5,000- 8,000 cases per year (96% female victims; 4% male victims) (Kazimirski et al., 2009). A total of 97% of these cases were reported from Asian immigrants in the UK. However, this estimate does not fully capture all victims, since many cases go unreported. Rates for other forms of 'honour' based violence are less available, due in part to the hidden and often unreported

nature of these crimes. Reports from the Home Office suggest there are approximately 12 'honour' killings annually, but the reality is likely much higher (Home Office, 2012). Forced marriage and 'honour' based violence may include acts of physical, psychological and emotional abuse, kidnapping or isolation, and can be fatal.

Abuse of elders or older adults by family members, also included in this review, affects a considerable number of UK residents. Findings from the 2009/ 2010 Home Office Statistical Bulletin found prevalence rates regarding mistreatment (including physical, emotional, financial or sexual abuse, as well as neglect) by a family member, friend or care worker within the past year in the UK to be: Northern Ireland (2%), England (2.6%), Scotland (3%) and Wales (3.1%) (O'Keefe et al., 2007). This study, similar to other international studies revealed that women were more likely than men to report experiences of maltreatment in the previous 12 months, and that people aged 70 and above report higher levels of abuse than those in the 65–69 age group (O'Keefe, et al., 2007). They also found that the prevalence of maltreatment increased with declining health status and the level of maltreatment was higher for people with a limiting long-term illness, a lower quality of life, and for those suffering from depression.

Clearly DV is a serious concern and interventions that adequately address DV are required. Interventions are needed that address the prevention, identification, and response to DV, as well as those that address children's exposure to DV and that include partnerships to address this complex issue. This report covers each of these five key areas for addressing DV.

3. Methods

The review was conducted in accordance with the second edition of *Methods for the development of NICE public health guidance* (National Institute for Health and Clinical Excellence, 2009) The following sections set out the methods used for searching, screening, and subsequent stages of the review process.

3.1. Searching

3.1.1. Database Searching

The following databases were searched from 2000 to May 2012:

1) AMED (Allied and Complementary Medicine)
2) British Nursing Index
3) Campbell Library
4) CINAHL (Cumulative Index of Nursing and Allied Health Literature)
5) Cochrane Central Register of Controlled Trials
6) Cochrane Database of Systematic Reviews
7) DARE (Database of Abstracts of Reviews of Effectiveness)
8) EMBASE
9) EPPI Centre Database
10) ERIC (Education Resources Information Centre)
11) HMIC
12) MEDLINE
13) UK Clinical Research Network
14) PsycINFO
15) Social Policy and Practice
16) Social Science Citation Index
17) Contemporary Women's Issues
18) Family & Society Studies Worldwide
19) LGBT Life
20) Social Work Abstracts
21) Studies on Women & Gender Abstracts
22) Violence and Abuse Abstracts
23) Women's Studies International
24) OpenGrey Repository

The full search strategies are set out in *Appendix A*. Once the searches were completed, references were imported into Endnote; 51,586 records were successfully imported. These references were then de-duplicated. At this point the records were screened using the methods and tools described below. Note that several databases (ASSIA, Sociological Abstracts, Social Services Abstracts) originally proposed in the protocol were not searched due to technical issues encountered with the Proquest Database.

3.1.2. Grey Literature: Web Searching

The following websites were searched manually for relevant grey literature materials:

1) NICE, including former Health Development Agency
2) NHS Evidence
3) Centre for Research on Violence against Women & Children (Canada)
4) Ending Violence Association of BC (Canada)
5) Canadian Research Institute for the Advancement of Women
6) FREDA
7) United Nations Entity for Gender Equality and the Empowerment of Women
8) Queensland Centre for Domestic and Family Violence Research
9) Domestic Violence Resource Centre Victoria, Australia
10) Australian Domestic & Family Violence Clearinghouse
11) National Centre on Domestic and Sexual Violence (US)
12) National Resource Centre on Domestic Violence (US)
13) National Network to End Domestic Violence (US)
14) National Online Resource Centre on Violence Against Women (US)
15) National Centre on Domestic Violence, Trauma and Mental Health (US)
16) Futures Without Violence (US)
17) Institute on Domestic Violence in the African American Community (US)
18) Courage Network (US)
19) Daphne II Programme (Europe)
20) Convention on Preventing and Combating Violence against Women and Domestic Violence (Europe)
21) World Health Organization
22) Clearinghouse on abuse and neglect of the elderly
23) Child and women abuse studies
24) Gender Violence and Health Centre
25) Violence prevention
26) Coordinated Community Response Model Online Toolkit
27) Action for Children
28) Africa Advocacy Foundation (AAF)
29) Against Violence & Abuse (AVA)
30) Age UK
31) Alcohol Concern
32) ASPECT
33) Association for Family Therapy and Systemic Practice in the UK
34) Barnardos
35) Blackpool Council Domestic Abuse Team
36) British Association for Adoption and Fostering
37) CARE
38) Care Quality Commission
39) Catch 22
40) Cheshire West & Chester Domestic Abuse Partnership
41) Addaction
42) Adfam
43) Department for Education
44) Department of Health
45) Domestic Violence Intervention Project
46) Domestic Violence Training Ltd
47) Drinksense
48) Economic and social research council
49) Faculty of Public Health
50) Family Action
51) Family Lives
52) Forward
53) FPA
54) Girlguiding UK
55) Hindu Forum of Britain
56) Home Office
57) Home-Start UK
58) London Development Centre for Mental Health
59) Men's Health Forum
60) Mozaic Women's Wellbeing Project
61) National Children's Bureau
62) National Federation of Women's Institutes
63) National LGB&T Partnership
64) National Treatment Agency for Substance Misuse
65) NORCAS
66) Northern Rock Foundation
67) NSPCC
68) PACE
69) Parents First
70) Primary Care Child Safeguarding Forum
71) Refuge
72) Respect
73) Restored
74) Savera
75) Social Care Institute for Excellence
76) Social Justice Foundation
77) Soroptimist International Great Britain & Ireland
78) South Asian Health Foundation
79) Standing Together Against Domestic Violence

80) Stonewall
81) TAMHS
82) The Albert Kennedy Trust
83) The Alcohol & Drug Service
84) The ManKind Initiative
85) The NIHR Evaluation, Trials and Studies Coordinating Centre
86) The Survivors Trust
87) Victim Support
88) WAVE Trust
89) White Ribbon Campaign
90) Wolverhampton DV Forum
91) Women's Aid Federation of England
92) Women's health and equality consortium

3.1.3. Additional Sources

Several additional sources were utilised to locate data:

1) The citation lists of all included studies were scanned;
2) A collective virtual inquiry process was conducted, inviting Programme Development Group (PDG) members to provide key documents, and if there was sufficient interest meet virtually with British Columbia Centre of Excellence for Women's Health (BCCEWH) staff to provide and discuss key literature.
3) As part of the guidance development process, a call for evidence was issued by NICE.

References arising from all these sources were screened manually.

3.2. Inclusion Criteria

The following inclusion criteria were applied:

1) Does the study address one/ more of the following populations:
   - Adults and young people/ teenagers in current or former intimate relationships who are experiencing or have experienced domestic violence;
   - Abuse of elders (65 years or older) or other adults by family members;
   - Those who have been the victim of, or perpetrator/ s of honour based violence or killings;
   - Adults or children at risk of or experiencing forced marriage;
   - Those who are perpetrating domestic violence;
   - Children who are exposed to domestic violence (i.e. The violence is not perpetrated on them directly, but they witness or experience it);
   - The general population;

2) Does the study evaluate an intervention/ approach to identify, prevent, reduce or respond to domestic violence between adults and young people who are, or have been, intimate partners, or the abuse of older people by a family member;

3) Does the study focus on the following settings: health-care, social care and specialized domestic violence service settings;

4) Was the study conducted in one of the following OECD countries: Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom, United States;

5) Was the study published in 2000 or later;

6) Was the study published in English;

7) Is the study a randomised controlled trials (RCT); a case-control study; interrupted time series; cohort study; cross sectional study; observational study; systematic review, or qualitative study (not already covered in an included systematic review)?

For the first criterion, studies that only address the following groups were outside the scope of the review: children who are the victims of direct DV and perpetrators whose violence is directed at children; victims and perpetrators of female genital mutilation; violence perpetrated against older vulnerable persons by paid caregivers; and violence enacted in occupational settings.

Studies that did not evaluate the effectiveness of an intervention of approach to prevent, identify, reduce or respond to violence were not included in the review. However, some of these studies (theoretical papers, prevalence studies, programme overviews, etc.) provide contextual material for the reviews and are covered in the background section of each chapter. For qualitative studies, only those studies that provided qualitative evaluations of interventions (e.g. thoughts and experiences of a particular intervention/ approach) were included. A table of grey literature reports from the UK that did not meet inclusion criteria, but provided contextual material for the report is provided in *Appendix B.*

Interventions involving the activities of the police, criminal justice, education, early years and services for young people that are not linked with health and social care were also outside of the scope of the review, and were therefore excluded.

Studies from non-OECD countries (low- and middle-income countries) and select OECD countries were excluded because of the likely difficulty in generalising the findings from such studies to the UK context. We chose to focus on recent data in the field, and therefore limited the search to studies published between 2000- 2012.

Systematic reviews that included any of the study types listed above were collected and the individual studies covered by these reviews were excluded from this review; a high level summary of reviews is provided prior to the main report of findings. Note that Q4 (Interventions for Children who are Exposed to Domestic Violence) was the first sub-section reviewed and the protocol was somewhat different; findings from one systematic review were included in the main report of findings, but the individual studies covered by the review were not individually reviewed/ rated. Correlational studies were also excluded from the review.

3.3. Screening

All references from the database searches were uploaded into Endnote and initially screened on title and abstract against the criteria above (a copy of the screening checklist tool is available in *Appendix C*). Data were organized in Excel spreadsheets to keep a record of screening decisions, to support reconciliation for double screening, and to provide the data for calculating inter-rater reliability.

A randomly selected initial sample of 10% of records (n=514) was screened by three reviewers independently. The rate of agreement for this sample was 83%. These figures were deemed satisfactory by both NICE and the BCCEWH, and remaining references were screened by one reviewer only. When possible to ascertain from the abstract, papers were sorted into one or more of the five research questions. Where there was uncertainty about the relevance of a research report from the abstract, the full text was retrieved and reviewed.

Where abstracts met all the criteria, or if it was unclear from the study abstract whether it did, or if no abstract was available, the full text was retrieved and screened. Full-text screening was again carried out by two reviewers independently for a randomly selected initial sample of ~10% of records (n=106). The rate of agreement for this sample was 88%. These figures were deemed satisfactory by both NICE and the BCCEWH, and remaining references were screened by one

reviewer only. Reasons for exclusion for all papers screened at the full paper stage are provided in *Appendix D*.

3.4. Quality Assessment and Data Extraction

All studies included on full text were quality-assessed and data were extracted using the appropriate standard forms in NICE's methods manual for public health reviews. A randomly chosen sample of 10% was independently coded by two reviewers; the remaining references were coded by one reviewer and fully checked by a second. Study quality was summarised using the codes [++] (high quality), [+] (medium quality) and [-] (low quality). Qualitative studies received a single quality rating. Quantitative effectiveness studies received a rating for internal validity and one for external validity; the rating for internal validity is the quality score presented in the evidence statements. A copy of the quality appraisal checklist tool is available in *Appendix E*.

Note that Q4 (Children who are exposed to DV) and question 2 (Identification of DV) were the first sections reviewed, and a slightly different inclusion protocol based on study rating was applied compared to the other review sections. In Q4, poorly rated studies were included in the findings of the report. In Q2, only studies that received both a [-] internal and [-] external rating were excluded. However, in all other sections quantitative studies receiving a [-] internal quality rating, and qualitative studies with overall [-] ratings were excluded. A full list of studies excluded due to quality ratings are provided in *Appendix F*.

3.5. Data Synthesis

Studies were synthesized narratively and evidence statements developed as outlined in the guidelines in the NICE public health methods manual (2009). In addition, potential sex, gender and diversity based issues will be noted in the discussion section.

3.6. Summary of Included Studies

3.6.1. Flow of literature through the review

We located 51,586 references through database searches, of which 29,375 were duplicates. 20,597 references were excluded based on title screening and 3,582 were excluded based on initial abstract screening. Following discussion with NICE staff, we developed additional exclusion criteria (excluding correlational studies and studies conducted in: Chile, Czech Republic, Estonia, Hungary, Israel, Japan, Korea, Mexico, Poland, Slovak Republic, Slovenia and Turkey). A second abstract screening was conducted applying this exclusion criterion, leading to a total number of 4,237 papers excluded based on abstract screening.

At the full text screening stage, the 899 included references were sorted into one or more of the 5 research questions. A total of 125 papers were identified for Q1; 188 papers were identified for Q2; 402 papers were identified for Q3; 69 papers were identified for Q4; and 115 papers were identified for Q5. Full paper screening was then conducted for each review section, resulting in a further reduction in the number of studies included and reported on. The breakdown of studies for each section is provided within each review chapter, prior to the summary of systematic reviews and report of main findings.

4. Research Question 1: Effectiveness Review of Interventions for Preventing Domestic Violence

4.1. Background

The first section of the review focuses on the types of interventions or approaches effective in helping all those working in health and social care to prevent DV. While the scope of this question is specifically on primary prevention of DV, or preventing violence before it ever occurs, sometimes in the academic literature, primary and secondary prevention approaches are combined. Therefore we will begin by briefly defining and discussing the varying levels of interventions, and then discuss some of the key considerations, challenges and recommendations for preventive work.

Levels of prevention have been based on either the time point that the intervention is implemented relative to the experience of violence (primary, secondary, tertiary); or the population that is being targeted (universal, selective and indicated), although these terms are often used interchangeably (Chamberlain, 2008). Primary prevention involves intervening before DV has occurred; examples include school based or educational campaigns (Guterman, 2004). Secondary prevention involves identifying and intervening with those who are at risk of DV; examples include prevention interventions with young pregnant women or home visitation for families at high risk of violence. Tertiary prevention involves intervening after violence is clearly identified and causing harm; examples include treatment services for victims and batterers. Universal programs are aimed at whole populations; selective or targeted programs are aimed at a subgroup of the population that is deemed at risk; and indicated prevention is aimed at those demonstrating initial signs of at-risk behaviours (Cavanaugh, Solomon, & Gelles, 2011).

Universal or primary prevention programs, due to the fact that they are aimed at a larger audience have the potential for greater impact; however, targeted or secondary prevention programming may hold more promise in supporting those who are most vulnerable to abuse and have the most to benefit from a prevention intervention (Hamby, 2006). Targeted programs typically require more resources and specialized providers, compared to universal programs that utilize existing personnel (for example, teaches often provide school based prevention programming).

The majority of programme evaluations have tended to focus on the microsocial level (individuals or couples), while less research has examined macrosocial (societal) or mesosocial (institutional; community) levels of prevention (Godenzi & De Puy, 2001; Hamby, 2006). Prevention programs also differ in whether they are aimed at increasing protective factors (e.g. conflict management skills) or reducing risk factors (e.g. teaching youth to avoid controlling or jealous relationships) (Hamby, 2006). Hamby argues that research is required to compare these various levels and foci of interventions to determine the circumstances associated with the success of each approach.

Prevention programs tend to be psycho-educational in nature, providing education on attitudes towards violence and positive alternatives to violence. Primary prevention programs are most often offered to young people, often in school settings and attitudinal change is generally a key target of public education campaigns. Flood and Pease discuss the importance of attitudes as a key target of media and community-based educational prevention campaigns, and the importance in understanding the various social, cultural and institutional factors that shape attitudes associated with violence against women. In particular, issues such as experience of trauma and gender roles require special attention when addressing partner violence, and therefore may warrant specialized programming (Flood & Pease, 2009).

A report from the Virginia Sexual and Domestic Violence Action Alliance provides guidelines for the development of primary prevention strategies (Virginia Sexual & Domestic Violence Action Alliance, 2008). They claim that prevention strategies should: address protective

factors, be comprehensive, be sustainable and expandable, use various teaching methods to address multiple processes for learning, have a theoretical bases, be tailored to the developmental level of the audience, be community based and culturally sensitive, and include a systematic method for evaluation of effectiveness.

4.2. Summary of the Literature

A total of 125 full-text study reports were retrieved. An additional 23 reports relevant to Q1 were collected through the grey literature search (a breakdown is provided in the flow-charts in *Appendix G*), including: web-searches and the OpenGrey database.

A total of 148 reports were retrieved for full text review. Of these, 128 papers were excluded at the full text screening stage. We were unable to locate one paper and therefore it was excluded (see *Appendix H* for all papers that were unable to be located during the review). Two systematic reviews (which included one relevant individual paper that was then excluded from our main report of findings) were located. A high level summary of these reviews is provided. Two studies received a [-] internal quality rating and are not included in the report of findings, but are listed in *Appendix F*. A total of 14 studies are included and reported on in this review. A summary of the studies included in the review is listed in *Appendix I.*

4.2.1. Systematic Reviews

Two systematic reviews were identified. *Appendix J* lists the reviews that were assessed. A summary of these reviews is provided prior to the reporting of findings.

We compared the studies retrieved using our search criteria, with the studies covered by the above two reviews, and excluded one relevant study that was assessed.

4.2.2. Included Studies

The results of quality assessment are presented in *Appendix K*. Of the studies reviewed, for internal validity, one was judged to be of high quality [++], and 13 of medium quality [+]. For external validity, 10 studies were judged to be of medium quality [+] and one of low quality [-], while three were qualitative studies and did not receive an external validity rating

Applicability

Two studies were conducted in Scotland; and twelve studies were conducted in the USA. Potential applicability issues that pertain to specific studies are discussed within the findings of the report and provided in the evidence statements. The main source of potential barriers to applicability is the sample population included, or methodological limitations that impact generalisability.

4.3. Summary of Systematic Reviews

Intimate Partner Violence Intervention Programs

IPV is a serious public health concern, with high incidence rates and significant costs to the healthcare system and the economy (Murray & Graybeal, 2007; Whitaker et al., 2006). In an effort to stop IPV from even occurring, some intervention programs focus on primary prevention. Although there is still little data on these programs, two systematic reviews have analysed the available literature: Whitaker et al. (2006) reviewed the effectiveness of primary prevention IPV interventions for adolescents, and Murray and Graybeal (2007) examined methodological strengths and weaknesses in IPV prevention research.

Selection Criteria

Three selection criteria are shared by the two reviews (Murray & Graybeal, 2007; Whitaker et al., 2006). 1) Studies must be explicitly related to IPV prevention. Murray and Graybeal included studies on preventative intervention at the primary, secondary, and tertiary levels;

however, Whitaker and colleagues only looked at primary prevention interventions. (Primary targets the general population and includes efforts to change social norms, secondary involves early detection of IPV, and tertiary initiatives attempt to prevent disability or death due to violence). 2) Studies must be published in a peer-reviewed journal (or book chapter or government report for Whitaker et al). 3) Studies must be published after 1990 (Whitaker et al. restricted their search to studies published in English between 1990 and March 2003).

In addition, Murray and Graybeal (2007) also selected studies that describe and evaluate preventative interventions demonstrating an empirical basis. In total they identified nine studies. Whitaker and colleagues (2006) specified two additional criteria: interventions must use a pre/ post design or a comparison group, and focus on adolescent dating violence prevention programs. They identified 11 studies.

Despite the different focus of each systematic review, both selected six common studies: Avery-Leaf, Cascardi, O'Leary, & Cano (1997); Foshee, Bauman, Arriago, Helms, Koch, & Linkder (1998); Jaffe, Suderman, Reitzel, & Kilip (1992); Lavoie, Vezina, Piche, & Boivin (1995); MacGowan (1997); and Weisz & Black (2001).

Study Findings

Murray and Graybeal (2007) concluded that there is a need for more methodologically sound research, and that little attention has been paid to the empirical research in IPV prevention. They arrived at this conclusion after subjecting all nine studies to a set of standardized evaluation rating criteria they developed (adapted from Heneghan et al., 1996). Their 15-item questionnaire evaluated the most significant methodological characteristics of each study, and was divided into four sections: 1) sampling and group assignment procedures; 2) treatment and control group conditions; 3) measurement procedures; 4) statistical analyses and follow-up assessment. A study received one point for each affirmative answer for a final score out of 15. Studies with scores of at least 70% were classified as "acceptable," those with scores between 40-69% were "adequate," scores below 40% were "unacceptable". Of the nine studies, the results showed: one study was acceptable (McFarlane, Soeken, & Wiist, 2000); three were adequate (Foshee et al., 1998; MacGowan, 1997; Weisz & Black, 2001); and five were unacceptable (Avery-Leaf et al., 1997; Jaffe et al., 1992; Lavoie et al., 1995; Matthews, 2000; Rynerson & Fishel, 1993).

Whitaker and colleagues (2006) explained it is too early to make strong conclusions about the efficacy of adolescent dating violence prevention programs. Early results are promising, but more data is required. They found that 9 out of the 11 studies they examined showed at least one positive intervention effect in knowledge, attitude or behaviour. Overall, Whitaker and colleagues reported positive attitude change in five studies:

1) Avery-Leaf et al. (1997) showed a positive attitude change in the justification of IPV. This study was conducted in school classrooms and the intervention consisted of five sessions during one school week based on courtship aggression as a multi-determined phenomenon. The curriculum focused on attitude change and skill enhancement to promote equity in dating relationships.
2) Foshee et al. (2004) (see below) found positive attitude changes in regard to dating violence norms, communication skills, and responses to anger.
3) Lavoie et al. (1995) measured 17 items on attitudes toward dating violence. The intervention occurred in schools in either a short version (2-2.5 hours) or a long one (4-5 hours) and focused on control over one's environment and other people, identified different forms of control, examined violence, respect, and responsibility in relationships.
4) MacGowan (1997) reported a positive effect from a composite scale score that reflected knowledge about relationship violence, attitudes about nonphysical and physical/ sexual violence, and attitudes related to dealing with dating violence. The intervention took place in classrooms for 5 hours over 5 days and was based on evidence that attitudes of control, possessiveness, and jealousy are linked to violent behaviour in relationships.
5) Weisz and Black (2001) found positive change based a 25-item scale derived from a rape attitude scale, a youth dating violence survey and a teen life relationship questionnaire. Interventions took place in school classrooms for 18 hours, over a 6-

12-week period. The programme goals were to increase knowledge about sexual assault and dating violence and community resources, increasing intolerance for sexual assault and dating violence, and increasing behaviour appropriate to prevent sexual assault and dating violence.

Whitaker and colleagues found no positive effect in attitude in three studies:

1) Hilton et al. (1998) held the intervention in school classrooms and large group assemblies with the purpose of increasing knowledge rather than change attitudes.
2) Jones (1991) conducted the intervention in school classrooms over 5-6 days. The intervention, based on feminist theory, consisted of training teachers to implement the Skills for Violence-Free Relationships curriculum that focused on defining abuse, dispelling myths about abuse, providing information about why battering occurs, offering and information and skills to reduce the likelihood of abuse.
3) Pacifici et al. (2001) found null results from a sexual attitude survey. The intervention was held school classrooms and lasted 6.7 hours. It focused on increasing awareness of sexual coercion, exploring the underlying thoughts, attitudes, and beliefs on sexual coercion, and building positive social skills to handle expectations and refusal about sex.

Finally, Whitaker and colleagues reported that Jaffe et al. (1992) indicated attitudinal changes in the non-desired direction for boys at the 6-week interview. These results came from a 48-item scale assessing attitudes and knowledge about wife assault, sex roles, and dating violence. The intervention took place in the school classroom and auditorium, where one group received half-day intervention, and the other full-day intervention. The methodology was based on feminist and social learning theory and speakers from the community and police department discussed wife assault, following which students formed a school action plan to generate ideas for violence awareness and fundraising.

Behavioural change was looked at by four studies selected by Whitaker et al., and two – Foshee et al., (2004) and Wolfe et al., (2003) – as indicated in detail below, showed a positive intervention effect, while Avery-Leaf et al., (1997) and Hilton et al., (1998) showed a null effect.

Strengths and Weaknesses of the Existing Research

Whitaker and colleagues found two-thirds of the studies to be of low quality, exemplified by lack of behavioural measures, short follow-up periods, low or unreported retention rates, and little attention to fidelity. These observations were echoed by Murray and Graybeal (2007), who maintained that common methodological challenges in IPV prevention research are measurement issues, a lack of long-term follow-up, and validity issues (such as attrition).

Both author groups agreed that that although the majority of demonstrated positive intervention effects are “knowledge” or “attitude,” these indicators are easier to change than behaviour. It is unclear whether change in knowledge or attitude leads to behavioural change (Murray & Graybeal, 2007; Whitaker et al., 2006).

Finally, Whitaker and colleagues explained that the variability between studies should prevent broad conclusions about the efficacy of these intervention programs from being made. They found that although all the studies except for one (Wolfe et al., 2003) were offered on school premises and grounded in feminist and social cognitive theory, there were considerable differences in the duration of the programs and the rigor of the approaches. Nevertheless, the two studies showing positive indicators for behavioural change were rigorously evaluated with randomized design, good fidelity, acceptable follow up periods and attrition rates, and acceptable measures (Foshee et al., 2004; Wolfe et al., 2003).

In the Foshee et al. (2004) study, a curriculum called the SafeDates programme, based on the premise that changes in norms on partner violence and gender roles can lead to primary prevention of dating violence, was offered in schools. The average age of the participants was 13.9 years, and 50% were male. The programme used strategies such as theatre productions, poster contests, and community-based activities; it also provided services to adolescents in violent relationships and community service-provider training. Classroom activities consisted of 10 45-minute sessions, although community activities were not reported, and a 45-minute

booster session randomly given by phone to half of students. Results showed a favourable effect concerning perpetration of physical violence, serious physical violence, and sexual violence at the 48-month follow up; a null effect for psychological violence; and no effect for the booster session. The Wolfe et al. Youth relationships project was offered in a group setting, with 18 2-hour sessions over four months. It targeted 14-16 year olds considered at risk for developing abusive relationships. The curriculum focused on alternatives to aggression-based interpersonal problem solving and gender-based role expectations through education and awareness, skills development, and social action. Classroom activities included presentations, guest speakers, videos, modelling, and role-playing, while the community activities included action planning, community awareness, and fundraising. At the 16-month follow up, a positive intervention effect was found in the measure for physical abuse, although there was a stronger effect for girls than boys. A positive effect was also found for trauma symptoms (from a trauma symptom checklist). Null effects were found for healthy relationships skills (based on a questionnaire measuring emotional support, negative assertion, self-disclosure, conflict management, conflict resolution) and hostility (from a symptom checklist-90). Despite the positive indicators in both these studies, there remain questions regarding their generalisability.

Recommendations

Although the two systematic reviews contained overlap in the selected studies, their diverging focuses produced different sets of recommendations. Whitaker and colleagues offered the following general recommendations:

- **Expand theory and programme development:** the reviewed programs demonstrate only a limited range of theoretical approaches, using mostly feminist theory and social learning (cognitive behavioural) theories. A wider range of theoretical positions should be considered, for instance: a "background-situational" model of courtship aggression (Riggs & O'Leary, 1989); a focus on the role of coercive interactional processes in the development of partner violence, as suggested by Wekerle and Wolfe (1999), and an understanding that power, reciprocity, and intimacy are developmentally important for adolescents (Wolfe & Feiring, 2000); or consideration of whether partner violence can be classified as adolescent risk behaviour in the same was as are fighting, delinquency, substance use, risky sexual behaviour, smoking, and school failure (Duncan, Duncan, Biglan, & Ary, 1998; Jessor & Jessor, 1977). Although these alternate models contain certain limitations, they could still provide the means for building prevention programs.
- **Culturally sensitive/ specific programs:** some data has shown a higher incidence of dating violence among racial/ ethical minorities than white adolescents (Foshee et al., 1996); specific cultural contexts should be considered in the development of prevention strategies.
- **Targeted interventions**: all 11 studies offered universal interventions, but selective interventions can target at-risk populations or environments and address their specific needs. Only Wolfe et al., (2003) employed selective interventions for those they thought had elevated risk for partner violence.
- **New settings for interventions**: ten studies were conducted in schools, but offering programs outside of schools, including in family settings, may access a broader range of adolescents and reach out to them in a different way.

Murray and Graybeal made these methodological recommendations:

- **Sampling procedures and group assignment**: more attention to participant selection and assignment of participant conditions to increase internal and external validity of findings. Only one reviewed study used representative sampling procedures; none used random assignment to groups.
- **Exclusion criteria**: increased attention to excluding inappropriate participants from a study. Screening guidelines should be set, used, and then explained in the research.
- **Assessment instrumentation**: only one study demonstrated standardized, psychometrically sound assessment instrumentation. Instrumentation should be carefully selected, ensuring it demonstrates adequate psychometric properties. Researchers are encouraged to communicate with practitioners and be aware of measurements needs in the field.

- **Multiple levels of assessment**: only three studies examined multiple levels of variables; most relied only on attitudinal measures. Researchers should examine violence perpetration and victimization experiences in addition to attitudinal variables. In addition to self-report measures, other objective forms of assessment should also be used, such as coding behaviour.
- **Scope of research:** interventions should be expanded beyond the individual level to include larger social networks, such as the organizational and community levels (see Foshee et al., 1998).

Overall Conclusions

There is still a need for more, methodologically sound research and programme development in the area of IPV prevention.

Summary Statement

Evidence regarding the efficacy of adolescent dating violence prevention programs is inconclusive. Early results are promising in demonstrating positive changes in attitudes; although the majority of studies reviewed were pre-2000 and therefore outside of the scope of our review. More methodologically sound research is required which includes behavioural measures (which may be more challenging to change than 'attitudes' or 'knowledge'), longer follow-up periods, and attention to validity and fidelity. Programs are also required that: include a diverse range of theoretical approaches, are culturally sensitive, targeted, are implemented in a range of settings, and include larger social networks.

4.4. Findings

Antle et al., 2011

A US-based before and after study by Antle et al., 2010 [+] examined the impact of a brief health relationship programme on knowledge and attitudes of healthy relationships and violence for high risk youth. The study included a total of 233 youth from socially and economically disadvantaged areas of an urban centre. The programme was developed by the Louisville Healthy Relationships Programme and implemented within a specialized programme within public schools (the Youth Opportunities Unlimited programme). Participants were 60.1% female and 39.9% male; primarily African American (73.6%); unemployed (61.9%); and with a gross family income of $30, 000 or less.

The programme, called 'Love U2: Communication Smarts,' included 7 modules which address: unhealthy and healthy relationships, and conflict management, communication and problem solving skills. An additional module focused specifically on dating violence. All modules were covered over two days and facilitated by trained staff members. Each day involved 4 hours devoted to the programme curriculum plus two hours for pre and post programme evaluation and breaks. The classes included an average of 10 youth per group. Following completion, participants received a certification of completion.

Pre-test was completed on the first day of class, prior to the programme, and post-test was conducted on the last day immediately prior to dismissal. A total of 202 participants (of the original 233) completed the post-programme assessment. Survey assessments included questions related to: learning (a multiple choice test of participant knowledge on key programme content); transfer of skill (measured communication and conflict resolution skills using the Communication Patterns Questionnaire and Conflict Resolution Styles Inventory-Partner); and attitudes toward relationship violence (assessed using the Acceptance of Couple Violence scale).

In regards to communication patterns, findings revealed a significant decrease in the demand-withdraw form of communication ($t(155)=3.59$, $p<0.0001$). The mean pre-programme score was 25.67 (SD=10.34); the mean post-programme score was 22.68 (SD=10.51). The mutual avoidance pattern of communication also decreased significantly ($t(158)=2.85$, $p<0.01$). The mean pre-programme score was 8.36 (SD=3.95); the mean post-programme score was 7.43

(SD=3.98). For conflict resolution measures, they found a significant decrease in the withdraw dynamic for conflict resolution, (t (167)=2.04, p<0.05). The mean pre-programme score was 10.00 (SD=3.89); the mean post-programme score was 9.46 (SD=3.71). A decrease in conflict engagement was also observed (t (167)=4.35, p<0.0001). The mean pre-programme score was 9.64 (SD=4.12); the mean post-programme score was 8.48 (SD=3.51). Finally, attitudes towards couple violence significantly improved (t (114)=2.04, p<0.05). The mean pre-programme score was 17.16 (SD=6.90); the mean post-programme score was 16.09 (SD=6.99).

Findings suggest that a brief educational programme on relationships and dating violence was associated with significant improvements in communication skills, conflict management skills and attitudes towards violence among at risk youth. Limitations of the study include: lack of comparison group and follow-up, potential self-report bias, and lack of gender analysis. Further research is required to examine the impact of this programme on relationship violence and relationship quality among youth. The study was conducted with low income, socially disadvantaged, primarily African American youth, and therefore may not be generalisable.

Edwardsen and Morse, 2006

A US-based cross-sectional study by Edwardsen and Morse, 2006 [+] examined the educational impact of providing partner violence resource information in an emergency department washroom. Participants included a total of 122 patients and visitors of an emergency department who were 18 years and older. Those who could not be interviewed separately or whom were Spanish speaking with no interpreter available were excluded from participating. Participants were: a mean age of 35 (women) or 34 years (men); 71% were female and 29% male. There was a 70% participation rate (122 of 175); 26 potential participants declined to participate, 6 were excluded for language barrier, and in 21 cases, an interviewer was not available. A total of 51 of participants were patients and 71 were visitors.

Information for ‘Alternatives for Battered Women’ (ABW, a woman’s advocacy agency) and ‘Men’s Education for Non-Violence’ (MEN’s, a batterer’s counselling service) was posted in a single occupancy restroom accessible to both sexes. Information included: 4”X9” ABW pamphlets, 4"X6" MEN’s pamphlets and 2"X3.5" business cards for both ABW and MEN’s. The ABW pamphlet provided information on the agency mission, hotline, shelter, counselling groups, children’s services, court advocacy, and dating violence education. The MEN’s pamphlet addressed: abusive behaviour, contact details for a counselling programme, alternatives to abusive behaviour, and self-responsibility for violence. Pamphlets and resource cards included telephone contacts for support services. Women's literature was available in Spanish and English, while the MEN’s was provided in English only.

Outcome measures included a 10-question survey developed by the authors to assess respondent awareness, knowledge and usefulness of the information presented. A total of 65 (53%) participants reported that they had noticed the cards or poster presented; 10 (8%) reported reading the materials; and 7 (6%) had retained a copy. A total of 19 (16%) respondents reported that they knew someone who could benefit from the information provided, and 9 (7%) reported that the information presented was new to them. In total, 15 ABW cards and 12 ABW pamphlets, and 13 MEN’s cards and 15 MEN’s pamphlets were taken. Women were more likely to report that they had noticed the information presented (60.9% vs. 34.3%, p=0.009). There were no other significant differences between women and men, or between patients and visitors.

Findings reveal modest indicators of exposure to DV materials, following placement in an emergency department washroom. Limitations of the study include: small sample size, lack of demographic information, non-experimental nature of the study, and lack of provision of men’s literature in Spanish. Due to the lack of demographic information, it is difficult to determine applicability.

Enriquez et al., 2010

A US-based before and after study and qualitative report by Enriquez et al., 2010 [+] examined the feasibility of an HIV and IPV prevention intervention, Women Empowering

Women (WEW), for low-income single African American mothers. In particular, they examined which of 3 programme lengths was best received by participants. The study included a total of 25 women who had child/ children attending an urban daycare centre. Participants were a mean age of 31 years, primarily African American (74%), single (87%), with a mix of education levels (23% incomplete high school; 35% completed high school; 35% some college).

Participants were asked to choose one of three start dates, unaware that each start date was linked to a different length intervention: either 4 sessions (n=10), 8 sessions (n=5) or 12 sessions (n=10). Sessions were 90 minutes in length, and were held weekly in the evenings, with childcare offered. The shorter programs covered the same content but with less time spent on each activity. The intervention was held in groups and included: a socialization period, work in small groups, and a wrap up activity of either spiritual dancing or journaling with music. Topics included: goal-setting, sexual health, reproductive health, relationship negotiation, violence against women, and IPV strategies (including: safety planning, protection from IPV, available services and supports). Final sessions provided a review of skills learned, ongoing support materials, and celebrated women's completion. The intervention focus was on: improving self-esteem, social support and readiness for healthy behaviour change. Researchers volunteered at the centre for 3 months prior to the intervention to build relationships with staff. Lay intervention facilitators were trained with 6 sessions, 2 hours in length and were supported by an on-site nurse.

Outcomes assessed included: the Medical Outcomes Study (MOS) Social Support Survey (SSS) to measure social support and positive social interaction; the Perlow Self-Esteem Scale (PSES) to examine self-esteem; the Index of Readiness Scale to measure readiness for healthy behaviour change; the Acceptance of General Dating Violence subscale from the Couple Violence Scale (CVS) to assess attitudes about IPV; and the Self-Care Index (SCI) to assess preventive and protective health related behaviours. Follow-up was conducted immediately post-intervention completion.

They found that only women who participated in the 12 session group reported significant change in social support (p=0.006), self-esteem (p=0.002), readiness for change (p=0.049), IPV attitudes (p=0.054), and protective health behaviours (p=0.004). No significant changes were found on any of the measures for the 8 and 4 session groups.

Focus groups were also conducted with 14 of the 25 participants (demographic characteristics for this sub-sample were not provided). Focus groups were transcribed and an external researcher conducted a content analysis. Details were not provided on when focus groups were held. Participants revealed that following WEW, they felt better informed and more capable to recognize and prevent sexually transmitted diseases, address IPV and improve their overall health. One woman noted: "I do not know what to do about my relationship but I know where to go if I have to get out." Women also reported an improved sense of social support: "it helped me socially because I pretty much keep to myself and am pretty quiet but now I can joke with her [another participant]." Focus group participants also provided positive reports of staff and the dancing/ music based activities. Finally, they indicated that they prefer the 12-session intervention format.

Findings reveal that the longer (12 session) but not shorter (4 or 8 session) prevention intervention improved social support, self-esteem, readiness for change, IPV attitudes and protective health behaviours among low income single African American mothers. A sub-sample of focus group participants expressed improvements in social support, IPV and health knowledge following participation, and preferred the 12-session format. Key limitations of the study include: small sample size, lack of control group, lack of follow-up, and no assessment of IPV experiences before and after the intervention. The intervention was for low-income single African American mothers and therefore will have limited applicability to other groups of women.

Enriquez et al., 2012

A US-based before and after study by Enriquez et al., 2012 [+] pilot tested the "Familias En Nuestra Escuela" programme, an intervention aimed at increasing ethnic pride, self-efficacy

for self-control and attitudes about gender and violence among Hispanic high school students. The intervention was implemented in a high school, but was based on an intervention developed using participatory action research methods in the community. The study included a total of 51 participants. Participants were: 58% female, 42% male, and primarily Latino (88%). Participants were a mix of freshmen (n=26) and sophomores (n=25). The mean time spent in the community was 15 years, and mean household size was 4.5.

The intervention was aimed at shifting attitudes towards violence and dating violence and improving ethnic pride (including self-respect, and respect for extended family and the Hispanic community). The intervention included 14 weekly 45-minute sessions held in small gender- and grade- level specific groups. Each session included a mix of education with a creative activity (such as mask making, or making spirit necklaces/ bracelets). Topics covered included: giving and keeping one's word, addressing stereotypes, Hispanic identity, gender roles, the impact of teen violence on the community, self-control, relationships, cultural pride, and goal-setting. Upon completion, a closing celebration was held for participants.

Outcome measures included: ethnic pride measured by Ethnic Identity Scale; perception of self-control was measured with the Self-Efficacy for Self-Control scale; acceptance of couple violence was measured using the Attitudes About Couple Violence; gender stereotyping was measured with the Attitudes about Gender scale; incidence of physical fighting was measured with the Physical Fighting Behaviour scale; incidence of dating violence was measured with the Victimization in Dating Relationships scale; and acculturation was measured with the Short Acculturation Scale for Hispanics (SASH). Assessments were conducted pre- and post-intervention.

Ethnic pride was found to increase significantly from pre- to post- intervention ($p<0.05$). No other measures were significant, although there were positive changes in gender attitudes, self-efficacy for self- control, couple violence and incidents of violence. The linear model revealed a significant difference in physical fighting between 9th grade and 10th grade boys from pre- to post- intervention ($p<0.05$).

Findings reveal that a culturally tailored prevention intervention for Hispanic youth was associated with significant improvements in ethnic pride, and positive (though non-significant changes) in gender attitudes, couple violence and incidents of violence. Limitations of the study include: the lack of a comparison group, lack of follow up, and use of a small sample size. Due to the small pilot nature of this study, conducted with only one school population of Hispanic youth, findings may not be generalisable.

Ernst et al., 2011

A US-based individual RCT by Ernst et al., 2011 [+] compared two brief computer based IPV perpetration education interventions delivered in an emergency department. Participants included a total of 239 women and men presenting to an emergency department who were able to participate (not too ill/ injured, etc.) and who could speak English. Participants were: 48% male and 52% female; primarily 21-30 years (38%); primarily White (42%) or Hispanic (32%); primarily earning less than $10, 000 (32%) or $10-20, 000 (28%); primarily high school educated (61%); and single (52%) or married (24%). Just less than one-third had witnessed IPV as a child (31%) and a minority indicated that their children had witnessed IPV (15%).

Eligible patients were randomized to either intervention (n=121) or control (n=118). The intervention was a PowerPoint slide addressing IPV prevention, shown privately on a touch screen computer. The intervention was available in English only. This was followed by a five-minute video demonstrating IPV among adults by trained actors. One of the scenes shows a bystander unable to stop IPV at home, but later intervening with a male friend and his partner. The control group received the PowerPoint presentation only. Participants were referred to a social worker or their physician following the intervention if they expressed distress.

Survey questions to assess knowledge, attitudes and practices (KAP) related to IPV were completed by participants pre- and post- intervention. In this study, 'practices' referred to participants' willingness to intervene if they were to witness an incident of DV. Prevalence of perpetration was also assessed using the PERPS (Perpetrator Rapid Scale), and OVAT

(Ongoing Violence Assessment Tool), plus questions on whether the participant had witnessed IPV as a child and whether the participant had children who witnessed IPV.

They found an overall improvement in correct answers to all questions, from 46% pre- to 59% post- intervention (13%, 95% CI 4-22). The intervention condition demonstrated significantly higher improvement (15%, CI 6-24). A total of 40 participants were identified as perpetrators (17%, CI 12-21), and 52 participants were identified as victims (22%, CI 17-27). No significant differences were found on KAP scores between the intervention and control for either perpetrators or victims. In addition, no significant difference was found in KAP scores for men and women. However, men in the intervention improved significantly more on KAP scores than men in control (29% vs. 6%, $p<0.05$). There was no significant difference between women in the intervention and women in the control.

Findings reveal overall improvements in knowledge and attitudes related to IPV, with somewhat greater improvements for the intervention condition. Limitations of the study include: the potential bias introduced by extensive exclusive criteria (due to the context) and refusals to participate, use of non-validated measures, and limited information on the educational content of the computer based intervention. The study was conducted within an emergency department, with a largely single, White and Latino sample, and therefore may have limited applicability to other contexts and populations.

Florsheim et al., 2011

A US-based RCT by Florsheim et al., 2011 [+] pilot tested the impact of a couples-focused preventive intervention for pregnant adolescents and their partners. The study included first-time mothers who were between 14 and 18 years old, and no more than 26 weeks pregnant and fathers between ages 14- 24 years. Participants were recruited through health clinics and school pregnancy education programs. A total of 105 couples participated in the study. Adolescent girls were a mean of 16 years old, and men 18 years old; participants were primarily Hispanic (45%) or White (42%).

Couples were randomized into either the intervention (n=55 couples) or control condition (n=50 couples). The intervention, the Young Parenthood Programme (YPP) was a 10 week (plus or minus 2 weeks), co-parenting counselling and IPV prevention programme, following an intervention manual. The focus is on improving communication and relational skills, to support young couples in managing unplanned pregnancy and parenthood, and prevention of IPV. Goals of the programme include: the development of positive relationship skills, expressing positive emotions, providing support, managing conflict and hostility, expressing personal needs and feelings, listening skills, and encouraging empathy. Counsellors included: clinically trained graduate students, a marriage and family therapist and the programme director. Assignment of couples to counsellors was also done randomly, apart from "high-risk" couples that were assigned to the programme director. The control group did not receive co-parenting counselling or IPV prevention, but had access to prenatal and psychosocial services. Control participants who had experienced IPV or child maltreatment were referred to support services. There were no differences between the intervention and control groups at baseline.

Private semi-structured interviews were conducted at baseline and at 2-3-months and 18-months postpartum, to assess relationship conflict and physical aggression. Interview questions were open-ended with follow-up probes (no further details of the interview protocol were provided). Scores were based on the average of both partner's responses.

Overall occurrence of IPV at baseline was 48%, increasing to 54% at 2-3 months postpartum, and 56% at 18 months post-partum. At 18 months post-partum, 13% of couples reported severe violence. On a scale of 0-3, the mean score for IPV was 0.57 at baseline, 0.74 at 2-3 months, and 0.84 at 18 months. For many, violence across all time points was reported to be bi-directional (45%), with some participants reporting only female-to-male violence (36%) or only male to female violence (19%). An increase was found for male to female violence between baseline (14.5%) and 18-month follow up (28%). A significant treatment effect was found in IPV scores from baseline to 2-3 months postpartum ($F (1, 86)=3.50$, $p=0.065$; partial $\eta 2=0.04$); IPV scores in the intervention group remained steady, while IPV in the control

group increased. This difference was not significant at 18 months post-partum. Drug Use Index (DUI) was also used to assess lifetime drug use. They found that women's DUI score was significantly correlated ($p<0.05$) with IPV scores at all follow-up points, and father's DUI score was significantly correlated with partner's DUI score ($p<0.01$). These findings suggest the need to address the links between alcohol and substance use and IPV in future interventions.

While the intervention appeared to have a slight preventive impact, this effect was not sustained at 18-month postpartum follow-up, and IPV increasing among both groups. Limitations of the study include: small sample size, limited detail on the source population and method of randomization, and potential that control participants were accessing variable types of services (psychosocial or prenatal services). Due to the small pilot nature of the study, findings may not be generalisable. Furthermore, the intervention may not be appropriate for couples that have already experienced violence and require a higher level of intervention.

Gadomski et al., 2001

A US-based before-and-after study with a comparison group by Gadomski et al., 2001 [+] examined changes in societal attitudes and behavioural intentions following a rural public health education campaign. Participants (age 18-50) were drawn from a county population of 62, 000, and contacted by telephone survey (using random digit dialling) to participate. The total number of participants pre-intervention was 378, and at post-intervention this was 633, including participants from another county who were matched to act as the control condition. Post-intervention participants were primarily 35-44 (34%) or 45-50 (31%) years old; 60% female and 40% male; primarily full time employed (62%); a mix of education levels (30% high school, 25% partial college, 35% college graduate), and primarily married (50%) with children under 18 living at home (54%).

The campaign was 7 months in length and included: 4, 000 radio spots 30 seconds in length during the first and final months; 12 weeks of TV public service announcements; 105 bulletin board posters; mail-outs to clergy and libraries; 10 newspaper articles; 36 print advertisements; 15 community presentations; and participation by 3 health clinics including posting of 55 restroom posters and the distribution of cards in clinical areas. The radio and televisions advertisements were first tested in focus groups to ensure appropriate messages. The key messages of the campaign were: recognition of DV, education on different forms of abuse, the impact of DV on health and on children, encouragement of public disapproval and taking action against DV. Messages were gender-neutral or used reversed messages (e.g. man showing concern about abuse of a neighbour, during discussion with another female neighbour). Radio messages encouraged the audience to speak with one's doctor. The campaign used the slogan: "no one deserves to be abused."

At baseline, 240 people were interviewed in the intervention county and 138 in the comparison county; at post-intervention, 433 people were interviewed in the intervention county and 200 in the comparison county. They assessed norms targeted for change using questions from a prior research project. Pre-intervention questions measured: tacit approval of DV, not talking about DV, and nothing can be done about DV. The interview ended by assessing response to a bystander vignette of DV against a neighbour. Post-intervention included the same questions but also included questions on: recall of the campaign, and experiences with health care providers regarding DV and availability of DV materials in the clinic (to examine exposure to change among health care providers). Telephone surveys were conducted by a survey research firm. Follow-up was conducted at post-intervention.

There was a significant increase in the intervention county in hearing slogan and exposure to materials, 6% ($p=0.03$). In response to the vignette where a neighbour was hypothetically abusing their partner, the percentage of respondents who thought most people would: talk to victim increased 8% in the intervention county compared to 3% in the comparison county ($p=0.04$), talk to friends increased 4% in the intervention county compared to a 7% decrease in the comparison county ($p=0.002$), and talk to a doctor increased 3% in the intervention county compared to a 2% decrease in the comparison county ($p=0.004$). A significantly higher proportion of respondents in the intervention county (59%) than in the comparison county

(49%) reported finding educational materials on DV in clinics (p=0.02). Calls to hotline increased from 520 pre-campaign to 694 during the campaign, and 1,145 post campaign.

Findings reveal an increase post-campaign in the participant's recall and exposure to campaign slogan and materials and hypothetical bystander actions. Limitations of the study include: potential contamination in the comparison county (which had its own radio campaign and posters on DV distributed by a perinatal health network), and lack of behavioural measures. The ethnicity of participants was not identified and therefore it is difficult to determine wider applicability. The study was conducted within a rural county, and therefore may not be applicable to non-rural contexts.

Keller et al., 2010

A US-based before-and-after study by Keller et al., 2010 [+] examined the effects of a DV media campaign, "Open Your Eyes." The intervention was directed at the general public in a rural area, and analysis included all participants who received and completed a mail-in survey. Participants were matched to the source community (by gender, age, ethnicity, etc.), by using a stratified sample strategy (further demographic details not provided). A total of 430 participants were included at baseline, and 374 completed the post-test survey.

The media campaign was based on the health belief model. The media campaign ran from Spring through Winter. It was composed of 3 print ads and 4 television ads. These included: "Barbecue" which depicted a man hitting his wife during a family barbeque with a spatula and being taken to jail; "Brain injury" which showed a man "freaking out" as an ambulance arrives to treat his wife who has suffered head trauma from the abuse; "Teddy bear" which showed a boy shaking his teddy bear after witnessing an argument between his parents; and "MP3" which depicted a young woman running in a wealthy in a wealthy area, with an audio clip of her husband's emotional abuse. Each ad concluded with information on the prevalence of DV, and a hot line number to call for support.

Awareness of campaign, awareness of available services, attitudes about the issue of violence, and perceived severity of DV were measured using a survey completed at pre- and post- campaign. The authors developed the survey, with some questions based on previous research examining DV awareness.

Post- test analysis revealed that 21% of women and 21% of men recalled seeing the ads Television was most commonly cited as the format where the ad was seen (15%), with less recall reported for the billboard ads (7%). Following seeing the ads, a total of 4 participants reported helping others, 2 reported leaving a relationship, and 5 recommended someone else leave a relationship, 3 intervened with a friend/ family member, and 2 called the police. In regards to respondents' perceptions of how severe DV is (e.g. "DV is a serious problem", "Perpetrators should go to jail"), the gender X campaign exposure interaction was found to be significant ($F=27.27$, $p<0.00$); women's mean score increased significantly from pre-campaign (4.36) to post-campaign (4.55) ($p=0.01$), while men's scores decreased significantly (4.48 pre-campaign to 4.15 post-campaign, $p=0.000$). Women perceived greater response efficacy (i.e. beliefs that DV counselling and support services are good ways to help DV victims) post-campaign than pre-campaign, whereas the men did not change significantly.

Findings demonstrate similar recall among women and men following a TV and print campaign, but women reported significantly greater awareness of available services, increased perception of severity of violence and greater response efficacy compared to men. Limitations of the study include: short follow up, lack of comparison, potential self-selection bias, and lack of measures of behaviour. The study was conducted in a rural area, although demographic characteristics of participants are not provided, making it difficult to determine applicability.

Khemka et al., 2005

A US-based non-RCT by Khemka et al., 2005 [+] examined the effectiveness of an abuse-prevention curriculum for women with learning disabilities. The study included a total of 36 women aged 22-55 years, with mild or moderate learning disabilities (IQ 35-75), recruited

from an urban adult services agency. Participants were a mean age of 34.3 years, had a mean IQ of 55.9, and were primarily African American (50%) or White (33%).

Participants were matched based on scores on social interpersonal decision making related to sexual, physical or verbal abuse, and then randomly assigned from matched pairs to either the intervention (n=18) or control (n=18) group. The intervention, 'An Effective Strategy-Based Curriculum for Abuse Prevention and Empowerment' (ESCAPE), was aimed at empowering women with learning disabilities to improve decision making that would protect them from violence and abuse. Sessions were 40-50 minutes in length, held once or twice a week for 6 or 12 weeks in small groups (3 women), and delivered by a trained facilitator. The curriculum included 12 sessions focused on: knowledge of abuse and empowerment using interactive skill building activities and decision making strategy training in response to simulated situations of abuse. In addition, a 6-session support group was provided for further review and integration of skills, during which participants could share and discuss their experiences and the potential application of learned skills. Support groups were co-facilitated by the trained facilitator and a social worker from the agency. Participants in the control group received no intervention, but did have access to abuse prevention services provided by the agency (typically counselling by social workers and sex education). There were no significant differences between groups at pre-test.

Assessment tools were modified to be appropriate to the comprehension level of participants. Measures included: the Knowledge of Abuse Concepts Scale to assess understanding of various types of abuse and the meaning of providing consent to a relationship; The Empowerment Scale (developed for this project) assessed perceptions of control and self-efficacy; the Stress Management Survey assessed self-reported stress; the Self Decision-Making Scale assessed decision- making in situations of abuse.
Post-testing was conducted from 1 week to almost 3 months after the initial 12 sessions (different women had different availabilities). A second post-test was conducted from 1 week to 4 months after support groups were completed (most women completed this second post-test within 1-3 weeks of completion).

Significant differences were reported between groups on three of the four measures: Knowledge of Abuse Concepts Scale ($t(34)=2.91$, $p<0.01$), Empowerment Scale ($t(34)=2.15$, $p<0.05$), and Self Decision-Making Scale ($t(34)=3.13$, $p<0.01$). Participants in the intervention group had higher post-test means (revealing higher knowledge, empowerment, and prevention-focused decision-making for self) than did control group participants on all three measures. These effects were maintained at the second post-test follow up (following the support group component). There was no significant difference between groups for post-test scores on the Stress Management Survey.

Findings reveal that an abuse prevention curriculum for women with learning disabilities improved knowledge, empowerment and prevention focused decision making for self, but did not impact stress management. Limitations of the study include: small sample size, short term follow up and lack of assessment of the presence of DV. While they note that women with learning disabilities are vulnerable to intimate partner violence and violence by family caregivers in the home, they do not provide further details. An additional limitation is the attrition at second post-test follow that was reported for the control group; only 10 of 18 control participants completed 2nd post-test, compared to all participants in the intervention. The study was conducted with women with learning disabilities and therefore findings may not be applicable to other populations.

Salazar and Cook, 2006

A US-based RCT by Salazar and Cook, 2006 [++] evaluated the efficacy of a prevention programme for adjudicated African American male adolescents. The study included 37 adolescent males from an urban juvenile justice courthouse who were mandated by their probation officers to attend the prevention programme. Participants were referred if they had committed mildly violent/ abusive behaviour towards a female, if they had experienced violence within their homes, or if they had indicated to court personnel some behaviours that were influenced by violence (e.g. threat-making, gang involvement, etc.). Participants were predominantly African American (92%), and the majority did not have a father living at home

(65%). Most participants were attending school (84%), and were in a mean grade level of 8.83 in school. Most had committed a minimum of one act of violence towards a female (76%), while under half (40%) had witnessed at least one act of male to female partner violence between their parents.

Participants were randomly assigned to either intervention (n=21) or control (n=16). While the intervention was delivered in a juvenile court and adult court, the programme was developed by a social change agency, 'Men Stopping Violence' (MSV). The intervention was 5 sessions, based on feminist theory and was aimed at IPV prevention among African American males. Session 1 was a 2-hour session aimed at setting the stage for the intervention by providing an overview of their location at the courthouse, the nature of their delinquency and responses regarding violence against girls and women. The next session was a 2 hour class held at an adult courthouse for men who had been arrested for battering, which provided an overview of the basic principles covered in the 6-month batterers intervention programme (Men Stopping Violence, MSV). The next two sessions involved 30 minute introductory meeting with co-instructors followed by attending a 2-hour class with adult male batterers involved in the 6-month MSV programme. The final session/s was a forum to discuss their experiences in the previous adult male batterers group; participants could attend as many review sessions as desired. The control group also participated in the intervention, although two weeks later. The control group completed the post-test after the 2-week delay, but prior to participation in the intervention, while the intervention group completed their post-test following involvement in the intervention. A 3-month follow-up was conducted for the intervention group only. There were no significant differences between the intervention and control group on socio-demographic variables or study variables at baseline.

Knowledge of IPV and patriarchal attitudes was assessed using 'Violence in relationships: A Seventh Grade Inventory of Knowledge and Attitudes' and the Wife Beating Is Justified subscale of the Inventory of Beliefs About Wife Beating. The authors also examined whether outcomes differed depending on whether participants had witnessed parental violence or committed violence themselves. For the prevalence of witnessing parental violence and prevalence of committing violence, the authors used a modified form of the Revised Conflict Tactics Scale (CTS2). Two White participants were included in the study, and so the authors compared results including and excluding these participants, and compared their results to the rest of the sample.

At post-test, the intervention group reported high levels of knowledge (R-squared=0.12, $p<0.05$) and less patriarchal attitudes (R-squared=0.08, $p<0.05$ one-tailed on the Wife Beating is Justified subscale only, but not on the Seventh Grade Inventory) than the control group, and these effects were maintained at 3-month follow-up. Committing violence was not found to be associated with intervention effectiveness. The impact of witnessing-parental-violence approached significance for effect on patriarchal attitudes ($p=0.08$); adolescents in the intervention group reported greater improvements than the control group, but only for those who witnessed high levels of parental male-to-female violence. Finally, excluding the two White participants' scores did not impact findings.

Findings reveal that adjudicated African American male adolescents who participated in a DV prevention intervention reported increased knowledge and decreased patriarchal attitudes. Limitations of the study include: small sample size, potential for socially desirable responses, and assessment of only knowledge and attitudes (not behaviours). The study was conducted with a small sample of predominantly African American adjudicated adolescent males and therefore findings may not be applicable to other groups.

Scottish Executive, 2002

A Scottish qualitative study conducted by the Scottish Executive, 2002 [+] evaluated a pilot of the 'Respect' educational programme for the primary prevention of violence against women among young people. The programme was held in two secondary schools, two primary schools and seven youth groups in Edinburgh and Glasgow in 2001. The programme was developed by the Zero Tolerance Charitable Trust, an organization addressing violence against women.

Data used included: project-related materials of the pilot and related work in Scotland; interviews with steering group members before (n=7) and after the project (n=6); interviews with staff at the start (n=37) and end (n=34) of the project; interviews with youth participants at the start (n=81) and end (n=71) of the project; data from self-report questionnaires for all young people at the start (n=377) and end (n=236) of the project; along with staff feedback forms after each session, and group discussions and debriefing sessions. The demographic characteristics of participants were not reported.

The "Respect" programme includes primary prevention work of violence against women and the promotion of equal and respectful relationships. The educational package included teaching materials for 7-8 sessions in each setting, along with a complementary CD (that was available for older participants), advertising on the sides of buses, posters and a screensaver. Young people at secondary schools and youth groups participated in eight sessions using a variety of activities to address the following topics: the meaning of respect, demonstrating respect, power and misuses of power (e.g. physical violence, racial and sexual harassment, bullying), unfair treatment, violence in relationships, discrimination, and gender stereotypes. In primary schools, age appropriate materials were used to cover similar topics, including: communication, respect, cooperation, name-calling, appearances, group identification, bullying, power, harassment, and stereotypes (including gender stereotypes).

The questionnaire content was not described in the report. Though some gender-specific findings were noted (e.g. "more than 1 in 7 boys thought it was fun to 'make fun of people'"), the findings related to programme outcomes/ impacts were presented as summary statements across both genders. As an evaluation of a pilot programme, many of the findings focused on the delivery and implementation of the programme, which is outside of the scope of the question and therefore not reported here. In regards to programme outcomes, most young people reported that the programme had increased their knowledge of available sources for help, and overall there was a perception of improved understanding of violence/ abuse among participants (percentages not provided). The majority (85%) of staff reported that ‘Respect’ was successful; benefits for staff that were noted included: improved skills and knowledge and a chance to consider the issues addressed. For young people, benefits noted included: enhanced awareness of the issues, encouragement to engage in respectful interactions and working towards the prevention of abuse and violence. Both young people and staff perceived changes among many young people following the programme, although the authors note that these improvements may not necessarily be measurable. The majority (78%) of primary school students and nearly half of the older students perceived personal changes following their involvement in the programme. Overall, 80% of young people reported improved understanding of respect for others. Approximately 3/4 of all young people felt they had improved knowledge of communication and over 3/4 reported improved knowledge of equality and power. The majority (approximately 80%) of older participants felt they had improved knowledge of abuse and violence. However, despite these improvements, some issues, which the authors note as requiring further work, include: gender stereotyping, perceptions of violence against women and harassment. For example, they report that nearly one-third of primary school children believed it was okay to “treat other people badly if they treat you badly first,” over 1 in 7 boys thought it was fun to “make fun of people,” and three quarters of boys thought it was fun to “whistle at girls.” There was evidence of gender stereotyping among older participants; 61% sometimes agreed or agreed with the statement that “women and men are good at different things and they should stick to them”, 21% that “calling people names if they’re different from you is just for a laugh”, and 74% that “girls can provoke violence and abuse because of how they dress or behave.” In addition, 37% did not always agree with the statement that “men are violent to women much more than women are violent to men” and more than half that “there is never an excuse for men to be violent to women”. Finally, only just over half (56%) of older participants agreed, “When young women say no to sex, it always means no”.

Findings suggest that an educational primary prevention programme may improve self-reported improvements in knowledge of respect, communication, equality and power among young people, and knowledge of abuse and violence among older participants. However, other topics that were the focus of the programme, including gender stereotyping, perceptions of violence against women and harassment, showed less improvement and require further

intervention. Limitations of the study include: the focus on primarily subjective opinion data using un-validated tools, limited information on methodology and analysis (including questionnaire content), lack of demographic information, and lack of gender analysis.

Solomon and Fraser, 2009

A Scottish cross-sectional study [+] evaluated the impact of wave 12 of an annual domestic abuse media campaign. A total of 1, 040 respondents were included. The authors note that quota sampling was used and that the sample was representative of the Scottish adult population (age 16 and over) in sex, age, employment, and socioeconomic status. Demographic characteristics of respondents were not provided.

The media campaign had been conducted in Scotland for 11 years, by the Scottish government under the 'Safer Scotland' name. Post-campaign assessments are conducted to measure attitudes and perceptions towards DV and the media campaign. The key message of the evaluated campaign (wave 12) was that help is available to those who experience abuse. The length of the campaign was four weeks and included TV and online advertisements, including contact information for the Scottish Domestic Abuse helpline and the website.

The researchers used a monthly in-home survey based on the previous wave to ensure comparability, with additional questions regarding the current advertising campaign included. Portions of the survey that were deemed to be particularly sensitive were completed by the respondents on CAPI machines. The questionnaire included Likert-scale and multiple-choice questions related to: awareness, opinions, beliefs, and behaviours of domestic abuse.

They found that the proportion of respondents who had any experience of DV decreased between wave 11 (38%) and wave 12 (21%), with 8% of wave 12 respondents reporting that they had personally been the victims of DV. Respondents who reported that DV occurs in all age groups decreased from 45% in wave 11 to 32 in wave 12, yet the proportion who felt DV was most common among younger people remained the same (76%). Participants were most likely to respond that DV is more common among working classes (87%). In regards to services available, almost half (45%) of respondents reported: "police/ ambulance/ emergency services" for women experiencing DV, followed by Women's Aid (42%), while only 13% noted the Scottish Domestic Abuse Helpline (the focus of the ad campaign). The authors note that the proportion of respondents who were spontaneously aware of advertising about DV decreased from 70% in the past four waves, to 30% in the current wave (39% recalled when prompted). They note that this could be due to the reduced spend on media, the use of media mix (online and TV) and the softer campaign strategy used (which focused on empowerment messages/ images rather than images of violent scenes). Of the respondents who recalled the campaign, 90% were able to recall at least one element of the TV message and one-third recalled the message directing the audience to the helpline and website. Just over one-third (36%) agreed with the statement: "I believe there are enough services available to help women who may be experiencing domestic abuse." In assessing attitudes regarding DV, there was little change, although a decrease was observed for those agreeing that those who experience DV: "can escape from domestic abuse and make a new life for themselves", and a correlating increase in those agreeing that people who have experienced abuse "just had to learn to live with it". Most respondents felt that prostitution and pornography were exploitative of women (56% and 63% respectively) and that "pressuring a woman to take part in sexual activities if she doesn't want to" was unacceptable or totally unacceptable (97%), which was a slight increase from the previous wave. However, 26% reported that a woman was partially responsible for being raped "if she is drunk", but agreement with responsibility on all other circumstances (dressed in revealing clothing, flirting, previous sexual partners, married to perpetrator) decreased.

Overall, the study found a lack of improvements for awareness of DV and the media campaign, compared to previous waves. In particular, awareness of DV support services advertised in the campaign was very low. Limitations of the study include: focus on awareness of the campaign rather than awareness of DV, the use of a single-group post-test only (no pre-test or comparison group), and provision of only simple descriptive statistics. The study was conducted in the UK and should therefore be applicable, although methodological

weaknesses (lack of pre-test and comparison group, limited information on demographics) limit generalisability.

Toews et al., 2011

A US-based qualitative study by Toews et al., 2011 [+] examined the impact of a skill-based relationship education programme on conflict strategies in dating relationships for pregnant adolescents and mothers. Participants included a total of 199 pregnant and parenting adolescents enrolled in a Pregnancy, Education, and Parenting (PEP) programme in six high schools. Adolescent girls who participated were: a mean age of 16.4 years, primarily Hispanic (87%), and the majority had a child (83%).

The project was guided by social learning theory. The programme, 'Strengthening Relationships,' was designed to support parents in developing and maintaining healthy relationships by teaching interpersonal and relationship skills. Curriculum was based on the 'Connections: Relationships and Marriage' programme. Twelve weekly sessions were held with groups of 10-30 adolescent parents. Sessions were both didactic and interaction, including topics such as: developing realistic relationship expectations, communication and conflict management skills, and skills to develop health relationships.

A total of 23 focus groups were held with 3-16 participants in each group following programme completion. A semi-structured protocol included questions on: helpfulness of the programme, specific topics that were most helpful, the impact of the programme on conflict resolution skills, impact of the programme on relationships, and benefits of the programme. Focus groups were recorded, transcribed and then independently coded by team members (with discrepancies resolved during team meetings and codes refined and developed as needed).

Four key themes were identified. First, mothers were both victims and perpetrators of psychological and/ or physical abuse. Some girls noted how they now realized the impact of their behaviour on their partners. One girl said: "But, now [after participating in the programme] I see, dang I was mean to him. I was abusing him. But, now I don't." Second, participants reported learning positive conflict management skills during the programme. For example, one girl noted: "[We learned the importance of] communicating more instead of us always yelling. Actually talk." Many participants indicated that the skills they learned were new to them because they had not observed positive communication or conflict management skills among role models in their lives. Third, girls provided examples of how because of the programme; they had implemented new conflict resolution strategies. For example, one girl said: "Every Wednesday we would learn something new and I would try it out and it would work for me. I haven't done nothin' crazy lately." Fourth, a minority of the girls (numbers not provided) even reported ending abusive relationships. As one girl expressed: "What I'm looking for, I'm not getting it from him, so that's why I'm not with him no more. I broke up with him."

Findings suggest that the relationship education programme for adolescent mothers had a positive impact on: understanding abuse, developing conflict management skills, and in some cases leaving an abusive relationship. Limitations of the study include: reliance on self-report by only the female partners, lack of follow-up, and use of focus groups as the only data source. The authors note that future programs are needed that specifically address abusive behaviours and that include education for both partners. The study was conducted with primarily Hispanic adolescent mothers and therefore may not be generalisable.

Wray et al., 2004

A US-based cross-sectional study by Wray et al., 2004 [+] evaluated the impact of a radio awareness campaign for DV prevention in the African-American community called "It's Your Business." Note that while the study was designed to be a before and after study, due to implementation issues the final analysis was cross-sectional. Respondents had to be over 18, African American, able to respond in English, and a listener of the relevant radio station. The study included only one of four evaluation cities that were originally considered due to insufficient airtime of the radio serial. A random digit dial sample was conducted, focusing on

specific telephone exchanges where the likelihood was over 60% that the respondent would be African American. Further demographic characteristics were not provided. The total analytic sample was 1,083 (pre-broadcast sample n=385; post-broadcast n=698).

The radio serial included 12, 90-second episodes in a 'social drama' format. The programme focused on encouraging African Americans to discuss and support abuse with victims and condemn DV during conversations. The serial included a central figure that would introduce each episode, Ma B, who was also a host of a community affairs radio show. Prior to each episode, Ma B would offer an update of a local DV trial, as a way to frame and reinforce each lesson. The initial episode focused on speaking out against DV, while subsequent episodes included fictional characters that would offer support to victims. Fictional characters included an extended family that was trying to encourage a young woman to leave her abusive partner. At the end of every episode, a list of support contacts was provided. The radio serial was provided to a range of African-American owned network of radio stations, and the suggested schedule was for several repeats of one episode over the course of one week, with new episodes offered each week for a total of 12 weeks. In each city, links were made with local DV agencies to promote the broadcast and include local contact information.

Telephone surveys were conducted in five waves. Pre-broadcast surveys were 15 minutes long, while post-broadcast surveys were approximately 18 minutes long. The pre-broadcast assessment measured: demographic characteristics, experiences of DV, media use, and beliefs, attitudes, intentions, and behaviours related to campaign goals. A question was also included in the pre-broadcast survey related to recall of the programme, in order to identify false positives. The post-broadcast analysis measured beliefs about DV, intentions to discuss DV with a victim in a hypothetical case, and respondents' discussion of DV with victims or engagement in conversations where they condemned DV.

They found that 66% of respondents did not recall the radio serial, 9% reported moderate exposure (i.e. recalled the serial, answered a simple storyline question, and had heard at least 3 episodes or any episode 3 or more times), and 25% reported ambiguous exposure (i.e. recalled the series, but could not correctly answer the recall question or did not hear at least 3 segments). Those respondents who were moderately exposed scored higher those who did not recall the series on 21 out of 27 anti-DV beliefs and behaviours; 10 of the reported differences were statistically significant ($p's<0.05$). Yet, respondents who were moderately exposed only demonstrated significantly stronger outcomes than the ambiguous exposure respondents in 2 out of the 27 outcomes, which is similar to what would be found by chance.

The authors therefore conclude that the association of moderate exposure with anti-domestic violence outcomes was most likely not due to exposure alone, but likely due to greater recall of the serial among those already concerned about the issue of DV. The authors note that the radio serial was aired less frequently than intended, and the programme schedule differed between radio stations that impacted exposure. The low levels of exposure made it difficult to test the impact of the radio serial on beliefs, attitudes or behaviours. Due to issues with implementation and the non-experimental design of the study, further research is required to examine impact or generalize findings.

4.5. Evidence Statements

We have organized the findings using the following categories:

1) Prevention interventions/ approaches for young people
2) Media campaigns
3) Prevention interventions/ approaches implemented in health settings
4) Prevention interventions/ approaches implemented in community settings for at-risk women

Evidence Statement 1- Prevention interventions/ approaches for young people

There is moderate evidence from six studies that prevention interventions for young people are associated with improvements on various outcomes including: knowledge of IPV, attitudes towards violence and gender roles, interpersonal skills, although some studies reported improvements on some but not all measures. Some studies conducted with young people at high risk for abuse also reported modest improvements in abuse/ violence outcomes.

One study evaluated a primary prevention programme, aimed at preventing violence before it ever occurs. A qualitative study (Scottish Executive, 2002 [+]) found that an educational primary prevention programme improved self-reported knowledge of respect, communication, equality and power among young people overall, and knowledge of abuse and violence among older participants; however, other topics that were the focus of the programme, including gender stereotyping, perceptions of violence against women and harassment, showed less improvement and require further intervention.

The remaining five studies were aimed at preventing violence among diverse sub-groups identified as high risk for intimate partner violence (i.e. secondary prevention approaches). An RCT (Salazar and Cook, 2006 [++]) found that adjudicated African American male adolescents who participated in a DV prevention intervention reported increased knowledge and decreased patriarchal attitudes. A before and after study (Antle et al., 2011 [+]) found that a brief educational programme on relationships and dating violence was associated with significant improvements in communication skills, conflict management skills and attitudes towards violence among at risk youth. A qualitative study (Toews et al., 2011 [+]) found that a relationship education programme for Hispanic adolescent mothers had a positive impact on: understanding abuse, developing conflict management skills, and in some cases leaving an abusive relationship. In contrast, a RCT (Florsheim et al., 2011 [+]) which examined a pregnancy education programme including IPV prevention for adolescent couples, found that the programme had a slight preventive impact on partner abuse, but this was not sustained at 18 month postpartum follow-up, with IPV increasing among both intervention and control groups. Finally, a before and after study (Enriquez et al., 2012 [+]) found that a culturally tailored prevention intervention for Hispanic youth was associated with significant improvements in ethnic pride, and positive (though non-significant changes) in gender attitudes, couple violence and incidents of violence.

Scottish Executive, 2002 (qualitative [+], Scotland, (steering group members pre- (n=7) and post (n=6); staff interviews pre- (n=37) and post- (n=34); interviews with young people pre- (n=81) and post- (n=71); questionnaires with young people pre- (n=377) and post- (n=236) (no demographics reported), project start and end) ['Respect' programme: primary prevention programme on violence against women and girls; promote equal and respectful relationships. 7-8 group educational sessions addressing in secondary schools: respect, power, gender stereotyping, relationship violence, discrimination; in primary schools: similar but age appropriate topics addressing: communication, respect, cooperation, name-calling, appearances, group identification, bullying, power, harassment, and stereotypes; complementary CD (for older participants), advertising on buses, posters and screensavers] Most young people reported increased knowledge of available sources for help, and overall perception of improved understanding of violence/ abuse. Majority (85%) of staff reported that programme was successful; benefits included: improved skills and knowledge and a chance to consider the issues. For young people, benefits included: enhanced awareness of issues, encouragement to engage in respectful interactions and working towards violence prevention. Majority (78%) of primary school students and nearly half of the older students perceived personal changes following the programme. Overall, 80% of young people reported improved understanding of respect for others. Approximately 3/4 of all young people felt they had improved knowledge of communication and over 3/4 reported improved knowledge of equality and power. Approximately 80% of older participants felt they had improved knowledge of abuse and violence. The authors note the need for further work on: gender stereotyping, perceptions of violence against women and harassment.

Salazar and Cook, 2006 (RCT [++], USA, n=37 adjudicated African American male adolescents (primarily African American, no father at home, attending school, mean grade

level of 8.83, most had committed a minimum of one act of violence towards a female, under half had witnessed parental male to female violence), post-test, 3 month follow up (intervention only) [Intervention (n=21): 5, 2-2.5 hour sessions including: attendance of classes for adult male batterers (Men Stopping Violence Programme) at adult courthouse, along with review sessions to discuss experiences in male batterers groups; compared to control (n=16) who participated in intervention but with a 2 week delay] At post-test, intervention reported high levels of knowledge (R-squared=0.12, $p<0.05$) and less patriarchal attitudes (R-squared=0.08, $p<0.05$ one-tailed on the Wife Beating is Justified subscale only, but not on the Seventh Grade Inventory) than control, and these effects were maintained at 3-month follow-up. Committing violence was not associated with intervention effectiveness. Impact of witnessing-parental-violence approached significance for effect on patriarchal attitudes ($p=0.08$).

Antle et al., 2011 (before and after [+], USA, n=233 socially and economically disadvantaged youth (60.1% female and 39.9% male; primarily African American, unemployed, low income), post- intervention [Specialized group prevention programme within public schools; 7 modules over 2 days addressing: unhealthy and healthy relationships, and conflict management, communication and problem solving skills, and dating violence] There was a significant decrease in the demand-withdraw form of communication ($t (155)=3.59$, $p<0.0001$), mutual avoidance pattern of communication ($t (158)=2.85$, $p<0.01$), withdraw dynamic for conflict resolution, ($t (167)=2.04$, $p<0.05$), and conflict engagement ($t (167)=4.35$, $p<0.0001$). Attitudes towards couple violence significantly improved ($t (114)=2.04$, $p<0.05$).

Toews et al., 2011 (qualitative [+], USA, n=199 pregnant and parenting adolescents (mean age 16.4 years, primarily Hispanic, majority had a child), post-programme) [12 weekly group interactive and didactic sessions delivered in high schools within Pregnancy, Education, and Parenting (PEP); designed to support parents in developing healthy relationships by teaching interpersonal and relationship skills] Four key themes identified: 1) mothers were both victims and perpetrators of psychological and/ or physical abuse; 2) learning of positive conflict management skills; 3) implementation of new conflict resolution strategies; and 4) a minority of girls (numbers not provided) reported ending abusive relationships.

Florsheim et al., 2011 (RCT [+], USA, n=105 pregnant adolescents and their partners (Mean age of 16 years (girls) and 18 years (partners), primarily Hispanic or White), 2-3 months and 18- months postpartum) [Intervention (n=55 couples): 10 week (plus or minus 2 weeks) couples counselling programme in high school pregnancy education programme aimed at improving communication and relational skills, to support young couples in managing unplanned pregnancy and parenthood, and prevention of IPV; compared to control condition (n=50 couples): did not receive co-parenting counselling or IPV prevention, but had access to prenatal and psychosocial services] Overall occurrence of IPV at baseline was 48%, increasing to 54% at 2-3 months postpartum, and 56% at 18 months post-partum. At 18 months post-partum, 13% of couples reported severe violence. For many, violence across all time points was bi-directional (45%), with some participants reporting only female-to-male violence (36%) or only male to female violence (19%). An increase was found for male to female violence between baseline (14.5%) and 18-month follow up (28%). A significant intervention effect was found in IPV scores from baseline to 2-3 months postpartum ($F (1, 86)=3.50$, $p=0.065$; partial $\eta 2=0.04$); IPV scores in the intervention group remained steady, while IPV in the control group increased, although this was not significant at 18 months post-partum. Female drug use scores (measured by DUI) were significantly correlated ($p<0.05$) with IPV scores at all follow-up points, and father's DUI score was significantly correlated with partner's DUI score ($p<0.01$).

Enriquez et al., 2012 (before and after [+], USA, n=51 Hispanic high school students (58% female; 42% men; freshman and sophomore high school students, primarily Latino), post-intervention) [Developed with community consultation and implemented in high school. 14 weekly, 45 min educational and creative activity sessions in gender and grade-level specific groups aimed at changing attitudes towards violence & dating violence and enhancing ethnic pride] There was a significant increase in ethnic pride ($p<0.05$), but no significant changes in: perception of self-control, acceptance of couple violence, gender stereotyping, incidence of physical fighting or dating violence, or acculturation, although positive trends reported on

some measures (gender attitudes, self-efficacy for self- control, couple violence and incidents of violence). Linear model revealed significant difference in physical fighting between 9th grade and 10th grade boys from pre- to post- measures ($p<0.05$).

Applicability

Five studies were conducted in the USA (Salazar and Cook, 2006 [++]; Antle et al., 2011 [+]; Toews et al., 2011 [+]; Florsheim et al., 2011 [+]; Enriquez et al., 2012 [+]) and one in Scotland (Scottish Executive, 2002 [+]). The Scottish study did not include demographic information, although was conducted in the UK and therefore should be applicable. The other studies were conducted with specific minority groups including: African American adjudicated adolescent males who had committed 'minor' acts of violence or witnessed violence (Salazar and Cook, 2006 [++]); low income, socially disadvantaged, primarily African American youth (Antle et al., 2011 [+]); Hispanic youth (Enriquez et al., 2012 [+]), and primarily Hispanic pregnant or parenting adolescents (Toews et al., 2011 [+]; Florsheim et al., 2011 [+]) and therefore may not be generalisable to other groups.

Evidence Statement 2- Media campaigns

There is inconsistent evidence from four studies that media campaigns addressing DV are associated with improved recall, hypothetical bystander actions, and awareness of available resources, calls to hotlines and knowledge and perceptions of DV. Two studies reported limited improvements in awareness and/ or attitudes towards DV following a media campaign. One cross-sectional study (Wray et al., 2004 [+]) found low recall of a radio serial aimed at African Americans (potentially connected to issues with implementation); while moderate exposure was associated with limited improvements on anti-domestic violence belief outcomes, these were similar to that reported by chance. Another cross-sectional study (Solomon and Fraser, 2009 [+]) found that following a TV and online campaign, reports of any experience of DV were lower yet spontaneous awareness of DV decreased compared to previous campaign waves, and there was low reported awareness of the advertised DV services. Two studies found some improvements in awareness and attitudes following a media campaign. One before and after study (Gadomski et al., 2001 [+]) reported increased recall and exposure of the media campaign, improved hypothetical bystander actions, increased calls to hotlines, and greater awareness of resources following a rural mixed media campaign. Another before and after study (Keller et al., 2010 [+]) found similar recall among women and men following a rural TV and print campaign, but women reported significantly greater awareness of available services, increased perception of severity of violence and greater response efficacy compared to men.

Wray et al., 2004 (cross-sectional [+], USA, n=1,083 (pre-broadcast sample n=385; post-broadcast n=698) (African American), post-broadcast) [Radio serial included 12, 90second episodes using 'social drama' format; aim to encourage discussion of DV and support of victims of abuse and condemn DV during conversations. Each hosted episode included DV trial update, and fictional characters acting out episodes with lessons related to DV. List of support contacts provided at end of each episode. Suggested schedule of 12 episodes with each episode repeated several times per week] 66% of respondents did not recall the radio serial, 9% reported moderate exposure, and 25% reported ambiguous exposure. Moderately exposed respondents scored higher those who did not recall the series on 21 out of 27 anti-domestic violence beliefs and behaviours; 10 of the reported differences were statistically significant ($p's<0.05$). Yet, moderately exposed respondents only demonstrated significantly stronger outcomes than ambiguous exposure respondents in 2 out of the 27 outcomes, similar to what would be found by chance.

Solomon and Fraser, 2009 (cross-sectional [+], Scotland, n=1, 040 respondents (age 16 and over, representative of Scottish population in sex, age, employment, SES; demographic characteristics NR), post-campaign) [4 week TV and online campaign (in it's 12th year/ wave) Key message was that help is available to those who experience abuse; included contact information for the Scottish Domestic Abuse helpline and the website] Respondents who reported any experience of DV decreased between wave 11 (38%) and wave 12 (21%), with 8% of wave 12 respondents reporting that they had personally been the victim of DV. For services available, almost half (45%) reported: "police/ ambulance/ emergency services" for

women experiencing DV, followed by Women's Aid (42%), while only 13% noted the Scottish Domestic Abuse Helpline. The authors note that the proportion of respondents who were spontaneously aware of advertising about DV decreased from 70% in the past four waves, to 30% in the current wave (39% recalled when prompted).

Gadomski et al., 2001 (before and after study [+], USA, n=378 pre-campaign; n=633 post-campaign) (post-campaign participants primarily 35-50 years old; 60% female and 40% male, full time employed, mix of education, primarily married with children) post-campaign [7 month campaign including: 4, 000, 30 second radio spots; 12 weeks of TV ads; 105 posters; mail-outs to clergy and libraries; 10 newspaper articles; 36 print ads; 15 community presentations; and posting 55 posters in health clinic restrooms and cards in clinical areas. Messages were gender neutral/ reversed focusing on: recognition of DV, education on different forms of abuse, impact of DV on health and children, encouragement of public disapproval and taking action against DV. Campaign slogan: "no one deserves to be abused" Intervention county (pre-campaign n=240; post-campaign n=433) compared with comparison county (pre-campaign n=138; post campaign n=200)] Significant increase in the intervention county in hearing slogan and exposure to materials, 6% (p=0.03). In response to a vignette where a neighbour was hypothetically abusing their partner, respondents who thought most people would: talk to victim increased 8% in the intervention compared to 3% in the comparison (p=0.04), talk to friends increased 4% in the intervention compared to a 7% decrease in the comparison (p=0.002), and talk to a doctor increased 3% in the intervention compared to a 2% decrease in the comparison (p=0.004). Significantly more respondents in the intervention (59%) than in the comparison (49%) reported finding materials on DV in clinics (p=0.02). Calls to hotline increased from 520 pre-campaign to 694 during the campaign, and 1,145 post campaign.

Keller et al., 2010 (before and after [+], USA, n=430 pre-campaign; n=374 post-campaign) (demographic details NR), post-campaign) [3 print ads and 4 television ads run from spring-winter, depicting various forms (physical and verbal/ psychological), severity and impacts of abuse; each ad concluding with information on DV prevalence and a support hotline] Post-test analysis revealed that 21% of women and 21% of men recalled seeing the ads; TV was the most commonly recalled format (15%), with lower recall of billboard ads (7%). Following seeing the ads, a total of 4 participants reported helping others, 2 reported leaving a relationship, 5 recommended someone else leave a relationship, 3 intervened with a friend/ family member, and 2 called the police. In regards to respondents' perceptions of how severe DV is, the gender X campaign exposure interaction was found to be significant (F=27.27, p<0.00); women's mean score increased significantly (p=0.01) from pre-campaign to post-campaign (p=0.01), while men's scores decreased significantly (p=0.000). Women perceived greater response efficacy post-campaign than pre-campaign (p=0.01), whereas men did not change significantly.

Applicability: One study was conducted in Scotland (Solomon and Fraser, 2009 [+]) and the remaining 3 studies were conducted in the USA (Wray et al., 2004 [+]; Gadomski et al., 2001 [+]; Keller et al., 2010 [+]). Although the Scottish study (Solomon and Fraser, 2009 [+]) should be applicable to the UK context, methodological weaknesses (lack of pre-test and comparison group, limited information on demographics) limit generalisability. One study was tailored to African American participants (Wray et al., 2004 [+]) and therefore may not be applicable to other groups. The remaining two studies were conducted within rural areas and therefore may not be applicable to non-rural settings (Gadomski et al., 2001 [+]; Keller et al., 2010 [+]).

Evidence Statement 3- Prevention interventions/ approaches implemented in health settings

There is weak evidence from two studies that prevention interventions implemented in health care settings (both emergency departments (ED)) are associated with exposure (reports of noticing, reading or retaining of materials), or changes in knowledge and attitudes related to DV. One individual RCT (Ernst et al., 2011 [+]) reported overall improvements in knowledge, attitudes and practices (willingness to intervene in bystander scenario) related to IPV following a computer based IPV prevention presentation, with somewhat greater

improvements for the intervention condition, and no differences in outcomes noted between women and men or identified perpetrators and victims. A cross sectional study (Edwardsen and Morse, 2006 [+]) reported modest indicators of exposure (noticing, reading, retaining materials) to DV materials posted in ED restrooms, and women were more likely to report that they noticed the materials presented.

Ernst et al., 2011 (individual RCT [+], USA, n=239 women and men presenting to an emergency department (48% male, 52% female; primarily 21-30 years, White or Hispanic, earning less than $10, 000 or $10-20,000, high school educated, primarily single; 31% witnessed IPV as child, and 15% had child that witnessed IPV), post-intervention) [Intervention (n=121): PowerPoint slide addressing IPV prevention shown privately followed by a five minute video demonstrating IPV bystander scenes among adults; control (n=118): PowerPoint presentation only] Overall improvement in answers to all questions on knowledge, attitudes and practices (KAP) survey related to IPV, from 46% pre- to 59% post- intervention (13%, 95% CI 4-22%), with significantly higher improvement in the intervention (15%, CI 6-24%). A total of 40 participants identified as perpetrators (17%, CI 12-21), and 52 identified as victims (22%, CI 17-27%); no significant differences between the intervention and control for these groups. No significant difference in KAP survey scores for men and women. Men in the intervention improved more on KAP survey scores than in control (29% vs. 6%, $p<0.05$); there was no significant difference between women in intervention and control.

Edwardsen and Morse, 2006 (cross-sectional [+], USA, n=122 patients and visitors (mean age of 35 (women) or 34 years (men); 71% female, 29% male), n/a) [Pamphlets and business cards for 'Alternatives for Battered Women' (ABW, a woman's advocacy agency) and 'Men's Education for Non-Violence' (MEN's, a batterer's counselling service) posted in restroom accessible to both sexes in emergency department. ABW included: agency mission, hotline, shelter, counselling groups, children's services, court advocacy, and dating violence education. MEN's included: abusive behaviour, contact details for a counselling programme, alternatives to abusive behaviour, and self-responsibility for violence. All resources included contacts for support services] 65 (53%) participants reported that they had noticed the materials; 10 (8%) reported reading the materials; and 7 (6%) had retained a copy. A total of 19 (16%) respondents reported that they knew someone who could benefit from the information, and 9 (7%) reported that the information presented was new to them. In total, 15 ABW cards and 12 ABW pamphlets, and 13 MEN's cards and 15 MEN's pamphlets were taken. Women were more likely to report that they had noticed the information presented (60.9% vs. 34.3%, $p=0.009$).

Applicability

Both studies were conducted in the USA in emergency department settings (Ernst et al., 2011 [+]; Edwardsen and Morse, 2006 [+]). One study included limited demographic characteristics for participants and therefore it is difficult to determine wider applicability (Edwardsen and Morse, 2006 [+]). The other study included a largely single sample of White and Latino participants and may have limited applicability to other groups of women and men (Ernst et al., 2011 [+]).

Evidence Statement 4- Prevention interventions/ approaches implemented in community settings for at-risk women

There is weak evidence from two studies that prevention programs implemented in community settings are associated with improved knowledge and skills, attitudinal and psychological outcomes, social support and health behaviours for women who are vulnerable to abuse. A non-RCT (Khemka et al., 2005 [+]) found that a group abuse prevention programme for women with learning disabilities at an adult services agency was associated with improvements on empowerment, knowledge of abuse, and prevention focused decision making, but there were no improvements in women's stress management. One before and after study (Enriquez et al., 2010 [+]) found that a longer (12 session) HIV and IPV prevention group programme for low income single African American mothers delivered in a daycare was associated with improved: social support, self-esteem, readiness for change, IPV attitudes, and protective health behaviours; improvements were not found for shorter sessions.

Khemka et al., 2005 (non-RCT [+], USA, n=36 women with learning disabilities (mild or moderate (IQ 35-75); mean IQ of 55.9, mean age 34.3 years, primarily African American or White), post – initial intervention (1 week to 3 months post-), post- support group intervention (1 week to 4 months post-) [Intervention (n=18): 40-50min small group sessions held once or twice per week for 6 or 12 weeks aimed at empowerment, improved decision making, knowledge of and protection from violence/ abuse; Interactive skill building & decision making and follow up support group forum; compared to control (n=18): no intervention but access to abuse prevention services (counselling/ sex education). Setting: urban adult services agency] Intervention scored significantly higher on: Knowledge of Abuse Concepts Scale ($t(34)=2.91$, $p<0.01$), Empowerment Scale ($t(34)=2.15$, $p<0.05$), and Self Decision-Making Scale ($t(34)=3.13$, $p<0.01$). Effects were maintained at the second post-test follow up (following the support group component). No significant difference between groups on the Stress Management Survey.

Enriquez et al., 2010 (before and after [+], USA, n=25 women with children (mean age 31 years, primarily African American, single, mix of education levels), post intervention) [Urban daycare based intervention addressing HIV and IPV prevention. Weekly, 90min group socialization, educational and skill building activities along with creative activity, aimed at: improving self-esteem, social support and readiness for healthy behaviour change. Topics included: goal-setting, sexual & reproductive health, relationship negotiation, violence against women, and IPV protection & safety planning. Examined feasibility of 3 different programme lengths: 4 sessions (n=10), 8 sessions (n=5) or 12 sessions (n=10); all covering same content but with varying time devoted to activities. Focus groups with sub-sample (n=14)] Only women in the 12 session group reported improvements, including significant change in: social support ($p=0.006$), self-esteem ($p=0.002$), readiness for change ($p=0.049$), IPV attitudes ($p=0.054$), and protective health behaviours ($p=0.004$). Focus group participants reported improvements in social support, IPV and health knowledge and noted preference of 12-session format.

Applicability

Both studies were conducted in the USA with specific vulnerable groups of women (women with learning disabilities (Khemka et al., 2005 [+]) and low income single African American mothers (Enriquez et al., 2010 [+]), and therefore will have limited applicability to other groups of women.

4.6. Discussion

4.6.1. Key Findings

A total of 14 articles were identified within the scope of the review on interventions for preventing DV, informing four evidence statements related to: prevention approaches for young people; media campaigns; interventions implemented in community settings for at-risk women; and interventions in health settings. Note that school based programs that were not linked with health, social care, or specialized DV services were outside of the scope of this review (e.g. violence campaigns developed by and delivered on college campuses or within school settings) and therefore excluded during screening.

There was moderate evidence from six studies that prevention interventions for young people are associated with improvements on various outcomes including: knowledge of IPV, attitudes towards violence and gender roles, and interpersonal skills. However, some studies reported improvements on some but not all measures. One study evaluated an educational primary prevention programme (Scottish Executive, 2002 [+]), while the remaining studies were all secondary prevention approaches aimed at preventing violence among diverse sub-groups identified as high risk for IPV. These targeted approaches included: a brief educational programme for low income youth (Antle et al., 2011 [+]), a court delivered intervention for adjudicated African American male adolescents (Salazar and Cook, 2006 [++]), relationship education programs for Hispanic adolescent mothers (Toews et al., 2011 [+]) and adolescent couples (Florsheim et al., 2011[+]), and a tailored educational programme for Hispanic youth (Enriquez et al., 2012 [+]). Prevention programs tended to focus on attitudinal changes, yet

some studies conducted with young people at high risk for abuse also measured and reported modest improvements in behavioural outcomes such as a reduction in violent behaviours. While there is weak evidence on primary prevention programs for young people, there is modest evidence that prevention programs that target young people at risk for partner violence may improve knowledge, attitudinal and interpersonal outcomes.

There is inconsistent evidence from four studies that media campaigns addressing DV are associated with improved recall, hypothetical bystander actions, and awareness of available resources, calls to hotlines and knowledge and perceptions of DV. Two studies reported low awareness/ recall of the campaign, indicating issues with the implementation and reach of the campaigns (Wray et al., 2004 [+]; Solomon and Fraser, 2009 [+]). Two studies that were both conducted in rural settings reported some improvements in awareness of services and/ or attitudes towards DV (Gadomski et al., 2001 [+]; Keller et al., 2010 [+]). Together, these findings suggest that media campaigns may be useful in raising awareness of DV and services, particularly in rural contexts, yet ensuring the reach of a campaign is a potential barrier to effectiveness.

There is weak evidence from two studies that prevention interventions implemented in health care settings (both emergency departments) are associated with exposure (reports of noticing, reading or retaining of materials), or changes in knowledge and attitudes related to DV. None of the studies examined changes in behaviours. While one of the studies (Ernst et al., 2011 [+]) identified one of their measures as that of 'practices' related to DV, this was a measure of participants' willingness to intervene in a bystander scenario, and may be better understood as an attitude towards DV rather than a practice. Further research is required to examine prevention interventions within or linked to health settings, and also to explore behavioural change following an intervention.

Finally, there is weak evidence from two studies that prevention programs implemented in community settings are associated with improved knowledge and skills, attitudinal and psychological outcomes, social support and health behaviours for women who are vulnerable to abuse. While evidence was limited to only two studies, both were conducted with high-risk groups, including: women with learning disabilities (Khemka et al., 2005 [+]) and low income single African American mothers (Enriquez et al., 2010 [+]). The intervention for African American mothers was implemented in a daycare, a novel setting for a prevention intervention, emerging from a community based approach to service delivery to facilitate accessibility for disadvantaged women. While evidence is weak, findings suggest that engaging high risk groups may require tailored and innovative approaches to programme delivery.

4.6.2. Gaps in the Literature

There are a number of significant gaps in the literature. In particular, there is a lack of research among several populations relevant to the scope of our review. No studies were located that examined interventions to address the prevention of 'honour' based violence or forced marriage, or elder abuse. In addition, only two interventions were located that were delivered within health care settings, both within emergency departments, (Ernst et al., 2011 [+]; Edwardsen and Morse, 2006 [+]), with the remaining studies conducted in schools (though linked with health or social care settings) or community settings. Other authors have also noted the relative lack of IPV prevention work (Cavanaugh, et al., 2011; Godenzi & De Puy, 2001), particularly within the health sector (Kalaga, Kingston, Penhale, & Andrews, 2007).

The majority of studies measured attitudes and knowledge or exposure to educational materials and messages, rather than behavioural outcomes. This is largely due to the fact that most studies were aimed at intervening to reduce and prevent violence before it begins. However, some studies did assess impact on decision making, protective health behaviours, calls to a DV hotline, self-reported skills (e.g. communication, conflict management), or reports of partner abuse. Similarly, a review of communication components of social marketing and awareness campaigns by VicHealth, found that in prevention programs behavioural outcomes were often not measured, and if so, the most common measure was

calls to a DV hotline (R. J. Donovan & Vlais, 2005). This is in part due to the challenge in measuring violence/ abuse outcomes at the community level.

The majority of studies addressed DV prevention among young people, with relatively fewer studies aimed at violence prevention among adults. Hamby notes that rates of violence are higher during late adolescence and young adulthood and therefore this is a key developmental target for IPV prevention programs (Hamby, 2006). However, the best age/ time to engage young people in prevention programming, or if there are particular time points (e.g. marriage) which are key for prevention efforts, has been under-examined. Further research is also required to examine whether youth programs should focus exclusively on the issues of IPV, or if programs should be general and include other topics such as substance use, sexual health or other risk behaviours (Hamby, 2006).

The included studies did address diverse sub-populations of women and men or girls and boys, including: African American male adolescents (Salazar and Cook, 2006 [++]); Hispanic youth (Enriquez et al., 2012 [+]) and adolescent mothers (Toews et al., 2011 [+]); parenting adolescent couples (Florsheim et al., 2011 [+]); women with learning disabilities (Khemka et al., 2005 [+]); low income single African American mothers (Enriquez et al., 2010 [+]); and media campaigns with African Americans (Wray et al., 2004 [+]) or with rural dwelling participants (Gadomski et al., 2001 [+]; Keller et al., 2010 [+]). The range of diversity in these studies may reflect efforts to address DV prevention among some vulnerable sub-groups. Only one study was of high quality (Salazar and Cook, 2006 [++]) and the remaining 13 studies were of medium quality [+]. The majority of studies reviewed were non-experimental (primarily before and after studies or cross-sectional studies). Often, studies did not include a comparison group, and lacked follow up beyond the end of the intervention. Therefore, it is not possible to generalize many of the findings reported. More robust studies are required to determine effective approaches to preventing DV among these groups. Other authors have also noted methodological issues with prevention intervention evaluations including: short follow up, lack of analysis of appropriate programme length or curriculum, lack of comparison of different interventions, lack of behavioural measures, facilitator effects, reliance on self-report, contamination effects, limited statistical analysis, and lack of community and cultural tailoring (Hamby, 2006). Authors have urged for the need for longitudinal research on behaviour change, longer periods of follow up, comparison of different interventions approaches and examination of intervention components (Cavanaugh, et al., 2011; Hamby, 2006; O'Leary, Woodin, & Timmons Fritz, 2006).

Interventions aimed at adults tend to be media or awareness campaigns. The evidence for media campaigns was inconsistent, with some studies demonstrating effectiveness while others did not, largely related to limited awareness of the campaign by the audience. Other authors have noted similar challenges and considerations when developing educational campaigns. Wray discusses the importance of reach, long-term planning and culturally sensitive programming (Wray et al., 2004). Campbell & Manganello recommend that education campaigns develop a clear understanding of barriers and motivations to preventing DV among the target audience, and knowledge of how the target audience conceptualizes DV, to develop the most appropriate and effective messages (Campbell & Manganello, 2006).

Mancini et al. argue that the community should be a setting, target and force for prevention campaigns (Mancini, Nelson, Bowen, & Martin, 2006). They claim that education and media campaigns geared at changing attitudes towards violence tend to be passive and that to be effective, programs need to be part of a comprehensive strategy and utilize community networks. While only two prevention interventions were conducted within community settings, the intervention for African American mothers by Enriquez et al., 2010 [+] aligns with the call by Mancini and colleagues. This intervention was developed using an innovative, community based approach to service delivery to facilitate engagement of disadvantaged women. More tailored, community based approaches to violence prevention are required.

Several authors have suggested alternate approaches and frameworks for DV prevention. For example, Chamberlain suggests a spectrum of prevention including the following non-hierarchical action levels: 1) strengthening individual knowledge and skills; 2) promoting community education; 3) educating providers; 4) fostering coalitions and networks; 5)

changing organizational practices; and 6) influencing policy and legislation (Chamberlain, 2008). A review of peer violence and substance use literature by O'Leary et al. (2006) revealed that programs aimed at individuals at-risk showed larger effects than those aimed at all individuals. Therefore, they propose a pyramid response to the prevention of partner aggression among young adults, which involves offering increasingly intense interventions based on the level of aggression present. Other authors have also discussed the importance of linking violence prevention approaches to the community (Sabol, Coulton, & Korbin, 2004), or developing awareness campaigns that operate concurrently at both the societal and individual level to create a supportive context for violence prevention (R. J. Donovan & Vlais, 2005).

5. Research Question 2: Effectiveness Review of Interventions for Identifying Domestic Violence

5.1. Background

The second review question examines interventions for identifying and responding to DV. Victims of DV often are not identified in health settings, due to both the under-reporting of violence (often due to safety concerns) and lack of screening by health care providers. The majority of research on screening has focused exclusively on examining the evidence for screening women for intimate partner violence, and not screening of perpetrators of violence, or screening for other sub-populations who experience violence (including older adults, children exposed to violence, or 'honour'-based violence).

Screening Women for Domestic Violence

Various systematic reviews have found a lack of clear evidence regarding screening women for DV (Feder et al., 2009; Nelson, 2012; Ramsay, 2002; Waalen, Goodwin, Spitz, Petersen, & Saltzman, 2000). The majority of these reviews have examined the effectiveness of universal or routine screening within health services of all women meeting with a health care provider. For example, reviews conducted for the UK National Screening Committee (UKNSC) revealed that screening more often results in increased identification of violence for women and is acceptable to most women, yet they did not find sufficient evidence that screening resulted in improved health outcomes or a decrease in recurrence of violence, and found mixed reports from health care providers regarding acceptability (Feder, et al., 2009; Ramsay, 2002). These authors have argued that before a screening programme is implemented, further evidence is required on the effectiveness of interventions and lack of harm from routine screening for women, along with a strategy for shifting the views of clinicians about screening (Feder, et al., 2009). Similarly, reviews conducted for the US Preventive Services Task Force (USPSTF) (Nelson, 2012) and the Canadian Task Force on Preventive Health Care have also concluded that there is insufficient evidence of health benefits for victims of DV to either support or reject screening for DV (Moracco & Cole, 2009)

However, organizations of health care professionals including the American Medical Association continue to recommend routine screening of all women for DV (Moracco & Cole, 2009). Ramsay (2002) notes that calls for routine screening assume that effective identification of DV will result in appropriate interventions and levels of support, and decrease further cases of DV and associated health consequences. Some researchers have suggested that distinctions need to be made between the need for universal or routine screening of all women, and "case finding" or "clinical/ selective enquiry" which involves identifying women who are suspected to be at risk of abuse, and providing various forms of support and resources to these women (Klevens & Saltzman, 2009; Moracco & Cole, 2009; O'Campo, Kirst, Tsamis, Chambers, & Ahmad, 2011). As Olson et al. note, the question is not simply whether or not women should be screened for DV, but more importantly how can health professionals best ask about violence and adequately support/ respond to women who have experienced violence (Olson, Rickert, & Davidson, 2004). While, in general, minimal adverse effects of screening have been found for women (Feder, et al., 2009; Nelson, 2012), some women do experience negative impacts including: emotional distress and discomfort, fear of further abuse, and a loss of privacy (Nelson, 2012). Therefore, identification of DV needs to be performed with sensitivity to the potential for further harm of women. Many providers hesitate to ask women about DV because they feel ill equipped to intervene. Health care providers note that they often lack time, training and knowledge of available resources and knowledge of or access to effective interventions for responding to DV, and concerns about offending the patient (O'Campo, et al., 2011; Olson, et al., 2004; Waalen, et al., 2000).

Screening for other forms of domestic violence

Augustyn & Groves note some similar issues regarding screening children who have been exposed to violence (Augustyn & Groves, 2005). Common provider concerns include: how to ask about violence when children are present, how to respond if it is clear that children have witnessed violence are required, and when to report a child to protective services. Adequate training of paediatric health care providers on how to ask and respond to exposure to violence for children is required.

While identification and assessment of the perpetrator of violence is an essential first step towards rehabilitation (Peterman & Dixon, 2001), there are important safety concerns associated with identification . Several methods are used to assess perpetrators of DV, including: behavioural assessments, victim reports and qualitative methods (Peterman & Dixon, 2001). However, issues to consider with the application of these assessments include: the safety of the victim, assurance of confidentiality and issues of under-report by perpetrators. It may be necessary to discuss safety planning and provide additional support resources to the victim in order to protect them from further harm (Peterman & Dixon, 2001).

There are several barriers to the identification of and response to 'honour' based violence. Enforcement agencies and social services (outside of specialized services) are often not aware of how 'honour'-based communities operate (Brandon & Hafez, 2008). In addition, police may be reluctant to respond to reports of risk or cases of 'honour' based violence due to a belief that this is a cultural practice or lack of awareness of the severity of these crimes (Brandon & Hafez, 2008). Women who are victims may be afraid to report their experience due to safety issues and a lack of safe, available resources. Initiatives have been implemented in the UK in an attempt to address some of these issues. The Home Office introduced a system of "third party reporting" where victims of DV can report cases to community organizations rather than directly to the police. This is meant to provide a safe place for women to report violence, as some women may not trust police or may be concerned about being seen entering a police station. In 2008, the Association of Chief Police Officers also introduced a strategy to improve identification of and response to 'honour violence.' This includes training of officers, providing resource tools, and including 'honour' violence in inspections and performance management of police forces.

Screening for elder abuse raises a different set of concerns. Older adults are more likely to be in contact with health care professionals, and for many older adults who are socially isolated this may be one of their primary forms of contact and support (Joubert & Posenelli, 2009). However, some older adults may be reluctant or unable to discuss experiences of DV, particularly if the perpetrator is a family member (out of fear, dependency or loyalty to the family member/s) (Joubert & Posenelli, 2009). Identification of abuse is important for improving health, yet screening must be conducted with sensitivity, and health professionals often lack the knowledge of elder abuse and confidence to ask about and respond to abuse. Further education of health professionals is required, as are screening tools that more accurately capture the current context, rather than potential future risk, of abuse.

5.2. Summary of the Literature

A total of 188 full-text study reports were retrieved. An additional eight reports relevant to Q2 were collected through the grey literature search (a breakdown is provided in the flow-charts in *Appendix G*), including: web-searches and the OpenGrey database. For Q2, further suggestions of grey literature were not actively sought from PDG members, but three voluntarily provided suggestions were included.

A total of 199 reports were retrieved for full text review. Of these, 130 papers were excluded at the full text screening stage. We were unable to locate three papers and therefore they were excluded (see *Appendix H* for all papers that were unable to be located during the review). Ten systematic reviews (which included 23 relevant individual studies that were then excluded from

our main report of findings) were located. A high level summary of these reviews is provided. Five studies received both a [-] internal and [-] external quality rating and are not included in the report of findings, but are listed in *Appendix F*. Note; two quantitative studies were included in Q2 with negative [-] internal quality ratings, but moderate [+] external quality ratings. A total of 28 studies are included and reported on in this review. A summary of the studies included in see *Appendix I.*

5.2.1. Systematic Reviews

Ten systematic reviews were identified. *Appendix J* lists the reviews that were assessed. A summary of these reviews is provided prior to the reporting of findings.

We compared the studies retrieved using our search criteria, with the studies covered by the ten reviews, and excluded 23 relevant studies that were assessed.

5.2.2. Included Studies

The results of quality assessment are presented in *Appendix K*. Of the studies reviewed, for internal validity, six were judged to be of high quality [++], and 21 of medium quality [+] and two of low quality [–]. For external validity, four studies were judged to be of high quality [++], 19 were of medium quality [+], and five of low quality [-].

Applicability

Two studies were conducted in the UK; one in Australia; one in the Netherlands; six in Canada; and 18 studies were conducted in the USA. However, for the majority of the interventions there is no reason to believe that the approach could not be applied to the UK context. Potential applicability issues that pertain to specific studies are discussed within the findings of the report and provided in the evidence statements.

The main source of potential barriers to applicability is the method of screening examined, or the sample population included. Some studies examined universal screening, while others examined routine or clinical inquiry methods for identifying DV. Therefore, these may only apply to UK settings where comparable policies for identifying DV exist. Studies that included specific sub-populations of women, and may not be applicable to the UK context, are also discussed within the findings and evidence statements.

5.3. Summary of Systematic Reviews

Background

Intimate partner violence (IPV) is an undisputed health concern; however, a range of opinions has been expressed on whether screening instruments for IPV should be instituted. Eight systematic reviews have examined the effectiveness of these tools: Coulthard et al. (2010), Feder et al. (2009), O'Campo, Kirst, Tsamis, Chambers and Ahmad (2011), O'Reilly, Beale and Gillies (2010), Rabin, Jennings, Campbell and Bair-Merritt (2009), Ramsay, Richardson, Carter, Davidson and Feder (2002), Trabold (2007), Stayton and Duncan (2005). The effectiveness of intervention programs following IPV identification was analysed by a ninth study from Nelson, Nygren, McInerney and Klein (2004), as well as by Coulthard et al. (2010), Ramsay et al. (2002) and O'Reilly et al. (2010).

Study Purposes

Two reviews were based on the UK National Screening Committee criteria. Feder et al. (2009) identified, appraised and synthesized research on IPV screening programs and evaluated whether current evidence fulfills NSC criteria for IPV screening. Ramsay et al. focused on three of the Committee's criteria: that a test is acceptable to the population, that there is evidence the

screening is acceptable to health professionals, and that effective treatment or intervention is available.

In 1996, the U.S Preventative Services Task Force determined that that there was insufficient evidence either in favour of or against implementing IPV screening. The author groups led by Rabin and Nelson used this decision as their starting point for updating the literature (2009).

The focuses of the remaining five studies varied. Coulthard and colleagues looked at whether any literature has measured the benefits and harms of intervention programs for adults presenting with facial and/ or dental injuries and assessed the outcomes of those screening practices (2010). Trabold presented literature on IPV screening, measuring screening practices, victim safety and evaluated research limitations (2007). O'Campo et al. reviewed the literature from a healthcare context, focusing on how, for whom and in what circumstances screening practices are effective (2011). Stayton and Duncan examined "Mutable" influences; they looked at which factors could be changed to improve screening tools (2005). Finally, O'Reilly and colleagues examined the effectiveness of IPV screening and interventions for pregnant women (2010).

Key Findings

- **Effectiveness of screening tools:** Overall, it was accepted that higher rates of IPV are identified through screening tools. O'Reilly and colleagues' review of five studies on IPV screening of pregnant women found that such tools increase IPV identification, more so when women are screened several times during prenatal care. O'Campo and colleagues indicated that comprehensive programs – those that implemented screening components at different levels, such as practitioner training, and were given institutional support, investment and approval – had higher levels of IPV identification than non-comprehensive ones (2011). Trabold reported higher levels of IPV identification through screening tools, finding that even higher numbers were reported when the tool was administered by a social worker (2007). Finally, Feder and colleagues concluded that screening tools such as HITS are effective in identifying IPV (2009). Unlike the other studies, the Coulthard et al. group could not find any randomized controlled trials on screening or intervention programs for their area of focus: adults with dental and facial injuries (2010).
- **Women's and healthcare workers' approaches to screening:** Three reviews reported that women were much more likely than physicians to agree with screening practices. Feder and colleagues showed that most women indicated that screening is a means of increasing knowledge, removing stigma, earning a sense of self-validation and getting support (2009). These results were echoed by Ramsay et al., who reported that half to three quarters of women patients in primary care health settings indicated that screening is acceptable (even higher for those women who had experienced abuse), while a minority of doctors and nurses thought so (2002). They attributed the low acceptance rate among healthcare providers to a lack of training on IPV, fear of offending patients, lack of effective interventions, limited time to screen or patients not complying with screening. Stayton and Duncan found that after practitioners received IPV training, screening rates increased by 15.2 percentage points (2005). Nonetheless, delivery rates varied between healthcare workers. Those more likely to screen for IPV are: female physicians (rather than male), women's health specialists (rather than other specialists) and public health nurses (rather than office-based or hospital-based nurses).
- **IPV intervention:** All groups of authors but one reporting in this category concluded that, based on current intervention results (or lack thereof), there is insufficient evidence to recommend implementing IPV screening. Coulthard et al. (2010), Feder et al. (2009), Ramsay et al. (2002), and O'Reilly et al. (2010) all came to this conclusion. Rabin and colleagues elaborated that intervention results are inconclusive because more reliable and valid testing of IPV screening tools are required, in addition to a need for standardizing comparison measures (2009). Even the most commonly studies tools, including HITS, indicated wide ranging sensitivities and specificities across studies that

need further investigation. Nelson et al. wrote that no studies indicated whether screening resulted in reduced harm or whether there were adverse effects of screening (2012). They also could not find any evaluation of the optimal methods for administering screening instruments. Although referrals to external resources (e.g. police, shelters, social workers) increased with screening, it was unknown whether these interventions improved violence or health outcomes. Conversely, Trabold concluded that because screening increases disclosure rates, there is an opportunity for advocacy intervention, a strategy linked to decreased violence, isolation and increased safety practices (2007).

Key Recommendations

- **Research:** All authors agreed that more research is needed. This research should be conducted with diverse populations using universally accepted comparison measures (Rabin et al., 2009) and include randomized controlled trials of interventions (Coulthard, et al., 2010; Ramsay et al., 2009). In addition, the research should determine which type of health care provider is best positioned to administer screening and in what setting, and consider practice-related factors, such as continuity of care and visit length (Stayton & Duncan, 2005). Future research should examine the relationship between IPV screening and safety practices (Trabold, 2007). The group led by Feder further specified several recommendations for future research, stating it should include: trials of system-level, psychological and advocacy interventions; tests of theoretically explicit interventions to understand what works for whom, when, what context; qualitative studies exploring what women want from interventions; cohort studies measuring risk factors, resilience factors and the lifetime trajectory of partner violence; and, longitudinal studies measuring long-term prognosis for survivors of partner violence (2009). Nelson and colleagues called for more research on violence in pregnancy and postpartum, the health implications of IPV on mother and child, the role of violence in reproductive decision making, and effective screening and intervention strategies for pregnant women (2012). Future studies should also examine the effectiveness of treatment programs for victims and perpetrators, evaluating the feasibility of screening procedures and interventions in health care settings and the strategies for enlisting health systems and community programs. Coulthard and colleagues stated that randomized controlled trials should be conducted in busy hospitals that treat large numbers of patients with facial or dental injuries (2010).
- **Training**: More IPV training and education should be provided to healthcare workers (Coulthard, et al., 2010; Trabold, 2007), especially to clinicians-in-training, who are likely to be receptive to the information and willing to put it into practice (Stayton & Duncan, 2005). In addition, more education, feedback and practices should be integrated into early stage of professional work, as well as further research identifying useful components of healthcare provider training.
- **Precise screening practices**: Three author groups indicated a need for a more precise or well-adapted screening tool, as well as a standardized screening instrument. According to Trabold, there is currently no consistent screening method across studies, making it difficult to compare results (2007). She recommended adopting the Centre for Disease Control's definition of IPV across studies to facilitate comparisons. Nelson and colleagues agreed with the need for a standardization of terms, including "abuse," "neglect," "severity," "chronicity" (2012). They added there should be more testing and validation of existing screening instruments.

In addition to the above recommendations, it was suggested that patient settings adapt screening techniques that best suit their needs, while policy makers examine how screening can be effectively and efficiently implemented (Stayton & Duncan, 2005). Furthermore, screening tools should be brief, comprehensive and tested across a diverse population. Each provider should be able to decide on the optimal balance between brevity and comprehensiveness when chosen the appropriate screening tool (Rabin et al., 2009). Finally, partnerships between healthcare providers and local DV organizations should be solidified in order to provide more comprehensive delivery of policy and practice (Coulthard et al., 2010).

Summary Statement

Overall, there is insufficient evidence for the effectiveness of a screening programme for IPV. While women have generally supported screening, less support has been observed among health care providers. There is a need for: more research and development of interventions that include follow-up with victims beyond identification, more IPV training and education for healthcare workers, and more precise and tailored screening techniques.

5.4. Findings

Ahmad et al., 2009

A Canadian individual- RCT by Ahmad, 2009 [++] examined the effectiveness of computer-assisted screening for the identification of intimate partner violence and control (IPVC). The study included what the authors describe as “diverse patients” in an “inner city” multi-physician clinic. Female patients 18 years and older who were in a current or recent (in the past year) relationship were eligible to participate. A total of 314 women were included in the initial allocation of the study (intervention n=156; control n=158), although the final analysis included 293 women (intervention n=144; control n=149). Intervention patients were: a mean age of 43.5 years; primarily married (60%); primarily college (37%) or university educated (29%); full or part-time employed (74%); and reported a range of income levels. The majority of participants (83%) used a computer regularly (daily to three times per week). At baseline, the control group did not differ significantly from the intervention group on the reported demographic variables.
Physicians were 64% female, 36% male; 64% White; and a mean age of 46 years. They had a mean clinical practice of 16.1 years, and mean of 40.6 practice hours per week.

Participants were randomly assigned to either intervention or control using computer generation. The intervention was a validated patient survey delivered by a computer programme. The programme, “Promote Health”, included 79 questions related to IPVC, alcohol, tobacco and other substance use, sexually transmitted diseases, road and home safety, depression, cardiovascular risks and socio-demographic factors. IPVC related risks that were assessed included: physical or sexual violence, threat of violence and control by a partner. Following completion of the survey (mean time of completion was 7 minutes), a computer generated risk report sheet was produced which was appended to women’s medical chart for their physician. Any positive responses to IPVC questions were noted as “possible partner abuse- assess for victimization.” Suggested referrals to community resources were listed at the end of the physician’s report, and patients were also provided a sheet with a report of their health risks and a list of recommended resources. Participants in the control condition received usual care (no computer screening prior to their medical appointment).

Medical visits were audiotaped. Blinded researchers assessed whether the patient or physician brought up possibility of patient risk of IPVC during the appointment (discussion opportunity) and in cases where this did occur, if the risk was identified when the woman indicated that risk was present and/ or recent (IPVC detection). Transcripts were coded as either “yes” or “no” for discussion opportunity, and “absent”, “present and recent,” or “present in the past” for IPVC detection. Patient safety and provision of appropriate referrals and follow-up advice were also coded. Following their medical appointment, women filled in a written exit survey which included the computer survey questions in addition to questions related to: demographic, health status and acceptance of computer screening.

Based on exit survey data, overall prevalence of any form of IPVC was 22%, and there was no significant difference between the intervention and control conditions (20% vs. 23%). The computer risk report was found to improve IPVC discussion opportunities, which were noted in 35% of the intervention participants and 24% of the control (adjusted relative risk (RR)=1.4, CI: 1.1-1.9). Detection of IPVC was also greater in the intervention compared to the control (18% vs. 9%; adjusted RR=2.0, CI: 0.9-4.1). For detected cases, physicians were more likely to assess

patient safety in the intervention group (9 of 25 participants) than control group (1 of 12 participants). A total of 3 intervention group patients and 1 control group patient received referrals. Physicians requested follow-up appointments more often in the intervention (20 of 25 participants) than in the control group (8 of 12 participants). Computer screening also facilitated improved discussion of (adjusted RR=1.5, CI: 1.1-2.0) and detection of (adjusted RR=1.5, CI: 1.0-2.2) mental health disorders; other risks were not statistically significantly different between groups. On average, participants perceived screening as beneficial but some concerns regarding privacy and interference with physician interactions were reported.

Computer screening during the wait period for appointments appears to improve screening for partner violence. Limitations of the study include: the focus of the study on one clinic; lack of analysis of differences for patients with co-occurring conditions; lack of information on types of IPVC; and lack of assessment of patient use of referral services. While the authors note that 40% of the patient population was foreign born, patients who could not read or write English were excluded, which may limit generalisability.

Bonds et al, 2006

A US-based before and after study by Bonds et al, 2006 [+] examined the effectiveness of an intervention designed to increase DV screening in primary care settings. The intervention included both standardized educational sessions and components customized to the needs of participating practices. At a minimum, the primary care clinics were asked to screen all women over the age of 18 at least once per year.

The setting was 15 primary care clinics in North Carolina USA. The intervention was tested by a pre/ post cross-sectional telephone survey of a random sample of female patients from each of the practices. Population for the documentation of screening rates were a random sample of 1,482 women attending primary care clinics in the 12 months prior to the baseline survey and intervention, and a random sample of 1,527 women attending the clinics over a twelve month period between the baseline and post intervention survey. Participants in the initial survey were a mean age of 49 years, primarily white (62%), married (46%), had a child at home (40%), were health insured (90%), employed (46%), and earning an income under $25,000 (50%). Demographics of participants in the follow-up survey were similar (a mean age of 48 years, 50% White, 54% married, 41% child at home, 89% health insured, 50% employed, 50% income under $25,000). The mean number of visits to a health care provider in the last year was similar between the two groups (7.5 and 8.0 respectively) as was the number of women who reported seeing a female primary care provider (52% and 48% respectively).

The intervention was delivered over an 18-month period and included: attendance by 2 local resource persons in a one day centralized training session (covering legal issues relevant to DV and clinical training lessons), an audit of baseline rates and feedback to the clinic of these rates, and ongoing educational visits (lunch and learn). Providers included in the intervention were: nurses, midwives and physicians. Following the central training, the two local resource people conducted either a single 90-minute or two 45-minute training sessions at their own clinic with the help of study staff. The clinics selected patient education material appropriate for their patient population. The clinics also selected a preferred screening method, oral or paper, and a preferred screening tool from among 5 options.

Change in the percentage of female patients reporting screening by their health care provider in the past 12 months for violence in the home was assessed by telephone survey. The outcome question was embedded in a survey on general healthcare. The survey asked participants whether their health care provider had asked about particular behaviours that may affect health, and conducted or ordered clinical screening exams.

The outcome achieved from using this practice-centered intervention, was a 10 percent absolute increase in patient-reported screening for DV. Pre-intervention, 16% (n=236) of women surveyed

reported being screened; post intervention 26% (n=398) of women surveyed reported being screened. When patient characteristics, health care provider characteristics and clustering by practice were accounted for, patients were 79% more likely to have been screened after the intervention than at baseline (OR 1.79, 95% CI 1.43–2.23).

Study limitations include the small number of clinics involved (which did not allow for comparison between the variable methods for screening used across clinics) and the lack of a comparison group. In addition, the vagueness of the question in the post survey (where women were not asked directly about being screened for DV, but instead about "concerns about safety or violence in the home") may have affected their responses. The study authors and the clinical staff put considerable effort into customizing aspects of the intervention to better fit the specific needs of the practice. While the authors considered the increase in patient-reported screening for DV to a level of 26% to be successful as an indicator of changing practice patterns, it seems a modest achievement given the multimodal approach to supporting improvement in screening rates, and that these clinics had shown the commitment to be involved.

Calderon et al., 2008

A US-based cluster RCT by Calderon et al., 2008 [++] examined the impact of provider cueing on patient-provider discussions of intimate partner violence (IPV) when seeing pregnant women. Women age 18 and older who were less than 26 weeks pregnant and reporting at least one health risk (tobacco, alcohol, drug use, or IPV) were recruited from 5 urban prenatal clinics in San Francisco, California. A total of 32 women were included in the intervention group and 27 in the control condition. Women who participated were a mean age of 27.4 (SD=6.4), 31% were Latina, 35% African American and 16% White, the majority (72%) had a high school education, and 88% had previously been pregnant. There were no significant differences in demographics between intervention and control at baseline.

Women were stratified by potential risk combinations and randomly assigned by computer to intervention or control group. Participants in the intervention completed a private computer-based risk assessment prior to a regularly scheduled prenatal visit, called the Health in Pregnancy (HIP) programme. The assessment included demographic questions, and screening for tobacco, alcohol, drugs and IPV. A cueing sheet was then attached to the patient's medical record that summarized risk for the doctor and provided recommended counselling statements. Providers were given a brief orientation in the use of cueing sheets. Participants in the control group completed the risk assessment but the cueing sheet was not provided to the physician, and they received usual care. Both intervention and control group participants completed a brief interview after their appointment to assess discussion of risks, how helpful they felt the discussion was and acceptability of the HIP programme.

They found that 17 out of 20 women reporting IPV in the intervention reported a discussion with their provider (85.0%, 95% CI: 62.1%-96.7%). In the control group, 4 of the 17 participants reporting IPV reported a discussion with their provider (23.5%, 95% CI: 6.8%-49.9%). Of the total 21 participants who discussed IPV with their physician, 19 rated the discussion as helpful, and 2 rated the discussion as not helpful. All participants who reported IPV (n=37) indicated that they enjoyed using the computer programme and found it easy to use; 33 felt they had enough privacy, while 4 indicated that they would appreciate more privacy. A total of 12 participants reported risk for both IPV and smoking.

While this study design is robust, they did focus on self-report and therefore it is possible that there was a reporting bias. The sample size was also small, and the study included a primarily low education and ethnic minority sample with at least one risk factor, which may limit the generalisability of findings.

Colarossi et al., 2010

A US-based before and after study by Colarossi et al. 2010 [+] compared two screening tools used in reproductive health practice clinics run by Planned Parenthood located in New York city at two points in time. The population for the study was adolescent and adult women accessing reproductive health services at three clinics in New York City, prior to, and during 2007 (total n=805, old screening tool n=420, new screening tool n=385). Old screen participants were a mean age of 24.7, primarily African American (41%) or Latina (27%), spoke English as a first language (93%), and the majority were single (95%). New screen participants were a mean age of 25.1, primarily African American (39.5%) or Latina (26%), spoke English as a first language (95.5%), and the majority were single (95.5%).

Health care centre procedures were the same for both time periods of screening: all patients completed a written medical history form prior to their medical appointment. The older screening tool used prior to 2007 was comprised of 2 questions, with yes or no response options. The new screening tool used in 2007 was comprised of 6 questions, 4 of which asked about experience of violence in the past year, with a 5-point scale of frequency. The new tool also incorporated 2 questions about lifetime experience of violence with yes or no response options. Levels of disclosure were captured from a chart review.

More women completing the new screening questions reported any IPV (23.6%) than those completing the old form (11.2%) ($p=0.000$). The new screening form also resulted in over twice as many affirmative reports in all IPV categories than the old form (OR's are from logistic regression models adjusted for age and centre site): any violence OR=2.66 ($p<0.001$), current violence OR=2.56 ($p=0.07$), past violence OR=2.61 ($p<0.001$), and both current and past OR=4.18 ($p<0.05$). An additional multinomial regression, also adjusted for age and centre site, with violence history as the dependent variable revealed that women completing the new screen were 2.5 times as likely to report current and past violence, and 4.2 times as likely to report both current and past violence histories. Age was significantly related to IPV disclosure; for every additional year of age, reporting increased about 4% (OR for age as an interval variable in number of years was 1.04, $p=0.001$).

The authors cite the benefit of brief and effective DV screening tools (such as the new one applied in this study) for busy health care settings. The tool developed is brief, but allows for a range of responses using a frequency scale format, and includes a wider range of experiences than many other tools. While the study did not document the follow-up to the disclosures, the authors see the potential benefit as promoting individualized health care planning by health care providers that takes into account relationship dynamics associated with IPV. The authors acknowledge that additional training for health care providers may be needed to increase comfort for responding to disclosures of IPV and knowledge about how IPV may impact reproductive health and how to help women develop an individual safety plan in the area of sexual and reproductive health care.

Key limitations are that the study relied on retrospective chart review, and the tools were not tested simultaneously, but over two years of consecutive use, with different groups of women represented. A range of temporal and environmental factors could have been associated with disclosure rates, for example it is unknown how many women were verbally screened or who had a partner at the appointment when completing the medical history. In addition the new screening questions were prefaced by an introductory question asking, ''Have things been going well in your relationship?'' which may have affected responses.

Coonrod et al, 2000

A US-based RCT [+] aimed to test the effect of providing a brief educational intervention at orientation for incoming medical residents at a major US teaching hospital, on the rate of diagnosis of IPV in the 9 to 12 months post orientation. Population for the study was 102 medical residents with family practice, emergency medicine, obstetrics-gynaecology, paediatrics, internal

medicine, psychiatry, and surgery specialties. The setting was a 500-bed hospital in a suburb of Phoenix, Arizona, USA over two years (1995-6 and 1996-7).

The residents were computer randomized, stratified by sex and specialty. The participants in the experimental group in the first year viewed a 20-minute videotape about prevalence of IPV and the importance of screening; and the additional experimental participants in the second year participated in a 20-minute programme comprising a nine-minute videotape and a role-play that demonstrated interview techniques for detecting DV, as well as selected readings (total n for the experimental group across both years was 53). Control group participants (n=49) attended education sessions on topics unrelated to DV. In a follow-up phone call at 9 to 12 months, participants were asked to report on diagnoses of DV sometime between the intervention and the follow-up. To blind the participants to the purpose of the study, it was presented as a test of different educational interventions; the specific interest in DV education was not revealed.

Findings revealed 71% of the residents in the experimental group diagnosed DV; 52% in the control did so (RR=1.35, 95% CI: 0.96-1.90, p=0.07) in the nine to 12 months following the intervention. Broken down by year, in 1995, the percentages were 75% intervention compared to 60% in the control (p=0.29), while in 1996, the percentages were 67% intervention compared to 46% in the control (p=0.15). There was no difference based on the sex of the physician, but there was difference (p<0.01) by specialty: all (100%) of family practice and medicine-paediatrics residents, 90% of emergency medicine, 80% of obstetrics–gynaecology, 67% of psychiatry, 63% of paediatrics, 47% of internal medicine and 0% of surgery residents diagnosed cases of DV. Change in knowledge was assessed in the second year, and significant improvement was noted: Intervention mean=73% correct vs. control mean=56% correct on the post-intervention test (p=0.002).

Limitations include the use of a small sample size, and reliance on self-report outcome measures. The study was conducted in one hospital only, and no significant difference was found in the rate of diagnosis of IPV between those receiving the two types of brief educational intervention. The brief educational intervention significantly improved the residents' knowledge but not their rates of diagnosis. The variation across specialties indicates a need to tailor screening to support the specific medical context.

Duncan et al., 2002

A US-based interrupted time series by Duncan et al., 2006 [+] evaluated the impact of providing performance feedback to OB/GYN residents on screening for DV over a 9-month period. Participants included 1st and 2nd year OB/GYN residents from an urban hospital. Of the 12 residents included, 10 were female and all were white; all spoke English and none spoke a second language. The population screened was predominantly low income and Latina, and the majority of patients visit the clinic during their second trimester of pregnancy (69.2%).

The clinic protocol requires the screening of all prenatal patients once per trimester of pregnancy for IPV (at first visit, week 16, and week 28). However, baseline measurements suggested this protocol was not being followed (screening only half of required patients). Following baseline measurement, residents participated in a two-hour training on screening for DV. They were requested by the director to ask screening questions and document screening findings. The following screening questions were to be included: 1) Are you in a relationship with a spouse, partner, or family member who makes you feel afraid? 2) Have you been emotionally, physically, or sexually harmed by your spouse, partner, or other family member (a. ever, b. within the last year, c. during this pregnancy)? 3) Have you been hit, slapped, kicked, or otherwise physically harmed by your spouse, partner, or other family member (a. ever, b. within the last year, c. during this pregnancy)? One month following training, the director met again with residents to discuss the importance of screening and the baseline screening results. Two months later, researchers provided the residents with personal reports comparing screening performance against their colleagues at four times (the authors refer to this as "individualized performance feedback" (IPF)).

The research team collected patient records at first visit, week 16, and week 28 for five data collection periods each: 1) pre-IPF, 2) following the first IPF report, 3) following the second IPF report, 4) following the third IPF report, and 5) following the fourth IPF report. They examined medical records before and after the provision of each set of IPF reports, and also examined notes pertaining to protocol dates, and any notes on patient's condition and care. Residents were grouped into either Team A, Team B, or Team C for a peer comparison of utilization of screening protocols with IPF. Teams A and C were composed of female first year residents. Team B included two male and four female second-year residents. A total of 518 visits were analysed.

They found that residents screened approximately 60% of all appropriate visits before IPF; following the final (fourth) report, these same residents screened 91% of all visits (chi square=28.4, p<0.001). Team A residents screened 88.9% of visits prior to receiving feedback and 100% of visits following the final report (p-value not significant). In comparison, Team B residents screened 45.2% of visits prior to receiving feedback and 77.3% following feedback (chi square=10.3, p=0.036) and Team C residents screened 40.9% of visits prior to receiving feedback and 92.1% after receiving feedback (chi square=20.0, p<0.001). Both male residents were Team B members. Residents screened 70.2% of first medical visits before feedback, increasing to 95.1% following the final (fourth) report (chi square=17.7, p=0.001). Residents screened 46.5% of follow-up visits before feedback and 82.1% following the final (fourth) report (chi square=14.0, p=0.007). Standard logistic regression analysis revealed that the odds of screening after the last IPF report were 7.6 times greater than before IPF (OR=7.6, 95% CI: 3.0-18.9). The odds of screening following the second and third reports were approximately three times that of the pre-IPF period (OR=2.8, 95% CI: 1.3-6.1 and OR=2.9, 95% CI: 1.5-5.8, respectively). The odds of screening during the first visit were approximately twice that of screening at follow-up visits (OR=2.0, 95% CI: 1.0-3.9). Overall, the odds of screening were greatest for the second trimester of women's pregnancy. First year residents' rates improved from 71.4% prior to feedback to 95.4% following final report (chi square=16.1, p=0.003); second year residents' rates improved from 45.5% to 79.2% (chi square=11.7, p=0.02). Male residents screened 33.3% of all visits prior to feedback and 66.7% of visits following final feedback report (chi square=10.6; p=0.032). Female residents screened 64.7% of all visits prior to feedback and 93.8% of all visits following final feedback (chi square=22.0, p<0.001). The odds of screening by the male residents was nearly half that of the odds of screening by female residents (OR=0.46, 95% CI: 0.21-0.98).

Limitations include: the lack of men in the study (only two) to adequately examine gender differences in screening, the short period of follow-up (the study was only 9 months in duration), and a small sample size which may limit generalisability beyond the study setting and patient-reach (low income minority women). The authors also recommend further research to test training among more established clinicians, as it has been suggested that they are more resistant to change.

Feder et al, 2011

A UK-based cluster RCT by Feder et al, 2011 [++] examined the effectiveness of the Identification and Referral to Improve Safety (IRIS) programme on the identification and referral of DV cases from primary care settings. The IRIS is an education and advocacy intervention for primary care physicians and includes a training and support programme focused on the identification of women experiencing DV, an appropriate initial response by clinicians, and referral to a specialist advocacy service to assist with non medical needs and issues, if desired.

Fifty-one primary care practices in Hackney and Bristol were randomised. Of these, 24 received a training and support programme, 24 did not receive the programme, and three dropped out before the trial started. Practices without electronic records were not eligible. The 48 included physician practices had a median of 45.3% full-time equivalent female doctors, served a median of 7,142 registered patients, and had a median of 32% of registered patients on low-income.

Clinicians received two sessions of two hours each to improve identification of DV and referral to advocacy services. Sessions included case studies and practice exercises for asking about and responding to violence. A clinical psychologist or an academic family doctor alongside an advocate delivered this training. All trainers had backgrounds in DV issues. Each site also received additional materials, and quarterly or semi-annual feedback at practice clinical meeting where they discussed practice data and reinforced training. Administrators and reception staff also received a one-hour training session on confidentiality and safety and use of posters and leaflets. Each practice nominated a champion who received an additional eight hours of training. Medical records had a prompt and a simple referral to a named advocate. All clinicians were targets of the intervention. Specifically, “clinicians were trained to have a low threshold for asking about DV as a clinical enquiry, not screening" (p.1790). Patient outcomes were examined for women age 16 or older.

The intervention had a substantial effect on increasing the referrals to an external advocacy agency. Within the practices that received the intervention, there were 223 referrals compared to the 12 referrals in the control primary care practices. The adjusted incident rate ratio (IRR) was 22·1 (95% CI: 11.5-42.4), indicating that after controlling for area stratification and minimization factors, the intervention group was 22 times more likely to make a referral than the control group. Intervention practices recorded 641 disclosures of DV and control practices recorded 236 (adjusted IRR=3.1, 95% CI: 2.2-4.3). In measuring referrals received by the DV agencies, they found 238 referrals of patients from intervention practices and 40 from control practices (adjusted IRR=6.4, 95% CI: 4.2-10.0). No adverse events were recorded. Limitations of the study include the lack of checking of fidelity in delivering the programme, and the lack of contact with 30% of the referrals.

Garcia and Parsons, 2002

A US before and after study by Garcia and Parsons, 2002 [+] examined the effectiveness of a multilevel organizational and educational intervention in an inpatient obstetric setting, on identification of and intervention with pregnant women experiencing DV. Participants included a convenience sample of 80 clinicians (social workers, doctors and nurses) working at an academic medical centre in Arizona, offering inpatient obstetric care. The majority were women (97%), ranging in age from 20 to 64 years. Nursing professionals made up 74% of the participants.

This study was based upon an ecological model of change. The intervention involved: a) a policy change requiring universal DV screening of obstetric patients in the clinic, at each trimester, and on admission to hospital; b) the development of a DV screening kit to support providers in intervening with patients who self identify as victims; c) cueing providers (via medical records) to screen during routine care; and d) training (3 hours duration) to orient staff to the policy change, the medical records modifications, and the use of the screening kit. The kit included a simple screening response algorithm, documentation forms for the medical record, a safety planning tool, and educational materials for patients including local resources and referrals. The 3 hour educational programme included: a review of information on DV; a clinical screening and intervention model; an overview of a team approach to prevention and intervention for DV; and an orientation to the new materials, protocols and policies. Before and after the training programme, respondents completed a questionnaire that assessed staff knowledge of IPV using a subscale of the Massachusetts Medical Society Survey. Random record audits for all admissions were conducted 3 months before the implementation and at 3 and 9 months after the implementation. A blinded researcher reviewed the charts.

Compared with baseline (26.3%), following the intervention 75.0% were able to identify the existence of an institutional protocol on DV ($p < 0.01$). The majority (78.8%) could identify available patient resources and materials (compared with 26.3%, $p < 0.01$, pre-intervention). Similarly, 75% of respondents reported knowledge of the community resources for referral and follow-up (compared with 17.5%, $p < 0.01$, pre-intervention). At baseline, 9% (10/109) of the patient charts indicated that DV was addressed and documented, increasing to 47% three

months following implementation (51/109 records, p<0.01). At 9 months post-implementation, a further increase to 90% (99/110 records, p<0.01) was observed. Before implementing the educational programme, documentation of DV was addressed by social workers and other non-nursing staff. Three months after implementation, 90% (46/51) of the screening and documentation regarding DV was performed by the nursing staff, compared with 70% pre-implementation (7/10, p<0.05).

The four part policy (universal screening), protocol (chart cuing), tools (kit) and educational (3 hour training) changes, resulted in significantly increased screening and documentation by health care workers working with pregnant women. However, limitations that may impact findings include lack of a comparison group and small sample size (80 clinicians within one setting).

Grafton et al, 2006

A Canadian before and after study by Grafton et al., 2006 [+] evaluated the implementation of a professional development strategy for public health nurses, called Routine Universal Comprehensive Screening (RUCS). The strategy was designed to assist public health nurses in identifying new mothers at risk for domestic abuse within Healthy Babies, Healthy Children (HBHC), a home visiting programme for new mothers. To support the RUCS, a year long professional development strategy including workshops and small group work was provided. Specific training was given on the dynamics of woman abuse, how to ask about abuse, what best practices were in responding to woman abuse, and how to record abuse. Training included videos, discussions, role-playing, and group discussions with community DV service providers. Best practice advocates helped facilitate the programme. Participants were expected to assess for abuse during all postpartum visits when the woman was alone and to document all assessment findings. Assessment forms were revised to include abuse inquiry reminders. A retrospective chart audit of cross-sectional data was conducted to determine the proportion of women for whom there was documented abuse inquiry both one year before and after the introduction of the RUCS Programme. Charts of all postpartum women who lived in an Ontario county (Canada) and who received a PHN home visit post delivery were retrospectively reviewed (pre-RUCS n=1,151, post-RUCS n=1,193)

The mothers were first asked, while in the hospital, for consent to be assessed using the Parkyn tool that assessed 14 factors associated with risk of poor child development, and categorizes women into low or high risk. After they returned home, one visit was paid to consenting women, during which abuse related questions were asked of all mothers, not just the high risk group as had been previous standard practice. Prior to the RUCS intervention, there was documentation of abuse inquiry on only 0.8% of low-risk postpartum client charts. Women aged under 20 years and single mothers were significantly (p=0.001) more likely to be asked, suggesting case-finding was taking place among the public health nurses. Post- RUCS abuse inquiries increased to 20.5% for low-risk women with no demographic differences among those asked about abuse versus all low-risk women. Low-risk mothers with documented abuse inquiry ranged from 9.2% in September 2002 to 28.9% in June 2003.

Successful implementation was facilitated by: buy-in from the multiple levels of the organization, engagement of practice champions, access to community experts and educational resources, the development of policy expectations, the use of inquiry reminders on documentation forms, and the provision of positive feedback by programme managers. RUCS was also integrated into orientation for new public health nurses to ensure sustainability. Policy changes affecting practice of public health nurses that provide specific expectations and documentation cues can improve routine abuse inquiry.

Some limitations affecting the study outcomes are that some women did not consent to either the in hospital assessment or the home visit, and some women were not asked about abuse due to lack of privacy in the home.

Halpern et al., 2009

A US-based cross-sectional study by Halpern et al., 2009 [+] compared a diagnostic protocol (DP) with an emergency department's (ED) standard operating procedure (SOP) for the identification of intimate partner violence. They measured sensitivity, specificity, positive predictive value (PPV) and negative predictive value (NPV) of these protocols for women presenting to the emergency department for injuries. The diagnostic protocol (DP) classifies risk for intimate partner violence into low and high risk. They recruited women aged 18 and over from an urban (Boston) emergency department who were seeking evaluation or management of non-verifiable injuries (such as assaults or falls). They do not provide demographic data for the total sample of women who participated. A total of 286 women participated in the study; of these, 145 received the diagnostic procedure (an assessment of IPV risk based on location of the injury and results from the Partner Violence Screen (PVS)), while 141 participants received the standard procedures. The PVS includes 3 brief questions addressing physical violence and women's perception of safety, intended to identify women at risk for injuries from DV. One positive response to any of the questions indicates a positive screen for DV. This tool was developed for an ED setting and validated against other established tools. Data were collected in a face-to-face interview and recorded on a data collection form. In comparison, the SOP involved questioning by a nurse during intake for injury aetiology (including: domestic abuse, child abuse and elder abuse) on a triage form. Note that all participants in the DP group were first screened by the triage nurse using the SOP before going through the DP.

Using the SOP as the reference category, those participants identified as being at high risk using the DP were 38 times more likely to report an injury aetiology related to DV (OR=38, 95% CI: 4.5-327, p=0.01). Frequencies of self-reported IPV injuries were 11.5% for the DP and 5% for the SOP ($p<0.03$). The sensitivity for the DP vs. SOP was 94% vs. 50%, specificity was 76% vs. 95%, positive predictive value was 34% vs. 50%, and negative predictive value was 98% vs. 95%, respectively. They also found that IPV-related injuries were associated with age, race, injury location and substance abuse ($p<0.05$). In the adjusted model, the DP continued to be associated with reports of injury aetiology (OR=38, 95% CI: 4.5-327, p=00.01), race (OR=7.5, 95% CI: 1.8-30.1, p=0.01) and age (OR=0.95, 95% CI: 0.9-1.1, $p<0.05$). Specifically, older women were less likely to report an injury aetiology related to DV, and non-white women were more likely to report an injury aetiology related to DV.

Findings suggest that a diagnostic protocol assessing risk based on the location of injury and responses to the PVS may be more effective than SOP in early identification of women with DV injuries. Younger women were more likely to report injuries related to DV than older women. Limitations to this study include: the reliance on self-report, and the lack of demographic information on the source population, making it difficult to determine external validity of the screening approach.

Hamberger et al., 2010

A US-based before and after study by Hamberger et al., 2010 [-] investigated the effect of adding a chart prompt to the patient data sheet in an urban family practice clinic in the Midwest of the US.

At baseline all first-year family practice residents received 3 hours of IPV training, which included definitions of IPV and dynamics, physical and psychological consequences of IPV, and the health care provider role in addressing IPV. Residents learned and practiced using specific skills for inquiring about and responding to victim reports of DV. A chart prompt reminding practitioners to screen for IPV was added to the medical record for the annual physical (used with both genders) for a 7-month period. The IPV chart prompt was removed 18 months later and replaced by a pain screening prompt.

The intervention effect was measured by chart review and comparison to baseline. In the prompt removal phase, the outcome was measured by chart review and by a post-visit interview with a nurse (asking the patient if they were screened). The charts for 274 visits for routine medical

exams were reviewed at baseline, 137 visits in the intervention phase and a sample of 25 charts for the withdrawal phase. Baseline screening rate was 2%. In the intervention period, 92% of patient visits had documentation of IPV inquiry ($z=-18.6$, $p<0.0005$). The chart prompt removal phase showed a significant decrease in documented screening at 36% ($z=7.0$, $p<0.00005$), which remained significantly lower than the intervention phase even when adding nine patients who reported in the follow-up interview being asked about IPV by their physician even though it was not documented in the record (72%, $z=3.0$, $p=0.003$). Male providers were more likely to document screening than female providers (males 39% vs. females 29%, $p=0.03$).

This study clearly showed how a written prompt to ask about IPV increases inquiry rates among primary care physicians. It also suggests that these prompts need to be kept up. The authors raise the issue of electronic records, and if chart prompts would have the same effect in settings where screening is computerized. It is of interest that more patients reported being screened for DV than was documented on the charts, suggesting that in other studies lack of documentation, not lack of screening may be a factor. Finally, a more robust study design is required to support findings.

Hamby et al., 2006

A US-based RCT by Hamby et al, 2006 [+] examined the impact of questionnaire tool and format on reporting of partner violence. They compared written versus computer-assisted self-interviews (CASI), and the standard Revised Conflict Tactic Scales (CTS2) versus dichotomous (yes or no) response categories with a sample of 160 urban undergraduate students in intimate relationships. Participants were a mean age of 19.16 years (SD=2.95), and were primarily: freshmen (70%), female (82.5%), European American (97.5%), from middle- to upper-middle-class backgrounds (median family income was $50,000 to $59,999 per year), and from 2-parent families (71.3%). Most participants (88.8%) described their relationship as dating, the median relationship length was 1-2 years, all relationships were heterosexual, and 82.5% of participants were sexually active with their partner.

The study design included two experimental manipulations. In the manipulation of administration method, half of the participants completed the CTS2 in a written format and half completed the CTS2 on a personal computer using a programme that presents questions in sequence (limiting participants from reading the entire questionnaire before answering). In the manipulation of response category, participants either completed the CTS2 categories that ask for frequency of abuse (once, twice, three to five times, etc.) or the dichotomous categories, which ask whether or not abuse has occurred (yes or no). The CTS has strong validity and reliability and is widely used to measure IPV. The revision used in this study, CTS2, has clarified wording and discriminates between severe and minor forms of assault. The CTS2 includes 78 questions regarding both perpetration and victimization in regards to: negotiation, psychological aggression, physical assault, sexual coercion and injury.

They examined reports of psychological aggression, physical assault, sexual coercion and injury, and examined if gender interacted with questionnaire formats. For response category, both perpetrated and sustained sexual coercion were more often reported using the standard CTS2 categories compared to the dichotomous categories (chi-square=7.06, $p<0.01$ and chi-square=6.18, $p<0.05$, respectively), as was inflicted injury (chi-square=4.44, $p<0.05$). For analysis of screening format (written vs. computer format), a chi-square analysis of the administration of the questionnaire revealed two significant differences. More physical assault was reported on the computer format (chi-square=4.43, $p<0.05$), and more sexual coercion was reported in the written form (chi-square=7.06, $p<0.01$). No other differences were found to be significant ($p>0.15$) in bivariate analyses.

Logistic regression revealed no significant administration format or response category effects for perpetration of psychological aggression, injury or physical assault ($p>0.20$). For perpetration of sexual coercion, there was a significant response category effect, with 22.5% of participants

receiving the standard CTS2 reporting perpetration of sexual coercion compared to 7.5% of participants in the dichotomous condition (OR=3.37, p<0.05). For victimization scales, there were no methodological effects for psychological aggression or sexual coercion (all p>0.15). There was a significant Administration Method by Response Category interaction for physical assault (B=1.36, SE=0.68, p<0.05). For the dichotomous category condition, slightly higher rates of physical assault were reported for written (37.5%) compared to computer administration formats (32.5%); but for the CTS2 condition, higher rates of physical assault were reported in the computer format (47.5%) than the written format (22.5%). In analyses of mode scores (number of different types of violence reported by each participant), the multivariate effects for response category, administration method, and the interaction term were not significant (p's>0.05).

More males than females reported perpetrating sexual coercion using CTS2 (26% vs. 22%), and this difference was greater in the dichotomous category (47% vs. 3%) (p<0.01 for the interaction term of response category x gender). Overall, males were more likely than females to report perpetrating sexual coercion (36% vs. 12%) (p<0.01 for the main effect of gender). Mode scores confirmed that males more likely reported perpetrating sexual coercion (F(1,144)=8.24, p<0.01), and also found that females were more likely to sustain a physical assault (F(1,144)=4.30, p<0.05).

In short, there were few differences between administration methods, and no consistent direction in differences found. However, CTS2 categories provided higher rates than dichotomous categories, as they were thought to provoke more thoughtful reporting. The study was not robust for the following reasons: method of recruitment and allocation was not well described, and they used a relatively small and non-diverse sample. More methodological research with diverse samples is required. However, the inclusion of a gender analysis is important, as is the examination of screening perpetration of IPV among women and men, as these levels of analysis are rare in other screening evaluations.

Humphreys et al., 2011

A US-based individual RCT by Humphreys et al., 2011 [+] examined the impact of a computer-based prenatal screening intervention on patient-provider discussions of intimate partner violence (IPV) with pregnant women who had reported ever experiencing physical or sexual IPV in urban prenatal medical clinics. Participants included a subset of English-speaking women aged 18 and over who had participated in the larger Health in Pregnancy Study, a RCT to determine if a brief, interactive multimedia intervention for pregnant women can reduce their risks related to IPV, smoking, alcohol, and illicit drug use. A total of 50 women participated in the study, with 25 in the intervention group and 25 in the control group. Women who participated were primarily: Latino (34%), Black (22%) or White (30%), mean age of 27.7 (SD=7.1, range 18-43), never married (46%), had completed high school as their highest level of education (36%), and had a previous pregnancy (76%). Most women had experienced physical violence in the year before pregnancy (86%, with 50% having experienced 4 or more incidents during that time period), 38% had experienced sexual violence in their lifetime, 8% had experienced sexual violence during pregnancy, and many had experienced physical violence during pregnancy (38%, with 14% having experienced 4 or more incidents in that time period). Baseline comparisons revealed similar demographics, pregnancy history, and risk profile (p>0.05). Women in the intervention group completed a computer-based risk assessment with audio voiceover called the "Video Doctor" prior to their clinic appointment. In the programme, an actor playing the "Video Doctor" provided risk reduction messages based on motivational interviewing techniques. Based on participant responses, the programme provided tailored messages. The programme also provided a cueing sheet for the medical record including a risk profile and suggested counselling statements for reducing risk, and an educational worksheet for patients with self-reflection prompts, harm reduction messages, and suggestions for local support resources. All health care providers in the study received a brief training in the use of the cueing sheets, but not on assessment or counselling for IPV. Women who were in the control group received care as usual.

A research assistant asked participants verbally whether or not they had discussed IPV with a provider, and were also questioned on the helpfulness of the programme.

They found that the intervention group was more likely to report patient-provider discussions of IPV when compared to the control group at baseline (81.8% vs. 16.7%, p<0.001) and at one-month follow-up (70.0% vs. 23.5%, p=0.008). Overall, participants in the intervention group were more likely to have a discussion of IPV risk at one or both visits, when compared to usual care (90.0% vs. 23.6%, p<0.001). The majority of participants (90.9%) rated the discussions as helpful or very helpful at baseline, and all (100%) rated the discussions as helpful or very helpful at one-month follow up. While the authors do not discuss the links to other substance use, they do note that current tobacco use was the most common co-occurring behavioural risk (28%), with few participants using alcohol (2%) or other drugs (6%).

The authors suggest that this computer programme is a promising approach to encourage patient-provider discussions with minimal training of providers. Limitations of this study include: the use of a very small sample of women already identified as at risk of IPV, reliance on self-report, a lack of reporting on changes in IPV exposure or follow up care, lack of randomization of providers, and limited information on the use of cue and educational sheets by providers.

Janssen et al., 2002

A Canadian before and after study by Janssen et al., 2002 [+] evaluated the implementation of a DV screening protocol based on Roger's innovation-diffusion model in a postpartum clinical setting. They note that the patients served by the hospitals are 35% Chinese descent.

Roger's innovation-diffusion model includes 5 stages: 1) knowledge, 2) persuasion, 3) decision, 4) implementation and 5) confirmation. In the knowledge phase, they engaged key administrators as advocates for the screening protocol and began offering one-hour training sessions to 300 nurses (although classes were not restricted to nurses) in two hospitals. The first education session focused on building knowledge on DV dynamics, impacts on health, assessment principles and documentation. The next step of Roger's model, persuasion, was addressed by encouraging staff to make changes. This was done through education sessions that shifted DV from the academic to the personal realm by engaging staff in dialogue with survivors and clinical storytelling. In the decision stage, trainees engaged in supervised assessments or observed assessments conducted by an identified "preceptor"- an early adopter of the protocol who could act as a model for behaviour change. The fourth stage of the diffusion process, implementation, assumes that individual's willingness to adopt new ideas differs and therefore they anticipated that the protocol would be adopted by hospital staff in different stages over time. Confirmation, the final stage is about developing sustainability. This was achieved by integrating various supports for assessment. For example, assessment of DV was a criterion included in competency checklists for new staff members, and in performance appraisals. Reference binders were updated with DV information, a newsletter was distributed, and ongoing support was available to health services staff that chose to disclose their own experiences with violence.

The DV screening protocol that was implemented was a shorter version of the Abuse Assessment Screen. This screening tool was chosen because it has been validated among pregnant women, and because the shorter version was believed to be suitable to a busy clinical setting. The tool included the following questions: 1. Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by an intimate partner? 2. Have you been afraid of a current or former intimate partner during your pregnancy? These questions were to be asked in private, and not in the presence of partners or family members. A visual aids programme supported implementation and included posters titled "Let's Talk" and resource cards with referral services for women. All hospital staff were encouraged to support the protocol. For example, housekeeping staff stocked washrooms with resource cards, and unit clerks also helped with the distribution of support materials. The screening programme was also tailored to ethnicity. A native speaking nurse acted as a liaison for Chinese women, while South Asian women received a

tailored video, and First Nations women had referral cards and a hospital Aboriginal Women's Advocate. The assessment was translated into Punjabi and Vietnamese as well as Chinese.

Following the implementation of the screening protocol, they examined assessment forms completed for DV. They found that the initial screening rate of 42.1% increased to 53.8% at 4 months and 60.7% at 6 months. The final measurement at 18 months, revealed a screening rate of 62.1%. One of the key barriers noted included the inability of nurses to find an opportunity to meet with women alone as they are typically accompanied by a partner or family member during the postpartum period. Other barriers included the cost of providing training and finding suitable translators for women who did not speak English.

The study has several weaknesses including: limited analysis (they do not provide effect sizes), lack of data on the number and roles of all staff who participated, no assessment of the use or effect of supporting/ secondary materials (such as binders, referral cards, etc.). Finally, a follow up interview or questionnaire with staff following implementation to examine acceptability of the screening protocol may have revealed why a portion of staff did not adopt the assessment procedures.

Kapur et al., 2011

A US-based before and after study by Kapur et al., (2011) [+] investigated the optimal method and screening instrument for IPV among women and men in an urban primary care resident clinic by comparing a self-administered questionnaire and an interview with the primary care provider. Participants included patients age 18 and over attending the primary care clinic for a non-urgent appointment with their primary care provider, and included both English and Spanish speakers. Participants were a mean age of 43.9 years, 67.8% were female and 32.2% male, and 45.3% were non-Hispanic White. The study was conducted in two phases. There were a total of 466 participants in the study; of these, 340 participated in phase one of the study, and 126 participated in phase two. Phase one, lasting three months, involved patients completing a written self-administered questionnaire on IPV, using questions from the Partner Violence Screen (PVS) and Hurt, Insulted, Threatened or Screamed at Questionnaire (HITS). Patients who participated in phase one of the study were excluded from phase two. During the second phase, lasting 17 weeks, residents conducted face-to-face screening, using the same questions asked in phase one. Prior to the second phase, all residents were trained in screening for IPV in two training modules. The first training module included an IPV prevention training video for health care providers, an introduction to the PVS and HITS screening tools, and methods for counselling victims of IPV. The second training module included education on IPV screening, based on the Yale Office-Based Medicine Curriculum. This included a 30-minute conference introducing residents to screening issues, concerns, and methods, and the provision of laminated cards with screening questions and support resources. Following training, residents completed a knowledge, attitude and behaviour survey (KAB) about their training in IPV.

The research team conducted a separate analysis for women and men. A smaller proportion of men were screened face-to-face in phase two of the study (25.2%) compared with those who completed self-administered questionnaires in phase one (35.9%), ($p=0.05$). Overall, patients doing the self-administered questionnaire were more likely to report IPV (17.3%) than those screened face to face (9%). For women who completed the written questionnaire, screening prevalence of IPV was lower on the HITS (9%) than for the PVS (17.8%, $p=0.008$). They found no significant differences in face-to-face screening prevalence between the PVS and HITS for women. For men, screening prevalence for IPV was lower for HITS (4.0%) than for PVS (8.7%), but this was not statistically significant ($p=0.25$). There were no differences in IPV screening prevalence for the face-to-face formats of the PVS and HITS in men ($p=1$).

Medical residents who participated felt more equipped to ask their patients about violence (72.5%), reported knowing a moderate to great amount regarding screening for IPV (82.5%), felt routine screening should be included in the annual physical exam (92.5%), and felt more

comfortable asking patients IPV-related questions (87.5%). However, screening rates remained relatively low: residents only reported screening 11.7% of male patients and 38.4% of female patients. In addition, 27.5% reported screening male patients, and 25% reported screening female patients only when there were abuse indicators on patient history or physical exam. Half of the residents also reported a lack of time to routinely screen patients for IPV.

This study suggests that women, compared to men, may underreport IPV in a face to face screening situation, and that these gender differences may indicate different screening methods and instruments for women and men. The study also suggests that women may benefit from a self-administered approach prior to the clinical encounter. This study does not capture all abuse, as they only assessed abuse within the past year. Furthermore, residents only screened 28.5% of eligible patients, which the authors suggest may have been due to a lack of time experienced during a move of clinics in the study period. Preferential screening of women and men with abuse indicators may also have biased the findings towards the null hypothesis. They did not reach the expected sample size to achieve a power of 80% for each group, with only 126 patients included in face-to-face screening. Finally, they did not examine if and how the gender and age of residents may have impacted reporting of abuse.

Klevens et al., 2012

A US-based RCT by Klevens et al., 2012 [+] compared two forms of screening for IPV and three forms of referring women who had experienced IPV to support services, for women age 18 and over attending a women's health clinic in a public hospital in Chicago. Women who participated were a mean age of 35.8 years, predominantly African American (78.6%), and had a high school education or less (42%) or some college or vocational education (42%). Over half of the sample was uninsured (57.1%), with approximately one-third receiving Medicaid (37.3%). At baseline, no demographic differences were found between groups. A total of 126 women were randomly assigned to one of three groups using a computer programme. These groups included: 1) Provider Screened and Referred Group (n=46): in this group, participants received IPV screening by a health care provider first, and if positive, support to seek support services from a printed resource guide; 2) A-CASI Screened and Referred Plus Provider Support Group (n=37): participants completed an audio-computer assisted self-interview (A-CASI) IPV screening, and if positive, a computer printout of local support resources, and A-CASI encouragement to the patient to discuss IPV with their provider, and for the provider to refer the patient to IPV services if the patient disclosed her results; and 3) A-CASI Screened and Referred Plus Video Support Group (n=43): in this condition, participants received an A-CASI IPV screening, and if positive, a short video segment offering support for help seeking, and a computer-printout of local resources.

The screening tool used was the Partner Violence Screen (PVS), which is a three-question tool to assess the presence of IPV in the past year and women's perceptions of safety. The tool does not specify gender of the perpetrator. This was administered either by a health care provider (group 1) or via A-CASI (groups 2 and 3). In all groups, women screening positive received the same print directory of local resources for IPV, as well as a list of other types of resources (e.g. health, counselling, parenting, legal, and alcohol and drug treatment services). Women who screened negative for IPV received a similar printout but without the IPV resources. All participants completed an A-CASI interview and were seen by their health care provider, although not in the same order. Participants who were screened using A-CASI (groups 2 and 3) first completed the A-CASI screening interview and screening prior to the visit with their provider; participants in group 1 saw their provider first and then completed A-CASI questions. Providers in each clinic were briefly trained on asking questions, providing support and encouraging use of support services. Six days after the first assessment, participants were followed up in a phone interview during which they were questioned about their experience of being asked about IPV and use of support services from the directory provided.

They measured rates of disclosure of IPV, preference of screening mode (by provider or computer), and impact of screening (positive or negative reaction for participant) at one-week

follow up. They also measured referral outcomes including women's: recollection of receiving a directory of services, sharing of services list with others, contact of services on the list, and interaction with an in-house IPV advocacy programme within 3-months of screening. The finding that women who were screened using A-CASI (groups 2 and 3) disclosed IPV more often (21.3%) than those screened by a health care provider (8.7%, p=0.07) approached significance. Overall, the majority of women (41.3%) had no preference for mode of screening. They did not find differences between the provider-delivered and A-CASI delivered screening groups for impact of screening (positive or negative reactions). No women reported problems due to being screened. They found that women referred by their provider were more likely both to share the list and to contact services, but these differences were not statistically significant (p=0.17 and p=0.36, respectively). No women were found to have interacted with local advocacy staff within 3 months after screening.

Limitations of this study include: a small sample size which limited the researchers' ability to examine significant differences for variables with low prevalence, a reliance on providers' self-reports for measuring their compliance with the screening and referral protocols, lack of measurement or analysis based on the gender of the perpetrator, and a lack of information on the acceptability of computer screening by socioeconomic status (SES). The authors encourage further research to examine the use of this screening and referral approach for other settings and sub-populations.

Lo Fo Wong et al., 2006

A Netherlands-based RCT by Lo Fo Wong et al, 2006 [++] examined whether family doctors' awareness of and inquiry into intimate partner violence increased after attending a focus group and training session, or focus group only. They recruited doctors from family practice clinics in Rotterdam and surrounding areas. A total of 54 family doctors were included in the study (28 women, 26 men). Sample demographics are as follows: 51.9% female and 48.1% male; 37% age 40-50 years, 35.2% over 50 years old, 27.8% under 40 years old; 50% worked in an economically deprived district, 24.1% in a wealthy district and 25.9% in a mixed district; the majority worked part-time (68.5%) and had been in residence less than 15 years (53.7%); the majority worked in a duo/ group practice (46.3%), with 20.4% in a solo practice and 33.3% in a health centre practice (where they worked with other primary health providers). Participants were grouped into strata (based on sex, district, and practice type) and then randomized to one of the intervention groups or the control group. Doctors working in the same practice were allocated to the same group to avoid contamination of the study. The sample sizes were: focus group alone (n=14), full training (n=23) and control (n=17).

Those in the focus group only group participated in six 1.5 hour group discussions, led by a social scientist, on views, experiences, barriers and practices related to intimate partner violence. Topics that emerged during these discussions informed the full training intervention. In the full training intervention, in addition to participating in focus groups, the group also completed a 1.5-day training session. The training included discussion of strategies to overcome barriers to working with abused patients, with the goals of improving: awareness of non-obvious signs of abuse, active questioning, and attitudes towards addressing abuse. Training included discussions of attitudes, theory in the field of DV research, epidemiology, consultation skills, information on referral services, legal aspects of abuse, and vignettes. The control group did not participate in the focus group or receive any training related to domestic abuse.

They examined reports for a period of 6 months for cases where partner abuse was discussed, suspected or disclosed. Comparison of the full training intervention (n=87 cases) and the control group (n=14 cases) revealed that identification of partner abuse was 4.54 times greater for the full intervention group (rate ratio 95% CI: 2.55-8.09, p<0.001). Comparison of the focus group only group (n=30 cases) and the control group (n=14 patients) revealed that identification was 2.2 times more likely for the focus group only condition (95% CI: 1.14-4.26, p=0.019). Comparison of the full-training intervention (n=87 cases) and the focus group only group (n=30 cases) revealed

that identification was 2.19 times more likely for the full-training intervention group (95% CI: 1.36-3.52, p=0.001). When comparing the full training group with the untrained groups for awareness of partner abuse in case of non-obvious signs they found that the full training group was 5.92 times more likely to engage in active questioning when there were “non-obvious” signs (chronic pain, depression, anxiety, etc.)(OR=5.92, 95% CI: 2.25-15.62, p<0.01). They corrected all computations for sex, district, setting, part-/ full-time work status, experience, and doctor age. They did not find any significant differences between female and male providers.

Their findings suggest the full training improves awareness and identification of DV, and that increased awareness through focus group discussions of DV also resulted in some improvement in identification of DV when compared to the control group. While the study was robust, there are several limitations to the application of these findings. The authors note that those family doctors who were recruited may have been more interested in addressing the issue of DV than those who did not. Second, over half of doctors who participated were female who, according to some studies, may be more likely to detect abuse in women. Yet, their statistical analyses did not find any significant differences to support this theory. The study was also slightly underpowered, but they note that the effects found (significant outcomes, low p-values) justify the final sample size. Finally, it is impossible to determine the longer-term effects of the intervention due to the short period of follow up (6 months).

MacMillan et al., 2009

A Canadian cluster-RCT by MacMillan et al., 2009 [++] examined the effectiveness of IPV screening and discussion of a positive screening result for clinicians compared with no screening in reducing improving violence outcomes and quality of life. The study included women presenting for care between July 2005 and December 2006 at 12 primary care sites (family practices and community health clinics), 11 acute care sites (emergency departments) and 3 specialty care sites (obstetrics/ gynaecology clinics). To be eligible, women had to be between 18-64 years old, have a male partner in the past year, attending the health care visit alone, live in the area, be able to speak and read English, be healthy enough to participate and able to provide informed consent. Only 7% of women visiting the health care sites were eligible to participate; 81% of eligible participants were randomized. A total of 411 women participated (screened n=199; non-screened n=212). Screened participants were a mean age of 33.8 years, had a mean education of 13.7 years, 35% were single and 4% were pregnant. Non-screened participants were a mean age of 33.9 years, had a mean education of 13.5 years, 39% were single and 9% were pregnant.

In the intervention condition, participants completed the Woman Abuse Screening Tool (WAST) prior to meeting the clinician. For positive screenings, the completed questionnaire was added to the patient chart for the clinician to review. It was then left up to the provider whether or not the positive findings were discussed or a referral for treatment was provided. Following the medical visit, all women completed the Composite Abuse Scale (CAS). The no-screening group completed the WAST and CAS following their medical appointment. Other measures included the psychological scales from the World Health Organization Quality of Life (WHOQOL)-Brief instrument; the Centre for Epidemiologic Studies Depression scale to measure depression; the SPAN (Startle, Physiological Arousal, Anger, and Numbness) to measure PTSD symptoms; the TWEAK screening tool to measure alcohol abuse/ dependency; the Short Form 12 health survey, version 2 to measure global mental and physical health and well-being; the Consequences of Screening Tool (COST) (developed for this study) to assess the effect of being asked IPV screening questions; and a modified version of the Health and Social Service Utilization questionnaire to measure violence-specific service use. Blinded interviewers met with participants within 14 days of the visit to conduct a baseline interview and again at 6, 12, and 18 months.

Analysis revealed that the trajectory of risk of IPV recurrence was downward, with a non-significant reduction in risk (at 18 months, OR=0.82, 95% CI: 0.32-2.12) for screened compared to non-screened women. Screened women exhibited greater improvement in quality of life (at 18

months, 3.74 points higher, 95% CI: 0.47-7.00). Only depressive symptoms showed a statistically significant reduction (at 18 months, -2.32, 95% CI: -4.61 to -0.03), but these findings were not robust: Estimates derived from multiple imputation were lower for both of these outcomes (2.29 for quality of life and -1.97 for depressive symptoms) and no longer statistically significant. The comparison of women exposed and not exposed to IPV for potential harm from screening (data available from the authors) did not reveal differences based on exposure status, and there no indication of harm associated with screening for either group of women.

Overall, screening did not significantly improve risk of violence and limited improvements in quality of life and depression measures. Limitations of this study include: potential contamination bias (both screened and non-screened participants received an information card with details about where to seek help in her community), loss to follow-up (43% for screened women and 41% for non-screened women), and potential self-report bias. In addition, those participants lost to follow-up had higher WAST and CAS scores and, therefore, may have been at higher risk of subsequent violence. Therefore, findings may not be generalisable to high-risk women.

Moody et al., 2000

A US-based cross-sectional study by Moody et al., 2000 [+] examined the psychometric properties of the Hwalek-Sengstock Elder Abuse Screening Test (HSEAST), a questionnaire to screen for elder abuse. The study included a total of 100 elderly women and men, age 60 years or older, who were living in an urban public housing unit. Participants were 55% female and 45% male; a mean age of 66.6 years; had been living in this public housing site for a mean of 6.5 years; were White (49%), Hispanic (32%) or African American (32%) (note that these are the percentages reported, though they add to more than 100%); and either spoke English (78%) or Spanish (22%) as their first language.

The HSEAST is a 15-item questionnaire completed either by self-report or in-person interview, which requires 5-10 minutes to complete. Instrument scoring is summative and based on responses to the 15 "yes" or "no" questions, with each "yes" response to an "abuse" item counting as one point. A response of "no" to items 1, 6, 12, and 14 and a response of "yes" to all other items are scored in the abused direction. Scores range from 0 to 15. Three conceptual categories were identified in a prior factor analysis of the screening test, including: direct abuse or violation of personal rights, characteristics of vulnerability, and a potentially abusive situation. A previous analysis (from 1991) found that a mean score of 3 or more on the HSEAST appears to be a probable indicator of abuse. The status of "past abuse" vs. "no abuse" was based on self-report of being a previous victim of abuse, and checked against the records of the social worker at the housing authority.

They found that the abused and non-abused groups were significantly different (p's<0.05) on 9 of the 15 items on the HSEAST. Mean total scores on HSEAST were significantly different for the abused group (4.01) compared to the non-abused group (3.01) (t=1.98, p=0.049). A factor analysis supported the 3-factor structure proposed and explained 38% of the total variance. Factor 1 (Violation of Personal Rights) explained 19% of the variance and included 5 items, Factor 2 (Characteristics of Vulnerability) included 2 items, and Factor 3 (Potentially Abusive Situation) included 3 items. Reliability (internal consistency) on the 15-item scale was weak, alpha=0.46. Reliability on the 10-item scale (including only items from the factor analysis) was 0.59. Factor analysis revealed that internal consistency results for the three subscales was: Factor 1 (5 items)=0.66, Factor 2 (2 items)=0.52, and Factor 3 (3 items)=0.38. A stepwise discriminant function analysis showed that a 6-item model was as effective as a 9-item model in correctly classifying cases as abused vs. non-abused (71% correct). The items which were the most powerful discriminators among the groups were: "Has anyone taken things that belong to you without your OK?", "Has anyone close to you tried to hurt or harm you recently?" and "Do you have enough privacy at home?" Compared to the 9-item model, the 6-item model had a lower rate of false positives (5.1%) and higher rate of false negatives (19.6%).

Overall, the authors state that the results provide additional evidence for the construct validity of the HSEAST. Findings suggest that a 6-item version may be effective, although further research is required. The main limitation of the study is that the classification of "abused" vs. "non-abused" was based on past abuse, and the time frame was not specified (e.g. ever abuse, past year, past month), so it is unclear how useful the tool is in predicting current or future abuse. The authors note that they used a convenience sample but do not provide further details on this method. Therefore, it is difficult to determine generalisability. The study was also conducted in what the authors describe as a high crime area and therefore may have limited generalisability to the broader population.

Power et al., 2011

An Australian before and after study by Power et al. 2011 [-] evaluated a domestic and family violence screening programme implemented in the emergency department (ED) of a hospital located in the suburbs of Adelaide. The screening programme assessed was based on the ecological model, and intended to address the integration of domestic and family violence screening within healthcare settings. The screening programme was introduced in the hospital in 2006, based on consultations with women, social workers and an advisory group comprised of other experts in the field. All women attending the emergency department over the age of 16 were to be screened, unless in the presence of partners or family members or if experiencing acute distress.

The screening tool used was based on the Domestic Violence Identification Tool (DVIT), a validated tool with 6 yes/ no questions related to partner violence. This tool was reduced to three questions: “Has a partner or significant other person ever done any of the following: Made you feel afraid? Hurt you physically or thrown objects? Constantly humiliated or put you down?” To assist in the identification and support of women experiencing DV, they developed a number of additional materials to support implementation of the screening tool, including: an ABCDE response protocol (with the following prompts: ‘‘Ask alone, Be supportive, Call on resources, Document, Ensure Safety’’), a list of telephone numbers for support services for staff, and a poster displayed in the emergency department with information about domestic and family violence, the three screening questions and responses and support services. If a woman responded ‘‘yes’’ to any of the screening questions, the staff provided her with: information, referrals to community support services and/ or counselling services. One-hour training sessions by senior social workers were provided to a total of 109 emergency department staff, including: social workers, Aboriginal Liaison staff, and nurses. Screening commenced after training of staff was complete. Some staff chose to participate in a full day training to become champions of the programme and support staff on an ongoing basis.

They collected data from: audits of social work referrals 3-months prior and 3-months following implementation and physicians’ records of IPV diagnosis, and 40 questionnaires completed by medical staff examining their perceptions regarding screening. Nurses comprised 70% of respondents (similar to the overall make-up of staff) and 70% of respondents were female. Data was collected by a senior social worker beginning at one month following screening, for a period of three months. They found that in the 3-month period following implementation, referral rates increased by 213%. The majority of respondents reported that they thought the screening questions were effective for identification of DV (M=3.8 on a five-point Likert scale, SD=0.68), while the impact of the tool for identification was thought to be mildly effective (M=3.2, SD=0.9). Responses to the questionnaire demonstrated general support for the appropriateness of using the tool within the ED (M=3.9, SD=0.9). The tool was not part of usual work for most (M=2.8, SD=1.1) but was not reported to have added significantly to workload (M=2.3, SD=1.0). Concerns that emerged in the comments included: time constraints, lack of private areas, the presence of family members or partners which prevented screening, reluctance to use the tool for universal screening, and the availability of support resources. However, some staff did report that they thought screening increased staff awareness and felt they had appropriate support to deal with DV issues that arise (M=3.6, SD=0.9). Some nurses noted that they felt more comfortable

screening when social workers were present. In regards to training, many felt they were effectively prepared to use the tool (M=3.5, SD=1.0) and the majority of staff were content with their knowledge of support services (M=3.2, SD=1.0). Some additional concerns identified by the comments provided included: short training period and reluctance to ask designated questions. Suggestions were made to provide ongoing training, administrative support of the programme, and the need for private areas to meet with patients.

The study suggests that the screening programme may increase identification and be supported by staff under certain conditions. However, there are several limitations to this study, including: poor description of the source population, sampling method, and data collection methods, and short period of follow-up. In addition, out of 75 questionnaires distributed, only 40 were returned. The authors suggest this may be a reflection of time constraints for staff. The use of a small sample in one setting makes it difficult to generalize findings beyond the hospital in which it occurred. While questionnaires were anonymous, it was common knowledge that the programme was in collaboration with the social work team and therefore responses may have been biased in their favour. Further research is required to explore the reach of this programme in different settings, and that is measured over longer periods of time.

Price et al., 2007

A UK-based before and after study by Price et al, 2007 [+] examined the impact of routine antenatal enquiry on rates of disclosure of DV. The Bristol Pregnancy and DV Programme (BPDVP) was introduced in the North Bristol NHS Trust which includes an education and support programme to encourage routine screening of DV during antenatal care. A total of 83 midwives participated in the education programme; of these, 79 participated in the research evaluation. Participants completed three questionnaires (one pre-implementation, one post-implementation, and one at 6-months post-implementation) that included questions on attitudes, skill and knowledge related to DV, and knowledge of the implications of routine enquiry. Open-ended questions were also included to allow participants to provide additional information on their experiences of routine antenatal enquiry. In addition, 34 (out of the 79) midwives participated in face-to-face and focus group interviews at 3- and 6-months post-implementation, during which women were asked to expand on their experiences of routine antenatal enquiry, issues they were experiencing and practice implications. Audits were conducted to assess changes in the identification of DV pre- and post-implementation. “Cause for concern” forms, which midwives completed when they were concerned about their patient, were also analysed.

89% of participating midwives completed all 3 questionnaires (n=70). Midwives who participated had a diploma (43%), certificate (39%) degree (12%), or Masters (5%) level of education. They found that in 17 months prior to implementation, the clinic saw 6, 764 women. During this time, a total 8 cases were recorded as DV being a main “cause for concern.” In a 9-month period following introduction of the routine antenatal enquiry programme, care was provided to 3, 779 women and 25 “cause for concern” forms listed DV. The 6-month follow-up questionnaire found that 65 midwives who reported patient disclosure of DV, reported a total of 100 patient disclosures. Note that not all disclosures of violence require a “cause for concern” form. Most midwives who completed “cause for concern” forms noted that time spent with the patient was one hour or more (9 out of 24). The majority of midwives (59%, n=38) reported that they screened between 41-60% of women, followed by 16 midwives who screened 61-80% of women; only 3 midwives reported screening 81-100% of women. Challenges noted on the questionnaire included the presence of a partner or family member, or a lack of time or resources such as interpreter services. However, the authors did not find these listed barriers matched up with midwives’ rating of barriers in another portion of the questionnaire, which revealed that concerns about relationship with client (2.84, SD=1.33) were the greatest concern.

Since they did not collect data on disclosures made prior to implementation, they cannot confirm that the programme led to increased disclosure rates. Due to the lack of comparison group, small

sample size and lack of information on the components of the educational programme, further research is required to examine effectiveness.

Rhodes et al., 2006

A US-based RCT by Rhodes et al. 2006 [+] examined the use of a computer screening risk assessment tool for facilitating discussion of DV between women and health care providers in a clinical setting. Women, aged 18-65 years were recruited from two socio-economically diverse emergency departments (ED), including one urban academic medical centre serving primarily inner city African American population who is publically insured, and a suburban community hospital serving a primarily white population who is privately insured. Only women who were medically non-emergent were invited to participate. In the intervention group, a total of 421 women had their ED visits audiotaped and analysed (urban n=262, suburban n=159), and a total of 446 women did in the control group (urban n=275, suburban n=171). Of all 1281 women who participated (including those who did not have audiotape data), 60% were African American, 45% were single, and 48% had greater than a high school education. Patients from the urban ED were younger (mean age=32 years), primarily African American (86%), unmarried (64%), and more likely to be living in poverty. Patients from the suburban site had a mean age of 36 years, were primarily white (80%), more likely to be married (43%), and to have higher levels of education, income and private insurance.

Participants were assigned to treatment or control by a computer randomization list. There were no significant differences in demographics based on group assignment. The intervention group completed a self-administered computer based health risk assessment tool (Promote Health Survey) which provides recommendations for patients and notifies physicians on various health risks including DV. Patients in the control group received usual care. Patient-provider discussions were recorded and outcomes were then measured by audiotape analysis. Outcomes examined included: rates of discussion and patient disclosure of DV with the health care provider, and evidence of DV services provided during the first visit (including safety assessment, counselling by a health care provider or social worker, or referrals to support resources for DV). They also measured medical chart documentation of screening for DV (positive or negative), DV “case finding” (chart documentation of current or prior experience of DV) and patient satisfaction based on completion of an exit questionnaire.

Computer screening resulted in an overall 75% increase in the odds of a DV discussion. Nevertheless, violence was still under-addressed by the providers in the emergency department visit, even after cueing. This was most marked in the suburban EDs, suggesting that providers may be biased against addressing DV with more affluent White women. Analysis of the exit questionnaire revealed rates of current risk for DV of 26% in the urban sample and 21% in the suburban sample. In the urban sample, the computer prompt increased rates of discussion of DV (56% vs. 45%, OR=1.99, 95% CI: 1.25-3.18, p=0.004), disclosure of DV (14% vs. 8%, OR=1.71, 95% CI: 0.96-3.05, p=0.07), and services provided (8% vs. 4%, OR=2.29, 95% CI: 1.04-5.02, p=0.04). In the suburban sample, there were no significant increases in discussion or disclosure of DV or services provided as a result of the intervention. Overall, only 48% of those patients who disclosed risk of DV on the computer were engaged in discussion of DV by their health care provided, and this percentage differed by site: Only 17% of women in the suburban sample who disclosed an experience of DV on the computer discussed DV during the visit with the health care provider, compared with 61% of the urban sample. Women with private insurance or higher education were also less likely to be asked about experiences of DV. Case finding based on chart documentation was not significantly impacted by the computer intervention. For the urban sample, discussion of DV was associated with patients reporting greater satisfaction with the visit; 62% of women who were engaged in a discussion of DV reported high satisfaction compared with 50% who did not discuss DV (p=0.01). This association was not found for the suburban sample of women.

While the design of this study is strong in many respects, including the use of randomization and a rigorous analysis, they are not able to identify why providers did not ask about DV even when computer prompted to do so. This is of particular interest for the suburban sample where low discussion rates were found. There may also have been systemic differences between the suburban and urban sites that contributed to differences in the actions of health care providers. Further research is required to investigate this gap between identification of risk and provider action. The authors also note that the sensitive nature of the topic may have resulted in some participants' refusal of audio-taping of the conversation (only 68% of conversations were recorded), and there were some inaudible recordings.

Rickert et al., 2009

A US-based RCT by Rickert et al., 2009 [+] examined the effectiveness of three different screening approaches for assessing violence among adolescent and young adult women who were reproductive health care patients, as well as provider satisfaction with these approaches. Women aged 15-24 were recruited from an urban reproductive health centre in Manhattan, NY. A total of 669 women were computer randomized to one of three screening approaches: 1) basic screening, n=232; 2) health relationship screening, n=243; 3) bidirectional screening, n=224. Participants were primarily 19 years and over, with nearly all reporting sexual intercourse within the past 6 months, most reporting a history of hormonal birth control, and 32% an experience of one or more pregnancies. 30% of participants reported one or more experiences of violence with similar numbers of women reporting physical violence (n=139) and/ or sexual violence (n=144). There were no demographic or reproductive health differences between participant groups at baseline.

Prior to meeting with a provider, each participant completed a routine health history using audio-assisted computer interview (ACASI) methodology. The ACASI programme assigned young women to one of the three screening approaches, providing a different set of screening questions for each of these groups. The health history and screening questions were completed on a laptop with a privacy hood to ensure confidentiality. In the basic screening group, young women were asked 5 questions based on standardized questions from a prior study: 3 about partner violence in the past year and two about lifetime experience of physical or sexual violence by a partner. Participants randomized to the healthy relationships approach were asked seven screening questions: 5 questions from the basic screen plus two questions regarding respect and treatment from their partner. In the bidirectional approach participants were asked a total of 8 questions: 5 questions from the basic screening plus three added questions regarding any time she was the perpetrator (physically harmed partner, questioned her partner's fidelity, or forced sex). Following completion of the ACASI interview, the medical history and responses to the screening questions were printed for the patient's chart which were then reviewed by a provider who was trained in partner abuse and the research protocol. The provider then carried out a face-to-face assessment to address screening responses. Following the appointment, young women were asked to complete a confidential evaluation form to evaluate experience of and comfort with the screening procedure. The provider also completed an assessment of the presence of violence and also evaluated the screening procedure.

The screening approaches took an average of 8 minutes, with the basic screening taking slightly less time than the other approaches. They found no significant differences between screening approaches in reports of lifetime experience of violence or past sexual/ physical violence. When segregated into sexual and physical components, they did find a significant difference in physical violence by screening approach; 11.6% in the bidirectional approach, 6.2% in the healthy relationship screen and 5.6% in the basic screen ($p<0.04$). The authors note that for 11 respondents, this was their first time disclosing recent relationship violence. In the analysis of provider assessments by screening approach, the only significant difference was as imagined, that the bidirectional approach more often included a provider assessment of women's perpetration against their partners. For the other two screening approaches, no young women were asked about their perpetration of violence. Providers did identify fewer women as

experiencing violence than identified in young women's reports; overall, 31% of women noted a lifetime occurrence of violence, yet only 18% were identified as victims of violence. Those women who reported violence but were not identified as victims of violence by providers were more likely to have reported one occurrence of sexual/ physical violence. Overall, 29% of women noted that their provider did not discuss partner violence. There were no significant differences in women's experiences of screening approach, with the majority reporting being comfortable with screening. There were also no significant differences regarding provider experiences of screening approaches, with providers on average reporting high rates of comfort with talking about violence, and screening was perceived to be moderately helpful for their assessment. in addition, the ACASI screening approach was perceived as moderately efficient and did not interrupt patient flow.

Findings suggest that ACASI may be a useful tool for improving screening of young women in a healthcare setting, and that bidirectional screening questions may improve detection of physical partner violence. The authors note that because there is no gold standard for screening women for violence, it is possible that questions used in this study may have limited rates of disclosure. Other limitations include: potential lack of generalisability to other locations or healthcare settings and lack of examination of user's comfort with the computer-based programme and potential age or SES-based variations. This study also focused on sexual and physical violence experiences, not other forms of violence.

Robinson-Whelen et al., 2010

A US-based individual RCT by Robinson-Whelen et al., 2010 [+] examined the efficacy of a computer-based abuse and safety assessment intervention for improving awareness of abuse, self-efficacy for safety, and safety promoting behaviours among women with disabilities. Participants who self-identified as having a disability were recruited through various disability NGOs, agency referrals and researcher networks, and were computer-randomized to either intervention or control groups. Previous experience of abuse was not an inclusion criterion. There were a total of 329 participants at Time 1 (T1) measurement; intervention n=172; control n=157. At Time 2 (T2) (3-month follow-up), intervention n=126 and control n=133. Women who participated were a mean age of 50.75 (SD 12.88), the majority lived alone (51.8%) and had some college education (41.3%); 21.3% were employed and the mean income was $11, 813 (SD 10,567); 56.7% were White, 30.5% African American and 7.5% Latina. Of these women, 46.2% described their disability as an ongoing health condition (e.g. diabetes, obesity); 36.1% had a mental illness; 18.7% a vision- related disability; 17.4% cognitive disability; 15.1% hearing-related disability; 11.8% learning disability, and 8.2% speech-related disability. Many women who participated were using a personal assistant (47.5%). There were no baseline differences in demographics, although women in the intervention group were more likely to have a personal assistant (60.3 vs. 48.1%, p=0.049), and those in the control group were more likely to have low vision/ blindness (24.1 vs. 12.7%, p=0.019). They did not adjust for these differences.

The intervention tested was the Safer and Stronger Programme (SSP). The SSP is a computerized self-screening tool for IPV for women with disabilities. Women are prompted to disclose exposure to abuse, describe their perpetrator and report any safety behaviours they may use. The programme was designed to be accessible for people with disabilities and included audio-video vignettes of four diverse survivors of IPV (of different ethnicities, ages, disabilities and types of perpetrators), who provide information on abuse, warning signs and safety promoting methods. The screening includes abuse by intimate partners as well as personal assistants. The programme was 1-1.5 hours in length and participants were provided with a mobile phone with programmed support line numbers. The intervention group completed the assessment intervention at T1 and 3 months later at T2. The intervention group received a Health Awareness Programme following completion of the SSP at T2. The control group received only a Health Awareness Programme at T1 but completed the intervention at T2.

They found that abuse awareness increased significantly in the intervention group from T1 to T2, particularly for women who had not experienced abuse in the previous year. At T2, women in the intervention group had significantly greater abuse awareness scores than women in the control group (p=0.015). They found no significant differences between the intervention and control groups on safety self-efficacy and safety promoting behaviours. Women in the low and no past abuse classes reported lower scores on abuse awareness (p<0.0001), higher scores on safety self-efficacy (p<0.0001), and fewer preventive safety behaviours (p<0.0001) than women in the other abuse classes (sexual, physical or multiple abuse).

The authors conclude that the computer assessment programme is a promising format for conducting abuse assessments and improving abuse awareness. There are several limitations to this study, including: short period follow up, lack of data collection on frequency or severity of abuse, lack of data collection on whether participants were living with a perpetrator and other situational factors, lack of description of the Health Awareness Programme, use of novel measures (due to lack of established measures for assessing abuse among women with disabilities), use of a community-based convenience sample of primarily middle-aged women, and long duration of the intervention which may limit applicability in certain settings.

Shye et al., 2004

A US-based non-randomized controlled trial by Shye et al., 2004 [+] compared the effectiveness of two system-level multifaceted quality improvement approaches to improve the secondary prevention of DV in an urban clinical setting. Participants included clinicians from 11 HMO medical offices who remained in their original study arm during the 10-month implementation and who had worked for a minimum of 6-months in a single medical office. Patients recruited included women aged 18-45 visiting family practice (FP), Internal Medicine (IM), or OB/GYN for “health maintenance visits”, as well as mothers who came to “well-baby” visits. At pre-intervention, clinicians who participated were a mean age of 43.9, 50.2% female; and 72% were physicians. At post-intervention, the mean age was 45, and the sample was 47.6% female and 69.5% physicians. At pre-intervention, the patient sample was primarily 26-35 years (44.6%), 74% were married or living with a partner, 51.8% were in full time employment, and 87% were White. At post-intervention, 44.6% of patients were 26-35 years old, 73% were married or living with a partner, 50.9% were employed full-time, and 87% were white. The total number of participating clinicians was n=273 (pre-intervention) and n=238 (post-intervention); the number of participating patients was n=1925 (pre-intervention) and n=1979 (post-intervention).

The intervention was an augmentation of the basic strategy (ABIS) by providing medical office social workers paid time to act as social change agents for DV. The role involved: 1) providing information to clinicians about prevalence of DV, risk markers and abuse dynamics; 2) advocating for secondary prevention with primary care clinicians; 3) clarifying the appropriate goals of screening and intervention activities; and 4) modeling secondary prevention skills (including: asking about DV, conducting risk assessment, documenting violence, etc.). These activities were carried out in department meetings and individual contact with clinicians. The Basic HMO implementation strategy (BIS) included dissemination of DV guidelines, continuing medical education (CME) and clinical and environmental supports and prompts to increase clinician assessment of and patient disclosure of DV exposure. The guidelines were a “routine inquiry” rather than universal screening approach which recommended that primary care physicians inquire about exposure to DV of female patients and mothers of paediatric patients at “health maintenance visits” (routine visits for non-acute care) and for patients who present symptoms suggesting abuse. A task force coordinated the training (through a half-day conference, circulation of educational articles, print materials and cards with referral services) of a DV response team (including nurses, social workers, medical assistants, and sometimes a female physician) to intervene with those patients exposed to DV. The HMO also provided a paediatrician co-chair to the task force to oversee administration, and provided funds and materials to support staff training and secondary prevention. However, no HMO funds were provided to support staff time for these implementation activities.

They measured clinicians' frequency of inquiry into key DV symptoms (including injuries, chronic pain, depression, etc.), and proportion of women who reported discussion of DV exposure during recent health visits based on patient interviews. At baseline, they found that 2.9% of participants had been asked by their provider about their exposure, which rose to 9.5% at one-year follow up (p=0.001). The proportion of women who reported discussing DV with a provider increased from 0.7% at baseline to 1.2% at follow up but this finding was not statistically significant. Logistic regression analyses showed a statistically significant increase in inquiry rates during the study period (OR=3.75, 95% CI: 2.41-5.84, p=0.0001). However, the ABIS was not significantly different from the BIS in affecting inquiry rates (p=0.61 for main effect of ABIS, p=0.38 for interaction effect of ABIS x time).

This study focused on process measures of provider attitude change (outcomes not reported here) and rates of routine inquiry about exposure to DV rather than detection and responses with abused women. The authors note that they were limited by time and financial constraints and the small sample of women who reported disclosing DV exposure to a clinician.

Sprague et al., 2012

A Canadian non-comparative study by Sprague et al. (2012) [-] examined if female fracture clinic patients who screen positive for intimate partner violence (IPV) using direct questioning also screen positive using a validated self-report questionnaires. A total of 282 participants were recruited from two level 1 trauma orthopaedic clinics in Ontario. To be included, participants must have been seeking treatment at the clinic for an orthopaedic injury. The majority of women who participated were white (85.1%), age 40 years or older (62.8%) and had an annual income of $40,000 or higher (59.6%), and all were English speakers. Participants were asked questions about their injury and demographics and then completed, in writing, the two validated self-report questionnaires: the Woman Abuse Screening Tool (WAST) and Partner Violence Screen (PVS) tool. Three questions from the WAST directly address physical, emotional and sexual abuse within the past year which were scored separately and referred to in the study as "direct questioning." They compared the prevalence rates of IPV identified by the 3 tools and calculated the sensitivity and specificity of the PVS tool using the "direct questions" from the WAST tool.

The direct questions revealed an IPV prevalence of 30.5%, compared to 12.4% on the WAST and 9.2% on the PVS. Using any of the tools, a total of 94 women screened positive for IPV. Of these women, the WAST identified 37.2%, the PVS identified 27.7% and the direct questions identified 89.4% of victims. Sensitivity of the PVS tool was 25.3% and the specificity was 96.9%. They conclude that rates of IPV may be under-estimated by both the WAST and PVS tools. The authors argue that is possible to screen negative on WAST or PVS despite experiencing abuse, due to the variety of measures used in these tools to calculate a positive or negative score.

Limitations of the study, noted by the authors, include the use of a small sample size and reliance on self-report measures. Due to confidentiality issues, the research team was not able to ensure questionnaires were completed, resulting in some missing or incomplete data. The study also relied on a subset of direct questions to evaluate screening tools, rather than a gold standard method. As well, some women may not be comfortable in responding to direct questions about abuse. During the questionnaire, each participant was asked the PVS questions, followed by the WAST questions, with direct questions asked last. The authors claim that this may have encouraged women to over-estimate experiences of abuse when responding to the direct questions.

Svavarsdottir, 2010

An Iceland-based cross-sectional study by Svavarsdottir, 2010 [-] compared a written self-report screening questionnaire with a clinical screening interview. Women were recruited from two urban clinical settings: an emergency department and a high-risk prenatal clinic. Women were eligible if 18-68 years in age, if seeking health services from the emergency department or prenatal clinic, if

they could read and write Icelandic or English, and if they were able to participate without their partner present. A total of 101 women were recruited from the emergency department, and 107 women from the prenatal clinic. Women recruited from the emergency department who participated were a mean age of 38.01, and primarily: Icelandic (96.1%), married (41.8%) or co-habiting (28.6%), in full-time employment (61.5%), were in good physical health (41.7%) and psychological health (50.5%), had a partner of a mean age of 40.59, and had either no children (25.2%) or one (24.3%) or two (21.4%) children in the household. Women recruited from the prenatal clinic who participated were a mean age of 30.39, and primarily: Icelandic (96.6%), married (41.5%) or co-habiting (38.6%), in full-time employment (68%), were in very good (40%) or good (41.9%) physical health and very good (42.3%) or good (40.4%) psychological health, had a partner the mean age of 33 years, and had one child in the household (41.9%).

All women who were recruited completed two questionnaires (one on demographics and one screening questionnaire) and participated in a clinical interview. The screening questionnaire used was the validated Woman Abuse Screening Tool (WAST) - an 8-item tool to assess current partner violence. The first two questions assess relationship tension while the remaining questions assess the frequency of feelings and experiences related to abuse on a scale from 1 (never) to 3 (often). All questionnaires were available in English and Icelandic and together required 4-12 minutes to complete. Following completion of the written questionnaires, women were invited to an interview with either a nurse (emergency department setting) or midwife (prenatal clinic setting). Women were interviewed using a tool developed by the author Svavarsdottir and Orlygsdottir, and established as valid by a panel of expert researchers and clinicians. The interview is comprised of 9 open-ended questions regarding lifetime and current (past 12 months) physical, sexual and emotional abuse, along with current safety and support needs. Interviews ranged from 10-54 minutes in length. Training (a lecture, 90-minute film on IPV and 2-5 seminars) was received by 21.5% of emergency department nurses and 91.7% of midwives.

In the emergency department sample, 10.8% self- reported physical abuse following an argument, compared to 3.0% in the prenatal clinic sample; 15.1% in the emergency department and 4% in the prenatal clinic self- reported partner physical abuse; and 3.2% in the emergency department self-reported partner sexual abuse, compared to no women in the prenatal clinic. Comparatively, the face-to-face interviews revealed a lifetime abuse rate of 49.5% for the emergency department sample and 39.3% for the prenatal clinic sample; former or current physical abuse was 32% in the emergency department sample and 21.5% in the prenatal clinic sample; past 12-month physical abuse was 17.5% in the emergency department sample and 7.5% in the prenatal clinic sample; sexual abuse was 3.9% in the emergency department sample compared to none in the prenatal clinic. In sum, findings reveal that the most effective method of screening varied between sites and type of abuse being reported and there were no clear-cut results indicating which methods were more effective in revealing abuse. Women more often disclosed physical abuse in the face-to-face interview in both settings. Women at the emergency department more often disclosed emotional and sexual abuse on the written self-report questionnaire, while women in the high-risk prenatal clinic disclosed emotional and sexual abuse at the same rate regardless of format. The authors note that the face-to-face methods resulted in less missing data.

The design of this study was not robust due to the use of a relatively small sample size, a lack of estimates of effect sizes and information on significance of findings, and differences in the approaches of the written (covering only current abuse) and face-to-face interviews (covering lifetime and current abuse). The authors note that because the study was conducted with a sample of primarily Icelandic women, findings may not be generalisable to other populations of women outside of these clinical settings.

Trautman et al., 2007

A US-based before and after study by Trautman et al., 2007 [+] compared a computer-based method of screening for intimate partner violence with usual care in an emergency department

(ED) of a large inner-city hospital in the USA. The hospital primarily serves African American and low-income patients. Participants included women aged 18 and over who were presenting to the emergency department who were not in critical condition and were presenting alone. A total of 1,005 women participated; intervention=411, control=594. The authors note that a large population was ultimately excluded because they were too ill to perform the health assessment. The intervention group reported the following experiences of abuse: 10% physical violence, 5.4% forced sex, 6.3% feeling unsafe in current relationship, and 5.4% feeling unsafe from former relationship. The majority of women were age 35-54 (41.4%), non-White (83.9%), had a child/ children in the household (50.9%), had never been married (53.8%), had graduated from high school (42.3%), were employed (45%), and had an annual household income less than $10,000 (42.4%). Baseline measurements revealed that women who declined were more likely to be 55 years or older. For included participants, there were no significant differences between control and intervention on all measured demographic characteristics. The study involved three consecutive 2-week enrolment periods. Women presenting at the ED during the first and third periods were the control/ comparison groups, while women in the second period were the intervention group.

In the intervention, patient service coordinators recruited women to participate in a web-based health survey which included 4 questions on intimate partner violence within the past year. The survey was approximately 6 minutes in length (SD 4.4 minutes), and was completed on a laptop in a private area of the emergency department (ED) while the women were waiting for care. Those screening positive for IPV had a form printed out for their medical record and social services referral. Participants were also asked to provide feedback on their opinion of the health survey. The usual care condition was based on current ED policy which recommends, but does not enforce, routine screening of intimate partner violence by nursing staff. They examined rates of screening, detection, referrals, and receipt of services for IPV from a review of medical records. They found that 99.8% of the intervention group was screened (completed the IPV questions in the computer survey) for intimate partner violence, compared with 33% in the control groups (67.1% difference, 95% CI: 63.3%-70.9%). Detection of IPV was 19% in the intervention group versus 1% in the control group (17.8% difference, 95% CI: 13.9%-21.7%). Of the 87 participants with a positive screening, only 46 (53%) were referred to social work services, with those in the intervention group being more likely to be referred (10.5% vs. 0.5%, 10% difference, 95% CI: 7%-13%). Similarly, participants were more likely to receive IPV services by a social worker if they were in the intervention group (4% vs. 0.3%, 4% difference, 95% CI: 2%-6%).The majority of women (88%) reported that they were comfortable with answering health questions using the computer format. The health survey did also screen for alcohol use; they found that 6.9% of women screened positive for likely problem use, but no further analysis of this measure was provided.

While this study did find that the health survey significantly improved screening, detection, referral, and receipt of IPV services, there are several limitations with this study, including: lack of follow-up on impact of screening, no measures of emotional abuse and low rates of participation (there was non-participation rate of 35% for control group one, 33% for control group three, and 27% for the intervention group). As well, because participants were primarily low-SES African American women, findings may have limited generalisability to other sub-populations. They did not examine the impact of improved screening rates or referrals on women's health or safety.

Vanderburg et al., 2010

A Canadian before and after study by Vanderburg et al., 2010 [++] investigated the effects of a maternal home visiting programme on the inquiry and disclosure of DV, before and after the implementation of a universal screening programme. The home visiting programme examined was community based and focused on urban areas; rural public health records were not assessed. The Healthy Babies Healthy Children (HBHC) programme was provided by a Northern Ontario public health unit and delivered by public health nurses. The HBHC programme consists of two forms of voluntary visits: a universal 48-hour postpartum home visit, and a long-term home

visit for those families identified as being at “high risk.” Between 2002 and 2004, a routine universal comprehensive screening (RUCS) protocol was implemented within the HBHC programme. Several changes were made to the programme to facilitate implementation, including: a dedicated budget, support from the health unit’s programme director, research support staff to review records and enter data, and a project lead to support procedures and staff training. Staff training included small and large- group education, presentations by key experts and orientation of new staff. Prior to implementation of the RUCS, the 48-hour flow chart for documenting abuse used the term “family relations” for documenting abuse and did not include guidelines for practice. With the implementation of the RUCS, this was changed to family violence/ RUCS protocol, and included guidelines such as inquiring about abuse only when women are alone (with neither partner, family member nor any children over 2-years). The family assessment tool used for long-term visits with “high risk” families was not adapted to the RUCS because it is a standardized and validated assessment tool used by all HBHC programs in the province of Ontario. The tool records family violence and abuse, and abuse/ neglect of the caregiver to the child, and included guidelines for practice. The researchers conducted a retrospective chart audit of cross-sectional data from all HBHC home visits completed in 2001 (before implementation of RUCS) and 2005 (after implementation of RUCS). In the pre-RUCS (2001) audits, they examined 48-hour home visit charts (n=459) and long-term home visit charts (n=79). For the post-RUCS (2005) audits, they examined 48-hour home visit charts (n=485) and long-term home visit charts (n=66). They do not provide demographic data for the women who were included in these home visits.

They analysed abuse inquiry, abuse disclosure and alone status. They found that in 2001, alone status was recorded on 32% of the 48-hour home visit records, which significantly increased to 86% in 2005 (chi square=287.5, $p<0.001$). For long-term home visits in 2001, alone status was documented in 75% of records, which significantly increased to 92% in 2005 (chi square=7.9, $p<0.01$). Disclosure of abuse also significantly increased for both types of home visits: from 3% in 2001 to 11% in 2005 for 48-hour home visits ($p<0.01$) and from 48% to 75% for long term home visits ($p<0.01$). Protecting privacy by not asking about abuse when women were not alone also significantly improved; for 48-hour visits, women who were not alone were not asked about abuse in 19% of the records in 2001, which significantly increased to 98% in 2005 (chi square=357.4, $p<0.001$), and for long-term visits this increased from 2.3% in 2001 to 38% in 2005 (chi square=191.2, $p<0.001$). However, practices in the long-term home visit programme did not improve as much as in the 48-hour visits; in the long-term visits, 23 women (out of 37 who were not alone) were asked about abuse in the presence of someone in 2005; in the 48-hour home visits, only 6 women (out of 383 who were not alone) were asked about abuse in the presence of someone in 2005. The authors note that this is likely due to the lack of a screening guideline regarding privacy in the long-term assessment tool.

The authors conclude that the implementation of a universal screening protocol into an existing maternal home visiting programme improved practices to ensure privacy and safety of women and also demonstrated an increase in disclosures of abuse. They did not examine the impact of screening on women’s health, or acceptability of the assessment tool by providers or women. However, they state that focusing on practical measures such as rates of disclosure and provider practices is a more “realistic” evaluation of universal screening than measurement of health-related outcomes. Other limitations of this study include: the lack of demographic data for women who participated in home visits and a lack of information on the questions asked in the assessment tools.

Wahl et al., 2004

A US-based before and after study by Wahl et al, 2004 [-] examined the impact of a screening tool for IPV in a paediatric setting for identifying children exposed to violence. Women were recruited form the University of Arizona Paediatric Clinic. A total of 7,070 questionnaires were completed during this two year study. The Paediatric Clinic provides care for 16,000 patients annually and has an ethnic composition of 30% Hispanic and 5% African American patients, with

approximately 75% of patients with coverage by Medicaid. Each parent/ couple who brought their child to check in at the clinic was provided a “Child Safety Questionnaire” to complete during their wait. Questionnaires were age-appropriate for each child, and multiple questionnaires were provided if the parent was presenting with multiple children. Included in the questionnaire were 4 questions addressing intimate partner violence, including: 1. Have you ever been in a relationship with someone who has hit you, kicked you, slapped you, punched you, or threatened to hurt you? 2. Currently? 3. When you were pregnant did anyone ever physically hurt you? 4. Are you in a relationship with someone who yells at you, calls you names, or puts you down? Parents who responded yes to #1, 3 or 4 were classified as experiencing DV. Participants who responded yes to #2 were classified as experiencing current DV, and those who responded no were classified as experiencing past DV. Each parent/ couple completed the same questionnaire one year later. Providers were advised to discuss any safety concerns indicated on the questionnaire during their appointment with the family and provide necessary support and referral to the local social worker. Screening occurred for a 3 month period. They examined prevalence rates for current and past DV during the 3-month baseline period and for two subsequent years during which active screening occurred.

Prior to active screening with the child safety questionnaire, they found 5 cases of DV in a population of approximately 5,000 children over a 3-month period. Screening with the questionnaire resulted in the identification of 69 cases of current DV (2% of all screened) during each of the two years of screening. The questionnaire was associated with significantly increased odds of detecting current DV (OR=3.6, 95% CI [1.4, 9.1], p=0.007), with 72% [26–84%] of the cases identified through the use of the questionnaire. Overall, they found that 2% (138 cases) of children were currently exposed to DV, and 13% (915 cases) had been exposed to DV in the past.

There are a number of limitations to this study. In the first year, 27%, and in the second year, 35% of participants did not complete and/ or return a questionnaire. Therefore, it is likely that the prevalence rate found is lower than the number of actual cases. They also note that due to the large number of responses, they were unable to provide adequate support to all women and therefore focused on women at highest risk. They note that they were unable to measure the sensitivity or specificity of the tool, because the incidence of family violence in the population studied is unknown. Finally, while they suggest that men (fathers) may have also completed the questionnaire (when provided to a couple, they were not instructed on who should complete the questionnaire) they do not provide further analysis or discussion of who completed the questionnaire, and the study focuses on women/ mothers as the victims of abuse. They also do not address the safety of women answering the questionnaire’s four questions on victimization, if such were being answered in the presence of a perpetrator. Finally, most of the patients served were covered by Medicaire, and therefore the findings may not be generalisable to non low-income populations.

Wathen et al., 2008

A Canadian RCT by Wathen et al, 2008 [+] compared the Woman Abuse Screening Tool (WAST) with the Composite Abuse Scale (CAS). Women were recruited from 26 community based primary health care sites between 2005-2006, and were eligible if they were age 18-64, literate in English, presenting for their own health care, had a male partner in the past year, were able to participate alone, and lived within 120km of the healthcare site. A total of 5,607 women completed the screening tools (used to calculate a measure of agreement between the tools), and the 399 of these women who were in the intervention group, screened positive for IPV, and completed the follow-up interview were included in analyses looking at mental health and substance use covariates. Among the 399 participants in the latter analysis, women were primarily: under age 30 (38.6%); had less than 12 years of education (20.8%); were common-law, separated, divorced, or widowed (56%); 8.3% were pregnant; and 15.6% had a partner employed less than part-time. Prevalence of health conditions among these women included: 67.4% reported depression, 35.9% somatisation, 23.6% panic disorder, 57.3% PTSD, 19.2% alcohol

problem, 39.1% drug problem, 28.6% had a partner with an alcohol problem, and 22.3% had a partner with a drug problem.

Participants completed the 8-item WAST which measures physical, sexual and emotional abuse in the past year, and the 30-item validated "criterion standard" Composite Abuse Scale which includes 4-subscales to measure partner abuse (severe combined abuse, emotional abuse, physical abuse and harassment) in the past year. Intervention participants completed the WAST before the clinical visit, and completed the longer CAS after the visit. The completed WAST was attached to the patient chart to notify the health care provider. Those in the comparison group completed both the WAST and CAS following their clinical visit. The authors note that providers were trained in the identification and response to DV, although no further details are provided. All who participated were provided with a card listing local support services for DV. Within two weeks, women in both groups who had scored positive for IPV were contacted and completed a written interview in the presence of a researcher to measure mental health, substance use and to gather partner information. A total of 11% did not complete the follow-up interview, and 33% were lost between intervention and follow-up. Those who did not complete interviews were more likely to have higher scores on the CAS than those who completed interviews (22.4 ± 29.4 vs. 17.8 ± 23.7, t=-2.1, p=0.040).

Findings revealed that the WAST identified 22.1% of women as experiencing abuse in the past 12 months, compared to 14.4% who were identified on the CAS (k=0.63, SE=0.01). They estimate that the brief screening (WAST) may actually over-identify women as being abused by a partner, with unknown consequences. They also found that women who were positive for IPV on both the WAST and CAS were more likely than those screening positive on the WAST only to report to be: married (OR=2.7, 95% CI: 1.3-5.5, p=0.009), have a mental health issue (OR=2.3, 95% CI: 1.3-4.0, p=0.002), have a drug problem (OR=1.7, 95% CI: 1.1–2.9, p=0.036), and have a partner with a substance use problem (OR=2.0, 95% CI: 1.2-3.2, p=0.006). These findings suggest that screening for and responses to intimate partner violence may need to be sensitive to the context of women's lives and often co-occurring issues.

The authors recommend further research on the potential implications of screening for women with mental health and substance use problems. They also raise the issues of the unknown negative and/ or positive consequences on women of screening, particularly if they are miss-identified, as well as the resource implications for the health care system itself. There are several limitations to this study, including: limited information on the follow-up interview and procedures, lack of validation of results, and high attrition rates (potentially of more vulnerable women, as suggested by the authors) at both intervention and follow-up. They also included only women who had a male partner within the past 12 months, limiting findings to partner violence between heterosexual partners.

5.5. Evidence Statements

We have organized the findings using the following categories:

1) Screening/ identification tools
2) Screening formats
3) Provider education that supports identification and intervention as relevant
4) Enhancing identification through additional protocols such as provider cueing
5) Organizational level supports for identification
6) Identification of violence with pregnant/ postpartum women.

Evidence Statement 5- Screening tools/ approaches

Seven studies compared the use of different screening tools or approaches on identification of DV. There is moderate evidence from these studies that the type of tool or approach used results in different rates of DV identification and/ or forms of violence identified, as well as the specific sub-populations of victims and/ or perpetrators identified. A RCT (Wathen et al., 2008 [+]) found

that women were over identified as experiencing DV when a brief screening tool (WAST) was administered prior to the visit to a health care provider compared to a longer validated tool (CAS). One before and after study (Colarossi et al., 2010 [+]) found that a longer tool including questions on frequency of abuse identified more victims of DV, compared to a short, yes/ no response tool. Another RCT (Rickert et al., 2009 [+]) found differences in the identification of physical violence among young women when comparing three screening approaches; they also found that use of a bidirectional approach resulted in greater screening and identification of women as perpetrators. A before and after study (Kapur et al., 2011 [+]) found lower rates of IPV prevalence using written formats of HITS compared to the PVS tool for women, but not for men. A cross-sectional study (Halpern et al., 2009 [+]) found rates of DV identification were greater when using a diagnostic protocol (3 question PVS which includes questions about women's perception of safety), compared to a standard operating procedure in an emergency department where women are asked as to the aetiology of their injury, and sub-populations of women were more or less likely to report DV. An RCT with university students (Hamby et al., 2006 [+]) found that some forms of violence were more often reported using a tool that measured frequency of abuse, when compared to a yes/ no response tool. Findings from a cross-sectional study suggest that a shorter version (6 item) may be as effective as a longer version (9-item) screening tool for identifying elder abuse; and that 3 items from the tool may be the most powerful predictors of abuse, including questions related to: belongings taken, being hurt or harmed by someone else, and privacy (Moody et al., 2000 [+]).

Wathen et al., 2008 (RCT [+], Canada, n=5,607 women, 2 week follow up) [Intervention participants completed 8-item WAST prior to clinic visit and 30-item CAS following their clinic visit. Completed WASTs attached to patient's health record and providers trained in screening DV. Comparison group completed both tools following clinic visit, and all participants received card listing local support services]. WAST identified 22.1% DV rate in women, compared to 14.4% on CAS (k=0.63, SE=0.01). Women positive for IPV on both WAST and CAS were more likely than women screened positive on the WAST only to be: married (OR=2.7, 95% CI: 1.3-5.5, p=0.009), had a mental health issue (OR=2.3, 95% CI: 1.3-4.0, p=0.002), had a drug problem (OR=1.7, 95% CI: 1.1–2.9, p=0.036), had a partner with a substance use problem (OR=2.0, 95% CI: 1.2-3.2, p=0.006).

Colarossi et al., 2010 (before and after [+], USA, n=805 women (mean age: 24.7 (old screen); 25.1 (new screen); primarily African American and Latina; English speaking, single), Jan-Dec 2006 (old screening); Jan-Dec 2007 (new screening) [Compared two screening tools in reproductive health clinics at two time points; the older (old screening) tool included 2 yes/ no questions and the new screening tool (new screening) included 6 questions measuring frequency of past year violence and lifetime violence] More women using the new form reported any IPV (23.6%) than on the old form (11.2%) (p=0.000). Twice as many affirmative reports of all IPV categories were found on the new form: any violence OR=2.66 (p<0.001), current violence OR=2.56 (p=0.07), past violence OR=2.61 (p<0.001), and both current and past OR=4.18 (p<0.05). For each additional year of age, reporting increased about 4% (OR for age as an interval variable in number of years was 1.04, p=0.001).

Rickert et al., 2009 (RCT [+], USA, n=669 young women (age 18-24), post-intervention) [Self-administered computer screening using one of 3 approaches. 1) Basic screening: 5 standardized questions regarding past year and lifetime violence; 2) Healthy relationships screening: basic screening plus two questions regarding partner treatment; 3)Bidirectional screening: basic screening plus 3 questions regarding perpetration against partner. Following computer screen, responses were attached to patient's chart and trained provider conducted face-to-face screen] No significant differences in reports of lifetime violence or past sexual/ physical violence. Significant difference found in physical violence by screening approach; 11.6% in the bidirectional approach, 6.2% in the healthy relationship screen and 5.6% in the basic screen (p<0.04). Bidirectional approach more often included a provider assessment of women's perpetration against their partners. Overall, 31% of women noted a lifetime occurrence of violence, yet

provider identified only 18% as victims of violence. No significant differences in women or providers' experiences of screening approach.

Kapur et al., 2011 (before and after [+], USA, n=466 patients (67.8% female; 32.2% male, primarily non-Hispanic White), post intervention) [Phase 1 completed written self-administered questions from PVS and HITS. New set of participants in Phase 2 participated in face-to-face screening interviews with trained residents using same questions]. For women completing the written questionnaire, screening prevalence of IPV was lower on the HITS (9%) than for the PVS (17.8%, p=0.008). No significant differences in face-to-face screening prevalence between the PVS and HITS for women. For men, there were no significant differences in screening prevalence for IPV based on tool (all p≥0.25).

Halpern et al., 2009 (cross-sectional [+], USA, n=286 women, post intervention) [Compared diagnostic procedure (DP) (PVS tool including 3 face-to-face questions on physical violence and safety, and an assessment of risk based on location of the injury) with standard operating procedure (nurse questioning at intake for injury aetiology) in emergency department]. Participants identified as high risk using DP were more likely to report DV injury aetiology (OR=38, 95% CI: 4.5-327, p=0.01). Frequencies of self-reported IPV injuries were 11.5% for the DP and 5% for the SOP (p<0.03). Older women were less likely (OR=0.95, 95% CI: 0.9-1.1, p<0.05) and non-white women were more likely (OR=7.5, 95% CI: 1.8-30.1, p=0.01) to report a DV injury aetiology.

Hamby et al., 2006 (RCT [+], USA, n=160 undergraduate students (primarily freshmen, female, European American, mid to upper class, post-intervention) [In manipulation of administration method: half completed written format of CTS2 (78-question measure of IPV) and half a computer format. In manipulation of response category, completed either standard categories of CTS2 (frequency of abuse) or yes/ no categories]. For response category, perpetrated and sustained sexual coercion were more often reported using the standard CTS2 categories compared to the dichotomous categories (chi-square=7.06, p<0.01) and (chi-square=6.18, p<0.05), respectively. Inflicted injury was also more often reported in the standard CTS2 than the dichotomous condition (chi-square=4.44, p<0.05). Overall, males were more likely than females to report perpetrating sexual coercion (36% vs. 12%) (p<0.01).

Moody et al., 2000 (cross-sectional [+], USA, n=100 elderly (age 60 or over) women and men living in an urban public housing unit (mean age of 66.6 years; 55% female, 45% male; White, Hispanic, African American), n/a) [Tested psychometric properties of HSEAST, a 15-item questionnaire to screen for elder abuse. Answers were yes/ no, completed by self-report or in person, with scores ranging from 0 to 15. The status of "past abuse" vs. "no abuse" was based on self-report of being a previous victim of abuse, and checked against the records of the social worker at the housing authority] Mean total scores on HSEAST were significantly different for the abused group (4.01) compared to the non-abused group (3.01) (t=1.98, p=0.049). A factor analysis supported the 3-factor structure proposed (Violation of Personal Rights; Characteristics of Vulnerability; Potentially Abusive Situation) and explained 38% of the total variance. Reliability (internal consistency) on the 15-item scale was weak, alpha=0.46. Reliability on the 10-item scale (including only items from the factor analysis) was 0.59. A stepwise discriminant function analysis showed that a 6-item model was as effective as a 9-item model in correctly classifying cases as abused vs. non-abused (71% correct). Three items, related to: belongings being taken, being hurt or harmed, and privacy, were identified as the most powerful predictors of abuse.

Applicability

One study was conducted in Canada (Wathen et al., 2008 [+]), and six studies were conducted in the USA (Kapur et al., 2011 [+]; Halpern et al., 2009 [+]; Rickert et al., 2009 [+]; Hamby et al., 2006 [+]; Colarossi et al., 2010 [+]; Moody et al., 2000 [+]). The study by Moody et al., 2000 [+] was conducted with a convenience sample of elders in a high crime area and therefore may have

limited generalisability. Otherwise, there is no reason to believe that the findings from these studies would not be applicable within similar practice settings within the UK.

Evidence Statement 6- Screening format

Moderate evidence from four studies suggests that screening format impacts the disclosure of IPV, forms of violence reported, or may improve awareness of abuse. One before and after study (Kapur et al., 2011 [+]) found higher reports of IPV for women in a self-report written format, compared to face-to-face format. Similarly, a RCT (Klevens et al., 2012 [+]) revealed that women more often disclosed IPV in a self-report computer format, compared to face-to-face screening by their health care provider. An individual RCT (Robinson-Whelen et al., 2010 [+]) found that computer screening of women with disabilities improved their awareness of abuse. One RCT (Hamby et al., 2006 [+]) found differences in the types of IPV reported in computer and written screening formats. However, a cross-sectional study (Svavarsdottir, 2010 [-]) found that the most effective format for screening varied between settings and types of abuse reported, with women more often disclosing physical abuse in face-to-face interviews, compared to written self-report.

Kapur et al., 2011 (before and after [+], USA, n=466 patients (67.8% female; 32.2% male, primarily non-Hispanic White), post-intervention) [Phase 1 completed written self-administered questions from PVS and HITS. New set of participants in Phase 2 participated in face-to-face screening interviews with trained residents using same questions]. IPV prevalence was 17.3% for the self-administered screening, compared with 9% using the face-to-face format. After adjusting for socio-demographic characteristics, women more likely to report IPV on the self-administered questionnaire than the face-to-face format (AOR=3.5, 95% CI: 1.4-8.6), but differences for men were not statistically significant (AOR=1.4, 95% CI: 0.3-5.8). Residents reported screening 11.7% of male patients and 38.4% of female patients; 27.5% reported screening male patients and 25% female patients only when abuse indicators were on patient history.

Robinson-Whelen et al., 2010 (individual RCT, [+], USA Time 1 n=329; Time 2 n=259 (women with disabilities, mean age: 50.75, primarily White and living alone), 3 month) [Safer and Stronger Programme (SSP): 1-1.5hr, culturally appropriate computer-based self-screening for IPV for women with disabilities]. Abuse awareness increased significantly from Time 1 to Time 2, particularly for women who had not experienced abuse in the previous year, and intervention participants had significantly higher abuse awareness than control participants ($p=0.015$). No significant effects differences between intervention and control on safety self-efficacy and safety promoting behaviours, but abuse awareness and self-efficacy for safety were significantly related to safety behaviours ($p<0.05$).

Hamby et al., 2006 (RCT [+], USA, n=160 undergraduate students (primarily freshmen, female, European American, mid to upper class, post-intervention) [In manipulation of administration method: half completed written format of CTS2 (78-question measure of IPV) and half a computer format. In manipulation of response category, completed either standard categories of CTS2 (frequency of abuse) or yes/ no categories]. More physical assault was reported on the computer format (chi-square=4.43, $p<0.05$). More sexual coercion was reported in the written form (chi-square=7.06, $p<0.01$). In dichotomous category condition, slightly higher rates of physical assault were reported for written (37.5%) compared to computer administration formats (32.5%); but for the CTS2 condition, higher rates of physical assault were reported in the computer format (47.5%) than the written format (22.5%) ($p<0.05$ for the interaction effect of response category x administration format).

Klevens et al., 2012 (RCT [+], USA, n=126 women (primarily African American), 1 week) [Three groups, all using PVS screening tool: 1) Provider Screened and Referred Group; 2) A-CASI Screened and Referred Plus Provider Support Group; 3) A-CASI Screened and Referred Plus Video Support Group]. Women screened using A-CASI disclosed IPV more often (21.3%) than those screened by a health care provider (8.7%, $p=0.07$). Most women (41.3%) had no preference for mode of screening. No differences between the provider-delivered and A-CASI

delivered screening groups for positive or negative reactions to screening. No women interacted with local advocacy staff within 3 months after screening.

Applicability

Four studies were conducted in the USA (Robinson-Whelen et al., 2010 [+]; Klevens et al., 2012 [+]; Kapur et al., 2011 [+]; Hamby et al., 2006 [+]). The study by Klevens et al., 2012 [+] was conducted primarily with African American women, so findings may not be generalisable to other sub-populations of women. There is no reason to believe that findings from the other studies would not be applicable to the UK context.

Evidence Statement 7- Cueing

There is moderate evidence from seven studies that cueing improves discussion of, disclosure of and referrals or services provided for DV among some populations. An individual RCT (Ahmad et al., 2009 [++]) reported improved discussion opportunities for and detection of intimate partner violence following cueing using a computer generated risk assessment prior to a medical appointment; and in detected cases, patient safety was more often assessed and a follow-up appointment more likely requested. Similarly, a RCT (Calderon et al., 2008 [++]) and before and after study (Trautman et al., 2007 [+]) observed improvements in screening rates in prenatal care, and in a emergency department, respectively, following cueing using a computer-based risk assessment. One cluster-RCT (MacMillan et al., 2009 [++]) did not find that cueing improve risk of violence and found only limited improvements in quality of life and depression measures. One RCT (Rhodes et al., 2006 [+]) found that a computer survey-based prompt improved rates of discussion and disclosure of DV in an urban, but not suburban, sample. An individual RCT (Humphreys et al., 2011 [+]) also found an increase in rates of discussion of IPV in prenatal care. Finally, a before and after study (Hamberger et al., 2010 [+] found that a chart prompt improved screening rates.

Ahmad et al., 2009 (individual- RCT [++], n=293 women (final analysis) (mean age 43.5 years, married, college or university educated, employed, range of income levels), post-intervention) [Computer based patient survey completed pre-appointment, including questions related to intimate partner violence and control (IPVC) and other health risks. Computer generated risk report attached to medical chart for physician, along with suggested referral resources and a patient sheet of health risks and recommended resources. Control participants did not receive screening prior to medical appointment] Based on exit survey data, overall prevalence of any form of IPVC was 22%, and there was no significant difference between the intervention and control conditions. The computer risk report improved IPVC discussion opportunities (35% vs 24%; adjusted relative risk (RR)=1.4, CI: 1.1-1.9) and detection of IPVC (18% vs. 9%; adjusted RR=2.0, CI: 0.9-4.1). In detected cases, physicians were more likely to assess patient safety in the intervention (9 of 25 participants) than control group (1 of 12 participants), and request a follow-up appointment (20 of 25 intervention participants; 8 of 12 control participants). On average, participants perceived screening as beneficial but concerns regarding privacy and interference with physician interactions were reported.

Calderon et al., 2008 (RCT [++], USA, n=59 prenatal patients (mean age 27.4; primarily Latina and African American, high school educated), post-intervention) [Private computer risk assessment (for multiple risks) completed prior to regular prenatal visit; cueing sheet attached to medical record for provider along with counselling suggestions] 17 out of 20 women reporting IPV in the intervention reported a discussion with their provider (85.0%, 95% CI: 62.1%-96.7%), compared to 4 of the 17 participants reporting IPV in the control group (23.5%, 95% CI: 6.8%-49.9%). Most rated the discussion as helpful, and were comfortable with using the computer programme.

MacMillan et al., 2009 (cluster-RCT [++], Canada, n=411 female patients (mean age of 34 years, mean education of 14 years), baseline, 6-, 12-, 18- months) [Intervention participants completed the Woman Abuse Screening Tool (WAST) prior to meeting the clinician. Positive screenings

questionnaires were added to the patient chart for the clinician to discuss at their discretion. Following the visit, all women completed the Composite Abuse Scale (CAS). The no-screening group completed the WAST and CAS following their medical appointment] Trajectory of risk of IPV recurrence was non-significant but downward (at 18 months, OR=0.82, 95% CI: 0.32-2.12) for screened compared to nonscreened women. Quality of life (at 18 months, 3.74 points higher, 95% CI: 0.47-7.00) and depressive symptoms (at 18 months, -2.32, 95% CI: -4.61 to -0.03) were somewhat improved in screened women but no longer statistically significant following estimates from multiple imputations.

Trautman et al., 2007 (before and after study [+], USA, n=1,005 women (majority age 35-54, non-White, never married, with a child, high school education, employed, low income), post intervention) [Self-report web-based health survey with 4 IPV questions completed and attached to medical record, along with social services referral for providers] 99.8% of the intervention screened for IPV, compared with 33% in control groups (67.1% difference, 95% CI: 63.3%-70.9%). Only 53% of positive screenings were referred to social work services.

Rhodes et al., 2006 (RCT [+], USA, n=867 (urban and suburban samples), post-intervention) [Intervention group completed self-report computer risk assessment; any risk notifications provided to physicians prior to appointment. Control group received usual care] DV rate of 26% in the urban sample and 21% in the suburban sample. For urban sample, computer prompt increased rates of discussion of DV (56% vs. 45%, OR=1.99, 95% CI: 1.25-3.18, p=0.004), disclosure of DV (14% vs. 8%, OR=1.71, 95% CI: 0.96-3.05, p=0.07), and services provided (8% vs. 4%, OR=2.29, 95% CI: 1.04-5.02, p=0.04). No significant increase in discussion or disclosure of DV in suburban sample.

Humphreys et al. 2011 (individual RCT [+], USA, n=50 women (mean age: 27.7, primarily Latina and Black, non-married, high school educated or more, and experience of physical violence in the year before pregnancy), one month) [Women in intervention completed computer based risk assessment with “Video Doctor” prior to prenatal clinic visit. Programme provided tailored messages and cueing sheet for providers, along with suggested messages and resources. Control group received usual care] The intervention group was more likely to report patient-provider discussions of IPV when compared to the control group at baseline (81.8% vs. 16.7%, p<0.001) and one-month follow-up (70.0% vs. 23.5%, p=0.008). Participants in the intervention group were more likely to have a discussion of IPV risk at one or both visits, compared to usual care (90.0% vs. 23.6%, p<0.001).

Hamberger et al., 2010 (before and after [-], USA, n=436 medical exam charts, 18 months) [Family practice residents received 3hr IPV training (both control and intervention participants) plus chart prompt (intervention only) to screen for IPV. After 7 months, chart prompt replaced by pain screening prompt] Baseline screening rate improved from 2% to 92% after chart prompt (z=-18.6, p<0.0005). Chart prompt removal showed a significant decrease in documented screening at 36% (z=7.0, p<0.00005). Male providers were more likely to document screening than female providers (males 39% vs. females 29%, p=0.03).

Applicability

Two studies were conducted in Canada (Ahmad et al., 2009 [++]; MacMillan et al., 2009 [++]) and five were conducted in the USA (Rhodes et al., 2006 [+]; Calderon et al., 2008 [++]; Trautman et al., 2007 [+]; Humphreys et al., 2011 [+]; Hamberger et al., 2010 [-]). Several studies were conducted with primarily African American and/ or Latina women (Rhodes et al., 2006 [+]; Calderon et al., 2008 [++]; Humphreys et al., 2011 [+]), so these findings may not be generalisable to other sub-populations of women. However, there is no reason to believe other studies would not be applicable to the UK context.

Evidence Statement 8- Provider education

There is inconsistent evidence from four studies that provider education interventions are effective in improving screening practices or clinical enquiry. The strongest evidence comes from an RCT (Lo Fo Wong et al., 2006 [++]) which compared focus group with full training interventions, and found modest improvements in awareness of and identification of DV for both conditions, but were greater in the full training condition, and another RCT (Feder et al., 2011 [++]) which found improvements in referrals, and an increase in disclosures of DV following an education and advocacy intervention. One before and after study (Bonds et al. 2006 [+]) found a modest increase in women's self-reports of screening following a multimodal education programme for health care providers. One RCT (Coonrod et al., 2000 [+]) found that a training programme for medical residents increased knowledge about DV but did not significantly increase rates of diagnosis of DV.

Feder et al., 2011 (RCT [++], UK, n=48 primary care practices (serving a median of 7,142 registered patients, with a median of 45.3% full-time equivalent female doctors, and a median of 32% of registered patients on low-income), 12-months) [Clinicians received two 2 hour sessions, delivered by a psychologist/ family doctor and an advocate educator, including cases studies and practice exercises; each site provided support materials and regular feedback and meetings to reinforce training. 1hr training session on confidentiality and safety issues for administrative staff. Each practice nominated a champion who received additional 8 hour training]. The recorded number of referrals to an advocacy group was 22 times larger in the intervention practices than in the control practices, after controlling for potential confounders (adjusted incident rate ratio (IRR)=22.1, 95% CI: 11.5-42.4). Recorded disclosures of DV in the medical records were higher in intervention practices than in control practices (adjusted IRR=3.1, 95% CI: 2.2-4.3). Referrals received by DV agencies were also greater in intervention practices: adjusted IRR 6.4 (95% CI: 4.2-10.0).

Lo Fo Wong et al., 2006 (RCT [++], Netherlands, n=54 family doctors (51.9% female, 48.1% male; primarily: age 40-50 years, work in economically deprived district, work part-time, in residence less than 15 years, in a duo/ group practice), 6-month) [focus group alone: six, 1.5 hour focus group discussions on IPV views, experiences, practices, barriers; intervention: focus group plus 1.5 day training on overcoming barriers identified in focus group]. Discussion or suspicion of partner abuse was 4.54 times greater for the full intervention than control group (95% CI: 2.55-8.09, $p<0.001$). Discussion or suspicion of partner abuse was 2.2 times more likely for the focus group only than control group (95% CI: 1.14-4.26, $p=0.019$). Discussion or suspicion of partner abuse was 2.19 times more likely for the full-training intervention group than focus group only group (95% CI: 1.36-3.52, $p=0.001$). The full training group was 5.92 times more likely to engage in active questioning when there were "non-obvious" signs than untrained groups (OR 95% CI: 2.25-15.62, $p<0.01$).

Bonds et al., 2006 (before and after [+], USA, initial survey n=1,482 female patients; follow-up survey n=1,527 female patients (mean age=49 years, primarily: White, married, with child at home, health insured, employed, low income), post-intervention) [one day centralized training for providers delivered by 2 local resource persons, followed by one single 90min training or two 45-min training sessions, and ongoing educational lunch sessions over 18-month period; clinic choice of patient education materials and screening method (oral or paper), and choice of 5 screening tools]. Women's self-reports of screening for DV increased from 16% (n=236) pre-intervention to 26% (n=398) post-intervention. Patients were 79% more likely to be screened post-intervention compared to baseline after adjustments for patient and provider characteristics (OR 1.79, 95% CI 1.43–2.23).

Coonrod et al., 2000 (RCT [+], USA, n=102 medical residents entering residency in 1995 and 1996 (no demographic information provided), 9 months-12 months) [1st year: 20min video on prevalence of IPV; 2nd year: 20min programme including 9min video, role-playing of interview techniques and reading materials]. Residents' self-reports of DV diagnoses were not significantly

different in 1995: 75% intervention vs. 60% control (p=0.26), or in 1996: 67% intervention vs. 46% control (p=0.15). However, when pooling data from the two years together, the intervention group was 35% more likely than the control group to diagnose DV (RR=1.35, 95% CI: 0.96-1.90). Significant differences were found in reported diagnoses of cases of DV by specialty: 100% family practice; 90% emergency medicine; 80% OB/GYN, 67% psychiatry, 63% paediatrics, 47% internal medicine and 0% surgery residents. There were significant improvements in knowledge of DV (intervention mean=73% correct on the post-intervention test vs. control mean=56% (p=0.002).

Applicability

One study was conducted in the UK (Feder et al., 2011) [++], one in the Netherlands (Lo Fo Wong et al., 2006) [++], and the remaining studies in the US (Bonds et al., 2006 [+]; Coonrod et al., 2000 [+]). The Coonrod et al., 2000 study was based on an intervention with medical residents carried out in 1995-1996, so it may be less applicable to current residents. There is no particular reason to think that there may be barriers to applicability of the other non-UK based studies to the UK context.

Evidence Statement 9- Policy/ Organizational change

There is inconsistent evidence from two before and after studies that the implementation of policy or organizational changes to screening for DV improves screening rates, referral rates and/ or provider comfort with and ability to screen. Shye et al., 2004 [+] reported modest improvements in screening following augmentations to a HMO routine inquiry strategy. Power et al., 2011 [-] reported improvements in referral rates and providers' self-reports of awareness and efficacy of DV screening following implementation of a routine screening programme within an emergency department.

Shye et al., 2004 (non-randomized controlled trial [+], USA, pre-intervention n=273 clinicians, post-intervention n=238 clinicians (half female, majority physicians), pre-intervention n=1,925 patients, post-intervention n=1,979 patients (primarily 26-35 years, White, living with a partner, full-time employed), 12 months). [Augmented basic HMO routine inquiry implementation strategy by providing social workers with paid time to act as social change agents (providing ongoing support, training and advocacy) via regular meetings and individual contact with clinicians vs. a basic HMO implementation strategy that did not include this paid time for social workers to act as change agents for DV] At baseline, 2.9% of participants had been asked about DV exposure, increasing to 9.5% at one-year follow up (p=0.001). Women who reported discussing DV with a provider increased from 0.7% at baseline to 1.2% at follow up (not statistically significant). Logistic regression analyses showed a statistically significant increase in inquiry rates during the study period (OR=3.75, 95% CI: 2.41-5.84, p=0.0001). However, the ABIS was not significantly different from the BIS in affecting inquiry rates (p=0.61 for main effect of ABIS, p=0.38 for interaction effect of ABIS x time).

Power et al. 2011 (before and after [-], Australia, n=40 medical staff (70% female; 70% nurses), 3 months) [Implementation of routine DV screening programme within Emergency Department, supported by ecological model. Provision of screening tool to staff, list of referral services, response protocol, posters, 1hr training session, full day training of volunteer staff to champion the programme]. Referral rates increased by 213%. Medical staff supported the programme (M=3.9, SD=0.9) and thought the screening programme was effective in identifying domestic and family violence (M=3.8, SD=0.68), felt they had appropriate support to deal with DV issues that arise (M=3.6, SD=0.9), and that impact of the tool on identification was mildly effective (M=3.2, SD=0.9). Most felt prepared to use the tool (M=3.5, SD=1.0) and were content with their own knowledge of support services (M=3.2, SD=1.0).

Applicability

One study was conducted in Australia (Power et al., 2011 [-]) and one in the USA (Shye et al., 2004 [+]). These finding will be limited in applicability to those contexts in the UK where similar institutional policies may exist.

Evidence Statement 10- Identification in pregnancy/ Postpartum

There is moderate evidence from five before and after studies and one interrupted time series study, that universal screening or routine enquiry for DV in pregnancy, when supported by staff training and organizational support, improves screening practices and documentation of DV. Two studies examined the impact of a routine comprehensive screening protocol during postpartum home visits; one found significant improvements in the protection of women's privacy during screening (Vanderburg et al., 2010 [++]), while the other was supported by a year-long professional development strategy and found improvements in documentation of abuse inquiry (Grafton et al., 2006). One study (Duncan et al., 2006) examined the effect of providing repeated individualized feedback to OB/GYN residents on their screening performance, compared with that of other residents and found significant increase in rates of screening. Two studies examined policy and organizational changes to support the implementation of universal screening protocols within settings serving pregnant and postpartum women (Janssen et al., 2002 [+]; Garcia and Parsons, 2002 [+]) and found substantial improvements in screening rates. Another study (Price et al., 2007 [+]) examined the implementation of an antenatal routine enquiry programme but found only modest improvements, with most midwives reporting assessment of only a proportion of clients.

Vanderburg et al., 2010 (before and after [++], Canada, pre-implementation (2001) 48hr home visits charts n=459: pre-implementation (2001) long-term home visit charts n=79; post-implementation (2005) 48hr home visits charts n=485; post-implementation (2005) long term home visit charts n=66), post-implementation follow-up) [Routine comprehensive screening protocol (RUCS) implemented in home visiting programme in 2002-2004; included new guidelines to only inquire about abuse when women are alone. RUCS supported by budget, administrative support and training]. In 2001, alone status was recorded on 32% of 48hr visit records, increasing to 86% in 2005 (chi square=287.5, $p<0.001$). For long-term home visits in 2001, alone status recorded in 75% of records, increasing to 92% in 2005 (chi square=7.9, $p<0.01$). Disclosure of abuse increased from 3% in 2001 to 11% in 2005 for 48-hour home visits ($p<0.01$) and 48% to 75% for long term home visits ($p<0.01$). Women who were not alone were not asked about abuse in 19% of the 48hr records in 2001, increasing to 98% in 2005 (chi square=357.4, $p<0.001$); for long-term visits this increased from 2.3% in 2001 to 38% in 2005 (chi square=191.2, $p<0.001$).

Duncan et al., 2006 (interrupted time series [+], USA, n=12, 518 patient records at 5 data collection periods) [Two hour training on DV, provision of screening questions, individualized reports on screening performance compared with that of other residents 4 times starting 2 months after training]. Prior to intervention residents screened at 60% of visits, increasing to 91% (chi-square 28.4, $p<0.001$). The odds of screening by male residents compared to female residents was OR=0.46 (95% CI: 0.21-0.98).

Grafton et al., 2001 (before and after [+], Canada, pre-RUCS n=1,151; post-RUCS n=1,193 home visit charts, 12 months) [Year long professional development strategy to support use of routine comprehensive screening protocol (RUCS) during home visits, including: workshops and small group work, support by programme advocates, and revisions to assessment forms to prompt assessment of DV]. Prior to RUCS, there was only 0.8% documentation of abuse inquiry for low-risk clients, increasing to 20.5% post-RUCS. Women under 20 years and single mothers were more likely ($p=0.001$) to be asked.

Janssen et al., 2002 (before and after [+], Canada, n=300 nurses in ethnically diverse postpartum clinical setting, 4, 6, 18 months) [Implementation of a universal screening protocol based on Roger's innovation-diffusion model; engaged key administrators as advocates and offered 1hr

training sessions, support from early adopters acting as models for change, competency checklists, updated staff materials, and support from all hospital staff. Screening protocol was culturally tailored] Initial screening rate increased from 42.1% to 53.8% at 4-months, 60.76% at 6-months, and 62.1% at 18 months.

Garcia and Parsons, 2002 (before and after [+], USA, n=80 clinicians (97% female, 20-64 years, primarily nurses), 3 months, 12 months). [Implementation of a policy change for universal DV screening of obstetric patients; supported by development of DV screening kit, changes to medical records forms, 3hr staff training] From baseline, awareness of the protocol (26.3%), ability to identify patient resources (26.3%) and community resources (17.5%), all increased at post-intervention (75%, 79% and 75% respectively) (all p-values <0.01). At baseline, DV was addressed and documented on 9% of patients charts, increasing to 47% at 3-months and 90% at 9-months post-implementation (all p-values<0.01). Screening by nursing staff increased from pre (70%) to post-implementation (90%) (p<0.05).

Price et al., 2007 (before and after [+], UK, n=79 midwives, 3, 6 months) [Education and support programme to promote routine enquiry of DV in antenatal care] In 17-months pre-implementation, 8 “cause for concern” forms for DV out of 6, 764 patients; In 9 month follow-up, 25 “cause for concern” forms out of 3, 779 patients. Majority of midwives (59%, n=38) reported screening 41-60% of women.

Applicability

One study was conducted in the UK (Price et al., 2007 [+], one study was conducted in the USA (Garcia and Parsons, 2002 [+]) and three studies were conducted in Canada (Janssen et al., 2002 [+], Vanderburg et al, 2010 [++], Grafton et al., 2001 [+]). All studies evaluated the implementation of universal screening or routine inquiry for DV in a variety of contexts so will be applicable to similar settings in the UK where these policies exist.

5.6. Discussion

5.6.1. Key Findings

A total of 28 articles addressed the nature of the interventions and approaches used in health and social care settings for identifying DV, informing six evidence statements on: screening/ identification tools, screening formats, provider education that supports identification and intervention, enhancing identification through additional protocols such as provider cueing, organizational level supports for identification, and identification of violence with pregnant/ postpartum women.

There is moderate evidence from seven studies that the type of tool or approach used results in different rates of DV identification and/ or forms of violence identified, as well as the specific sub-populations of victims and/ or perpetrators identified. Screening tools of various kinds have been studied to understand their utility and impact in identifying those who have been subject to DV or intimate partner violence (IPV). Generally, these studies investigate whether a standardized approach to all patients in a range of health care settings, regarding their experiences with DV, is effective in improving quality of life, health and presumably, recurrence of violence. The screening tools in these studies cover a range of approaches, from brief tools to longer questionnaires, and a range of administration techniques, from self-report to direct questioning. Overall, these studies found differences in identification (rates, types of violence and groups identified) based on the length of the tool used, the types of questions asked (e.g. frequency of abuse vs. yes/ no question) and screening tool used (tools captured by these studies include: WAST, CAS2, PVS, HITS). However, the screening tools that were compared varied greatly between studies, so it is not possible to determine which tool or tools are most effective.

Moderate evidence from four studies suggests that screening format impacts the disclosure of IPV, forms of violence reported, or may improve awareness of abuse. For example, the method of administration of the tool aimed at screening, such as computer-assisted interviews, direct questioning, or written or verbal self -reports have been assessed for effectiveness. Formats can affect the frequency and rate of disclosure, and have been assessed in a range of populations and settings. Format affects effectiveness in terms of rates of disclosure as well as efficiency in the delivery of care in health care settings. Again, it is not possible to determine which format is most effective due to variability between studies in the formats compared. However, two moderately rated studies (Kapur et al., 2011 [+]; Klevens et al., 2012 [+]) found that women were more likely to disclose IPV in a self-report compared to a face-to-face format.

There is moderate evidence from seven studies that cueing improves discussion of, disclosure of and referrals or services provided for DV among some populations. Cueing generally refers to providing information about a patient prior to a clinical encounter that will "cue" or propel the provider to investigate issues of DV. These cues can range from chart prompts or stickers or notes placed on the medical chart as a result of interventions carried out prior to the patient visit, such as a computer assisted self-assessment. Interventions were conducted in various settings including: hospital, emergency department, a prenatal clinic and a paediatric setting. These studies typically involved an intervention to assess violence exposure, followed by a measure of the rate and quality of discussion of DV with a health care provider. Overall, these studies reported improvements in rates of identification and disclosure, although one study found improvements only in an urban but not suburban sample (Rhodes et al., 2006 [+]).

There is inconsistent evidence from four studies that provider education interventions are effective in improving screening practices or clinical enquiry. Interventions were typically aimed at increasing health care providers' ability to raise the issue, screen for or detect DV among their patients. Interventions included introduction of quality improvement practices, educational sessions, training resource persons, refresher sessions, and ongoing communications strategies. Some provider education programs are brief; others are more intensive, and/ or ongoing. Some programs are designed to support screening, while others are aimed at improving clinical enquiry or case finding. Many focus on epidemiological and clinical information about DV and related issues (such as legal issues, advocacy or referral destinations and community supports), provider attitudes, identification and communications practices. Methods involve didactic presentations, role-playing, in-office visits by physician educators (detailing), focus groups discussions, readings, quizzes and videos. Some studies reported an increase in awareness, screening and documentation of DV; in some studies, improvements were modest or limited.

There is inconsistent evidence from two studies that the implementation of policy or organizational changes to screening for DV improves screening rates, referral rates and/ or provider comfort with and ability to screen. Organizational changes, including policies on new procedures are used to address the issues of identification of DV. Practitioners and other staff are encouraged to improve their knowledge and practices regarding DV, and are engaged in quality improvement to that effect. Both studies were conducted in health settings (a medical clinic and emergency department). While there were only two studies, both reported improvements in screening practices following the implementation of new procedures.

There is moderate evidence from five studies that universal screening or routine enquiry for DV in pregnancy, when supported by staff training and organizational support, improves screening practices and documentation of DV. Pregnant and post-partum women are often screened for domestic because pregnancy is seen to be a risk factor for onset of abuse, and the health concerns of both woman and foetus are at stake. Obstetric patients and pre- and post-natal patients have been studied with respect to tailored interventions assessing DV with a view to improving both maternal and foetal/ infant health. Overall, studies reported modest to substantial improvements screening rates in clinical settings, and improvements in women's privacy during screening and documentation of abuse during home visitation.

5.6.2. Gaps in the Literature

There are several significant gaps in the literature. The majority of research on identification has focused on the evidence for identification of DV among women. While women are most often the victims of DV, there is a lack of research among other populations relevant to the scope of our review including: screening of perpetrators, children who witness violence, 'honour' violence, and elders. Only one study by Rickert et al., 2009 [+] addressed the issue of identifying women who perpetrate DV against men; the screening tool employed included bidirectional questioning regarding women's perpetration of violence against their partner. No studies considered children who witness violence. Only one study (Moody et al., 2000 [+]) examined the identification of elder abuse, by assessing the psychometric properties of a screening tool. No studies were located that examined identification of 'honour' based violence.

The majority of studies also focused on the identification of DV in emergency department, antenatal care, or primary care settings. There is a lack of research examining the identification of DV in social care settings, or evaluating integrated approaches to identification across various health and social care settings. There is also a lack of evidence on integrated approaches to the identification of co-existing issues including the links between DV and substance use and/ or mental health issues. One exception is the study by Wathen and McMillan, 2008 [+], which included an analysis of the links between DV and mental health and substance abuse among women and their partners. Given existing evidence of the links between DV and mental health issues and substance use (Guille, 2004; Taskforce on the health aspects of violence against women and children, 2010) interventions that consider and address these linkages are a clear research priority.

Overall, the interventions and approaches examined do reveal some modest improvements in rates of identification or practices and knowledge related to the identification of DV. However, there appear to be significant challenges in achieving identification, referral and support goals. For example, the study by Rhodes et al., 2006 [+] found that even when computer cueing identified women at risk, only 48% of providers engaged women who had reported experiencing violence in a discussion during their appointment. Similarly, Trautman et al., 2007 [+] found that referral to a social worker was not made for 41% of positive screenings. Further research is required to examine and address the barriers providers face in identifying and responding to DV. Interestingly, screening and routine enquiry interventions during pregnancy and postpartum appear to result in greater improvements in providers' inquiry or screening for DV. The relatively sustained and ongoing nature of the patient-provider relationship during pregnancy/ postpartum may be more appropriate for the discussion of sensitive topics.

A few studies did include a gender analysis, examining the differences in the outcomes of identification interventions for women and men (including: Kapur et al., 2011 [+]; Hamby et al., 2006 [+]). Very few studies examined the impact of identification interventions or approaches for diverse sub-populations of women or men. The majority of studies focused on abuse of women by a male partner. However, Klevens et al., 2012 [+] do note that the Partner Violence Screen (PVS) tool does not specify the gender of the perpetrator. Only one study focused specifically on adolescent dating violence (Rickert et al., 2009 [+]) despite the importance of intervening with young women. One study also examined differences in screening of sub-populations of women. The study by Rhodes et al., 2006 [+] found that when providers were prompted to discuss DV with women who had self-reported risk, they were less likely to do so with a suburban group of white, affluent women compared to a group of low income black women. The authors suggest that this may reflect the strength of providers' preconceptions of who experiences abuse, despite evidence of abuse. Further research is required to investigate potential differences in impact of screening and identification approaches for diverse groups of women and men.

Furthermore, interventions are required that include a post-identification intervention and that measure health outcomes for participants. Currently, only a handful of studies have examined the effectiveness of screening (e.g. Ahmad et al., 2009 [++]; Klevens et al., 2012 [+]; Rhodes et al.,

2006 [+]; Robinson- Whelan et al., 2011 [+]; MacMillan et al., 2009 [excluded by systematic review] or clinical enquiry (e.g. Lo Fo Wong et al., 2006 [++], Feder et al., 2012 [++];) approaches on outcomes beyond the identification of DV (including measurement of health outcomes or referral/ other follow-up outcomes). As discussed by Feder et al., 2009 [++], screening interventions that do not include some form of follow-up intervention are incomplete and may not improve health outcomes or minimize further risk of abuse. Attention in research needs to be turned from the effect of screening on rates of disclosure/ identification, to the design and evaluation of interventions that include a follow-up response for victims of DV.

Finally, the majority of studies were before and after studies and lacked follow-up. Several researchers have noted that research on screening women for violence is constrained by methodological challenges and ethical issues due to the nature of the topic. These include: the provision of services to women in control groups as required, inability to conduct double blind trials, use of self-reports, safety issues with enrolment and follow up of participants (Nelson, 2012). These methodological limitations have limited the formation of clear recommendations for universal/ routine screening (Spangaro, Zwi, & Poulos, 2009).

6. Research Question 3: Effectiveness Review of Interventions for Responding to Domestic Violence

6.1. Background

This section focuses on the types of interventions or approaches effective in helping all those working in health and social care to respond to DV. This section has been sub-divided into: interventions for victims of DV, interventions for perpetrators, and interventions for elders who have experienced DV.

Interventions for Victims of Domestic Violence

The grey literature enhances our understanding of the complex issues facing victims and survivors of DV, and the range of responses to them. There has emerged a common understanding of the continuum of services required to provide support, counselling and comprehensive assistance to victims of violence and prevent further harm, in large part due to the efforts of the women's movement. Indeed, in the past decade considerable literature has been published which describes good practice for the types of support and protection services to be offered to victims; and which joins up with academic research to define the range of health and social services required to be offered to victims (Council of Europe, 2008).

The range of services identified by the Council of Europe as relevant for delivery by health and social services include: helplines and shelters which offer immediate services with 24 hour access to counselling and safe accommodation for women and children; early proactive services; short term counselling and advocacy; trauma care and long term support; as well as outreach work and mobile services (2008). All of these health and social services need to be coordinated with legal aid and advocacy, children's services, other health and social services such as mental health services, measures to guarantee rights, affordable housing, perpetrator programs, and coordinated community responses. A continuum approach to service provision recognizes that victims of violence need services matched to the risks to which they are exposed, and that those at high risk of repeat violence and serious injury need a tailored and highly coordinated response (Cairns & Hoffart, 2009; WAVE, 2012).

To add to the concept of a continuum of services, material defining the ideal content of services is also emerging (Kulkarni, Bell, & Rhodes, 2012). Survivors' surveys indicate that various additional supports are desired by survivors such as: barriers to help seeking, and satisfaction with current programming In a multistate US survey (Lyon & Bradshaw, 2011) survivors from 90 DV programs reported their primary needs as information/ support, safety, legal advocacy, help with economic issues, and help related to their children as well as over a third indicated at least one immigration related need. Survivors also cited economic supports and help for the perpetrators as key unmet needs. Indeed, there is growing research on the prevalence of financial abuse and its impact, underlining the importance for advocacy programs to incorporate economic empowerment and address the complex intersections of public assistance, child support and DV as a part of their core services (Pearson, Griswold, & Thoennes, 2001; Postmus, 2010).

Several reports have identified the benefit of individualized advocacy that enhances the survivor's wellbeing and safety, involves tailored support (to the type and intensity of intervention needed), as well as access to relevant services at the right time (Coy & Kelly, 2011; C. Donovan, Griffiths, Groves, Johnson, & Douglass, 2010; Hester, 2012; Robinson, 2009). However, such an approach requires effective multi-agency links and relationships, which may be difficult to achieve and rely on advocates creating and maintaining the links. Other reports have described early proactive and advocacy services within health care settings (Short, Hadley, & Bates, 2002). For example,

expanding the work of health care settings beyond identification of victims, to placing dedicated project workers within the hospital setting to whom hospital staff can refer (Regan, 2005).

Attention has also been brought to outreach work and mobile services that reach victims with limited access to services by bringing the service to the survivor. A survey of 200 users of UK outreach services commissioned by Women's Aid (Humphreys & Thiara, 2002) found that 46% of women survivors were living with their violent partners at the time of first contact with an outreach service, and that following this type of intervention 90% of these women left the relationship. Women valued these services for their swift, flexible and proactive approach, prioritisation of their safety, and responsivity to diversity issues and special needs.

The multi-directional connection of DV to substance use and misuse (Zweig, Schlichter, & Burt, 2002) and the need for the DV and mental health sectors to provide quality, integrated services for survivors of DV who also have mental health problems has also been identified (Carter, Kay, George, & King, 2003; Itzin, 2006; Preston, 2002). Finally, the physical health needs of survivors and the links of physical health issues to both substance use and mental health concerns have been identified (Weissbecker & Clark, 2007; Wuest et al., 2009).

Interventions for Perpetrators of Domestic Violence

Programmes for perpetrators of DV are seen ideally to include a range of services designed to promote safety and support change including: assessment, risk assessment and management, inter agency working, group work for perpetrators, as well as linked individual and group support for victims and advocacy for victims (Respect, 2010a).Note that this review considers individual and group programming for perpetrators of DV offered in community or health settings, but not those offered solely by the justice/ corrections sector.

While group intervention programmes for perpetrators of DV began to be offered in the 1970's (Edleson, 2012) most have been established since the 1990s and most are directed to heterosexual men who abuse their female partners (Adams, 2003). More recently, challenges associated with understanding and assessing violence by victims who have used legal violence or other forms of violent resistance have been identified, and the implications for practice discussed (Respect, 2010b); however no studies were found in the academic or grey literature that assessed such tailored programming.

Many batterer interventions employ a cognitive-behavioural focus and seek to broaden their clients understanding of abuse as more than violent or illegal behaviour frequently drawing from the Duluth Model in the USA (Domestic Abuse Intervention Programs, 2011). The philosophical underpinnings of the majority of these interventions for perpetrators of DV are described as being informed by social learning and feminist theories, wherein battering is viewed as learned and socially reinforced behaviour motivated by a desire to control the victim, and more specifically to enforce gendered roles (Aldarondo, 2010). Following from this approach, most batter intervention programs are offered in a group format designed to promote social accountability through disclosure of abusive behaviour to others, and providing opportunities for peer support of nonviolence.

The Duluth Model (Domestic Abuse Intervention Programs, 2011) uses the "power and control wheel" depicting a hub of power and control, and eight categories of abuse as spokes. In group programming, for each category of abuse represented on the wheel, 3-4 group sessions are devoted to identifying how this type of abuse is manifested in relationships and how it affects the victim. The programs which work from a feminist and social learning lens discourage the use of psychotherapeutic approaches that focus on helping individual batterers to understand how unresolved issues stemming from their childhoods may have contributed to their violence as adults. Most programming has in common the goals of reducing or eliminating further violence, as well as attitudinal and behaviour change.

Attitudinal and interpersonal behaviour change goals for these programs include refraining from abuse, overcoming denial, taking responsibility for abuse, practicing alternatives to abuse, supporting gender equality, learning relaxation, anger management and respectful communication skills such as active listening, showing empathy, expressing feelings, receiving negative feedback, giving and receiving positive feedback. Recidivism rates as captured by official records of the police or court, such as restraining orders and records of arrest or conviction are also used to indicate the effectiveness of interventions for perpetrators.

In addition to the goals of reducing or eliminating violence and abuse, female partners/ ex-partners have identified attitudinal and changes in behaviour such as respectful/ improved relationships; expanded space for action; support/ decreased isolation; enhanced parenting; and partner's understanding the impact of DV as important indicators of success (Westmarland, Kelly, & Chalder-Mills, 2010). Several researchers have identified the importance of inclusion of such perspectives of women victims (including new partners) as to their sense of safety and well being following involvement by partners and ex-partners in batter intervention programs (Laing, 2003).

Some additional approaches to batterer intervention programmes include: tailoring the programming to the batterer's readiness to change, and to evoke readiness to change through the use of motivational interviewing approaches that promote choice and collaboration (Edleson, 2012; Kistenmacher & Weiss, 2008; Roffman, Edleson, Neighbors, Mbilinyi, & Walker, 2008) integrating parenting interventions (Bennett & Williams, 2001) and use of non-confrontational approaches based in narrative therapy techniques (Laing, 2002). Another important aspect to programming for perpetrators is the coordinated community response approach that brings agencies and individuals together to devise community-wide responses to DV that promote victim safety as well as abuser accountability (to be discussed in the partnership section of this review). Finally, some interventions have addressed couples, including both the abuser and the partner. While research in these areas is relatively limited, these approaches will be discussed in the summary of reviews and findings of the report.

Interventions to Address Elder Abuse or Maltreatment

The World Health Organization uses the term elder maltreatment and defines it as physical, sexual, mental and/ or financial abuse and/ or neglect of people aged 60 years and older (World Health Organization, 2011). A qualitative study of abuse and neglect of older people in the UK revealed that abuse was associated with various health issues, particularly psychological issues (Mowlam, Tennant, Dixon, & MacCreadie, 2007). Participants experienced depression, loss of self-esteem, suicidal thoughts, and social isolation. In addition, there were also negative impacts on physical wellness and in some cases experiences of financial loss.

Women are more likely to report experiences of maltreatment, and in the majority (80%) of cases of interpersonal abuse (i.e. physical, psychological and sexual abuse combined) among elders, perpetrators were men; however, the gender ratio for financial abuse was found to be more equal (56% men, 44% women) (O'Keefe, et al., 2007). Overall, 51% of maltreatment in the past year involved a partner/ spouse, 49% another family member, 13% a care worker and 5% a close friend. Given that the majority of elder abuse is perpetrated by a partner, some researchers have noted the need for clarity between the category of elder abuse and the experience of DV experienced by older women (Blood, 2004; Women's Aid, 2007).

In a 2007 UK report, the majority (70%) of those who had experienced mistreatment in the past year said that they had reported the incident or sought help (O'Keefe, et al., 2007). However, some authors note the need to address barriers to reporting of abuse by elders (Mowlam, et al., 2007). Common to survivors of all age groups, older people experiencing abuse may face barriers and issues such as fear of retaliation or being alone; shame and lowered self-esteem; and practical barriers related to income. Key reasons survivors may not seek help include not seeing themselves as abused; not knowing where to report abuse or find services, a lack of

services or a long wait list for services, a sense of shame and fear of consequences of any intervention (Action on Elder Abuse, 2004; Women's Aid, 2007).

The Department of Health guidance (Home Office, 2000) states that agencies should adhere to a number of overall principles related to empowering people including: support, help, information, recognition of the right to self determination, safety and protection. Multi-layered intervention strategies involving co-ordination between agencies, the sharing of information, and the raising of awareness of the negative impact of abuse have been recommended (Action on Elder Abuse, 2004; Centre for Ageing Research and Development in Ireland, 2011). Other interventions such as help-lines for elders, specialized refuges and resettlement support, homemaker services as well as accessible outreach and drop-in services, peer support groups for older women and men have also been recommended (Blood, 2004; World Health Organization, 2011). In addition, the specialized health and social needs of elders, including the over-prescription of medication, underline the need for tailored responses by the primary care system and in all services working with elders experiencing maltreatment (United Nations, 2002; World Health Organization, 2011).

6.2. Summary of the Literature

A total of 402 full-text study reports were retrieved. An additional 35 reports relevant to Q3 were collected through the grey literature search (a breakdown is provided in the flow-charts in *Appendix G*), including: web-searches and the OpenGrey database. One article suggested by a PDG member was also included. A total of 438 reports were retrieved for full text review (victims=166; perpetrators=152; elders=27; couples=93). A summary of the studies included in see *Appendix I.*

For victim interventions, 106 papers were excluded at the full text screening stage. We were unable to locate three papers and therefore they were excluded (see *Appendix H* for all papers that were unable to be located during the review). Three systematic reviews were located that were relevant to interventions for victims of DV (which included eight relevant individual studies that were then excluded from our main report of findings). A high level summary of these reviews is provided. Thirteen studies received a [-] internal quality rating and are not included in the report of findings, but are listed in *Appendix F*. A total of 33 studies on victim interventions were included and reported on in this review.

For perpetrator interventions, 103 papers were excluded at the full text screening stage. Three systematic reviews were located that were relevant to interventions for perpetrators of DV (which included nine relevant individual studies that were then excluded from our main report of findings). A high level summary of these reviews is provided. Four studies received a [-] internal quality rating and are not included in the report of findings, but are listed in *Appendix F*. A total of 33 studies on abuser interventions were included and reported on in this review.

For elder interventions, 20 papers were excluded at the full text screening stage. One systematic review was located that was relevant to interventions for elders experiencing DV (which included two relevant individual studies that were then excluded from our main report of findings). A high level summary of this review is provided. One study received a [-] internal quality rating and is not included in the report of findings, but is listed in *Appendix F*. A total of three studies on elder interventions were included and reported on in this review.

For other group interventions, 79 papers were excluded at the full text screening stage. We were unable to locate one paper and therefore it was excluded (see *Appendix H* for all papers that were unable to be located during the review). No systematic reviews were located that were relevant to interventions for other groups experiencing DV. Six studies received a [-] internal quality rating and are not included in the report of findings, but are listed in *Appendix F.* A total of seven studies on other group interventions were included and reported on in this review

6.2.1. Systematic Reviews

Seven systematic reviews were identified. *Appendix J* lists the reviews that were assessed. A summary of these reviews is provided prior to the reporting of findings.

We compared the studies retrieved using our search criteria, with the studies covered by the above seven reviews, and excluded 19 relevant studies that were assessed.

6.2.2. Included Studies

The results of quality assessment are presented in *Appendix K*. Of the victim intervention studies reviewed, for internal validity, four were judged to be of high quality [++], and 29 of medium quality [+]. For external validity, 4 studies were judged to be of high quality, 21 were of medium quality [+] and 5 of low quality [-], while 3 were qualitative studies and did not receive an external validity rating.

Of the perpetrator intervention studies reviewed, for internal validity, two were judged to be of high quality [++], and 31 of medium quality [+]. For external validity, 1 study were judged to be of high quality, 24 were of medium quality [+] and 4 of low quality [-], while 4 were qualitative studies and did not receive an external validity rating

Of the elder intervention studies reviewed, for internal validity, all three were judged to be of medium quality [+]. For external validity, 1 study was judged to be of medium quality [+] and 1 of low quality [-], while 1 was a qualitative study and did not receive an external validity rating

Of the interventions for couples studies reviewed, for internal validity, two was judged to be of high quality [++], and five of medium quality [+]. For external validity, six studies were judged to be of medium quality [+] and 1 of low quality [-].

Applicability

Seven studies were conducted in the UK; seven in Canada; one in New Zealand; one in Spain, one in Germany, and the remaining 58 studies were conducted in the USA. Potential applicability issues that pertain to specific studies are discussed within the findings of the report and provided in the evidence statements. The main source of potential barriers to applicability is the sample population included, or methodological limitations that impact generalisability.

6.3. Summary of Systematic Reviews

6.3.1. High Level Summary: Effectiveness of Interventions for Victims of Domestic Violence

Background

The preponderance and deleterious effects of IPV are well documented; however, the most effective interventions for reducing IPV are still being studied. Three systematic reviews have analysed studies that collectively cover a period of more than two decades, from 1985-2006, on the effects of IPV interventions: Ramsay et al. (2009), Ramsay, Rivas and Feder (2005), Wathen and MacMillan (2003).

Study Purposes

All systematic reviews assessed the impact of IPV interventions on victims of abuse and sometimes, the batterers themselves, although there was variability between each one's key objectives. Ramsay and colleagues focused on the effectiveness of advocacy interventions within and without health care settings by looking at seven outcome measures: incidence of abuse; psychosocial health; physical health; socio-economic implications; "proxy," or intermediate

outcomes; timing of outcome assessment (2009). Which women are likely to benefit from IPV intervention and in which way was one priority for Ramsay, Rivas and Feder (2005) in their review of "woman-centered" interventions (which include advocacy and advice, support groups, psychological interventions) and "system-centered" interventions (comprised of health care interventions with and without structured training, non-health care interventions). The three authors consulted with stakeholders and made recommendations accordingly, compared their findings to other reviews, and discussed the policy implications for the NHS). Wathen and MacMillan's (2003) priority was twofold: to determine the effectiveness of interventions in preventing IPV and to evaluate the interventions to which a clinician could refer a patient.

Overview of Key Findings from Each Review

Ramsay and colleagues found insufficient evidence that advocacy leads to a reduction or cessation of abuse (2009). Although certain outcome measures improved, the overall benefits of advocacy intervention are still to be determined. More specifically, brief advocacy interventions (those lasting 12 hours or under) have been shown to reduce minor physical abuse for women in antenatal care (Tiwari et al., 2005), but there is no indication that overall they lead to a decrease in more serious forms of abuse. Intensive advocacy (lasting more than 12 hours) has shown better results in the short- and medium-term, but much of the evidence is still inconclusive. These equivocal results can be attributed to factors such as the heterogeneity of interventions across studies, the variety of women participants across the reviews, insufficient evidence of criteria compliance, and difficulty in assessing the quality of many of the trials.

Ramsay, Rivas and Feder (2005) reported mixed results for three women-centered inventions. The first, advocacy, led to reduced abuse, and increased social support, quality of life and use of safety behaviours and community resources. The most effective advocacy intervention occurred when there were ten or more hours of contact time delivered in shelters. Still, the overall effectiveness of advocacy interventions is unknown. The second, support group intervention, was measured in only one study, which indicated this intervention is only effective in a feminist-informed, community-based support group facilitated by social workers. Data from the third form of intervention, psychological, did not indicate any decrease in abuse, although in some cases it has been shown to reduce depression. System-centered interventions results were more positive, demonstrating an increase of referrals to specialist services in the short term. However, data from longer-term studies showed that ongoing staff training is required to maintain a positive effect. Other potentially effective interventions are: prioritized health care for abused woman, which could increase health service use and the diagnosis and management of health problems; and, police initiatives, such as DV units, which could reduce the likelihood of further abuse.

Wathen and MacMillan (2003) found no high-quality evidence for whether shelters are effective in reducing abuse, although there is fair evidence that an advocacy and counselling programme provided to women who spent one night in a shelter led to a decreased rate of re-abuse. Still, there is a lack of studies measuring outcomes for interventions strategies treating men and women, and the potential harm of such interventions has not been assessed. There is a dearth of information on evidence-based approaches in the primary care setting for preventing IPV. Although studies have measured the effectiveness in screening for IPV, specific IPV intervention results have not been evaluated.

Key Recommendations

Most author groups repeated two recommendations. First, all agreed that there must be more research with rigorous design models measuring the effectiveness of IPV interventions. More specifically, there should be longer follow-up trials looking at medium- and long-term benefits of interventions, as well as cost-effectiveness studies (Ramsay et al., 2009; Ramsay, Rivas & Feder, 2005). Ramsay and colleagues specified that more advocacy interventions should be tested across a variety of settings, coupled with a debate over which outcomes should be measured. Ramsay, Rivas and Feder (2005) listed research recommendations targeting each form of intervention they analysed, which included mainstreaming formal training and supervision of

advocates, monitoring advocacy standards, and practitioner training on how to identify women experiencing IPV and how to support and refer them to community-based advocacy services. Future research should also include: an examination into whether screening in health care settings, along with appropriate, effective treatment, and reduces physical injury and psychological abuse (Wathen & MacMillan, 2003).

The two groups of authors lead by Ramsay also recommended tailoring interventions to specific cultural or contextual needs. Ramsay and colleagues expressed the need for theoretically explicit trials testing what interventions work and for whom (2009); while Ramsay, Rivas and Feder (2005) stated that health care services should provide appropriate responses to women experiencing abuse.

Overall Conclusions

All authors generally agreed that although the data on the effectiveness of IPV interventions is currently inconclusive, such programs should continue to operate. At the same time, good-quality research should continue to be conducted on the effectiveness of IPV interventions in improving the health and well being of abused women.

Summary Statement

Overall, evidence of effectiveness of IPV interventions for victims is inconclusive, although both intensive advocacy interventions and system centred interventions with ongoing staff training appear promising. More robust research is required, including studies: with longer periods of follow-up, tested across a range of settings, and tailored to cultural and contextual needs.

6.3.2. High Level Summary: Effectiveness of Batterer Intervention Programs on Reducing Intimate Partner Violence

Intimate partner violence (IPV) is a well-documented health concern. Currently, one common approach to reducing IPV is through batterer intervention programs (BIPs). Although little data exists on the effect of these programs, three systematic reviews and reported here: Feder, et al., (2008); Sheehan, et al. (2012); and Smedslund, et al. (2007). One review was reviewed previously in the victims section, but is included here because they also provide a discussion of perpetrator programs (Wathen & MacMillan, 2003).

Selection Criteria

All systematic reviews include the same four selection criteria: 1) experimental (randomized controlled trials) studies take precedence over rigorous quasi-experimental ones, although the latter are included when appropriate; 2) studies use a comparison or control group; 3) intervention programs were offered to heterosexual male adults who were violent to their wives, partners, or ex-partners; 4) sufficient follow up data or outcome measures are indicated. Sheehan also include studies that address perpetrators' motivations for changing their behaviour, and relate data from interviews, observation or focus groups (2012). Comparison of treatment models between cognitive behavioural therapy (CBT) and/ or psycho-educational/ Duluth model, and/ or other models are additional inclusion factors for and Feder et al., 2008. Smedslund and colleagues focused on CBT, comparing CBT groups to a no treatment group, and CBT to other treatment groups (2007). Each meta-review selected anywhere between five and ten studies.

Given the limited amount of data in this field and the common selection criteria across these systematic reviews, it is not surprising that certain studies are cited more than once. The following are included in at least two different meta-analyses: 1) Davis, Taylor & Maxwell, 2000 was cited by: Feder et al., 2008; Smedslund et al., 2007; 2) Dunford (2000), was cited by: Feder et al., 2008; Smedslund et al., 2007; Wathen & MacMillan, 2003; 3) Feder & Dugan (2002), was cited by: Feder et al., 2008; Smedslund et al., 2007; and 4) Palmer, Brown & Barrera (1992), was cited by: Feder et al., 2008; Wathen & MacMillan, 2003.

Limitations

All groups of authors faced methodological limitations and/ or expressed reservations about the overall findings because of the small amount of available data. Furthermore, occasionally there are very small sample sizes in the studies themselves, such as the Palmer, Brown & Barrera (1992) data that only includes 56 men, thus creating doubts about the recorded positive measures from certain samples (Feder et al., 2008).

Concerns were also expressed regarding how attrition rates and outcome measures were evaluated. Smedslund and colleagues author groups indicate that the method for calculating attrition rates can be unclear (2007). For instance, it is not always evident whether total group participants were counted at the beginning or the end of the study. Such inconsistencies make it difficult to compare the effective measures of the programs. Second, outcome measures that are based on official reports can be unreliable because women do not always report intimate violence (Feder et al., 2008; Smedslund et al., 2007). To overcome this issue, many studies also collect victim reports at a fixed interval following the intervention; however, as Feder and colleagues indicate, even this practice can yield uncertain results given some studies show low victim reporting rates following programme completion (2008).

Another reservation about the data is how participants are selected. In studies such as Palmer, Brown & Barrera (1992), it was surmised that the participant selection criteria were highly restrictive, making it difficult to apply the results to a greater violence offender population (Feder et al., 2008). Effect rates might also be influenced when groups of men with strong motivation to comply with treatment are highly represented, or when they have strong reasons for being in and completing therapy (for instance, their wives threaten to leave them, they were ordered to attend by the court, etc.) (Feder et al., 2008; Smedslund et al., 2007). One study illustrating all these concerns is Dunford (2000), where participants were servicemen in the San Diego Navy. The experiment received a good quality rating (Wathen & MacMillan, 2003) and general consensus is the methodology is strong. Results indicate a positive effect for intervention compared to the control group with a relative risk of 0.82 and 95% confidence interval from 0.63-1.09 (Smedslund et al., 2007). However, these participants did not represent the general offender population, and as Feder and colleagues point out, they were living on the naval base with their families and therefore might show a “higher risk of conformity than is true of other batterer samples” (2008). Results from such studies should be considered with care.

Finally, the potential for bias in the synthesis of qualitative data was voiced by Sheehan and colleagues (2012). This bias was minimized by applying constant comparative methods, even though the reviewers were reliant on the themes and verbatim text chosen by the study authors.

Effective Practices

The meta-analyses that compared treatment models – CBT versus the psychoeducational/ Duluth model – did not find conclusive data that one system was more effective than the other. In fact, the meta-analyses found mixed results for both methods (Feder et al., 2008).

One effective tool for identifying the motivations for why a perpetrator might change his behaviour is through “turning points” – the situation, reason, or attitude that encouraged a perpetrator to change (Sheehan et al., 2012). Often external factors (i.e.: fear of criminal sanctions, of losing a wife or partners etc.) are motivators for change. However, it is unclear whether the identification of turning points by perpetrators is related to the cessation or reduction of IPV.

Finally, an effective practice noted by Sheehan and colleagues is motivational interviewing (MI) (Rollnick & Miller, 1995). This strategy helps perpetrators move through the stages of change (Sheehan et al., 2012).

Results

Overall, the meta-analyses indicate mixed results on the effectiveness of batterer programs for reducing IPV:

- Feder et al. (2008): modest benefits in experimental studies, but when studies with a general population are included, the effect becomes non-significant. The effect is absent when victim report measures are examined
- Sheehan et al. (2012): studies have shown that BIPs have little effect on reducing recidivism; recent ones have tried to isolate individual characteristics that make perpetrators suited to BIPs
- Smedslund et al. (2007): a range of effects across all six studies, but there are still too few randomized controlled risks to determine the effect of CBT on male perpetrators of DV
- Stover et al. (2009): a lack of research on long-term effectiveness of BIPs. Six months after treatment, recidivism rates were about 20-30%
- Wathern & MacMillan (2003): there is not enough strong research to conclusively determine the efficacy of batterer programs

Recommendations

Several policy and research recommendations were put forward. Future research, according to Feder and colleagues, should not only include samples of batterers that are representative of the larger convicted batterer population, but also ensure higher victim retention for outcome measures (2008,). At the same time, the Criminal Justice System should investigate other types of IPV intervention tied to rigorous evaluations determining their impact (Feder et al., 2008). On a service level, programs might be more effective by tailoring interventions to specific clientele. Not one study recommends the cessation of BIPs; rather, all advocate for more large scale, randomized controlled trials to determine effective measures that will lead to the cessation of repeated intimate partner violence.

Summary Statement

Overall the evidence of effectiveness of batterer intervention programmes is inconclusive. All authors cited methodological limitations including: concerns over evaluation of attrition and outcome measures, potential bias in sample selection and in synthesis of qualitative data. There is a lack of conclusive data on the effectiveness of specific approaches (in general, effect on recidivism was small or non-significant), although motivational interviewing appears to be a promising approach. More robust studies that examine long-term effectiveness of interventions for batterers are required.

6.3.3. High Level Summary: Effectiveness of Interventions for Elder Abuse

Elder abuse is a significant problem that is expected to increase over the next decade. The one identified systematic review by Ploeg et al., (2009) asked whether elder abuse intervention is effective, and sought to determine if some interventions are more effective than others. The selection process found ten articles and reports published in English that addressed the pre-selected criteria: 1) the abuse of people aged 60 and over; 2) interventions focus on one or more abuses; 3) interventions are provided to individual clients, professional carers of older people, or the community; d) assessments of client, professional and/ or community outcomes. The analyses had to be primary studies using qualitative methods and comparison groups. Study participants were older adults, caregivers at risk of abusing older family members, or health care professionals. The range of interventions surveyed included psycho-educational support groups, case management programs, legal interventions, educational programs on elder abuse, and home visits by counsellors or police. Among the common limitations of the ten studies identified by the authors were: recurring failure to describe randomized procedures and to blind outcome assessors and data analysts, small sample sizes, and follow up rates of less than 80%. Overall, results were mixed, but most surprising were the conclusions from two studies examining recurrence of abuse after intervention. Both found higher recurrence rates than in the limited or

no intervention groups. It is possible, however, that these results were due to methodological limitations. A second troubling finding was a high rate of abused older adults associated with intervention programs who were relocated. There were no significant effects on case resolution and at-risk caregiver outcomes and mixed results for professional knowledge and behaviour related to elder-abuse. Finally, the results do not indicate which interventions are effective. The authors recommend clinicians take an active role in the identification and management of elder abuse and call for more high quality research that takes into account the above stated methodological limitations.

Summary Statement

Findings from the one review provide inconclusive evidence of effectiveness for interventions addressing elder abuse (results were mixed or ineffective post-intervention). More robust studies that include randomization, larger sample sizes, and improved follow-up rates are required.

6.3.4. High level summary: Non systematic review for couples

No systematic reviews on couples interventions for domestic violence were located. However, summary material relevant to interventions for couples has been summarized for this report.

Stover et al., (2009) conducted a survey of available interventions for perpetrators, children, victims, and couples that included randomized assignment and at least 20 participants. The results for couples are presented here. This review is not a full systematic review; searching, inclusion and assessment of papers are not reported robustly and there is no detail of paper assessment or quality (Stover, et al., 2009).

Couple-focused interventions

Couple treatment studies had the least methodological rigor; only one study utilized a randomized control condition. The four other studies included compared several types of treatments without a control group. Treatment completion and recidivism rates varied considerably from study to study, with no consistent patterning of findings to explain variability in rates across studies. One study found no group differences for couple treatment, men's CBT, or controls in reducing IPV recidivism for active-duty army personnel. Another study randomly assigned 58 couples to either a multi-couple group or individual couple counselling. While only 16% of the 23 couples assigned to the multi-couple group condition dropped out, 67% of the 35 couples assigned to individual couple counselling dropped out before completing treatment. For treatment completers, no significant differences in recidivism were found between the two treatments. Overall, a 20% recidivism rate was reported at 6-month follow-up, but given the high dropout rate; between-group comparisons could not be made.

Another study assigned 75 volunteer couples to either feminist cognitive– behavioural gender-specific groups or conjoint treatment. Dropout rates were high, limiting the ability of the investigators to compare group outcomes. For treatment completers, violence severity ratings decreased approximately 50% by post treatment and were comparably low at 1-year follow up. However, recidivism rates were 74% overall, with no between-group recidivism analyses conducted. A second study examining these two modes of treatment with 49 couples reported notably lower dropout and recidivism rates. The sample for this latter study was court referred and limited to men with alcohol use disorders.

The final study in this section found that behavioural couples therapy (BCT) was more effective than individual substance abuse treatment in reducing recidivism for men with co-morbid substance abuse and DV, with rates of recidivism at 18% for BCT versus 43% for individual treatment at 12-month follow-up. In BCT, men received weekly individual and group drug abuse counselling (both of which emphasize cognitive– behavioural anger management and coping skills training). Additionally, males and their female partners met conjointly for weekly BCT sessions. The BCT sessions were used to: support abstinence, teach communication skills, and increase positive behavioural exchanges between partners. While not initially developed to target

IPV, the CBT portion of BCT includes many of the CBT approaches used in batterer programs. The addition of substance abuse and couples treatment foci appears to have contributed significantly to the lower dropout rate and greater reduction in violence for men participating in this intervention.

Summary Statement

Interventions for couples had low methodological rigor (lack of randomization, lack of control, high dropout) and findings were inconclusive (variations in outcomes across studies). There is preliminary data to support the efficacy of behavioural couples therapy (BCT) and multi-group couples interventions for IPV for perpetrators of violence struggling with alcohol and substance use disorders. However, the efficacy of these approaches when substance use is not identified or addressed has not been consistently supported.

6.4. Findings

Interventions for Victims of Domestic Violence

Allen et al., 2004

A US-based RCT by Allen et al., 2004 [+] examined if the impact of community based advocacy on women's access to resources was dependent on the patterns of needs that women presented. A total of 278 women, who had spent at least one night in an urban shelter for battered women, were recruited. Women who participated ranged in age from 17 to 61 years (mean age=29 years) and were predominantly African American (45%) or White (42%); the majority had at least one child living with them (74%), had a high school education or GED (67%), were unemployed (59%), and were receiving governmental assistance (76%). The mean length of stay in the shelter was 19 days (range=1 to 76, SD=16.5). The majority of women were living with but not married to the perpetrator (42%); the remaining women were married (27%), intimately involved but not living together (7%), or no longer involved (20%) with the man who had abused them.

All participants were interviewed within one week of leaving the shelter by a research assistant and then assigned to either the intervention (n=143) or control condition (n=135), stratifying for order and for whether a woman was involved in an ongoing, intimate relationship with her assailant. There were no baseline differences in demographics between the intervention and control groups. Those assigned to the intervention group received free community based advocacy services for 10 weeks after leaving the shelter for 4 to 6 hours per week by a trained advocate, and assistance in development of a safety plan as needed. The intervention was strengths-based and family-centred, focusing on and guided by the strengths and needs of women and their families and inclusion of existing support networks. Advocacy included five phases: assessment (getting to know the woman and her support networks, and her needs and goals); implementation (meeting women's needs through connection to appropriate community resources); monitoring (of effectiveness of implementation by woman and advocate), secondary implementation (as needed, to address any of the woman's needs remaining unmet), and termination (transfer of skills from advocate to woman, so she could continue with self-advocacy). Women in the control group were not contacted again until 10 weeks after leaving the shelter. During the initial interview, all women identified which of the following needs they intended to work on in the next 10 weeks: housing, education, employment, transportation, legal assistance, health care, social support, financial assistance, material goods and services, child care, and issues for their children. During the second interview (10 weeks after leaving), women were asked which of the needs they had worked on since the initial interview, and what, if any, actions were taken to access resources.

Women reported that they wanted to work on: obtaining material goods and services (86%), address health-related issues (77%), improve their level of social support (77%), address school-

related issues (72%), address financial needs (68%), address transportation needs (66%), obtain employment (60%), and address legal issues (59%). For those women with children, 67% reported a need to address childcare issues, and 68% reported a desire to address other child-related issues. At 6 months after leaving the shelter, many women had engaged in at least one activity, including: access of community resources for housing (61%), education (61%), employment (62%), transportation (49%), legal assistance (59%), health care (62%), social support (37%), financial assistance (48%), material goods and services (69%), child care (40%), and issues for their children (50%). Women varied in how they accessed resources, with five subgroups emerging from the data: low activity, housing, education and employment, legal, and high activity. Women in housing, legal and education and employment clusters engaged in more activities related to respective need. Some women were also identified as belonging to low activity or high activity clusters, and engaged in relatively low or high levels of activities. Women in the intervention group were more effective overall at accessing necessary community resources ($F(1, 261)=42.90$, $p<0.001$). Univariate ANOVAs revealed that women involved in the advocacy intervention engaged in a greater number of activities to address education needs, ($F(1, 254)=19.41$, $p<0.001$); legal issues, ($F(1, 254)=5.72$, $p<0.05$); and acquiring material goods and services, ($F(1, 254)=47.07$, $p<0.001$). Across clusters, women in the control condition reported a mean level of effectiveness of 2.71 (SD=0.71), while women in the intervention condition reported a mean level of 3.26 (SD=0.57). In sum, the intervention improved women's' effectiveness in accessing needed community resources regardless of the particular needs women presented.

While this was a robust study design with a sufficiently large sample size, there are several limitations. Only women who access shelter services were included in the sample, and therefore findings may not be applicable to women who do not seek shelter-services. In addition, addressing some needs may involve more time and work (for example, due to limited available services in the community) and therefore women's ability to address some needs may not always reflect their motivation or the capabilities of the advocate. Finally, the study did not control for attributes of the advocates included, so it is possible that differences existed between these women that may have impacted outcomes.

Allen et al., 2011

A US-based mixed methods study (before and after and grounded theory) [+] examined the effectiveness of a holistic, integrative healing group therapy treatment. They were interested in facilitating transformative healing by supporting women in a shift from surviving to thriving via changes in social and personal identity. They recruited a sample of 11 rural and urban battered women from DV agencies in Michigan and Montana. The average age of women who participated was 35 years; 8 of the 11 women had some college, and 5 had completed a degree programme; 6 women were working and 5 were receiving state income assistance; all women reported previous experiences of being violated within their family of origin.

Women were screened by a therapist prior to involvement to ensure safety and readiness to engage in group therapy; to be included they could not be living with their abuser or in a state of crisis. Women then participated in structured interview that was transcribed and analysed for themes related to healing. A grounded theory approach was used to conceptualize healing and recovery, emerging from women's experiences and engagement in group therapy. The group therapy, called "Rites of Passage," is a ten week group which is based on the concept of healing from trauma as a transition through 3 stages: separation (separation and letting go), liminality (a time of uncertainty), and incorporation (new role identification and re-integration into society, facilitated by connection with women experiencing similar transitions). A semi-structured curriculum focused on supporting women in developing alternative ways of conceptualizing themselves and their futures via storytelling, meditation, active day dreaming and personal metaphors was used. Women were asked on a weekly basis to provide feedback about group activities and pacing, and community partners were involved as session facilitators. Sessions typically included a presentation by the group facilitators and community partners, followed by

various activities and exercises, along with facilitated discussions. Quantitative assessment was used to measure psychological distress, by using the 17-item Post-Traumatic Stress Disorder (PTSD) Checklist, completed by women at pre- and post- therapy. At six weeks, the women also participated in a focus group in which they were asked to define healing and recovery, which was transcribed and analysed by two reviewers.

Analysis of the PTSD checklists revealed significant improvements on 8 of 17 measures of the assessment (all $p<0.05$), including: repeated disturbing thoughts ($p=0.041$), reliving stressful experience ($p=0.010$), avoidance of thoughts/ feelings related to stressful experience ($p=0.003$), feeling emotionally numb ($p=0.025$), feeling as if the future will be cut short ($p=0.003$), trouble sleeping ($p=0.024$), being super alert ($p=0.007$), and feeling easily startled ($p=0.005$). Themes connected to healing that were identified by qualitative analysis included: creating a safe place, establishing autonomy, taking pride in appearance, reclaiming self, developing inner peace, and rejoining the community. Women talked about reclaiming their home as a safe place or "sanctuary" e.g. "Is about getting organized at home, doing a lot of things like when you're in abusive situation you give up everything, even cooking because you can't cook right…" Women described feelings of autonomy in being able to make their own choices: "I was standing in front of the mirror and I said, this is the life. I have no one to answer to. I'm the boss. Whatever decision I make, goes…" Women reported taking more pride in their appearance; as one woman reported, "Because I'm worth it." Reclamation of self involved integrating their past self with the present, sometimes by taking up old hobbies. As one woman noted: "For me healing is to feel whole again and to have myself back; the old self, more happy, confident and independent self back. I've noticed that this is what has happened to me." Women described the development of a sense of inner calm and improved coping skills: "…I'm calmer all the way around. I used to react and now I just rationally say something that makes sense. I don't have to think about it, I'm just different..." Finally, women spoke about rejoining the community by developing social connections, often with other women in the group or with family members: "Part of the process is moving beyond the isolation and reconnecting." The authors suggest that women shifted from "survivors" to "thrivers" during the group therapy, reconstructing themselves through their involvement in a supportive community and improvements in their capacity to develop positive future plans.

In sum, the study revealed improvements in some PTSD symptoms and women's reports of healing following involvement in holistic, alternative group therapy sessions. However, because only women who were safe and not in a current state of crises were included, it is difficult to interpret and translate these findings to other contexts. Women who participated had received prior intervention to deal with the immediate crisis of abuse, and all women had left their abuser. Therefore, healing experienced from the current intervention was grounded on previous intervention that helped the women establish safety, which is why they discouraged repeated discussion or disclosure of abuse within the therapy sessions. Therefore, this intervention may only be useful for women in a similar set of circumstances. Further research is required to identify the optimal delivery period for this intervention. It is also possible that some of the observed outcomes would be observed regardless of the group therapy (i.e. due to the initial crises- related intervention/ s). In addition, the study included a very small sample size and lacked a comparison group, further limiting the translation of findings to other settings. The authors note that they did not collect intake data on type or severity of abuse, although this information would be useful for understanding the application of this intervention to other groups of women who have experienced abuse.

Bair-Merritt et al., 2010

A US-based RCT by Bair-Merritt et al., 2010 [+] examined the impact of a home visitation programme after childbirth on mothers' rates of IPV victimization and perpetration over a 3-year period of follow-up. The study included new mothers enrolled in the "Hawaiian Healthy Start" home visitation programme between 1994-95 who had an infant at high risk of maltreatment, and who were not involved in child protective services. Women in the intervention group were primarily 19-25 years in age (48%), were Native Hawaiian/ Pacific Islander (34%), had a high

school education (69%), were dating the father of the baby (37%), used alcohol (40%), used other drugs (13%), had poor mental health (43%) and were employed in the previous year (52%). Women in the control group were primarily age 19-25 (45%), Native Hawaiian/ Pacific Islander (33%), high school educated (64%), were dating the father of the baby (37%), used alcohol (48%), used other drugs (15%), had poor mental health (50%), and were employed in the previous year (44%). At baseline, the mean (SD) past-year rates of IPV for the intervention group were: victimization, 4.2 (12.0); acts and perpetration, 10.5 (22.0). For the control group, these were: victimization, 5.7 (16.1); and perpetration, 10.4 (21.6). At baseline, a lower proportion of women in the intervention had problem alcohol use (40% vs. 48%) and poor mental health (43% vs. 50%), and a higher proportion were employed in the past year (52% vs. 44%).

A total of 643 women were included in the study. Families were randomly assigned to the 1) home visiting intervention group (n=373); 2) control group (n=270); or 3) testing control group, although participants in the testing control group were not included in the analyses provided due to a small sample size (n=41). Researchers were blinded to condition. The intervention included early childhood home visits by paraprofessionals, intended to improve family functioning and child health and decrease maltreatment. The paraprofessional connected families to community services including IPV shelters/ advocacy groups and mental health services, and taught about: child development, role modeling and problem solving, and providing emotional support. Initial home visits were to occur within one week of birth, and weekly thereafter until families developed greater capacity, at which point the frequency of visits would be decreased. Home visits were expected to occur for at least 3 years.

Interviews were conducted with the primary caregiver, typically the biological mother, in both the intervention and control groups at: baseline (when the child was born), annually when the child was age 1-3, and annually when the child was 7-9 years, up until 2005. The interviews collected information on whether home visitations were associated with changes in: rates of mothers' IPV victimization and perpetration, and rates of IPV types (physical, verbal, and sexual abuse and injury), using the Revised Conflict Tactics Scale (CTS2) tool.

They found that during the 3 years of implementation, women in the intervention group reported lower unadjusted rates of IPV victimization (21%) and lower rates of IPV perpetration (34%) compared with women in the control condition. Adjusting for potential confounders, women in the intervention group reported lower rates of maternal IPV victimization (IRR, 0.86; 95% confidence interval [CI], 0.73-1.01) and significantly lower rates of maternal IPV perpetration (IRR, 0.83; 95% CI, 0.72-0.96) compared with women in the control condition. Women in the intervention group reported lower unadjusted rates of maternal victimization and perpetration across all IPV types compared with women in the control group. In adjusted analyses, women in the intervention group demonstrated significantly lower rates of physical assault victimization (IRR, 0.85; 95% CI, 0.71- 1.00) and perpetration (IRR, 0.82; 95% CI, 0.70-0.96). With long-term follow-up, the unadjusted IRRs revealed a 16% decrease in overall maternal IPV victimization and a 2% decrease in maternal perpetration among women in the intervention compared with women in the control group. After adjustments were made for potential confounders, they found small decreases in the overall IRRs of maternal IPV victimization (IRR, 0.95; 95% CI, 0.77-1.17) and perpetration (IRR, 0.98; 95% CI, 0.79-1.22). The adjusted IRRs were lower for intervention compared to control group for: physical abuse, sexual abuse, and injury, yet greater for verbal victimization (IRR, 1.14; 95% CI, 0.97-1.34) and perpetration (IRR, 1.08; 95% CI, 0.92-1.26). Note, however, that none of these differences at long-term follow-up were significant.

Overall, they found the home visitation programme was associated with lower overall maternal IPV victimization and perpetration during the child's first three years; the greatest reduction for type of IPV was for physical assault. While the study design is robust (comparison group, blinding of researchers), there are a number of limitations to the findings reported. First, it is possible that the low prevalence of sexual abuse and injury impacted the analyses for these IPV types. Further, the authors note that the lack of programme content related to IPV and the fact that few families participated in the expected amount of home visits, impacts the interpretation of the effect of the

home visiting programme on IPV. Further research is required to investigate the components contributing to reductions in IPV. Women also self-reported their own and their partner's IPV in the past year, which may be subject to recall error or under-reporting. They also note that while the CTS2 is validated, there lacks a gold standard for assessing IPV. While baseline differences between intervention and control groups were accounted for, it is possible that confounders influenced findings. Finally, authors performed an intention to treat analysis in which women were analysed according to initial group assignment, irrespective of actual participation in the intervention, and therefore results from each group may not reflect the actual outcomes measured.

Cath Gregory Consulting, 2008

A UK-based qualitative report prepared by Cath Gregory Consulting, 2008 [+] evaluated the impact of the National DV Helpline. The report was prepared for Comic Relief, one of the funders of the helpline. A total of 47 women who had accessed the helpline were recruited primarily from DV agencies, to participate in an online questionnaire. A subset of these 47 women also participated in a 30-60 minute telephone interview. Of the 47 women who participated, 12 had experienced severe violence, 8 had mental health concerns, 5 had experienced violence in front of their children, and 4 were homeless from abuse. No demographic details were provided.

The helpline is a 24-hour telephone service for those seeking support related to DV. The focus is on: supporting the safety needs of callers, providing risk awareness and risk avoidance support, providing referrals to refuges and other sources of support and information or practical support. The length of support provided varies from a limited/ brief contact for information to ongoing support for a period of years. They note that the majority of calls come from female DV victims (70%), while the remainder (30%) comes from family, friends and professionals seeking to support victims. Reasons women noted for accessing the helpline included: seeking an escape (n=18), information seeking (n=12), recent experience of assault (n=7), and planning to leave a relationship (n=6). Of the participants, 50% had made only one call, 25% had made 2 calls, and the remaining 25% had made 3 or more calls.

They found that 83% of participants noted that they were able to change their situation and 70% had moved to a refuge or ended their relationship. Women spoke about making changes in their lives. For example, one woman expressed: "The Helpline is vital and it was a life and death situation at the time for me and my daughter. It's essential and vital and it all goes on behind closed doors." Another participant explained: "I often think that making that phone call was the first step to me making a new life." Women also spoke about how the helpline had helped change their understanding of abuse: "It sounds really stupid but I still didn't realise I was in an abusive relationship…What helped was that she [helpline worker] named it. She named it as `domestic abuse'. That really helped me. I surprised myself that I was never able to label it beforehand." Women also spoke about being enable to make a decision to act: "As a result of phoning the Helpline and getting in touch with my Support Worker, in less than one week I was not living with my partner any more." Women explained how they felt supported and believed by helpline workers: "Initially I talked to this woman and explained the situation and she knew exactly what was going on and she believed me. It makes me feel quite choked to say that. That was so important to me, to be believed. Being listened to and having the time to tell her what was going on and feeling that she understood me was so important." Women noted how helpline workers had linked them to important services: "They told me about where I could go and about how I could have a refuge support worker, and they told me that maybe I could get housing support, but that this was something that I could sort out with my key worker. They also told me about how I could get help to get back into education and studying again, get support with working and help, if I needed it, with the legal situation." Finally, some women spoke about the importance of 24 hour access that the helpline provides: "With the Helpline I was able to ring at 3 am in the morning when I most needed to speak to someone and they were there...You can't phone your family at 3 am when they have to get up for work the next day and you're in a state of fear or panic. Immediately after the call I calmed down enough to sleep again." In contrast, a minority of women

reported negative experiences with the helpline. Two women noted that the helpline worker they spoke with was unfriendly or unhelpful, while several reported feeling confused by the available services that were explained to them.

Findings suggest that a 24 hour helpline service help women who have experienced domestic abuse by improving understanding of abuse, facilitating changes, and offering guidance and support. Limitations of the study include: lack of description of analysis, inclusion of a self-selected sample, and lack of demographic data. While the study was conducted in the UK and should therefore be directly applicable to the UK context, demographic characteristics of participants were not provided.

Coker et al., 2012

A cluster randomized controlled trial by Coker et al., 2012 [+] compared the use of an in-clinic advocate to usual care for decreasing depressive symptoms and stress and improving safety among women experiencing IPV at rural health clinics. Six clinics were included in the study that: were located in the referral range, provided primary care to low income women, and had 1, 000 women as patients per year. Women visiting the clinics who were 18 and over, mentally competent and who were in an intimate relationship in the past 5 years were eligible for participation; women who were with someone at the time of visit were not eligible. Nurses conducted a verbal IPV assessment with women; those who identified IPV in the past 5 years were offered either an advocate intervention in the intervention clinic or external referral in the usual care clinics. Randomization occurred at the clinic level, with each of the 6 participating clinics operating as either an advocate intervention clinic or usual care clinic. A total of 231 women participated (intervention=138; control=93). Women were identified as experiencing current abuse (currently experiencing), or recent abuse (in the past 5 years). Women were also invited to participate in an evaluation of the effectiveness of the intervention, and told they would be interviewed every 6 months for 24 months. Those interested were contacted by phone (if a safe number existed, or at next clinic visit if not) 2 weeks after their initial assessment for a baseline interview. Women who participated were a mean age of 42.62 (intervention), or 38.08 (control); primarily African American (intervention=68.8%; control=55.9%); less than high school educated (intervention=31.4%; control=34.4%); currently separated/ divorced (intervention=22.5%; control=22.6%); had a mean number of 2 children and 3 household members; and were experiencing IPV by a current partner (intervention=46.4%; control=47.3%). Women in the intervention were older, but there were no differences in: race, education, marital status, number of children, number in the household, or the proportion currently experiencing IPV (all $p>0.05$).

Clinic staff was trained according to the type of intervention allocated to their site. In the usual care group, women were provided with a business card of their health care provider and a hotline number. In the advocate intervention, nurses asked women to meet with the advocate following their appointment; women who did not have time were encouraged to briefly meet the advocate and schedule another appointment. The advocate was available during regular clinic hours to offer needs assessment, education, support, referrals to services and safety planning. Women in the intervention also received the business card with provider and hotline information.

Questions from the National Violence Against Women Survey were used to measure help seeking, covering the following areas: law enforcement/ legal assistance, community services for abused women, mental health counselling, discussing IPV with a health care provider, and disclosure to family and friends. IPV and victim safety was assessed using the Danger Assessment Score and the WEB Scale. Women's perception of physical and mental health was assessed using five items from the Medical Outcomes Study, and depression and suicidal thoughts were measured using items from the CDC BRFSS. Follow-up was conducted at 6-, 12-, 18- and 24- months; 76% completed baseline assessment, and 70.6% completed at least one follow-up interview.

They found that more women in the advocate intervention clinic reported speaking with an advocate in the clinic (32.8%) compared to usual care (4.4%), although it is important to interpret this finding with the understanding that the usual care arm clinics had no in-clinic advocate. There were no differences between groups in calls to the hotline. Overall, IPV scores (DAS, WEB) were highest at baseline interview and decreased over time. Though not significant, IPV scores in the advocate intervention were in the direction of greater decline over time compared to usual care (Intervention × Time interaction for DAS scores, F=2.02, p=0.07). DAS and WEB scale scores were more likely to decrease in the first 6 months of the advocate intervention. No differences were observed in self-perceived mental health or impact of mental health on daily activities between intervention and usual care. They did find that scores for depressive symptoms and suicidal thoughts decreased over time among women in the intervention, compared to usual care (Intervention x Time interaction, F=3.10, p=0.01).

Findings suggest that providing referral to an on-site advocate may improve some negative health outcomes experienced as a result of IPV (depressive symptoms, suicidal thoughts). Limitations to the study include: the high drop out over time (with less women completing each follow up assessment), and the randomization of clinics rather than individuals which may have impacted findings as unknown differences between sites may have influenced results.

Crespo et al., 2010

A Spanish RCT by Crespo et al., 2010 [+] examined the efficacy of a group psychotherapeutic cognitive behavioural intervention for women who had experienced IPV. Women were recruited from DV agencies in Madrid, and were eligible to participate if they were 18 and over, had suffered IPV by a male partner and were presenting PTSD symptoms, yet not meeting diagnostic criteria for PTSD. To participate, women could not currently be receiving other forms of treatment. A total of 53 women participated in the study. Participants were a mean age of 41 years; middle social class (37.7%); had completed primary (34%) or secondary education (35.8%); worked outside of the home (43%) or in the home (36%); and were separated or in the process of separating (51%). At assessment, more than one-third of women reported living with their abuser and 41% were financially dependent on their abuser. History of abuse was a mean of 12 years and occurred daily in the past month (45%), with 40% identifying the current status of their abuse as “the worst moment.” Some women reported a combination of physical and psychological abuse (51%). The rate of women who had experienced psychological abuse was the highest (93%), followed by physical abuse (68%) and sexual abuse (11%). Nearly half of women (45%) were taking anti-depressive or anti-anxiety medications.

Women were randomly assigned to one of two experimental conditions: group with exposure techniques (n=28) or group with communication skills training (n=25). One programme included exposure therapy and the other (communication skills training) did not. Both treatment programs were multi-component CBT programs including the following modules: breathing exercises to control arousal, improving mood by planning of enjoyable activities, self-esteem improvement skills, restructuring biased cognitions, building independence skills via problem-solving, and psycho-education on IPV. The condition that included exposure therapy included therapy techniques for exposure in the imagination to scenes related to women’s trauma. In the programme without exposure therapy, participants were trained in communication skills, exploring emotions, expression and ability to communicate. Each programme included 8 modules (six common to both, one on either exposure or communication skills, plus a relapse prevention module), 90-minutes in length, with 3-5 women in each group, led by a trained female therapist. Women were provided with a workbook to complete various homework exercises. Measures were assessed in an interview format at pre- and post- test, and at 1, 3, 6 and 12 months following the end of treatment.

The outcomes measured included: overall posttraumatic symptoms, as well as: re-experiencing, avoidance and hyper-alertness, and depressive and anxiety symptoms. Other measured related to emotional status included were: alcohol use, self-esteem and expression of anger. Tools used

to measure these variables included: The Interview Guideline for Victims of Domestic Maltreatment (to measure history of violence and support received); The Severity of Posttraumatic Stress Disorder Symptoms Scale (to measure PTSD symptoms); The Beck Depression Inventory (BDI-II) (to measure depressive symptoms); The Beck Anxiety Inventory (to measure anxiety symptoms); Rosenberg's Self-Esteem Scale (to measure levels of self-esteem); Anger Expression Subscale from the State-Trait Anger Expression (to measure angry feelings and actions).

Level of education was significantly higher in the exposure group ($\chi 2$ (2)=13.78, $p<0.01$), as was the percentage of women who had received psychological or psychiatric treatment due to violence ($\chi 2$ (1)=9.61, $p<0.01$). Mean level of depression was higher in the communication skills group (F (1,51)=4.90, $p<0.05$). There were no other differences at baseline. Overall, just over half (51%) of women reported high levels of post-traumatic symptoms (levels of clinical severity); under half (42%) of women reported re-experiencing, just over half reported hyper-alertness, and less than one-quarter (21%) reported avoidance. Women's mean depression score was severe, mean anxiety score was moderate-severe, self-esteem was low, mean reported levels of anger were high and 39% of women reported suicidal ideation. However, mean alcohol use was minimal.

ANCOVAs analysis revealed that overall, general post-traumatic symptoms improved at 1-month follow-up, (F (1, 36)=4.41, $p<0.05$). Changes found in specific PTSD symptoms for both groups included: re-experiencing at post-treatment assessment, (F (1, 37)=8.84, $p<0.01$); avoidance at 1-, 3-, and 6-month follow-ups, (F (1, 36)=4.62, $p<0.05$; F (1, 36)=11.54, $p<0.01$); and (F (1, 36)=9.39, $p<0.01$), respectively; and hyper-alertness at post-treatment, (F (1, 37)=3.37, $p<0.05$). The intervention group with exposure demonstrated greater improvements in general posttraumatic symptoms, avoidance and hyper-alertness; while the communication skills group demonstrated greater improvements regarding re-experiencing. For hyper-alertness, the time × programme interaction was significant, (F (1, 34)=6.92, $p<0.05$), demonstrating a decrease at post-treatment that for the exposure group remained stable at follow up, and decreased progressively for the communication skills group. Significant differences were found at 1-month follow-up for: depression: (F (1, 36)=7.81, $p<0.01$); in post-treatment anxiety: (F (1,3 7)=4.52, $p<0.05$); and all follow-up times for anger expression: (F (1, 37)=4.08, $p<0.05$); (F (1, 36)=5.30, $p<0.05$); (F (1, 36)=3.85, $p<0.05$); (F (1, 36)=5.08, $p<0.05$); and (F (1, 36)=5.49, $p<0.01$), respectively. For all measures, scores were lower for the exposure group.

The study found improvements in emotional status, posttraumatic stress, depression, and anxiety for both intervention groups, with greater effects for the exposure condition. Since the study did not include a control group (both conditions received a version of treatment), it is possible that findings were due to meeting with a therapist in general rather than outcomes of the individual programme, or due to gradual changes over time. The study also included, but did not analyse differences between, women who live with and women who have left their abuser. However, these women may be experiencing different symptoms and levels of safety, and may respond to treatment differently.

Glass et al., 2009

A US-based before and after study by Glass et al., 2009 [+] examined the impact of a computerized safety decision aid for decisional conflict with victims of IPV. Women were recruited via DV shelters and support groups and were eligible if they spoke English or Spanish, were 18 or over, and reported physical or sexual violence in an intimate relationship in the past year. A total of 90 women were included in the study. The mean age of participants was 34 years; the majority of women identified as White (64%), followed by Latina (33%); most women (89%) had children, and nearly half (46%) had a child living with them; an equal proportion of women had completed high school (28%) or attended some college (28%); and just over one-third (37%) reported working either full or part-time. Only 7 of the 90 women currently lived with the partner who abused them.

The decisional conflict model teaches that when a person is informed of alternatives, develops decisional priorities, is supported in the change process, and improves in their certainty of the decision, then conflict will be omitted and the decision will be made. The computerized safety decision aid is based on this model and provides feedback on risk, safety options, assistance with developing priorities and creating safety, and develops a personalized safety plan for the user. In Phase 1 of the project, the safety aid was developed (via evidence reviews, validated measures and feedback from user groups of women) and in Phase 2, they examined the impact of the aid on women's decisional conflict. Women were provided access to a laptop computer and headphones and completed the computerized decision aid on their own at their own pace.

The safety aid included: demographic questions, questions on safety-seeking behaviours and resources, a low-literacy version of the Decisional conflict scale (to assess decision making before and after), and an activity to support women in setting safety priorities. Participants were provided with a summary of their priorities. Women with children received a priority setting activity that included children. After participants set their safety priorities, they completed the Danger Assessment (DA) to assess danger of lethality of abuse. Women were then provided with personalized information regarding priorities and level of danger, and were offered the option to reprioritize their safety based on feedback. Finally, women were debriefed by a research assistant and provided with a print out of local resources and the option to take home a print out of results and the personal safety plan (if deemed safe).

A total of 12 questions were combined to measure: certainty about safety plan, knowledge of options, support for decision-making, clarity of priorities, and total conflict about the safety decision. Following use of the safety decision aid, women reported feeling more supported in their decision (baseline score 39.44 improved to 31.3, p=0.012), and reported less total decisional conflict (baseline score 39.35 improved to 33.01, p=0.014).

Findings suggest that a computerized safety decision aid may improve the decision process for women who have been abused, by reducing decisional conflict. The study included a sample of women who were already seeking services for abuse (from DV shelters or support groups where they were recruited) and therefore it is possible that they had greater engagement in a safety decision process than would women who have not sought DV resources. Other limitations of the study include lack of a comparison group, short term of follow up (exact timing not stated, though authors suggest that this occurred post-intervention), and limited description of methods and participants (e.g. unclear what supports women were receiving prior to participation).

Grip et al., 2011

A Swedish before and after study by Grip et al., 2011 [+] investigated if participation in a psychosocial group intervention was associated with self-reported improvements in mothers' trauma symptoms, symptoms of general psychopathology, improvement in sense of coherence, and perceived parental locus of control. The study included a total of 42 women with children who were seeking help for intimate partner violence at a community-based treatment centre, who were not living with the perpetrator and did not have a drug or alcohol use problem. Women were a mean age of 38.8 years; the majority was single parents (93%); just over half were born in Sweden (54%); all women had a minimum education of 11 years; the majority of women were working, studying or on parental leave (65%); and socioeconomic status was low (30.80). Women had been in the abusive relationship for a mean of 7 years, and 60% of women had been abused more than 25 times. Almost half of women had stayed in a shelter on more than one occasion (48%) and almost all women (90%) had sought other forms of help before contacting the treatment centre in the study. In nearly all cases, the abuser was also the biological father of the child (81%) and often the child had also been abused (71%). No associations were found between demographic characteristics or factors related to abuse and symptoms.

In the mothers' intervention (the focus of this article), women participated in group therapy for 15 weeks. The women's groups included 6-8 participants, was based on the parent type of the "Children Are People Too" treatment programme and included: information on IPV, reactions to IPV, the effect of IPV on personality, family interactions and communication. Women completed an in-person questionnaire and assessment prior to treatment (pretest) (n=42), at post-intervention (n=28), and at 1-year follow-up (completer group n=20). No differences were found between the completer and ITT group on demographic characteristics, psychological health, trauma symptoms, sense of coherence, and parental locus of control. Mothers were interviewed about their current situation, relationship to the abuser, exposure to violence, and physical injury from abuse. Validated self-report measures included the Impact of Event Scale (IES) (to measure trauma symptoms); the Brief Symptom Inventory (BSI) (to measure psychological problems and physical symptoms); the Sense of Coherence (SOC) (to measure meaningfulness and manageability); and the Parental Locus of Control (PLOC) (mother's ability to impact/ direct child).

They found that in the completer group, trauma symptoms decreased significantly following treatment and 1-year follow-up ($F (2, 36)=17.273$, $p<0.001$). Effect sizes (all Cohen's d) were .75 from pre- to post-treatment, and 1.04 from pre-treatment to 1-year follow-up. ITT analysis also demonstrated a significant effect, ($F (2, 82)=12.584$, $p<0.001$), with effect sizes being .52 and .63, respectively. The BSI measure revealed that 80% of women reported psychological symptoms prior to treatment. Completer analyses demonstrated significant reductions in symptoms following treatment and at 1-year follow-up, ($F (2, 36)=9.97$, $p<0.001$). Effect sizes following treatment were .76, and between pre-treatment and 1-year follow-up were .91. ITT analysis also revealed significant reductions in symptom levels ($F (2, 82)=12.82$, $p<0.001$). Effect sizes were .62 and .71, respectively. The completer group demonstrated a greater sense of coherence on the SOC following treatment and at 1-year follow-up, ($F (2, 36)=6.88$, $p>0.01$ [sic]). Effect sizes were .38 from pre- to post-treatment and .60 from pre-treatment to 1-year follow-up. ITT analysis revealed a similar effect ($F (2, 80)=6.17$, $p>0.05$ [sic]). Effect sizes were .31 and .46, respectively. There was no significant change in parental locus of control post-treatment or at 1-year follow-up, for either the completer group or the ITT sample.

Overall, women who participated in the therapy significantly improved self-reported mental health, sense of coherence, and demonstrated a reduction in trauma symptoms post- intervention and at 1-year follow-up. Limitations of the study include: lack of comparison group, use of a small sample size, and high attrition rate.

Hassija et al., 2011

A US-based before and after study by Hassija et al., 2011 [+] examined if tele-health cognitive behavioural counselling sessions for abused women were associated with a reduction in post traumatic stress disorder (PTSD) and depression symptoms. The study included a total of 15 rural women attending distal DV and rape crisis centres in Wyoming. Clients who had started formal treatment and received at least four sessions or trauma focused individual therapy were eligible to participate. Participants were primarily Caucasian (86.7%); a mean age of 30.20, and primarily single (46.7%) or married (46.7%). Women were primarily referred distress from DV (80%) followed by sexual assault (20%). Women participated in a mean number of 13.33 (SD=13.89) videoconferencing sessions.

Secure videoconferencing-based psychological services were provided at the DV centres. Participants engaged in free, weekly 60-90 minute trauma-focused psychotherapy services delivered by a Master's level therapist. Sessions 1–2 were focused on gathering information-building trust. Participants then engaged in individual sessions of trauma-focused, evidence-based therapy. Participants received a mean of 13.33 videoconference sessions. Treatment manuals for prolonged exposure (PE) or cognitive processing theory (CPT) were used as the foundation of the intervention, with components adapted to the needs of the patient. In addition, motivational interviewing (MI) techniques were used in cases where there were concerns regarding leaving an abusive partner to help facilitate decision-making. Assessments were

conducted after every four sessions using the following self-report measures: Post-traumatic Stress Disorder Checklist (PCL) to measure presence and severity of PTSD symptoms; and the Centre for Epidemiological Studies Depression Scale (CES-D) to measure depression symptoms. Client satisfaction with the videoconference therapy programme was also measured.

At the start of treatment, women's self-reported symptom levels were 50.07 (SD=17.77) on the PCL, and 27.47 (SD=14.12) on the CES-D. At post-treatment, women had a mean PCL score of 32.20 (SD=12.68). Using Cohen's d to measure treatment effect size, women exhibited a large decrease in PTSD symptoms (d=1.17). For the CES-D, women's post-treatment score was 13.07 (SD=9.07), also revealing a large decrease in depressive symptoms (d=1.24). There were significant improvements in measures of PTSD and depressive symptoms. When analysed by trauma type, effect sizes for each group on PTSD and depression outcomes were: DV (d=1.00, d=1.33); sexual assault: (d=2.18, d=1.05), respectively. Women also reported satisfaction with the videoconference therapy programme (M=52.93, SD=2.43).

Overall, these findings suggest that videoconferencing may be an effective format for providing trauma-focused treatment to rural women who are abuse victims. However, there are several limitations to the study, including: the lack of a comparison group, no follow-up on participants after the cessation of treatment, the use of a small convenience sample. These limitations limit the ability to generalize to other settings, or confirm that findings were not impacted by various confounders. They also chose to include only women who completed at least 4 sessions in their analysis, omitting 22 women who participated in but did not engage in the minimum number of sessions. Therefore the findings may be biased towards women who are more likely to achieve improvements in health outcomes (for example, due to current capacity or interest in engaging in counselling). Further research is required to examine the efficacy of psychological interventions delivered through video-conferencing with diverse populations of women, as well as further research to understand the factors contributing to patient attrition.

Hernandez-Ruiz et al., 2005

A US-based RCT by Hernandez-Ruiz, 2005 [+] examined the effects of a music therapy intervention for improving anxiety and sleep among abused women in shelters. Women were referred to the study by shelter staff if they had been staying in the shelter for between 2 days and 1 week. A total of 28 women participated in the study (intervention=14; control=14). Women were a mean age of 35.26 years, with an average of 2 children. Women had been a mean of 7.94 years in the previous abusive relationship, and abuse had lasted a mean of 4.23 years. A total of 26 women reported verbal abuse and 23 reported physical abuse.

Women were randomly assigned to either intervention or control. All women met with the researcher in 30-minute individual sessions for 5 days. In the initial session, women completed a demographic questionnaire, noted music preference, and completed the Pittsburgh Sleep Quality Index to measure quality of sleep in the past 2 days. The instructor demonstrated how to complete the Fatigue Scale after waking. The researcher collected the Fatigue scale in the following two sessions (first and second pre-test). In the next session, participants completed the 'state' section of the State-Trait Anxiety Inventory (pretest) and then were instructed to lie down on a couch, in a dimly lit room for 20 minutes. A progressive music relaxation (PMR) script was included in a 15-minute recording of music, which was copied to allow for 20 continuous minutes of music (the last 5 minutes without verbal prompts). Women in the control group did not receive the music/ PMR, but were asked to "lie down quietly for 20 minutes." Following the 20-minutes of music or silence, participants completed the State Anxiety Inventory (post-test). Women in the intervention were also provided with the CD of the music/ PMR, and a portable CD player, and were asked to repeat the procedure before going to bed. All women completed a Fatigue Scale (first post-test) the next morning. The same procedure was repeated in the 4th session and 5th session, with further data collected (second post-test). All participants also complete the PSQI during the 5th session (post-test).

A statistically significant reduction of anxiety was found in the experimental group ($p<0.001$). No significant relationship was found between sleep quality and anxiety even though both significantly improved. A significant improvement in sleep quality was found in the experimental condition ($p=0.007$) but not in the control group ($p=0.105$). Overall, 78% of women (n=22) originally qualified as "bad sleepers" (PSQI score higher than 5); 4 of these women (28.57%) in the experimental group measured as "good sleepers" at post-test. They did not find sleep quality to be significantly associated with a decrease in fatigue upon waking.

Progressive music relaxation may improve anxiety symptoms and sleep quality in women who have been abused and are living in shelters. Because the study included a small convenience sample (of women who had been staying in one shelter for under one week), findings may not be generalisable.

Howarth et al., 2009

A UK-based (England and Wales) before and after study by Howarth et al., 2009 [+] examined the effectiveness of Independent Domestic Violence Advisor (IDVA) services for increasing safety and well-being of female victims of DV who were deemed to be at high risk of harm or homicide. All women who engaged with IDVA services in England and Wales over a 27-month period starting in January 2007 were included in the study. Women who did not meet high-risk criteria were excluded from the study. A total of 7 IDVA services were included, and were a mix of urban, suburban and rural, also ranging in size and period of establishment. At Time 1 assessment (intake), n=2,567; at Time 2 assessment (after 4 months of support), n=1, 247; at exit interview, n=411; at six-month follow-up, n=34. Demographic characteristics collected at time one revealed that the majority of women were White (74%), just over half were employed (51%); and 37% were age 21-30 and 31% ages 31-40. Demographic characteristics collected at time two revealed that the majority of women were White (72%), half were employed (50%); and 26% were age 21-30 and 33% age 31-40.

The main components of IDVA services included: a focus on safety as the primary goal, the targeting of victims at high risk of harm or homicide due to DV, the provision of intervention from the point of crisis, a risk based approach to intervening, and the proactive provision of help to reduce immediate risks to safety and improve long-term safety. At Time 1, the Risk Indicator Checklist (RIC) was used to assess risk to victims, and the severity of abuse grid was developed for the project to gather information on the type, severity and frequency of four types of abuse (physical abuse, sexual abuse, perpetrators' jealous and controlling behaviour, and harassment and stalking). At Time 2, well-being was assessed by asking IDVAs to indicate whether or not victims had made changes to coping strategies or access to social support. Follow up was also conducted at closure of case file and at 6-months follow-up.

No statistical differences were found at Time 1 between those who were and were not interviewed in the frequency of physical abuse, sexual abuse or jealous behaviour. However, a higher proportion of women who completed exit interviews were experiencing harassment ($\chi 2$ (1, n=1247)=7.67, $p<0.01$), and severe abuse ($\chi 2$ (1, n=1247)=7.08, $p<0.01$) at the point of referral. Following IDVA services, 57% of all victims experienced a cessation in the abuse they were suffering. There was a relative reduction of 75% for physical abuse, sexual abuse and jealous and controlling behaviour, and a 66% reduction for severe cases of stalking. The majority of victims (76%) reported improved feelings of safety; IDVAs also reported reduced risk in 79% of cases. Only a small minority (less than 1%) of victims who were asked about their safety reported feeling less safe following support from an IDVA. Positive outcomes increased with the number of interventions received; 37% of women felt safer after 0-1 forms of support compared to 77% of those receiving 2-5 forms and 88% of those receiving 6-10 forms of support. At 6-month following case closure, the majority of women surveyed (82%) reported no further abuse.

Findings suggest that IDVA services improved safety and well-being among high-risk women who had experienced DV. Limitations to the study include: the lack of a comparison group and high

attrition rate (only n=34 provided 6-month follow-up). A more robust study design is required to test findings and examine results at follow-up. The authors also note time constraints for IDVAs in regards to type and amount of data they could collect. They also note the lack of standardized measures, resulting in inconsistencies in defining and measuring support provided by IDVAs. Given that the study included only women deemed as high risk of harm or homicide, findings may not be generalisable to all women who experience abuse.

Iverson et al., 2009

A US based before and after study by Iverson et al., 2009 [+] examined the impact of a dialectical behaviour therapy (DBT) on measures of depressive symptoms, hopelessness, general psychiatric distress, and social adjustment from pre- to post-treatment. Women were referred to the programme through various DV agencies and were eligible to participate if they had ever experienced DV. A total of 31 women were included in the study. Women ranged in age from 22-56 years, with a mean age of 40.7 and were primarily: Caucasian (81%), earning less than $30,000, and had some high school or college education (72%). Just over half of the women (54%) reported being in an abusive relationship for between 1 and 5 years; 77% reported abuse by a current/ former husband, and 26% were currently living with their abuser.

Women completed a brief telephone screening prior to participation, which measured distress and included a general clinical interview. Eligible participants were then scheduled to participate in the next available group. A total of 7 groups were conducted, each with 6-8 women, 2-hours in length for a period of 12 weeks (12 sessions). Sessions included: skills development through teaching and practice, review of skills learned, discussion of problems in application of skills to daily life, planning opportunities to engage in effective behaviours, and provision of support and encouragement by therapists and other participants. Treatment was provided by two co-therapists per group who were trained in DBT and provided with ongoing support/ training. DBT is a comprehensive form of cognitive behavioural treatment intended to treat clients with multiple problems and severe emotional problems. Typical procedures include: treatment targets in a hierarchy with safety prioritized, chain analysis of targets, daily monitoring, validation, skill building and generalization, balancing acceptance and change, practicing and applying skills, and ongoing consultation with a therapist. Post- therapy, participants completed the same self-report assessment completed at baseline, which included the following tools/ measures: Beck Depression Inventory–II to measure depressive symptoms; Beck Hopelessness Scale to measure degree of hopelessness and suicidal risk; Social Adjustment Scale–Self-Report to measure social functioning; Symptom Checklist–90 –R. to measure of individual distress; and The Global Severity Index of the Symptom Checklist–90–R to measure general levels of distress.

ANOVA was conducted to assess effects for all women who completed the group therapy (n=31). Pre- and post-intervention effects were as follows: Beck Depression Inventory–II, ($F(1, 30)=12.97$, $p< 0.001$, $d=0.54$); Beck Hopelessness Scale, ($F(1, 30)=5.88$, $p<0.05$, $d=0.42$); Symptom Checklist–90 –R, ($F(1, 30)=14.82$, $p<0.001$, $d=0.78$); and Social Adjustment Scale–Self-Report, ($F(1,30)=7.67$, $p<0.01$, $d=0.53$). Pre- and post-test means and standard deviations were as follows: Beck Depression Inventory–II: pre-test ($M=18.3$, $SD=15.0$), post-test ($M=10.2$, $SD=11.4$, $F=12.97$, $d=0.54$, $p<0.001$); Beck Hopelessness Scale: pre-test ($M=5.1$, $SD=6.0$), post-test ($M=2.6$, $SD=3.0$, $F=5.88$, $d=0.42$, $p<0.05$); Symptom Checklist–90–R: pre-test ($M=44.7$, $SD=11.8$) post-test ($M=35.5$,$SD=13.3$, $F=14.82$, $d=0.78$, $p<0.001$); and Social Adjustment Scale–Self Report: pretest ($M=2.2$, $SD=0.57$), post-test ($M=1.9$, $SD=0.50$, $F=7.67$, $d=0.53$, $p<0.01$).

Women demonstrated significant improvements on all of the outcome measures, including: reduced depressive symptoms, hopelessness, and psychiatric distress and increased social adjustment. Study limitations that may impact findings include: lack of a comparison group and follow up, small sample size, and relatively high attrition rate (33%). More robust study designs are required to test findings with more diverse groups of women, to determine follow-up maintenance and generalisability.

Iverson et al., 2011

A US-based RCT by Iverson et al., 2011 [+] examined the effect of CBT for improving PTSD and depressive symptoms and future risk of IPV among women survivors of IPV. The study included women 18 and over who were experiencing PTSD due to sexual or physical assault in childhood or adulthood, who were participating in a larger study examining cognitive processing therapy (CPT, a form of CBT) for PTSD. A total of 150 women participated in the study. Women were a mean age of 35.4 years; Caucasian (62%), African American (34%), or other race (4%); had a mean education of 13.8 years; most had an income of less than $20, 000 per year (53.7%); 20% was married/ living with their partner. Most women had experienced adult physical assault (84%), adult sexual victimization (78%), childhood sexual abuse (78%) and childhood physical abuse (77%). The average time reported since the index event was 14 years, due to many women reporting child sexual or physical abuse as their index event (45.3%); 19.3% of the ITT sample identified IPV as their index event.

After completing baseline assessment, women were randomly assigned to one of three groups: 1) cognitive processing therapy (CPT) (n=53); 2) CPT-C (n=47); and 3) written account only (WA) (n=50). The CPT protocol focused on supporting the client in learning skills to realise and challenge cognitive distortions, beginning with most traumatic events and the meaning of those relative to themselves, others and the world. Therapy also involved: PTSD education, identifying relationships between events, thoughts and emotions, and developing more balance thoughts. The intervention involved detailed written accounts of participant's index trauma event and daily readings of accounts during beginning and middle sessions of therapy. Cognitive therapy was applied in sessions and also in worksheets completed after sessions to identify cognitive distortions that act as barriers to recovery. CPT-C condition was the same as CPT, but omitted the detailed writing account and readings of the trauma event. The therapy focused on additional questioning and cognitive skill exercises instead of the written account. The WA protocol expanded on the written account component of CPT. The initial two WA sessions were 60 minutes each and provided an overview of treatment, PTSD psycho-education, instructions on subjective units of distress (SUDS) and information on writing the index trauma account. In the remaining five sessions, women spent 45–60 minutes writing their index trauma account and reported SUDS ratings and information on their emotions before and after writing the account. Women then read out the account to the therapist. Therapists then provided comments and support, education, asked about emotions, but did not provide cognitive therapy or work on changing cognitive distortions. Women were also requested to finish their account at home if they were not able to do so during therapy and read it daily and report SUDS ratings. Assessment was conducted at 9 time points (i.e., pre-treatment, every week of the 6 weeks of therapy, and 6-month post-treatment) to evaluate changes in PTSD and depressive symptom. All 3-treatment conditions were 6 weeks long and included 12 hours of individual therapy, facilitated by trained clinical psychologists. All sessions were videotaped and monitored for adherence to treatment principles.

Assessment was based on the following tools: Standardized Trauma Interview (to assess physical and sexual victimizations); Conflict Tactics Scale-Physical Aggression Subscale (to measure physical threats and violence); Beck Depression Inventory-II (to measure depression and PTSD symptoms). Neither amount of treatment completed nor treatment condition (CPT, CPT-C, WA) were a significant predictor of IPV victimization at 6-month follow-up and were therefore excluded from the reported findings. Out of 150 women, 86 completed all 12 hours of therapy; participants in the ITT sample completed a mean of 8 therapy hours (SD=5.12; range: 0-12).

Of the 150 women included in the ITT sample, 61% (n=91) reported a lifetime history of IPV, and 16% (n=24) reported IPV by their current partner in the past year. Of the 118 women in this sample who completed 6-month follow-up, 22% (n=26) reported that they had experienced IPV in the 6 months post-treatment. Initial growth curve analysis revealed significant mean-level decrease from pre- to post- test in PTSD ($b1=-0.17$, $t=-12.38$, $p<0.001$, $\Delta\sigma 2=0.56$) and

depressive symptoms (b1=−0.16, t=−12.16, p<0.001, Δσ2=0.50). Hierarchical multiple regression analyses revealed significant associations between change in PTSD (b=3.37, t=3.06, p<0.05, pr2=0.07) and depressive symptoms (b=3.49, t=2.93, p<0.05, pr2=0.07) over the course of therapy and reductions in IPV at the 6-month follow-up. These associations maintained significance even after controlling for baseline IPV levels and previous exposure to interpersonal trauma.

Overall, they found improvements in PTSD, depressive symptoms and IPV at 6 month follow up, suggesting that CBT is a promising approach to treating women who have experienced trauma, including IPV. Since all participants received treatment for PTSD, it is difficult to ascertain if findings are reflective of the treatment or due to changes over time, or attention from a therapy provider. Future research using a control condition is required. The authors also note that women reporting higher depressive and PTSD symptoms were less likely to complete follow up assessments, so findings may not be applicable to women experiencing greater distress. Finally, the study only included measures of physical IPV, so may not be applicable to women who have experienced sexual or emotional IPV.

Johnson et al., 2011

A US-based RCT by Johnson et al., 2011 [+] examined the effectiveness of Helping to Overcome PTSD through Empowerment (HOPE), a cognitive behavioural intervention, to: reduce depression, PTSD, reduce re-abuse once women leave the shelter and increase empowerment, resources and access to support. A total of 70 women who had been abused (in the month prior to entering shelter), had PTSD (or sub-threshold) symptoms, and were attending a DV shelter were recruited from two inner-city shelters within the same shelter system over 8 months. Women with certain mental illnesses (bipolar disorder or psychosis), women who were participating in concurrent individual therapy, and women who changed psychotropic medications in the past month or who exhibited suicidal risk were excluded.

Women who participated were a mean age of 32.55; primarily African American (50%), followed by Caucasian (42.9%); most women had completed some college (42.9%), although some women had less than a high school education (27.1%), or high school education (22.9%); most were employed (27.1%); and almost all women had children (90%). All women reported either an IPV-related PTSD status (87.1%) or sub-threshold PTSD status (12.9%). Women also reported: depression (47%), substance use disorders (8%), or other anxiety disorders (51.4%), and less than a quarter (21.4%) of women were on psychotropic medications. In the month prior to entering the shelter, all women reported experiencing psychological abuse (100%), and the majority of women had also experienced physical abuse (92.9%) and sexual abuse (67.1%).

Women were stratified according to PTSD status and medication status and randomly assigned to either intervention (n=35) or control (n=35). All participants received standard shelter services (SSS), including case management, a supportive environment, and educational programs offered. Women in the HOPE intervention also received a maximum of 12 sessions, lasting 60-90 minutes, delivered twice weekly while living in the shelter, for a maximum of 8 weeks. The HOPE programme is a 9–12 session manualized, individual, cognitive–behavioural treatment, based on Herman's multistage model of recovery. Initial sessions include psycho-education on IPV, PTSD, safety planning, and teaching women skills to empower her and help develop independence. Later sessions include cognitive behavioural skills to cope with PTSD (e.g. managing triggers, cognitive restructuring), as well as optional modules to address any co-occurring issues (substance use, etc.). Sessions were delivered by either the author or one of five Master's trained therapists (all attended a 12 hour training workshop). Participants were interviewed at baseline, and then at 1-week, 3-months and 6-months after leaving the shelter.

Tools used for outcomes measured included: CAPS (to assess IPV-related PTSD diagnosis); Conflict Tactics Scale Revised (CTS-2) (to assess IPV the month prior to entering the shelter); Structured Clinical Interview for Axis I disorders SCID-I/P (to assess current comorbidity to

PTSD); The Trauma History Questionnaire (THQ)(to measure lifetime history of traumatic events other than IPV); The Beck Depression Inventory (to assess depressive symptoms); The Personal Progress Scale-Revised (PPS-R) (to assess empowerment or self-evaluation and self-esteem); The Conservation of Resources–Evaluation (to measure resource loss or gains); and The Inventory of Socially Supportive Behaviours (to measure social support).

They found no significant differences for PTSD status in the ITT sample ($p>0.05$). However, when looking at PTSD symptoms by factors, hierarchical linear model analyses revealed a significant treatment effect for emotional numbing symptom severity in the ITT sample, ($t(67)=-2.046$, $p<0.05$), and significant treatment effects for effortful avoidance symptom severity, ($t(49)=-2.50$, $p<0.05$), and arousal symptom severity, ($t(49)=-2.04$, $p<0.05$), in the MA sample. However, PTSD severity was found to decrease over time (χ^2 (67, N=70)=118.75, $p<0.0001$). Chi-square analyses revealed significant differences in rates of re-abuse at 6-month follow-up for the ITT sample (χ^2 (1, N=70)=8.68, $p<0.01$) and the minimal attendance (MA) sample (χ^2 (1, N=52)=15.70, $p< 0.0001$). In the ITT sample, women in HOPE (46.9%) were less likely to report re-abuse compared to control participants (81.8%), (OR=5.1, 95% CIs [1.66, 15.70], RR=1.75, 95% CIs [1.17, 2.61]). In the MA sample, women in HOPE (26.3%) were also less likely to report re-abuse compared to control participants (81.8%), (OR=12.6, 95% CIs [3.26, 48.65], RR=3.11, 95% CIs [1.44, 6.71]). Significant effects were also found in the ITT sample for depression severity ($t(67)=-3.13$ $p<0.01$), empowerment ($t(67)=2.09$, $p <0.05$), and social support ($t(67)=2.11$, $p<0.05$). In the MA sample, a significant treatment effect was found for depression severity ($t(49)=2.510$, $p<0.05$) but not for empowerment or social support.

Findings suggest that this cognitive behavioural intervention may improve various PTSD symptoms in women who have been abused. However, limitations of this study include a relatively small sample size, high attrition rate, and the use of study therapists to rate adherence and competence of participants (rather than independent raters). Finally, findings may not be applicable to women who are not using shelter services.

Kendall et al., 2009

A US-based cross-sectional study by Kendall et al., 2009 [+] examined the impact of an IPV counselling and resources referral intervention in an emergency department on patient-perceived safety and safety planning. The study included women and men 12 years and older who were visiting an urban emergency department; patients who did not speak English or were critically ill were not eligible to participate. All women were screened, and all boys/ men 12 and older who presented IPV risk factors were screened, using two questions from the Partner Violence Screen (PVS). A total of 350 females (97%) and 10 males (3%) participated in the study. Participants were primarily African American (64%), followed by Caucasian (26%); mean age was 32 years; and mean length of abusive relationship was 5 years. Relationships were classified as follows: heterosexual partners (62%), spouses (21%), ex-partners (15%); and homosexual partners (2%).

The study began shortly after the introduction of an IPV advocacy programme in the emergency department, which was connected to a community service organization. ED nurses and resident physicians at the hospital received 1-hour training and educational materials were distributed to staff. Patients who responded yes to screening questions were offered consultation with an IPV advocacy counsellor, and physicians were notified of the positive screen. Those who agreed to the consultation with an advocacy counsellor were enrolled in the study. IPV volunteer advocates were trained for 30 hours in crisis intervention. IPV advocacy counsellors used an Interpersonal Violence Assessment Form to evaluate the victim's situation, including type of abuse and demographic information on victim and abuser. Following this, they helped the victim develop a 5–point safety plan (this could include moving to a shelter, creating independence, education/ training, etc.). The advocate also provided information on available community resources, and if requested helped to arrange shelter stays.

Follow up was conducted by the advocate counsellor via telephone at 2 days, 2-weeks, 6-weeks and 12-weeks post intervention, to assess for: number of steps implemented from safety plan, patients perception of safety and whether or not community resources were contacted and perceived to be beneficial. Of the 360 patients who received the advocacy intervention, 157 were re-contacted. They found that 96% of participants perceived improved safety following the intervention. Of the 157 who provided feedback, 133 had developed a safety plan and provided information on achievement or failure of each component. Participants completed between 49% and 59% of their safety plan at the various follow-up intervals. The resources reported to be most important for improving safety were (out of 116 who responded to this item): law enforcement (n=38), IPV counselling (n=15), legal help (n=13), battered-women's shelter (n=13), clergy (n=7), victims' services (n=4), crisis intervention (n=4), social services (n=4), mental health (n=1), alcohol and drug rehabilitation (n=1), and vocational services/ employment (n=1). They found no significant correlation between age, income, race or length of the abusive relationship regarding percentage of safety plan completed. At 2 day follow-up, 97 patients had a safety plan and had completed a mean 55% of the plan; at 2 week follow up, 77 patients had a safety plan and had completed a mean 58% of the plan; at 6 weeks follow-up, 51 patients had a safety plan and had completed a mean 59% of the plan; and at 12 weeks follow up, 38 patients had a safety plan and had completed a mean 49% of the plan.

Findings suggest that an ED advocacy programme can improve victim's perception of safety and engagement in safety planning. However, there was a very low rate of follow-up. Only 44% of victims were re-contacted for one follow-up and less than 1% completed all four follow-ups. The authors note various reasons including: inability to contact, incorrect contact information, refusal to follow up and unknown reasons. Other limitations include: lack of a comparison group and, lack of information on measures used (and whether or not these were validated).

Kiely et al., 2011

A US-based RCT by Kiely et al., 2011 [+] examined the efficacy of a psycho-behavioural intervention for reducing IPV recurrence and improving birth outcomes for pregnant and postpartum African-American women. Women who self-identified as belonging to a minority, age 18 and over, English speaking and 28 weeks pregnant or less, were recruited from prenatal clinics in Washington, DC. Women attending 6 community-based prenatal clinics, primarily serving minority women, were screened for all four risk factors using an audio-computer self-report. Women deemed eligible at screening were randomly assigned to intervention or control group. Shortly after initial screening (average of 9 days), women participated in a baseline interview to collect demographic information, reproductive history and behavioural risk data. A total of 1, 044 women participated in the study (intervention=521; control=523). The women who participated were a mean age of 24.5, and the majority were: recruited prior to 22 weeks gestation (63.4%), were single (76%); had at least a high school education (68%), and were receiving Medicaid (79%). Less than a quarter of the women (22%) smoked during pregnancy, with the majority reporting risk of exposure to second-hand-smoke (SHS) (78%); the majority of women reported being depressed (62%); and a proportion of women reported using alcohol (32%) or illicit drugs (17%) during pregnancy. There were no significant differences between the intervention and control groups at baseline.

The integrated cognitive behavioural intervention was aimed at reducing smoking, SHS exposure, depression and IPV during pregnancy. This was delivered during routine visits by trained social workers or psychologists. During each session, the woman noted which of the four risks she was dealing with, and the intervention was then aimed at addressing all identified risks, regardless of which risks were previously reported. The IPV intervention focused on: safety, information on the various types of abuse and the cycle of violence, risk assessment, provision of preventive options and the development of a safety plan. A list of community services and resources was also provided. Intervention components were meant to be delivered over four to eight sessions, for 20-50 minutes per session (to address all individual risks). In addition, two "booster sessions" were provided to reinforce the work done in previous sessions. Participants in the control group

received the standard procedures provided at their respective prenatal care clinic. Follow-up data collection was conducted over the telephone during the second and third trimesters of pregnancy (at 22–26 and 34–38 weeks of gestation) and 8–10 weeks postpartum. IPV was assessed using the Abuse Assessment Screen, a measure developed and validated for use among pregnant women who had reported physical or sexual abuse in the past year. In baseline and follow-up interviews, frequency of physical and sexual assault was measured using the Conflict Tactics Scale.

They found that at baseline, 336 women (32.2%) had experienced IPV in the past year; or these, 169 were in the intervention condition and 167 in the usual care condition. Women experiencing continued IPV during pregnancy/ postpartum (n=94) were significantly different from women reporting no continued cases of IPV (n=212) for: care group (p=0.006), gestational age at baseline (p=0.035), alcohol use during pregnancy (p=0.014), and depression at baseline (p=0.009). After controlling for these variables in the logistic regression, only care group, alcohol use, and depression were significant. Logistic regression for continued IPV at all follow-up interviews (n=94) revealed that women in the intervention were less likely to report recurrent episodes of IPV (adjusted OR 0.48, 95% CI 0.29–0.80). At baseline, alcohol use in pregnancy and depression were associated with chance of recurrent IPV (adjusted OR 1.85, 95% CI 1.09 – 3.12 and adjusted OR 1.90, 95% CI 1.11–3.25, respectively). In the intervention condition, women were less likely to be victimized by their partner at the 2nd and 3rd trimester follow-up interviews, but this was not significant at postpartum. Women in the intervention group reporting minor intimate violence, were significantly less likely to experience additional cases of violence during pregnancy (OR 0.48, 95% CI 0.26–0.86, OR 0.53, 95% CI 0.28–0.99) and postpartum (OR 0.56, 95% CI 0.34–0.93) compared to the usual care group; for women with severe IPV, this was found at postpartum (OR 0.39, 95% CI 0.18–0.82). For birth outcomes, low birth weight (LBW) (less than 2,500 g) was not different in the two groups (intervention: 12.8%, usual care: 18.5%, p .204), although rates of very low birth weight (VLBW) (less than 1,500 g) were lower among women in the intervention group (intervention: 0.8%, usual care: 4.6%, p .052). Preterm birth rates (37 weeks of gestation) were not statistically different in the intervention and control groups (13.0% compared with 19.7%, p=0.135). However, very preterm delivery (less than 33 weeks) was lower in the intervention compared to control group (1.5% compared with 6.6%, P .030). Mean gestational age at delivery was also greater in the intervention than control condition (38.2 weeks compared with 36.9 weeks, p .016).

Findings from this study suggest that a psycho-behavioural intervention for multiple risk reduction among African American pregnant and postpartum women was associated with reductions in some adverse pregnancy outcomes and recurrent risk of IPV. This study also offers valuable contributions in examining, and intervening to address a co-occurrence of risk factors. While the study design was robust, there are several limitations to note. The study was powered to test the efficacy of the intervention for psycho-behavioural risks but not adverse pregnancy outcomes. There was also a high attrition rate; only 59% of participants completed the minimum amount of intervention sessions. This may be reflective of the population- high-risk minority women. Despite this, women who did participate demonstrated reduced risk factors. The authors note that it is possible that addressing additional risk factors which women were experiencing (alcohol and drug use) may have resulted in greater improvements. Another limitation is the lack of information on the usual care condition; the authors note that this differed between sites but do not provide further detail.

As this intervention was tested among African American women presenting with multiple risk factors, findings may not be generalisable to other sub-populations of women. Further research is required to test the intervention among other groups of women, and in other service settings.

Koopman et al., 2005

A US-based RCT by Koopman et al., 2005 [+] examined the impacts of an expressive writing intervention on symptoms of depression, PTSD and pain among women who have experienced

IPV. The study included English speaking women 18 and over, who were victims of IPV but judged as currently being safe from abuse. Women were recruited through fliers and then completed a brief telephone screening to determine eligibility. A total of 47 women were included in the study (intervention n=25, control n=22). Women ranged from 21-56 years old (mean=36.5), and the majority were single (38%), White/ European American (68%), employed full-time (43%) or not employed (36%), had no children (60%), and were heterosexual (83%), had a household income of less than $40, 000, and the median education was completion of high school. On average women had left an abusive partner 5 years prior, and were in the relationship an average of 6.3 years. At baseline, 28% of women in the expressive writing group were married, compared to 9% in the comparison group (p=0.01), and had also completed more years of education (mean=16.8 years, SD=3.0) compared to the control group (mean=14.8 years, SD=1.9).

Eligible women completed a questionnaire on demographics, bodily pain (using the Bodily Pain Scale of the SF-36 Health Survey), depression (the Beck Depression Inventory) and PTSD symptoms (The PTSD Checklist-Specific Version). Each participant was randomly assigned to either the expressive writing intervention, where participants were asked to write about the most stressful event/s of her life, or the neutral writing condition where she wrote about her daily schedule. In the expressive writing group, women were requested to do the following: 'Today I want you to write about the most traumatic experience of your life; really exploring your very deepest emotions and thoughts.' In the neutral writing group, women were asked to write about how they spend their time and were instructed: 'I am not interested in your emotions or opinions. Rather be as objective as possible.' Women were provided with a journal with these instructions and asked to write for 20 minutes for each of 4 weekly sessions, without discussing with the research staff. The writing sessions wee held at either (based on preference): a university, coffee shop or restaurant.

Follow up was conducted at 4-months post intervention and included the same measures as at baseline. At baseline, 40% of all women reported significant pain, 53% reported PTSD symptoms and 40% reported clinical depression. When comparing the expressive writing condition and neutral writing condition, they did not find a significantly greater reduction of symptoms of depression, PTSD or pain. However, women who were more depressed at baseline demonstrated a significantly greater reduction in depression in the expressive writing condition compared to the neutral writing condition (p=0.05, β for the interaction term in the linear regression=-.24).

Findings suggest that expressive writing about traumatic experiences may be particularly helpful in decreasing depressive symptoms in women who are experiencing depression following an experience of IPV. No differences were found between the two groups in regards to PTSD symptoms. Limitations of the study include: the use of a small and non-diverse (predominantly White) sample size, resulting in low statistical power for analysis of findings and limited capacity to generalize to other populations/ settings. Also because the study included only women who had left an abusive relationship, findings may not be applicable to women who continue to be in an abusive relationship, and it is also possible that women experienced gradual improvements in mood/ symptoms related to other previous/ current interventions (psychotherapy, medication, etc.)regardless of the intervention. Further research is required with larger sample of diverse participants, and which collect data on concurrent/ previous interventions to understand potential influence/ interaction with writing therapy.

Laughon et al., 2011

A US-based before and after study by Laughon et al., 2011 [+] examined the feasibility and acceptability of a combined brief nursing intervention (BNI) to prevent sexually transmitted infections (STI) and reduce IPV among rural women in a family planning clinic. A total of 19 English speaking women, age 18 and over, screening positive for IPV in the past year were recruited from two family planning clinics (one woman was subsequently lost to follow-up,

however). Women were primarily White (68%), followed by African American (26%); a mean age of 28 years, and most (72%) had a high school of higher education.

In the intervention, a PhD trained nurse or a doctoral student who was also a nurse practitioner conducted a 10-minute one-on-one educational intervention from the March of Dimes. IPV information was provided in a brochure, women were engaged in danger assessment and consciousness raising, safety planning options were discussed, and women were provided with a list of resources. Sexually transmitted infection (STI) components were also included (information, safe sex options and safety planning). They measured for changes in the Severity of Violence Against women scales for threats, physical violence, and sexual violence; and for safety behaviours (using the Safety Behaviour Checklist) and safer sex strategies (using the STI protective behaviours checklist). Outcomes were measured at baseline and 3-month follow-up.

They found that the frequency and severity of violence decreased at 3-month follow-up; there was a statistically significant decrease in the subscales of physical violence ($p=0.02$; baseline mean score=36.1 (SD 4.6); follow-up mean score=29.2 (SD 4.8)) and threats of violence ($p=0.04$; baseline mean score=34.1 (SD 7.6); follow-up mean score=29.6 (SD 7.0)). They also found that women increased the number of attempted safety behaviours and safer sex strategies, but the difference between baseline and 3 months was not statistically significant.

This small pilot study offers some promising findings regarding the potential for a brief intervention to improve violence related outcomes for women in a prenatal clinic. However, because of the lack of comparison group and small sample size it is not possible to confirm these findings or generalize to other clinical settings where women are also experiencing IPV. Further study of the intervention is required with a more robust study design and larger sample size.

McWhirter, 2006

A US-based non-randomized control trial by McWhirter, 2006 [+] tested a community-based group therapy intervention for women experiencing a life transition who are vulnerable to abuse. A total of 68 women participated in the study; 37 in a group therapy condition and 31 in an alternative therapy condition. Women who had recent experiences with major life transitions (divorce, death, disability, loss of home or job) were selected to participate, due to the increased vulnerability these women face to interpersonal victimization. Women in the group therapy condition were living in a homeless shelter and volunteered to participate in the study, which was offered as part of shelter services. Alternative treatment participants were women enrolled in a non-profit employee mentoring programme for women experiencing a major life transition. In the intervention group, women were a median age of 32 and primarily high school educated (37.8%), and primarily Caucasian (51.4%) followed by Latina (27%) and African American (13.5%). In the comparison group, women were a median age of 51, and were primarily college educated (35.5%), and Caucasian (90.3%).

The intervention involved 90-minute group therapy sessions held weekly for 5 weeks, with 8-11 women per group. Groups were facilitated by a professional counsellor with training in DV and substance abuse, and childcare was provided. The groups were structured on CBT and Gestalt therapy techniques; each session began with a CBT aspect (psycho-education and exploring thoughts and perceptions) followed be a loosely structured Gestalt intervention (group processing). The programme was designed to improve awareness of abuse and to examine the influence of alcohol and drugs and other unhealthy behaviours for coping with abuse. Sessions covered: exploration of personal belief systems, education on forms of abuse, emotional expression, understanding healthy relationships, and developing healthy methods to cope with stress. In the alternative treatment, women were assigned a mentor to work on professional development goals over the phone or email and in monthly face-to-face sessions. Women were also provided other forms of professional development training (resume writing, job skills training, etc.).

Women in the intervention completed a survey during the initial (week one) and final (week five) sessions. Women in alternative treatment were mailed surveys three days prior to weeks one and five; those completed and returned were included in analysis (n=31). Scales used in the survey included: Quality of Social Support Scale, Social Network Size, Self-efficacy (developed by the research team), Family Economic Pressure Scale, and Student Survey of Risk and Protective Factors.

While there were significant differences in demographics between the two groups (the alternative treatment included older, more educated and primarily White women), the author states that no ethnic differences were found as a function of study variables. Both groups demonstrated improvement on the social support, self-efficacy, and financial stress measures. The study found that the comparison group had significantly greater improvement in social support measure, $p<0.05$. The intervention group demonstrated significantly greater improvements in self-efficacy, $p<0.05$. No significant treatment effects were found for financial stress, family conflict, or family bonding.

These findings suggest that integrating group therapy treatment within community-based services may be beneficial for women who are in transition and who are vulnerable to abuse. While the programme is promising in that it integrates often co-occurring issues (abuse with alcohol and substance use), the use of a non-equivalent comparison group presents a significant source of bias and makes it difficult to interpret the effectiveness of the group therapy intervention. Small sample size also limits generalisability to other contexts.

McWhirter et al., 2011

A US-based individual RCT by McWhirter et al., 2011 [+] assessed the clinical effectiveness of two shelter-based group therapy treatments in reducing family violence and improving psychosocial outcomes for women and children exposed to IPV. The study recruited women who had experienced IPV in the past year with children ages 6-12 who had witnessed IPV, from a temporary family shelter. A total of 46 women and 48 children participated in the study. Women who participated were a mean age of 30 years (range of 18-47), primarily White (47%) followed by Latina (20%) and African American (16%); and less than high school (35%), high school (30%) or college educated (35%). The majority of women reported experiencing abuse while growing up, that was: physical (89%), emotional (80%) and/ or financial (89%).

Two community-based therapies were examined: one was emotion-focused and one goal-focused. Both included weekly 60-minute therapy session, held over 5 weeks for women only (with 4-5 participants in each session), with concurrent 45-minute sessions for children, followed by a 60-minute conjoint therapy (with 8-10 participants). Women were randomly allocated to either the emotion-focused (n=22) or goal-focused intervention. The women's emotion-focused intervention applied Gestalt principles within cognitive behavioural psycho-education; the focus was on examining relationships (healthy and unhealthy) and understanding the impact of adaptive and non-adaptive mechanisms in coping with experiences of abuse. The children's emotion-focused intervention focused on expression and emotional awareness through activities and discussion, including topics such as: stress, dealing with family and peer pressures, relationship-building and dealing with conflict. The goal-focused intervention was a cognitive behavioural approach with Motivational Interviewing based on the trans-theoretical model. In the sessions for women, participants were encouraged to choose a goal in relational, personal, or functional domains. Participants were then encouraged to identify barriers, and develop steps for moving towards their goals. The children's goal-focused intervention included art activities and visual aids to select and work towards goals. Both interventions were delivered by two Master's trained therapists and 2 Master's students, who received 15 hours of training over 6 weeks and received ongoing supervision.

Self-report assessment was conducted at baseline and at post-intervention. The following tools were drawn on for the assessment of women: Student Survey of Risk and Protective Factors to

measured family conflict and bonding; Quality of Social Support Scale to measure quality of social support; Centre for Epidemiological Studies Depression Scale to measure depressive symptoms; Generalized Self-Efficacy scale to measure belief in ability to manage adversity; Readiness to Change Confidence Ruler to measure confidence in ability to make change (in this case, to: alcohol use, violence, and therapeutic changes). Therapists were also asked to report their perception of women's readiness to change. Women's alcohol use and self-efficacy for discontinuing alcohol use were also measured. For children, they used a visual emotional barometer, as well as psychosocial measures based on child self-report of peer and family conflict, and self-esteem.

For women, they found significant improvements in both groups ($p<0.05$) for depression, family bonding, self-efficacy, readiness to decrease violence, readiness for therapeutic change, and facilitators' report of readiness to change. There was a significantly greater decrease in family conflict in the goal-focused intervention ($F(1, 44)=28.75$, $p<0.05$, $\eta2=0.40$ (main); $F(1, 44)=4.10$, $p<0.05$, $\eta2=0.09$ (interaction), and greater increase in the quality of social support in the emotion-focused intervention ($F(1, 44)=18.68$, $p<0.05$, $\eta2=0.30$ (main); $F(1, 44)=5.88$, $p<0.05$, $\eta2=0.12$ (interaction)). For children, they found significant improvements in both intervention groups (all $p<0.05$) for: emotional well-being ($F(1,46)=7.00$, $\eta^2=0.13$), peer conflict ($F(1,46)=4.97$, $\eta^2=0.16$), family conflict ($F(1,46)=22.27$, $\eta^2=0.43$), and self-esteem ($F(1,46)=7.87$, $\eta^2=0.24$). They also found that women in the goal-focused group reported a decrease in use of alcohol (mean pre-treatment score for alcohol use out of five=2.03 (SD 0.58), mean post-treatment score=0.55 (SD 0.74), which was not found in the emotion-focused group.

These findings suggest that both emotion-focused and goal-focused therapies have the potential for improving negative outcomes for women and children who have experienced IPV. As well, goal-focused interventions may be useful for women with co-occurring violence and substance use. Women who are isolated may benefit from emotion-focused interventions that improve quality of social support. While the study is relatively robust in design and provides a thorough description of the intervention and measures used, it is possible that women and children's access to and use of other services while living in the shelter influenced findings. Further research is required within other settings, and with a longer period of follow-up to confirm effectiveness.

Miller et al., 2011

A US-based RCT by Miller, 2011 [+] examined the impact of a clinic-based intervention on reducing effects of IPV and reproductive coercion, and encouraging women to leave an abusive partner. The population included English and Spanish-speaking women aged 16-49, attending four family planning clinics in Northern California. Most women (76%) were age 24 or under and self-identified as non-White.

The 4 clinics were randomized into either intervention or control (no further information provided). There were more Latina participants in the intervention group, while the control group included more women who were African American (data not provided). A total of 906 women participated. The control condition received usual care, which entailed responding to 2-violence screening questions, and if positive this was documented and women were provided with a list of services/ resources. The intervention included IPV screening followed by teaching the client about reproductive coercion and multiple forms of IPV and the impact on reproductive health and pregnancy. Participants were taught about harm-reduction behaviours, and clinic staff would contact resources or services. Participants completed modified versions of the Conflict Tactics Scale and Sexual Experiences Survey at 3 time points (not specified) on a laptop computer, listening to the questions through headphones.

For women reporting IPV within the past 3 months, women in the intervention clinics demonstrated a 71% reduction in the odds of pregnancy coercion compared with women in the control clinics (adjusted odds ratio [AOR]=0.29; 95% confidence interval [CI], 0.09-0.91). For

women who did not report IPV within the past 3 months, there were no significant changes in reports of pregnancy coercion. Awareness of IPV services increased in both groups, with no significant differences between them. More women in the intervention group also reported that they stopped dating a partner within the past 3 months because the relationship was unsafe (AOR=1.63; 95% CI, 1.01-2.63).

This pilot study reveals that a brief enhanced screening intervention including skill-building on reproductive health and IPV may improve women's understanding of coercive behaviours and reproductive health effects. However, limitations include a small number of clinics and participants, and limited discussion about the reliability and validity qualities of the two instruments used. Because the article is a brief communication on a pilot study, there are also limited details on study design (including details of the control and intervention samples, method of allocation, follow up time points, etc.).

Morales-Campos et al., 2009

A US-based qualitative study by Morales-Campos et al., 2009 [+] examined participants' experiences of a community based support group for immigrant Hispanic women exposed to gender-based violence. A total of 30 women who were 18 years or older, English or Spanish speaking and seeking assistance for violence or abuse were recruited from support group sessions and flyer postings. Participants were primarily Mexican/ Mexican American (90%); a mean age of 41 years; 50% were married, 20% separated and 20% divorced; 43% were US citizens, 30% residents, and 27% undocumented immigrants. Women had been living in the US for a mean for 37 years. Time spent in the support group ranged from 2 to 96 months.

The support groups were held in a community organization. Approximately 20–25 women attended each support group during a week. A psychologist from Mexico conducted all support groups in Spanish. No other details of the support groups were provided. Data was collected via archival research, oral interviews, and participant observation. Archival research examined included internal documents of the organization and intake records. The primary author examined 5 support group sessions over two months to understand the structure of the groups, participant interactions and issues addressed, and also conducted individual interviews with the 30 study participants. Questions addressed women's experiences of violence and the support groups. These were conducted in the community organization, recorded and transcribed. The research team coded transcripts independently and then met to discuss and reconcile emerging themes, resulting in the development of networks of codes.

They found that the support group provided a sense of community and support to group members by providing a space where women could share their stories. For example, one participant expressed: "They give me emotional support that sometimes you can't even find in your own family." Another woman noted how groups: "… [Stimulated] the new women who come into the group. They can find out how we have progressed and how we can speak with such certainty. It encourages them to one day feel good or better than us." Many women also spoke about how helpful they found the responses and advice of the counsellor and other group members. For example, one woman said: "If someone tells you something, then they are doing it for your good or giving you advice or an idea that you could use….We're a group where we're all united, we're in the same situations, and everything we talk about or tell you is to help you". The women indicated that they had learned coping and stress management skills and improved self-esteem from participating in the groups. One woman noted: "[The support group] has also helped me with my children. First, if we're going to talk, but I'm very upset I've learned that I need to calm down..." Another woman explained: "I learned to better recognize my values as a woman, as a human being. And I learned that there is an enormous potential within each of us and we only need to find a way to reach it and keep it developing". Women also spoke about how they had become less dependent on their partners. As one participant explained: "You have to prepare yourself, to do something for yourself, so as not to depend so much on the husband, because

sometimes they take advantage of this. You have to prepare yourself so that you can depend more on yourself in case something does happen."

Findings suggest that support groups may improve self-esteem, stress management and coping skills, independence and support for immigrant Hispanic women exposed to violence. Key limitations of the study include: the inclusion of both older and newer support group participants at different stages in healing, and lack of information on the intervention or interview protocol. Information on the immigration status of the women attending the support group was not collected, so it cannot be determined whether documented women attended support groups more than undocumented women or vice versa. The sample of women interviewed may not be representative of Hispanic immigrant women in other parts of the country. Due to the small and exploratory nature of the study, findings may not be generalisable.

Poole et al., 2008

A Canadian before and after study by Poole et al., 2008 [+] examined the change in types of stressors and rates of substance use before, and 3 months after, receiving DV shelter services. A total of 74 women entering 13 shelters between October 2002 and June 2003 were included in the study. All shelters included did not refuse access to women using substances. Women were eligible if they self-reported use of at least one substance or more 3 times per week, used multiple substances at least once a month and/ or identified as currently having a problem.

Because women came from 13 different sites, the intervention was not standardized, but in general these shelters offer refuge for up to 6 weeks in duration, and advocacy on a range of health, housing, financial and legal issues. For example, services may include: emotional support, parenting support, information on local resources, referrals, transportation, clothing, and accompaniment to court appointments. Shelters differed in how they addressed substance use concerns, from minimal (providing referrals to services) to more significant interventions including actively discussing substance use with women and offering onsite alcohol and drug treatment counselling. Participants were interviewed at the time of entering the shelter and then again 3 months later. Each interview included questions related to alcohol and other substance use, perceived stress, and types of stressors. The following measures were used: Brief Michigan Alcohol Screening Test, Drinking Motives Questionnaire, Timeline Follow-back calendar (TLFB), Index of Spousal Abuse, Perceived Stress Scale-10 and a non-standardized Stressors Questionnaire.

They found that tobacco use did not change between intake (77%) and follow up (73%) ($p=0.251$). Alcohol use (mean days >3 drinks) decreased significantly from 15.75 to 4.42 ($p=<0.001$). Stimulant use also decreased significantly from 20.19% (mean percent of days of use) at intake to 3.95% at follow-up ($p<0.001$). Non-medical depressant use did not show a significant decrease between intake (18.76% days of use) and follow-up (12.66% days of use) ($p=0.493$). Medical depressants also did not decrease significantly between intake (17.72% days of use) and follow-up (15.22% days of use) ($p=0.345$). Stress levels decreased in all categories from intake to 3-months follow up. Women's stress levels/ concerns reported at intake were as follows: money (82%), partner (73%), housing (65%), mental health (60%), legal issues (62%), physical health (46%), parents (43%), and children (31%). At follow-up, women's reported stressors decreased as follows: partner (35%) ($p <0.001$), housing (22%) ($p=0.012$), mental health (23%) ($p=0.001$), legal issues (20%) ($p=0 .002$), and physical health (12%) ($p=0.021$). No significant decreased was observed for stressors related to: parents (11%), children (8%) and money (16%).

This study is valuable in recognizing the intersections between experiences of violence, substance use, and a range of health, social and economic stressors and the role of the shelter experience in supporting stress reduction in key life areas, and change in use of some substances, regardless of whether specific substance use programming is offered. Limitations of the study include the lack of comparison group, lack of baseline comparison of shelter residents and possible self-selection bias.

Price et al., 2008

A UK based before and after study by Price et al., 2008 [+] examined the outcomes of the first 18 months of the DV Intervention Project (DVIP), which included an integrated women's support service. The programme also included a programmed for perpetrators, the findings of which are reported in that section. Women's support services were provided to women who were the partner of a man in the DVIP programme in the London boroughs of Barking & Dagenham, Newham and Waltham Forest. A total of 98 women with 161 children received services and 23 women attended the group programme during the period of investigation. A total of 47 questionnaires were received over 3, 6, and 18-month follow-up. No demographic details were provided for participants.

The authors note that the women's support service is the focus of the programme. The service is a varied, women-focused ongoing programme of support and safety planning for victims of abuse, while also holding the perpetrator accountable. When a man makes contact with the DVIP, he is required to provide the details of his partner, and regardless of his acceptance into the perpetrator programme, women are contacted via mail with a letter and information package (contact is attempted between 7 and 9 times). Contact is then made and a range of interventions are offered, including: one on one and group programmers, telephone support, and outreach meetings at the children's centre of social work offices. The main aims of the women's support service are: to improve women's safety, to improve women's emotional and mental health, to improve knowledge about DV, to promote realistic expectations about the perpetrator programme, to promote empowerment of women and connect women to other available local services. Women completed a self-report survey (no further details provided) at 3, 6 and 18 months follow up, and caseworkers completed an assessment of women and children's safety and quality of life at 18 months follow-up.

Findings from the caseworker assessment revealed that 88% of referring social workers assessed the women as 'much safer' or 'safer' and 78% of referring social workers assessed the children as 'much safer' or 'safer'. Based on the women's assessment across all three evaluations, 65% of women reported feeling 'safer' or 'much safer,' and 35% said that their safety had not changed. In addition, 69% assessed their children's level of safety as 'safer' or 'much safer,' and 31% said that their child's safety had not changed. The majority of women (93%) reported that their quality of life was 'much improved' or 'improved,' while 7% reported that their quality of life had not changed.

Findings reveal that the majority of women reported improvements in their safety and quality of life and their children's safety; caseworker reports also supported improvements in the majority of women and children's safety. Limitations of the study include lack of information on participant demographics and survey instruments, and the potential for self-report bias. While the study was conducted in the UK, demographic characteristics of participants were not provided and therefore it is difficult to determine wider applicability.

Rasmussen et al., 2008

A US-based non-RCT by Rasmussen et al., 2008 [+] evaluated the effectiveness of motivational interviewing (MI) to enhance outcomes of regular treatment services from shelter counsellors. A convenience sample of 20 women using the services of an urban shelter for a minimum of 48 hours was included. The mean age of participants was 37, and women were primarily Caucasian (45%), although over half of the sample was ethnic minorities: Latina (35%), African American (15%) or Asian American (5%). Women were primarily: married (63.2%), had some high school education (52%), were unemployed (80%), had no bank account (70%), no car (55%), and were receiving public financial assistance (50%). Women reported the following types of abuse: emotional abuse (100%), physical abuse (85%), threats of aggression (70%), sexual abuse (30%), and being threatened with a weapon (10%).

The study involved two conditions: a control group (n=10) who were provided regular treatment services from shelter counsellors before the counsellors were trained in MI; and an experimental group (n=10) who received regular treatment services from counsellors who had been trained in MI. The regular treatment services provided included individual counselling once per week for 4 weeks by trained counsellors, along with assistance from other staff in providing case management and psycho-educational group support. To prevent contamination, the MI intervention was conducted after participants in the control condition had left the shelter. At this point, shelter counsellors, case management and crisis line staff were trained by a certified MI trainer including: stages of change, key concepts of MI, inclusion of cultural sensitivity and MI intervention skills (open ended questioning and complex reflections). This was followed by a 2-day didactic training workshop, involving application of skills via role playing activities. Following completion, the trained counsellors offered additional individual therapy sessions, using their new MI skills within the experimental group. The MI trainer also conducted ongoing follow up consultation and coaching for the 4 months of data collection.

Counsellors' skills prior to MI training were assessed by the MI trainer, using a sample of audio tapes from the control group sessions. Fidelity of the MI intervention was assessed by coding a sample of the sessions and using the Motivational Interviewing Treatment Integrity (MITI) to assess skills. These were found to range from beginner level proficiency on some skills (e.g., making complex reflections) and competency level proficiency for others (e.g., using more reflection). The University of Rhode Island Change Assessment Scale (URICA) was used to measure pre-contemplation, contemplation, action, and maintenance, and the Process of Change in Abused Women Scales investigated ambivalence about the abusive relationship; both were used to measure motivational level at pre-test and post-test follow-up.

There were no group differences in motivational level at pre-test. At post-test, motivational level was significantly different (p=0.029, one-tailed), with 90% (n=9) of the experimental group in the high motivational category. In comparison, only 4 women in the control group were high motivational, a decrease from those identified as high motivational at pre-test (n=5). The experimental group also demonstrated a higher readiness to change at post-test (mean at post-test=11.1, compared to 9.9 for the control). Nine of ten participants in the experimental condition demonstrated either progression from a low to high level of readiness of change, or stayed at a similar level at post-test, and only one participant showed a decrease. Comparatively, 5 participants in the control showed a decrease in readiness to change, and only 5 demonstrated an increase. The sample was too small to perform cluster analyses or t tests, but the Mann-Whitney test of independent means revealed no significant differences between the groups on either tool.

This was a small, pilot study and therefore findings are not generalisable. Further, larger and more robust studies are required to test effectiveness. Other study weaknesses include: use of an English only instrument in a region with many Spanish-speakers, high attrition rate and problems with recruitment which impacted sample size, limited description of the shelter setting, and short period of follow up. While existing services may be improved by addition of MI intervention, further research is required to test this approach and potential for improving women's readiness for behavioural change.

Reed and Enright, 2006

A US- based RCT by Reed and Enright, 2006 [+] examined the effectiveness of Forgiveness Therapy (FT) for improving depression, anxiety and PTSD symptoms in women who had experienced emotional abuse. A total of 20 women were recruited through flyers and newspaper advertisements. Women who were divorced or separated from an abusive partner for a minimum of 2 years were eligible to participate; women who had a history of childhood physical abuse or psychiatric illness were not eligible to participate. Women who participated were a mean age of 44.95; primarily Caucasian (90%); had mixed education levels including: high school (20%), some college (30%), college degree (20%) or postgraduate (30%); the majority were employed full-time

(60%); had between one and four children living with them (70%); and were not in a new relationship (75%). Women reported the following forms of psychological abuse: being criticized (90%), being ridiculed (100%), jealousy and control (75%), being ignored (100%), threats of abandonment (30%), threats of harm (30%), and threat of harm to property or pet (20%). Some women also reported being sexually abused by their partner (30%). Women had been separated from their partner for a mean time of 5 years.

Participants were matched, yoked and then randomly assigned to either the forgiveness therapy (FT) intervention (n=10) or the standard therapeutic procedure (AT) comparison group (n=10). The intervention included 1 hour weekly individual sessions based on the Enright forgiveness process and manualized protocol. Each matched pair received the same amount of treatment regardless of condition; mean time for pairs was 7.95 months (SD 2.61, range 5-12 months). One counsellor delivered both the intervention and comparison treatment. The FT sessions followed the protocol which included discussion of: forgiveness, psychological defences, anger, shame and self-blame, cognitive rehearsal, commitment to forgiving, grieving the pain and losses, reframing the former abusive partner, empathy and compassion, practicing goodwill, finding meaning in unjust suffering, and considering a new purpose in life of helping others. The intervention ended when a woman reported completing forgiveness of her former partner. The AT group was designed (also using a written protocol) to be similar to the basic components of the intervention approach (including anger validation, assertiveness strategies and interpersonal skills). In the AT group, women engaged in 1-hr, weekly participant-initiated discussion of current life concerns (including past abuse, child care, work relationships, etc.), and therapist- facilitated discussions on the validity of anger regarding past abuse, strategies for making healthy life choices, and interpersonal skills. Women in the FT determined time spent on forgiveness topics and participants in the AT determined time spent on participant-initiated concerns.

Measurements were conducted at: pretest, post-test, and 7 month follow-up, using the following tools/ scales: Psychological Abuse Survey; Enright Forgiveness Inventory; Coopersmith Self-Esteem Inventory; State–Trait Anxiety Inventory; Beck Depression Inventory–II; Environmental Mastery Scale (to measure psychological well-being); Reed (1998) Finding Meaning in Suffering (includes questions about moral decisions as a response to suffering and support for decisions); PTSS checklist (to measure post-traumatic stress symptoms); Story measures (one page narrative from women, analysed for old (victim) and new (survivor) stories).

The FT group demonstrated significantly greater increase in: forgiving the former abusive partner, ($t(9)=5.80$, $p < .001$); self-esteem, ($t(9)=2.12$, $p<0.05$); environmental mastery ($t(9)=1.84$, $p<0.05$); finding meaning in suffering ($t(9)=2.34$, $p<0.05$); and in new stories (survivor status), ($t(9)=3.58$, $p<0.01$). The FT group demonstrated a statistically significantly greater decrease in: trait anxiety, ($t(9)=-2.43$, $p<0.05$); depression, ($t(9)=-1.88$, $p<0.05$); posttraumatic stress symptoms, ($t(9)=-2.54$, $p<0.05$); and old stories (victim status), ($t(9)=-5.01$, $p<0.001$). There was no statistically significant difference between FT and AT on state anxiety scores, but there was within-group statistical significance (FT from pretest to post-test): ($t(9)=-2.22$, $p<0.05$).

This study reveals significant improvements in women's symptoms related to emotional abuse following Forgiveness Therapy. While study design was relatively robust and included a longer period of follow up, the study has limited applicability. Participants included women who had a relatively high education and were almost entirely Caucasian. Furthermore, only women who had experienced partner emotional abuse were included. Findings may have limited application, as many women who have experienced abuse have experienced multiple forms of abuse, as well as childhood traumas (also an exclusion criterion). As well, the coding of "story measures" (which was an assessment developed by the lead author) by two raters revealed low IRR scores, which may have influenced findings related to this variable.

Resick et al., 2008

A US-based individual RCT by Resick et al., 2008 [++] examined the impact of components of cognitive processing theory (CPT) on PTSD symptoms for women who have experienced IPV.

Women were recruited from an urban centre through referrals from DV agencies, and through advertisements and flyers. Women who had experienced sexual or physical assault in childhood or adulthood and met criteria for PTSD, and were at least 3 months post trauma were eligible to participate. Women also had to be abstinent from drugs and alcohol for 6 months, and were not eligible if they were illiterate, had current psychosis or suicidal ideation, or were currently in an abusive relationship. A total of 162 women were initially recruited, however 12 dropped out due to a re-occurrence of violence (ITT n=150). Women were a mean age of 35.4 years; mean years of education was 13.8 years; 62% were Caucasian and 34% African American; 41% were on psychotropic medications. A minority of women had experienced only adult assault (6%) or only child sexual abuse (3%); most women had experienced adult physical assault (80.7%), adult sexual assault (80.7%) and child sexual abuse (78%). Nearly half of women had experienced 10 or more incidents of child abuse (47.3%) or 10 or more incidents of adult abuse (46.6%). Half of women reported major depression (MDD) (50%), over half reported DV (60.7%), and less than one-quarter reported panic disorder (20%).

The interventions were delivered by 8 Master's or Doctoral level clinical psychologists; each therapist delivered all 3 interventions. Each condition was individual therapy of the same intensity (all 12 hours total); the CPT and CPT-C involved 60 minutes twice a week, and the WA condition involved 2 hour sessions once a week. Participants were randomly assigned to one of the 3 conditions. The CPT sessions followed the manual developed by the lead author and included: education, writing detailed account of traumatic incident at home, re-reading incidents (to themselves and to the therapist), cognitive therapy with Socratic questioning, rewriting incident, completing worksheets, identifying problematic thought and response patterns, and confronting and challenging/ changing beliefs. The CPT-C condition was identical to the CPT condition except participants did not write-out their traumatic event; this was substituted with CPT (event-thought-emotion) worksheets. The WA condition included only the writing component. Writing of traumatic experiences was conducted by participants during therapy sessions and reading of the accounts occurred at home and during the sessions. Participants were also asked to rate their discomfort levels using the subjective units of distress (SUDS). Therapists did not engage in cognitive therapy with patients; they were only permitted to make supportive comments and occasional educational statements. They could ask the patient to re-write or focus on certain "hotspots" in more detail or request that the patient write about another traumatic event.

At baseline, the CPT group had significantly lower income (less than $20, 000 annually) (79%) compared to the CPT-C (46%) and WA group (42%). Many instruments were used for assessment including: Clinician-Administered PTSD Scale (CAPS), Structured Clinical Interview for DSM–IV Axis I Disorder (SCID), Sexual Abuse Exposure Questionnaire, Physical Punishment Scale of the Assessing Environments-III, and Physical Assault Scale of the Revised Conflict Tactics Scales. Self-report scales included: Beck Depression Inventory, The Experience of Shame Scale, The Personal Beliefs and Reactions Scale, Posttraumatic Diagnostic Scale, State-Trait Anger Expression Inventory, State-Trait Anxiety Inventory, Therapeutic Outcome Questionnaire, and Trauma-Related Guilt Inventory. Interviews and self-report were carried out: weekly during treatment, 2 weeks post-treatment, and 6 months post-treatment. The drop out rates for each condition is as follows: 34% for CPT, 26% for WA, and 22% for CPT-C.

All three treatment groups demonstrated improvements on PTSD and depression. There was no significant difference between treatment groups on total score on the Therapeutic Outcome Questionnaire. There was a significant group effect for PDS ($F(2,183)=4.5$, $p=0.01$) and BDI-II ($F(2,179)=3.1$, $p=0.05$), indicating that overall, the three groups differed. The CPT-C group reported significantly greater improvements on the PDS post-treatment than the WA group, though this difference was no longer there by the time of the 6-month follow-up assessments. For ITT analysis the CAPS score of PTSD decreased 36.1 points on average from baseline ($p<0.001$) for CPT, 31.9 points ($p<0.001$) for WA, and 40.8 points ($p<0.001$) for CPT-C group. On the completer analyses (all p values < .001), the CPT group decreased 37.7 points, the WA group decreased 36.5 points, and the CPT-C decreased 42.1 points. For the SCID, there were no significant differences between groups for major depressive disorder or panic disorder. All groups

decreased their scores significantly on the following measures over the course of the study: anger from the STAXI, state and trait anxiety from the STAI, ESS total, guilt cognitions from the TRGI and PBRS.

Findings suggest that cognitive therapy alone (CPT-C) may be effective for improving PTSD symptoms among women who have experienced IPV. The study was robust, including: validated measures, blinding, a relatively long period of follow up, and both ITT and completer analyses. However, findings may not be applicable to women who experience co-occurring substance use, alcohol use and IPV, because women with these other issues were specifically excluded from the study.

Rychtarik and McGillicuddy, 2005

A US-based cluster-RCT by Rychtarik and McGillicuddy, 2005 [++] examined the effectiveness of two interventions (coping skills training and 12-step facilitation) on levels of depression in the spouse or partner of men with problem drinking, partner drinking and partner physical violence. Women were recruited through media advertisements recruiting women who were experiencing stress from partner drinking. To be eligible, women had to be living with their partner, married or cohabitating for a minimum of 1 year, have no substance use disorder (based on the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST)); and could not be involved in a treatment programme for their partner's drinking in the past 3 months. A total of 171 women participated. Women were a mean age of 42.6, with a mean education of 13.44 years, and were predominantly White (84%) and employed (85%). Almost half of women (47%) reported physical violence in the past year and over half (59%) reported being violent to their partner.

Each consecutive set of 4-6 participants were randomized into cohorts. Counsellors trained in alcoholism and rehabilitation delivered interventions. Both interventions were manualized, 8 weeks in length and were in a group format. The Coping Skills training (CST) intervention (n=55) included: the stress and coping model and education on the relationship between thoughts, feelings and behaviours, and an introduction to problem-solving. The twelve step training (TST) sessions (n=58) included Al-Anon Steps, focusing on education on enabling behaviours and detachment and codependency relapse. All sessions were videotaped and reviewed by a supervisor to ensure proper delivery. A delayed treatment group (n=58) was used as a control group and then randomized into the treatment condition. At baseline, participants in CST had significantly ($p<0.01$) less months of employment in the past 3 years; there were no significant differences for other demographic characteristics and symptom scores.

Follow up was conducted at post-treatment assessment, telephone assessments at 3 and 9 months post-treatment, and in-person interviews at 6 and 12 months post-treatment. The outcome of interest to our review, the effect of treatment on partner violence (a secondary outcome in the study), was measured at 6 and 12 months using the Conflict Tactics Scale Physical Violence subscale; 73% of women completed all assessments. At follow-up, in the CST condition, 21.19% (SD 0.88) reported physical violence; in the TST condition, 31.16% (SD 2.17) reported physical violence ($p<0.05$). Partner violence in the CST condition declined significantly from 50% violence at baseline to 37% ($p<0.05$, proportion of variance (PV)=0.14). The TST condition demonstrated a non-significant increase from 44% to 51%. For those women who reported experiencing violence pre-treatment, the rate of violence at follow up was 63% in the CST condition and 85% in the TST condition.

Findings suggest that a coping skills treatment for women, who have partners with a substance use problem, may reduce partner violence. Limitations of the study include reliance on self-report and women's report of partner behaviour. Yet the study was robust, included blinding, and assessed treatment fidelity. The sample was mostly White and educated and therefore findings may not be generalisable to other sub-populations of women, or to women experiencing substance use problems (as these women were excluded from this study).

Sanders et al., 2007

This US based study used a quasi-experimental design [+] to test the effectiveness of economic education with a small sample of battered women in shelters in a large US city. The theoretical framework was that skills could be built and empowerment could be enhanced through economic education, as had been shown with other groups such as low-income people. Testing this assumption with battered women was the goal of this intervention. The framing of the intervention was grounded in a strong gender analysis, pointing out that women have economic disadvantages in general, compared to men, and that battered women were particularly affected by such issues as poverty, loss of credit and restricted access to money.

The intervention was called REAP (Realizing your Economic Action Plan) and had four main components. These components added up to 12 hours of curriculum and included “money and power”, “developing a cost-of-living plan”, “building and repairing credit” and “banking and investing”. These components were delivered in both individual and group formats over a period of two weeks while the women were living in the shelter. Improvements of basic skills such as budgeting, and paying off debt were considered successful outcomes. The entire curriculum was delivered in the context of understanding economic abuse as a component of DV, and in the context of understanding oppression.

The sample included two groups of battered women to whom the curriculum was delivered over a two-week period. Two other groups of battered women, residing in different but similar shelters, were the comparison group. Both groups of women were pretested before the intervention was introduced. On the protests, there were few differences between the two groups: they were similar on demographic characteristics and similar in abuse histories. However there was a difference in length of time with current partner, with the experimental group averaging 7 years with partner, and the comparison group 4 years. Hence, length of time with partner was controlled for in the analysis of the outcome measures.

The outcome measures were financial literacy (factual knowledge regarding financial issues) and financial efficacy (the sense of ones’ ability to make financial decisions). The two groups (experimental and control) were equivalent before the intervention on these two measures in a pre test. The findings were that for financial literacy outcome, the intervention group had a greater increase than the control group ($p<0.05$), but this was not significant when controlled for length of relationship. For the financial self-efficacy outcome, the intervention group had significantly improved scores, ($p<0.05$), which remained when controlled for length of relationship.

Controlling for differences in the length of time with the partner was found to be a significant predictor of change in the financial knowledge score. That is, the longer a woman had been with her abuser, the more her financial literacy score improved after the intervention. The authors suggest that the curriculum held more relevance for women in longer term abusive relationships, as they had likely experienced more negative economic effects.

There were several shortcomings to this study. The sample size was small (n=67) and the attrition rate was high at 43%. The women more likely to leave the programme were those experiencing the most sexual coercion and exploitation. The follow up period was short at two weeks, and occurred only once. Outcomes focused on self-reported belief and attitudinal changes and not changes in actual financial behaviours. The authors note that although their measures had good internal validity, the overall results are not generalisable. Nonetheless, they conclude that the link between economic literacy and empowerment for battered women needs more attention, more intervention and more study.

Sullivan et al., 2002

A US-based individual RCT by Sullivan et al., 2002 [++] examined the effectiveness of an advocacy and child education programme for improving the self-esteem of children and the psychological well-being of mothers in families who have experienced DV. Women with at least

one child (age 7-11) living with them who had experienced DV in the past 4 months were recruited from DV and social services agencies. A total of 80 mothers and their children (if more than one child, only one child randomly selected for data collection) participated. Women were a mean age of 31 years; 49% White and 39% African American; were primarily low income, receiving income assistance (88%); and nearly half (44%) were employed. The mean age of the children was 8.3 years, and 55% were female.

Women were randomly assigned to either the intervention or control group. 78 mother completed at least one post-intervention interview and were included in the analysis (intervention n=45; control n=33). Women in the intervention received 16 weeks of free services by a trained paraprofessional advocate. Advocacy was provided via home visitation twice per week (an average of 8.95 hours per week) with five phases: assessment, implementation, monitoring, secondary implementation, and termination. Forms of assistance provided for mothers included: housing, employment, education, transportation, child care, social support, and/ or material goods. For children, forms of assistance included: recreational activities, help with school, and/ or obtaining material goods. The intervention also included a 10 week group programme for children, delivered by ethnically diverse group leaders, that provided education on safety, emotional expression, and respect for themselves and others, and physical activities.

Measures of abuse against women included: Index of Psychological Abuse, Conflicts Tactics Scale (CTS), and an injury assessment that were combined to provide an overall index. Children's measures were conducted via mother's reports of emotional abuse, CTS, and injury inventory, and number of incidents of witnessing abuse; these were also combined into an overall index. Mothers' psychological well-being was measured using: Andrews and Withey quality of life scale, social support scale, Centre for Epidemiological Studies–Depression Scale (CES-D), and the Rosenberg Self-Esteem Inventory. Children's self-esteem was measured using the Self-Perception Profile for Children. Assessment interviews were conducted by advocates (typically in the woman's home) at baseline, post-intervention, and 4-months post-intervention.

Improvement in mother's well-being over time in the intervention group was described as a moderate difference, although not statistically significant ($F(10, 63)=1.81$, $p<0.08$). Mothers receiving the advocacy intervention reported significantly higher levels self-esteem and lower levels of depression than women in the control group (both p values <.05), and also higher quality of life, although this difference was not statistically significant. There was a significant improvement in children's well-being over time in the intervention group ($F(16, 57)=2.30$, $p <.01$). At 4-month follow-up children in the advocacy intervention were also less likely to be contacted by the abuser (11.1% in intervention compared to 27.3% in control), (one-tailed $\chi^2=0.04$). Children in the intervention reported significant improvements in global self-worth, self-confidence, physical appearance, and athletic subscales (all $p<0.05$).

Findings suggest that an advocacy programme for mothers and education programme for children may improve women's self-esteem and lower depression, and improve children's well-being. The study design was robust and the retention rate of participants was high. Limitations include the use of a small sample, limited information on randomization method and the children's education component and relatively short period of follow-up.

Sullivan et al., 2004

A US-based before and after study by Sullivan et al., 2004 [+] examined the effectiveness of a mother-child dyad cognitive behavioural intervention to improve mental health and reduce self-blame for mothers and children who have experienced IPV. The study included abused women with children seeking help for DV (demographic characteristics not provided). A total of 79 children and 46 mothers participated in the study.

The intervention was 9-weeks in length, held with mothers and children (concurrently and conjointly) using cognitive behavioural and systematic intervention and safety planning

approaches. The focus of the conjoint groups was to: learn about safety planning, work toward trauma resolution, reduce self-blame, and gain conflict resolution skills. The concurrent mothers' group focused on safety planning, parenting skills and social support from other group participants. Following concurrent mother and child sessions, families were brought back together to encourage communication and sharing of experiences from the groups.

Follow-up was conducted at intake and at the end of the group intervention with all mothers and children. Measures for mothers' outcomes included the Child Behaviour Checklist: Parent Report Version (CBCL) and Parenting Stress Index. Pre- to post-test analysis of CBCL scores found that only 3 of the 14 measures were significantly reduced. This included children's: anxious or depressive behaviours, ($t(76)=1.99$, $p=0.05$); internalizing behaviours, ($t(76)=2.41$, $p=0.02$); and externalizing behaviours, ($t(76)=1.95$, $p=0.05$). For the PSI scale, three significant differences in scores were found for mothers: isolation, life stress, and health significantly improved at post-test ($p<0.05$). Outcomes for children are provided in the Q4 report on children exposed to DV.

These findings suggest that a group intervention for mothers and children is effective in improving women's trauma symptoms. However, there are limitations to this study including: limited description of methods, small sample size, lack of comparison group, and analysis was limited only to women who completed the group. A more robust study design is required to test findings.

Taft et al., 2011

An Australian cluster-RCT by Taft et al., 2011 [++] examined the effectiveness of non-professional mentor support for reducing IPV and depression among pregnant and postpartum women who have experienced, or are at risk of experiencing IPV.

A total of 24 general practices and 8 maternal and child health teams in Melbourne were recruited; 4 of the general practices were Vietnamese. Pregnant women, or women with a child age 5 or younger, who were age 16 and over and who disclosed IPV or reported psychosocial distress suggesting abuse were eligible to participate. Women with a serious mental illness who were not taking medication, or who could not read and write English or Vietnamese were excluded. A total of 215 women (out of 258 referred women) were found to be eligible, of these women, 174 agreed to participate in the study. The sample demographics (for the 133 women who completed the study) for Intervention (I) and control (C) were: mean age of 32 (I), 32.4 (C); most women were married 32% (I), 26% (C); most women had 2 or more children 54% (I), 46% (C); most women had a healthcare card, indicative of lower income 74% (I), 70% (C); most women were on pension/ welfare: 62% (I), 53% (C); and around one-third of women were born overseas: 36% (I), 32% (C). The majority of women were experiencing IPV (as indicated by a CAS score): 79% (I), 74% (C), and depression 70% (I), 58% (C). Just over 20% of participants were lost to follow-up; participants experiencing the most severe IPV were more likely to be lost to follow-up.

Clinics were randomized by number of participating GPs (GP clinics) or by team (maternal and child health clinics) to either intervention or control. A total of 113 women participated in the intervention condition and 61 in the control condition. Participating clinics referred eligible women to the study. The intervention involved mentorship from non-professionals providing befriending, advocacy, parenting support and referrals. Meetings with mentors were provided in women's home or 'elsewhere' (not specified). Mentors were recruited via advertisements in local newspapers, schools and radio (Vietnamese). Potential mentors applied, were interviewed, provided references, and completed a police check. Training for mentors was 5 days in length and included skills related to: DV advocacy, befriending, working with depression, parenting support, safety and self-care. Mentors were also provided with ongoing training and support. Of the women who participated, 58% met with their mentor weekly, 18% fortnightly, and 20% reported no regular pattern. Participants reported being offered information most often about legal, self-care and parenting services. Women in the control condition received clinician care only, with

no mentoring component. A total of 6 hours of IPV training was provided for all clinicians in both intervention and control arms, to improve their capacity to identify, respond to and refer women at risk for or experiencing IPV.

Outcomes were measured at baseline and at 12-months follow-up. IPV was measured using the Composite Abuse Scale (CAS), a validated measure and maternal depression was assessed using the Edinburgh Postnatal Depression Scale (EPDS). Other outcomes measured included: general health and well-being using the SF-36; parenting stress and attachment, using the attachment sub-scale of the Parenting Stress Index Short form (PSI-SF); and social support using the Medical Outcomes Scale Short Form (MOS-SF). Women's use of, and satisfaction with, primary care services was also measured, and a process evaluation and economic cost-consequences analysis was also conducted.

They found that for IPV, as indicated by CAS scores, the adjusted difference in total CAS score from baseline was greater in the intervention arm (Adj Diff=-8.67, 95%CI -16.2 to -1.15, p=0.03), but the evidence for this difference was weaker after propensity score (PS) adjustment (Adj Diff=-8.75, 95%CI -18.2 to 0.70, p=0.07). The odds of experiencing violence at follow-up, adjusted for baseline abuse were 0.47 (95%CI 0.21-1.05), or 0.58 (95%CI 0.21, 1.58) after PS adjustment. For maternal depression, the difference in mean depression scores in the intervention arm was -1.90 (95%CI -4.12, 0.32, p=0.09), or -1.92 (95%CI -4.25, 0.41, p=0.11) after PS adjustment. Odds ratios for experiencing depression were 0.42 (CI 0.17, 1.06, p=0.07), or 0.72 (CI 0.24, 2.13, p=0.5) after PS adjustment. Mental health mean score was Adj diff=2.26 (CI -1.48, 6.00, p=0.2) or 3.42 (CI -0.52, 7.37, p=0.09) after PS adjustment. Physical health mean score was Adj diff=2.79 (CI --0.40, 5.99, p=0.09) or 2.14 (CI -2.07, 6.36, p=0.3) after PS adjustment. Parental distress (%) was OR=0.6 (CI 0.32, 1.49, p=0.3) or 0.82 (CI 0.34, 2.01, p=0.7) after PS adjustment. Parent-child dysfunctional interaction (%) was OR=1.0 (CI 0.44, 2.71, p=0.8) or 1.16 (CI 0.88, 3.49, p=0.8) after PS adjustment. Total parenting stress (%) was OR=1.0 (CI 0.45, 1.49, p=0.9) or 0.86 (CI 0.32, 2.33, p=0.8) after PS adjustment. Social support mean scores were Adj diff=-0.21 (CI -0.82, 0.40, p=0.5) or -0.29 (CI -0.91, 0.34, p=0.4) after PS adjustment. They also found that 32% of intervention participants had taken up or returned to training/ education, compared to 16% of control participants (OR=2.4, CI 1.08-5.02).

Findings suggest that non-professional mentor support be associated with modest improvements in pregnant women or mothers' safety and physical and mental wellbeing following IPV or risk of IPV. Study design was robust, yet the authors note that there were fewer referrals to the study than anticipated, particularly for the control condition, decreasing the power of the study. Other limitations mentioned by the authors were reliance on self-report measures, and no follow-up beyond the 12 month period. However, one-year follow-up is relatively long compared to other studies covered by this review.

Zlotnick et al., 2011

A US-based randomized control trial by Zlotnick et al, 2011 [+] examined the feasibility, acceptability and effects of an interpersonal psychotherapy intervention with low-income, pregnant women with IPV, in reducing PTSD and depressive symptoms both during pregnancy and in the postpartum period.

Pregnant women, age 18-40 years who attended a prenatal care visit, were recruited from two primary care clinics and one private OBGYN clinic in Rhode Island. Women who screened positive for past year IPV on the Revised Conflict Tactic Scale (CTS2) were invited to participate in the study. Women with current affective disorders, PTSD, substance use were referred to treatment and excluded from the study. From an initial 1633 women approached, the final sample was 54 pregnant women. Participants were a mean age of 23.8 years, 42.6% were Hispanic, 44.4% were single, 57.4% had a high school education; all met the low income threshold for their household and it was a first pregnancy for 42%. Participants reported on average 35.9 acts of physical, sexual, and/ or psychological abuse in the past year (intervention group, M=33.4;

control group, M=38.7; p=0.57). In terms of severity of abuse, 38 (70.4%) participants reported at least one act of severe abuse in the past year with the majority of severe abuse being acts of psychological abuse (average of 4.7 severe psychological acts; 2.4 severe physical and 0.6 severe sexual).

The randomized allocation schedule was generated by computer. Twenty eight women received the intervention, and the control group of 26 received standard medical care for pregnant women at their clinic, as well as educational material and listing of resources for IPV. The Revised Conflict Tactic Scale (CTS2), the Longitudinal Interval Follow-up Examination (LIFE), The Edinburgh Postnatal Depression Scale (EPDS), The Davidson Trauma Scale and the Criterion A from the PTSD module of the SCID-NP were used to measure abuse for each relationship within the past year, depression, and PTSD. These tests were administered at intake, 5–6 weeks after intake, 2 weeks after delivery, and 3-month postpartum. All analyses were conducted on the intent-to-treat sample. Primary analyses we assessed for a major depressive disorder and PTSD using repeated-measures analysis of variance. In secondary analyses the presence of childhood sexual trauma was controlled for.

The Interpersonal Psychotherapy (IPT) based intervention involved four 60-min individual sessions over a 4-week period before delivery and one 60-min individual “booster” session within 2 weeks of delivery. The intervention was designed to: facilitate improvements in relationships, shift expectations regarding relationships, assist participants in developing, or enhancing their social support networks, and facilitate mastery in their role transition to motherhood. The first session covered programme rationale, and education on healthy relationships, forms of relational disputes, and abuse. Session 2 addressed: stress management, consequences of and cycles of abuse, and developing a safety plan. Session 3 covered the emotional consequences of abuse, postpartum depression, PTSD and substance use, and transitioning in the role to motherhood. Session 4 addressed: developing a support system, methods of asking for support, resolving relational conflicts, and creating goals. The last session included review and reinforcement of previous session content and discussion of issues associated with the birth of the infant.

The intervention did not significantly reduce the likelihood of a major depressive episode, PTSD, or IPV during pregnancy or up to 3-month postpartum. However, it found moderate effects for the intervention in reducing symptoms of PTSD ($F(1, 44)=7.50$, $p=0.009$) and depression ($F(1, 34)=4.07$, $p=0.05$) during pregnancy. When the presence of childhood sexual trauma was controlled for, they found a larger overall effect size for PTSD symptom reduction, ($F(1, 42)=5.67$, $p=0.022$), increasing the intervention effect size from $d=0.59$ to $d=0.69$. The authors note that the women in this study had experienced severe abuse, and as such a relatively brief intervention such as this may be account for its limited effect. They suggest that additional sessions during pregnancy and an additional session in the postpartum period may have may have assisted with building trust and strengthened the effect of the intervention.

There are a number of limitations to the study related to recruitment and sample size. For example, it is unknown if participants in the study were representative of women with IPV as the study did not recruit women whose partners were present and 54% of women approached to be in the study denied any IPV or refused to participate. Overall the study is underpowered. However, the authors see that the findings of moderate effects for in reducing symptoms of PTSD and depression during pregnancy, and a large effect for PTSD symptoms from pregnancy up to 3 months postpartum suggest that the intervention may be efficacious with a larger trial. The study authors see the study’s strength as being the first study to examine whether an intervention with low-income pregnant women with recent IPV reduces the risk of postpartum depression and PTSD.

Interventions for Perpetrators of Domestic Violence

Alexander et al., 2010

A US-based individual RCT by Alexander et al., 2011 [+] compared the efficacy of a stages-of-change motivational interviewing (SOCMI) group intervention with a cognitive behavioural therapy gender re-education (CBTGR) group intervention on IPV, including whether efficacy varied depending on the batterer's readiness to change. The sample included English and Spanish speaking male batterers referred to the Maryland Abused Persons Programme. Men with previous substance use were required to have 1 month of sobriety before beginning group treatment. A total of 528 participants were included. Groups were language specific and randomly assigned: SOCMI (Intervention) n=247 (200 English, 47 Spanish); CBTGR (Comparison) n=281 (175 English, 106 Spanish).

Sample characteristics are provided for each of these groups: English speaking men in each of the CBTGR and SOCMI groups, and Spanish speaking men in each of the CBTGR and SOCMI groups (specific details for each in evidence tables). Overall, men were a mean age of 31.4 to 36.6 years; mean education ranged from 8.2-13 years; less than one-third of Spanish participants were employed, compared to nearly half of English speaking participants; English speakers were primarily African American or White, while Spanish speakers were primarily Latino; nearly all participants were court mandated; the majority had children; the mean age of the victim was 28.6 to 34.2 years, and the mean education of victims was 9.4 to 13.7 years. Spanish-speakers reported perpetrating less psychological and physical violence against their partners, but were more likely to have discrepant reports when compared to their partner’s reports of lifetime physical aggression.

Both intervention and comparison were 26-week group sessions for male batterers led by masters-level mental health professionals, with 10-12 men per group. In the SOCMI intervention, the first 14 sessions were targeted to men in the pre-contemplation and contemplation stages of change and the last 12 sessions focused on behavioural change processes. The SOCMI relied on motivational interviewing principles (e.g. focusing on men's values and motivations, making reflective statements). The comparison was the CBTGR treatment, which used behavioural techniques (e.g. time out strategies, anger journals), and addressed minimization and denial of IPV by working with clients to acknowledge their use of abuse, and facilitated a discussion of pros and cons of abuse. Due to issues with scheduling groups, there were more Spanish-speaking comparison groups (10 groups with a total of 106 men) than Spanish-speaking intervention groups (4 groups with a total of 47 men).

Outcome measures used included: The Conflict Tactics Scales-Revised (CTS2) to assess batterers' self-reported psychological aggression and physical assault towards partners; and The University of Rhode Island Change Assessment (URICA) to assess stage of (readiness for) change regarding violence against one's partner. Victims also completed the CTS2 and the Danger Assessment Scale (DAS). Batterers completed outcome measures at intake and post-treatment. Partners of batterers were followed up at 6- and 12-months post-intake. Only men who completed at least one session were included in the analyses. There was no significant effect of treatment condition on attendance. A total of 91 victims had usable follow-up data; whether or not a partner had been contacted for follow-up did not differ based on treatment completion, treatment type, or language spoken.

They compared English-speaking groups to Spanish-speaking groups. Language spoken neither predicted outcome nor interacted with treatment. Victim-reported physical aggression scores for the SOCMI group decreased over time between group entry and follow-up (p-value for relevant beta coefficient<0.05), but there were no significant changes in self-reported physical aggression. There were no significant changes in self-reported or victim reported psychological aggression. For victim-reported physical aggression, men who were initially less ready to change benefited more from the SOCMI approach while men who were more ready to change benefited more from

the CBTGR approach (treatment and treatment/ readiness-to-change beta coefficients both had p<0.05). Neither treatment type, language spoken, nor their interaction predicted change in URICA from intake to post-treatment.

Findings suggest that stages of change MI approach may improve victim reported physical aggression, and that tailoring interventions to men's readiness to change may be beneficial. Limitations include the low rate of follow-up with victims (<25%), lack of information provided on randomization methods, the low number of therapists who regularly audio-taped their sessions, and the uneven number of intervention vs. comparison groups among the Spanish-speaking participants. Findings may be applicable to ethnically diverse, court-mandated perpetrators of physical violence.

Bowen et al., 2008

A UK-based before and after study by Bowen et al., 2008 [+] examined the impact of the DV Perpetrator Programme (DVPP), a psycho-educational treatment programme for batterers, on psychological change (including measures of: (pro-domestic-violence attitudes, anger, locus of control, interpersonal dependency) post-treatment, and the association with post-treatment re-offending within an 11-month follow-up period. The study included male DV offenders in the West Midlands, UK sentenced to attend the DVPP. To assess clinically significant change, a non-offender comparison group was selected, comprised of members of staff at West Midlands Probation Service. Non-offenders had to be male, heterosexual, 20-59 years old, and currently in a relationship to participate in the study. There were a total of 84 participants (offenders n=52; non-offenders n=32). Offenders were a mean age 35 years, with an average of 1.6 children, had left school at a mean age of 15.9 years, and were primarily: White British (84%); with previous convictions (78%), employed (55%), had a history of alcohol abuse (59%). Non-offenders were a mean age of 40.2 years, with an average of 1.4 children, had left school at a mean age of 17 years, were primarily: White British (97%), very few had previous convictions (6%), all were employed (100%), and few had a history of alcohol abuse (19%).

The Domestic Violence Perpetrator Programme (DVPP) is a pro-feminist psycho-educational treatment programme consisting of 5 modules delivered over 24 sessions (2-2.5 hours long) offered once or twice per week, along with 5 monthly follow-up sessions of 2.5 hours. The 5 modules examined the nature of DV, male socialization, victim empathy, sexual respect within relationships, and accountability. Sessions were offered during the day for unemployed offenders and during the evening for employed offenders. Groups were scheduled quarterly and operated on a cohort basis so that the same group of offenders participated in the whole programme.

Measures included: The Sympathy for Battered Women Scale (alpha=0.86) of the Inventory of Beliefs About Wife Beating (IBWB) to assess attitudes toward DV; the Novaco Anger Scale (NAS) to measure levels of anger; the Emotional Reliance Upon Others subscale of The Interpersonal Dependency Inventory to measure interpersonal dependency; the Multidimensional Locus of Control scale to measure the extent that offenders felt in control of their lives and the extent to which they perceived chance and powerful other people as influencing their life events; and the Balanced Inventory of Desirable Responding (BIDR) to measure two components of desirable responding: self-deception and impression management. Police records were used to provide re-offending data. Follow-up was conducted at 11-months post-treatment. Only those with complete data were included in the study.

Limited significant psychological change was found for programme completers; changes were found for sympathy for battered women and locus of control (p's<0.05), but these were not found following adjustment for social desirability. Results for *clinically* significant change varied by individuals: 27% did not achieve reliable change across measures, 27% had pre- and post-treatment scores within the range of the normal population, 17% achieved clinically significant change, and 5% went from "functional" to "dysfunctional" scores. The level of clinically significant psychological change achieved had no association with re-offending (all tests non-significant).

Findings reveal that the psycho-educational treatment programme resulted in limited psychological change that was not associated with re-offense. Limitations noted by the authors include the potential for some outcome measures (e.g. re-offences via police records) to under- or over-estimate true outcomes, relatively short period of follow-up (should have been minimum 12 months), and the potential for bias in using questionnaires to detect psychological change. As well, only a subset of referred men was included in the study (43% of those referred), and the non-offender group may not be comparable to the offender group as they differed in significant ways (in offender status, as well as in: employment, alcohol use, and previous convictions). No information was provided on what 'completion' entails despite the completion rate being low (<50%). The sample was primarily White British and therefore may not be applicable to other ethnic groups of men.

Carney et al., 2006

A US-based before and after study by Carney et al., 2006 [+] evaluated a cognitive behavioural group intervention programme for female batterers involuntarily placed in treatment, and also examined differences in effectiveness between African American and White batterers. The intervention was conducted in a non-profit domestic abuse centre. The study included a total of 59 women who completed the treatment programme, excluding non-completers, non-completers and women who scored high on the BIDR Impression Management subscale (n=4) (noting that their desire to give a favourable impression may impact accuracy). Women who participated: were a mean age of 32.7 years; African American (51%) or White (49%); married (42%); had a mean education of 12.8 years, and a mean monthly income of $1, 412; had been arrested prior to the programme (81%); used alcohol at some time (93%); had been in their current relationship for a mean length of 71.2 months; and were still involved with the victim (69%). African American women in this sample were (all p's<0.05): less likely to be currently involved with the victim, less likely to report alcohol or "other" drug use at one time, and on average had more children.

The intervention programme is a feminist informed 16- week cognitive-behavioural programme that was originally designed for male batterers. The focus of the programme is on anger management and skills development, delivered in three phases: orientation and intake (2 sessions), psycho-educational classes (12 sessions), and group therapy regarding termination (2 sessions). Groups included approximately 15 batterers who participated in a weekly 2 hour session. The psycho-educational programme included 3 sessions on recognizing and overcoming defence mechanisms, 3 sessions focused on challenging the batterers' beliefs and values that encourage violent behaviour, and the final 6 sessions to help clients improve interpersonal skills and develop alternative, positive behaviours. All 59 women went through the full programme, and the outcomes for White vs. African American participants were compared. Assessment included: The Spouse-Specific Assertiveness Scale (SSAS) to measure assertive vs. passive/ aggressive behaviours towards partner; The Control of Partner Scale (CPS) to measure controlling behaviour; and The Propensity for Abusiveness Scale (PAS) to measure participants' likelihood of using physical force on their partner.

Scores on SSAS passive/ aggressive subscale were found to decrease from pre- to post-treatment (t=3.64, p=0.001, effect size d=0.44), revealing that the sample was less passive-aggressive after treatment. Scores on the CPS decreased between pre- and post-treatment (t=2.30, p=0.025, d=0.30), revealing a reduction in controlling behaviour. Scores on the PAS also decreased pre- to post-treatment (t=2.49, p=0.013, d=0.23) revealing that the sample was less likely to use physical force on their partner following treatment. There were no significant differences from pre- to post-treatment between African American and White participants. For the logistic regression analysis, only the change in score from pre- to post-treatment for spouse-specific assertiveness behaviour significantly contributed to the prediction of racial group membership (Wald chi-square=5.168, df=1, p=0.023).

Findings suggest that the court-mandated cognitive behavioural intervention resulted in improvements in psychological variables, with similar effects for African American and White participants. There are several limitations, including: lack of a comparison group, potential selection bias, and small sample size. The authors also note that while the measures they used were validated, there has been little research on the application of these measures to female batterers or ethnic minorities. Findings may have limited applicability due to the sampling of court-mandated women from a predominantly rural, southern state.

Connors et al., 2011

A Canadian before and after study by Connors et al., 2011 [+] evaluated the effectiveness of an IPV prevention programme for incarcerated male perpetrators. The setting was minimum, medium, and maximum security institutions, as well as within the community for offenders on various forms of release. The study included 298 federally incarcerated male offenders in Canada screened into the programme based on their level of estimated risk for DV (those in the moderate range on the Spousal Assault Risk Assessment) and with at least one prior incident of abuse against an intimate partner (through official documents, a conviction, or self report). Participants were: a mean age of 36.6 years; primarily White (61%) or Aboriginal (22%); primarily married (72%) and had children (81%). Self-reported number of assaults were as follows: never (10%); one assault (34%); two assaults (24%); three assaults (9%); four assaults (4%); five to ten (11%); ten to twenty (2%) or twenty or more (1%).

The programme involved 29, 3 hour sessions (with 12 participants per group), primarily group-delivered but including a minimum of three individual counselling sessions, led by two trained facilitators. Six modules were covered using adult learning and cognitive behavioural principles, including: motivational enhancement, awareness and education (incorporates components of the Duluth Model), managing abuse-related thoughts and emotions (identifying, disputing and replacing cognitive distortions), social skills, relapse prevention, and healthy relationships. The programme included role playing, skill-building exercises, autobiography, identifying offence pathways and high risk situations, and relapse prevention planning. Following each session, participants completed a quiz to test knowledge of the material taught, and remedial sessions are provided to participants as needed. Programme completion required attendance of all sessions, completion of all assignments and a preparation of a relapse prevention plan.

Batterer assessment included: the Interpersonal Relationship Scale (IRS) to assess jealousy; The Aggression Questionnaire-Revised (AQ-R) to measure various aspects of anger; and The Abusive Relationship Inventory (ARI) (to measure rationales for hitting, need for control, legal entitlement, and batterer's myths) pre- and post- programme (within 10 days of completion). Facilitator also completed 14 Facilitator Structured Ratings (FSR) to measure programme treatment targets (14 targets related to violence against a partner, motivation to change, overall participation, and overall programme performance) at early-, mid-, and post-programme. Domestic violence vignettes (DVV) were also used to evaluate participant reactions to potential risk situations related to family violence. Offender's self-rated readiness to change (OSRC) was assessed pre- and post-programme. Participants were classified into "ready" and "not ready" to change groups based on participant and facilitator ratings at the end of the programme.

There were significant (all p's<0.001) improvements between pre- and post-programme in the self-report questionnaires (IRS, AQ-R, and ARI), all FSR's, and the DVVs. Mean changes in readiness to change were in the positive direction from pre- to post on both self-report and facilitator ratings (p<0.001 for both). There was significantly greater pre-post change (p's<0.05) among those rated as "ready to change" vs. "not ready" for the IRS, AQ-R, DVV's, and content knowledge on the first 5 quizzes, but not for the ARI. A positive improvement in motivation was correlated with improvement in programme outcomes (the following p's<0.05: DVVs' and FSR's for offender- and facilitator-rated changes in motivation; AQ-R and ARI only for offender-rated changes in motivation). Significant within, between, and interaction effects were found when

participant programme performance over time was compared among grouped post-programme ratings of motivation.

While participants as a whole improved over time, those who were rated as motivated at the end of the programme improved at a higher rate. Limitations of the study include: a lack of ethnic diversity in the sample, the potential for bias in ratings by facilitators, lack of measure of recidivism, lack of follow-up, lack of a comparison group, and the lack of inclusion of effect sizes. The authors also note that the sample may differ from the typical perpetrator who completes programs (who is typically more likely to be employed, educated, married, and less likely to have a criminal record). It is also possible that the sample was motivated to complete the programme for the purpose of release and therefore may not be applicable to different contexts.

Cranwell Schmidt et al., 2007

A US-based before and after study by Cranwell Schmidt et al., 2007 [+] assessed short term changes in male batterers' attitudes and motivating factors to change abusive behaviours following completion of a group therapy intervention. The study included 278 men with complete data who participated in the Domestic Abuse Education Project (DAEP) from Nov 1999 to Nov 2002. Participants were a mean age of 33 years, primarily Caucasian (83%), with a mean monthly income of $1, 291. The setting of the intervention was not reported.

The intervention was a 27-session group programme using a pro-feminist, cognitive behavioural approach to DV based on the Duluth model. The purpose of DAEP is to provide the participants with the information needed to eliminate abusive behaviours. Programme objectives include: broadening men's understanding of controlling behaviours and their perceptions used to support their abusive behaviours, improving awareness of the impact of their abuse on themselves and others, challenging men's denial or justification of their abuse, improving their motivation to change, and supporting development of safety planning for their partner. A 23-item survey was designed to measure attitudes and beliefs, and factors motivating them to develop non-abusive relationships. The survey was completed at pre-test (n=278) and post-test (n=165). However, pre- and post-surveys were anonymous, so participants who completed the post-test may or may not be the same as those who completed the pre-test.

At post-test, participants reported a positive change in attitudes (i.e. disagreeing that abuse is ok) on 14 out of 15 survey items regarding abusive behaviour (all p values ≤0.01), such as: "it is ok to be abusive if you feel hurt, abuse is a part of human nature, women want to be dominated by men, and men are treated unfairly by the legal system." A positive change was also reported in attitude for 6 out of 8 survey items regarding support of a non-violent relationship (all p values <0.01), such as: what my partner thinks or feels is important even if I disagree. Participants also reported being more motivated to change their behaviour by the effect abuse has on their family relationships (p values <0.05 for several items on the motivation scale). Yet, many participants continued to agree that jealousy, insecurity, and drug and alcohol use can lead to violence. At post-test, more men viewed alcohol and drugs as a cause for violence, but completers showed a significant shift towards the hypothesized disagreement with the statement: "Alcohol and/ or drugs cause violence" (p<0.01).

This study reveals that a pro-feminist CBT- based group treatment for male batterers may result in improvements in attitudes regarding abusive behaviours and motivation to change. Limitations to the study include: lack of matching of pre- and post- test responses (due to anonymity concerns), low response rate, and lack of a comparison group and follow-up. These methodological weaknesses may limit generalisability of findings.

DeLeon-Granados et al., 2005

A US-based non-RCT by DeLeon-Granados et al., 2005 [+] compared the effect of an individual level intervention (facilitated by former offenders) and an informal community level intervention. The study included 474 male DV offenders arrested in one of 15 police jurisdictions. Participants

were: 54% Anglo, 28% Latino, 14% African American, and 3% Asian, Native American, or other. The individual-level intervention occurred at the jail. Community-level interventions occurred in four types of communities: high-density housing including primarily impoverished migrant Latinos; subsidized housing including primarily by African American residents; low- to middle-class suburbs with Latino, African American, and Anglo residents; and upper class Anglo communities. Demographics of those receiving and not receiving the individual level treatment were comparable.

Four groups were compared: arrest only (which served as the control group) (n=138), arrest and treatment 1 (n=78) (individual-level treatment), arrest and treatment 2 (n=138)(community-level treatment aiming), and arrest plus treatments 1 and 2 (n=120). In treatment 1, former domestic violence offenders acted as volunteers, meeting with recently arrested batterers. Volunteers were trained in a 52 week batterer intervention programme. When the offender agreed to meet with a volunteer, they met in the jail for approximately 30 minutes, during which time the volunteer would confront the batterer on the violence, provide information on community resources and encourage them to attend a batterer support group. The goal of the intervention was to demonstrate that former offenders could serve a useful community role, and was based on the theory that in doing so could stimulate conformity in the new offender (to achieve a similar change in community status). In Treatment 2, a professional community trainer from a DV advocate agency offered training to established and informal community groups (such as church groups) and social service providers, to train volunteers to provide community outreach. Outreach involved: training workshops, rallies, and information sessions within the community lasting 1-1.5 hours. These outreach events were held in an area when the DV advocate agency was contacted for support by community groups. It is unknown if batterers in the intervention were directly exposed to these outreach events, but the theory is that batterers would be informally exposed to the messages or actions of the active community groups/ members. A batterer received treatment 1 if they agreed to meet with a volunteer following their arrest. A batterer was noted as receiving treatment 2 if a community based event occurred in their place of residence 30 days before or after their arrest. Recidivism was measured via police records of DV related offences. Analysis was conducted at 6-months follow up from the time of first arrest. Survival analysis was an analysis of recidivism for the offenders' entire length of time in the study, and so, was variable.

Percent recidivism at six months was: 8% for arrest only, 14% for arrest combined with treatment 1, 4% for arrest combined with treatment 2, and 2% for arrest combined with treatments 1 and 2. Survival analysis revealed that the combination of both treatments was better than either: arrest only or arrest combined with treatment 1, and arrest combined with treatment 2 was better than arrest combined with treatment 1 (all p values<0.05).

These findings reveal that combining an individual level intervention with informal community level intervention was associated with the lowest recidivism, and that arrest combined with a community level treatment may be more effective than arrest combined with only an individual level treatment. The authors suggest that inclusion of the community intervention may have facilitated victims to seek help, although further research is required to investigate this theory. Limitations of the study include: use of a single outcome variable, the potential for differences between treatment groups due to non-random design (for example, community level intervention was associated with seriousness of offense), and lack of tracking of re-arrests outside of the country of study. The authors also did not provide information on how many arrestees, or the characteristics of those who declined treatment 1 (meeting with a volunteer), which may have influenced findings. Finally, no rationale was provided for the lack of inferential statistics in the 6-month follow up analysis. The study included Anglo, Latino and African American participants, and community level interventions were conducted in residents predominantly populated by these groups. Therefore, findings may be limited in applicability to similar sub-populations and settings.

Gondolf, 2008

A US-based non-RCT study by Gondolf, 2008 [+] evaluated a case management intervention for male batterers. The study included a total of 684 African American men who had been court ordered to attend a counselling programme at an urban counselling centre as a condition of bond or probation. In the case management group, 57% of men earned over $3, 000 and 46% were married. In the non-case management group, 45% earned over $3, 000 and 35% were married.

Men in the case management intervention (n=202) were compared with a group of men who did not receive case management (n=482). The intervention was offered at the Domestic Abuse Counselling Centre (DACC) in Pittsburgh, Pennsylvania. Case management included completion of an assessment and background questionnaire to determine abuse and criminal history and self-reported needs and problems. A case manager then reviewed the forms and provided referrals to the necessary community resources, including: employment and educational resources, parenting instruction, substance use and psychological treatment. Men were contacted periodically by telephone to monitor contacts made and support needs. The case management was embedded in the counselling programme for men (16 weekly sessions using gender-based cognitive behavioural curriculum). The non-case management group was comprised of men who had previously completed the counselling programme prior to the addition of the case management intervention. A computerized tracking form was used to record the number and content of follow-up calls with batterers. Men's partners were also contacted to gather their perceptions of safety and feedback on men's behaviour. Re-assaults were assessed through a questionnaire using the Conflict Tactics Scale (CTS). Re-arrests were measured from the statewide database of arrests. Follow-up was conducted every 3 months up until 12-months post-treatment.

There was no significant difference in dropout rates between the case management and non-case management groups (48 vs. 45%, non-significant). There was also no significant difference in rate of re-assault for the two groups (0–12 mos.: 26 vs. 24%, non-significant). Women's perceptions of safety, and the reported likelihood of further hitting, and men's change was also not significantly different. After controlling for batterer characteristics, case management was not a significant predictor of re-assault during 0-12 month follow up (OR=0.25; p=0.35). The case management condition was also not a significant predictor of re-arrest (OR=−0.12; p=0.83). However, men in the case management intervention reported significantly higher on seeking of additional assistance (44 vs. 29%; $p<0.01$; n=419).

Findings suggest that the case management component did not significantly improve batterer programme dropout, re-assault, and re-arrests, or women's perceptions of safety. Limitations of the study include: potential social desirability bias. The authors also note that due to economic crisis in the city where the intervention was conducted, referral sources may have been adversely affected, which may have impacted men's access to resources and findings reported. The intervention is linked with the DV court and includes all African American men and therefore may be limited to similar groups of batterers.

Gondolf, 2009

A US-based cross-sectional study by Gondolf, 2009 [+] examined if a supplemental mental health treatment for participants with mental health problems in a batterer counselling programme was associated with a reduction in batterer behaviours. They also examined the effect of referral on outcomes. To test the effects of receiving mental health treatment on batterer outcomes, a sample of 148 male batterers attending a Domestic Abuse Counselling Centre (DACC) who were court mandated to receive mental health treatment was included. They compared men who received a clinical evaluation (n=48) to men who did not (n=100). In addition, men who received mental health treatment and a clinical evaluation (n=28) were compared to men who did not receive mental health treatment (n=120). Receiving an evaluation was considered a type of treatment within this study. To measure the effect of referral to mental health treatment, a sample of 479 batterer programme participants was included. This included: men court mandated to

receive mental health treatment (i.e. intention to treat) (n=148), men under a partially implemented mandate (n=149), and a voluntarily referred sample (n=182). 44% of participants were under 30 years old, 51% were African American, 31% had completed some college, and 50% were unemployed.

The DACC offered weekly 1.5 hour group (13-15 men) counselling sessions, delivered for 16 weeks at the outpatient counselling clinic. The counselling approach is instructional, applying gender-based cognitive behavioural curriculum. They also completed mental health screening (using the Brief Symptom Inventory (BSI)); men screening positive for mental health problems were provided instructions for referral and access to a mental health clinic. Men were instructed to phone the mental health clinic to schedule a mental health evaluation appointment. The mental health treatment generally included an initial appointment and a 30-50 minute individual clinical evaluation to develop a treatment plan which combined individual and group therapy and in some cases medication. To create a group of voluntary referral men for comparison, participants who screened positive on the BSI were at first notified that the referral was recommended but voluntary (n=182). Men under the "partial referral" condition were required as part of the court order to comply with the referral and batterer programme (n=149). Men in the "mandatory referral" condition were also required to receive the mental health treatment (n=148) and were contacted by phone at 3 weeks post-intake to review programme compliance. At programme intake, and at 3-, 6-, 9-, and 12- months follow up, female partners were telephone interviewed to assess re-assault. These interviews included questions about relationship status, abusive behaviours (using questions from the Conflict Tactics Scale), intervention and help seeking. Re-arrest records were also assessed by reviewing a state-wide database of criminal histories.

No significant differences in re-assault rates were found across the referral stages at 12-months follow-up (no referral: 33% vs. partial: 32% vs. mandated: 30%). The re-assault rates following the batterer programme at 3 and 12 months were also not significant (25% to 26%). Female partners (n=256) reported significantly lower safety in the mandated referral group between 9 and 12 month follow-up, both in terms of the likelihood to be hit ("'very unlikely' to be hit": no referral: 67% vs. partial: 66% vs. mandated: 50%; $p<0.05$), and feelings of safety ("feel 'very' safe": no referral: 73% vs. partial: 69% vs. mandated: 54%; $p<0.05$). Men receiving an evaluation in the mandated referral were less likely to re-assault at 12-month follow up (no-evaluation: 31% vs. evaluation: 22%), and less likely to re-assault if they received treatment (no treatment: 30% vs. treatment: 19%), although these findings were non-significant. Not being married (OR=2.31; $p<0.01$), living with a partner (OR=2.05; $p<0.01$), and having been previously arrested for DV (OR=2.44; $p<0.01$) were significantly associated with re-assault. Participants in the mandatory referral group (intention to treat) were less likely to be re-arrested for DV although this was not statistically significant (no referral: 7% vs. mandated referral: 4%).

In sum, court referrals to mental health treatment were not found to be associated with improvements in re-assault, re-arrest for DV or partner reports of safety. Limitations noted by the authors include: a low compliance rate (only 48 of 148 men who complied with mental health evaluation) and the potential for false positives on the BSI. It is also possible that socially desirable responding at assessment may have impacted findings. Findings may be limited in applicability to a similar context and population (court mandated treatment referrals for male batterers screening positive for mental health problems).

Gondolf and Jones, 2001

A US-based before and after study by Gondolf & Jones [+] examined the effectiveness of three established urban batterer programs. The first 20 to 35 men enrolling in each programme each month were invited to participate in the study, until approximately 210 participants had been recruited in each of the 3 sites. A total of 640 batterers were recruited (break-down by site not provided). Participants were a mean age of 32 years and were primarily: court referred (82%), identified as an ethnic minority (55%), had not completed high school (24%) or were college

educated (36%), and were employed (64%). Approximately half were either living with a partner (49%) or not (51%), and the mean length of abusive behaviour was 3.5 years.

The programme in Denver was 9 months in length and included: individual evaluations, alcohol treatment, individual psychotherapy, and case management for victims. The completion rate for this programme was 53%. The programme in Dallas was 3 months and included: individual evaluations, individual counselling and a women's group. The completion rate for this group was 60%. The programme in Houston was 5 ½ months and included: referrals for substance use problems in batterers and counselling for battered women. The completion rate for this programme was 49%. Further details on each intervention programme were not provided.

The programme outcome was assessed primarily based on telephone interviews held with partners every 3 months for a period of 15 months. A total of 77% of partners were interviewed (n=480) at least once during this period, and the response rate for the full 15-month follow up period was 67%. The interview included open-ended questions from the Conflict Tactics Scale (CTS) along with any reports of injuries.

Based on women's reports, 42% of programme drop-outs re-assaulted, while only 26% of completers re-assaulted ($p<0.0001$). The length of the programme (3, 5 ½ or 9 months) was not found to be significantly associated with drop-out rate. Programme completion reduced probability of re-assault by 44% (bivariate probit) to 64% (two-stage specification) ($p<0.005$).

Overall, findings suggest that completion of a batterer treatment programme was significantly associated with reduced re-assault, and that programs of different lengths did not differ significantly in effectiveness. Limitations of the study include: limited details on the interventions and potential for differences between sites, potential for under-reporting by partners, and missing data (480 partners for 640 men participated). This study only measured physical assault, so findings may not be generalisable to other forms of DV.

Kistenmacher et al., 2008

A US-based RCT by Kistenmacher et al., 2008 [+] examined the effectiveness of motivational interviewing (MI) for changing the way batterers perceive their violent behaviour. The intervention was set in a university out-patient clinic. The study included men who had been arrested for partner violence, and were mandated to attend a batterers' treatment, but had not yet attended the first mandated group. A total of 33 men were included. Men who participated were a mean age of 37.3 years; had a mean monthly income of $1,381; were primarily Euro American (75% in the treatment; 94% in the control); and had completed a mean of 11.2 years of education. Based on response to the Conflict Tactics Scale (CTS), 48% of men reported committing at least one act of severe partner violence within the past year; men had an average of 6.94 arrests for any crime; and 64% had received a referral to drug or alcohol treatment. No significant differences were found between participants and nonparticipants; intervention participants and control participants; or completers and non-completers.

Participants were randomly assigned to either the intervention (n=16) or control (n=17) condition. At the first (time 1) visit, participants in both the intervention and control conditions completed self-report questionnaires (including the CTS, Stages of Change Questionnaire (SOCQ), and the Revised Gudjonsson Blame Attribution Inventory (BAI-R) to measure attributions for a particular crime). In the intervention condition, participants met for 50-60 minutes with one of four trained therapists who discussed the results of the questionnaires using MI techniques. Two weeks later, participants met with the same therapist, again for 50-60 minutes to discuss battering behaviour and treatment requirements. The focus was on identifying ambivalence about battering behaviour using the OARS techniques of MI (open-ended questions, affirmations, reflections, and summaries), and methods for handling resistance and eliciting change talk. Therapists sought to create a collaborative and non-judgmental space to allow the participant to develop his own arguments for change and increase motivation for reducing or eliminating battering behaviour.

Following the second visit, participants completed the same set of questionnaires. The control group received no intervention.

The dependent variables were pre-contemplation, contemplation, and action difference scores from the SOCQ. The group main effect was found to be statistically significant (Wilks's λ=0.70, F (3, 22)=3.3, p=0.04), with a pre-to-post increase in action for the MI group, and decrease in action for the control group. Compared to the control group, the MI group also reported a significantly greater decrease from pre-to-post test in external attributions, using a one-tailed t-test (t(11.68)=–1.9, p=0.04). However, neither of these effects was significant when outliers were included. There was also a trend for increases in the MI group for contemplation and pre-contemplation, although neither was statistically significant (p=0.06 and p=0.11, respectively). Analysis of the strength of association between the independent variable (group) and the linear combination of dependent variables from the SOCQ was η^2=0.31, revealing that 31% of the variance in the dependent variables may be attributed to group differences.

Findings suggest that this MI intervention may improve some measures of motivation to change (action), with limited significant effect of others (pre-contemplation and contemplation). Limitations of the study include a high refusal rate (73% of men approached) for participation resulting in a small sample size, the short intervention duration, and the lack of reported follow-up. In addition, while the authors note that the sample included in the analysis was n=33, only 28 men appear to have complete data (one control participant and 4 intervention participants did not complete both Time 1 and Time 2). They also do not provide information on randomization procedures, and limited information on some self-report measure scores. Due to these limitations, more robust study design with a larger sample is required to confirm and generalize findings.

Lawson et al., 2001

A US-based before and after study by Lawson et al., 2001 [+] evaluated the effectiveness of a group therapy programme for men who abuse their intimate partners. The study included a total of 21 men who were on probation for abusing their partners. Men with severe psychopathic profiles or substance abuse problems were excluded from the study. Participants were a mean age of 33 years and predominantly Hispanic (42%) or African American (35%), followed by Caucasian (23%). No information was provided on the setting of the intervention.

Therapy groups were 2.5 hours, held weekly for 15 weeks with 8-10 men and facilitated by a male-female therapist team of trained counselling psychology students. The focus of the therapy sessions was relaxation training, cognitive restriction and self-instructional training regarding abusive behaviours and gender issues. The sessions incorporated a balance of challenge and support for the abuser, with the goals of: developing trust, to allow insecure attachment expectations to be enacted, to guide the abuser in developing awareness of his actions while they are occurring, to confront the abusers typical enactment of roles, and encourage him to rethink and correct assumptions connected to his behaviours. Outcomes were measured using the Minnesota Multiphasic Personality Inventory-2 (MMPI-2), Conflict Tactic Scale 2 (CTS-2), and the Marital Satisfaction Inventory (MSI-R). The abuser and the partner (who remained with their abusive partner) reported recidivism. Follow-up was conducted at post-treatment.

A significant reduction was found in the following CTS-2 subscales: physical assault (F(l, 40)=9.72, p=0.003), psychological aggression (F(l,40)=8.81, p=0.005), and injury (F(l,40)=6.5, p=0.015). Significant reductions were found only on the aggression subscale of the MSI-R (F(l,40)=53.33, p=0.000). The frequency of violence was significantly reduced from pre-group to during group (p <0.05) and from pre-group to post-group (p=0.05). In some instances, violence stopped completely. The majority of women (12 of the 13 who remained with their partner) reported: a decrease in frequency of violence, a less severe form of abuse, or a cessation of physical abuse between pre- and post- group treatment, which was greatest for women reporting a large number of violent acts before treatment. Components of the group sessions that were

noted as being most helpful in decreasing violence were the time out procedure and teaching of communication skills.

The study found improvements in behaviour and abuse outcomes following involvement in a group therapy for batterers. Limitations of the study include: low internal validity due to lack of control group, lack of follow-up, questionable validity resulting from the men's tendencies to deny and minimize violence, reliance on retrospective accounts, and the potential for women who remained with their abusive partners to minimize and underreport violent behaviours. Findings lack generalisability due to the small sample size and lack of comparison group.

Lawson et al., 2006

A US-based before and after study by Lawson and Barnes, 2006 [+] examined the attachment pattern changes and symptom changes among partner violent men involved in an integrated cognitive-behavioural, feminist and psychodynamic group therapy. The study included a total of 33 men who were attending group treatment as a requirement of their probation, and excluded men who had missed more than two therapy sessions. Participants were a mean age of 32.8 years; primarily African American (42%) followed by White (27%) and Hispanic (27%); married (42%) or single/ divorced (33%); had a mean education of 11.8 years; and all were low or lower middle class. The location of the intervention is not provided.

The intervention involved 17 weeks of integrated cognitive- behavioural, feminist and psychodynamic group treatment co-lead by a male/ female team of therapists who had worked on a DV research team for a minimum of 1 year. The intervention addressed social influences, cognitive/ behavioural processes, and maladaptive relationship connected to partner violence.

Partner abuse was measured using the physical violence scale of the Conflict Tactics Scale (CTS). Police reports were also checked for agreement with the CTS responses (with only 4 differences noted). The Outcome Questionnaire-45 (OQ-45), was used to measure client progress on: Symptom Distress, Interpersonal Relations, and Social Role; The Global Assessment Scale (GAS) to measure global psychological functioning; and the Adult Attachment Scale (AAS) to measure current relationship attachment. Assessment was conducted at pre- and post- treatment.

The total sample reported significant reductions in partner violence from pre- to post-treatment ($F(1, 30)=6.06$, $p<0.05$). The number of men reporting secure attachment increased significantly from pre- to post- measures (Chi square=5.06, $p=0.024$). Secure-changed men were found to report significant increases in comfort with closeness and depending on others between pre- and post-treatment ($t(13)=4.88$, $p<0.001$). Insecure and secure-unchanged men reported an increase in avoidance of closeness ($t(12)=2.33$, $p <0.05$ and $t(6)=2.43$, $p<0.05$, respectively) from pre- to post- treatment. Finally, secure-changed men reported lower anxiety and depression than insecure men at post-treatment ($p <0.05$).

Findings suggest that the group therapy intervention was associated with reduction in partner violence, and the level of improvement on certain psychological and relational measures differed based on attachment patterns. The key weaknesses of the study include: small sample size, lack of control group, lack of follow-up, and lack of intervention description and details. The small sample size and lack of comparison group limit the generalisability of findings.

Lawson, 2010

A US-based non-RCT by Lawson 2010 [+] compared the effectiveness of group cognitive behavioural therapy (CBT) with integrated group CBT and psychodynamic therapy (CBT/ PT) in reducing partner violence (PV). The study included male perpetrators attending treatment for partner violence in the study area (unspecified). Men who missed more than two sessions, men who did not complete all measures, and men who refused consent or whose partners refused consent were excluded from the study. A total of 45 men participated in the study (CBT=18; CBT/

PT=27). Demographic characteristics for the CBT group were: mean age of 35.8 years; 50% African American, 33% Hispanic, 17% Caucasian; and 10.6 mean years of education. In comparison, the CBT/ PT group was a mean age of 30.1 years; 41% African American, 26% Caucasian, 19% Hispanic, 4% Native American, 11% omitted response; and a mean of 10.4 years of education.

Group assignment was not random; participants were assigned to the next available treatment group. Treatment groups were facilitated by trained male and female co-therapists (four were assigned CBT and four were assigned to CBT/ PT). Each of the 17 weekly sessions lasted 2.5 hours and included 7-10 men per group. The CBT treatment group focused on: motivation to change, establishing a commitment to nonviolence, self-monitoring of triggers for violence, time-out methods, reflecting on and changing attitudes toward women and partner violence, responsibility planning, anger management and coping with stress, relaxation skills, cognitive restructuring/ coping statements, communication skills, and assertiveness. The therapists sought to develop a therapeutic relationship through supportive listening, and skills were practiced both in-session and in homework assignments. The CBT/ PT group involved the CBT elements in addition to a psychodynamic component based on Time-Limited Dynamic Psychotherapy. This component was integrated into the CBT components, and focused on identifying maladaptive interpersonal patterns learned during childhood that are related to abusive behaviour.

Pre- and post- treatment assessment was made using The Conflict Tactics Scale (CTS) to assess partner violence. The following pre- and post- treatment measures were also assessed: The Adult Attachment Scale (AAS) to assess attachment; the Inventory of Interpersonal Problems (IIP-SC) to assess interpersonal function; The Outcome Questionnaire-45 (OQ-45) to measure client progress on symptom distress, interpersonal relationships, and social role (life satisfaction); The Global Assessment Scale (GAS) to assess overall psychological functioning; and The Millan Clinical Multiaxial Inventory III (MCMI-III) to assess for psychopathology. Compared to the CBT/ PT group, the CBT group was found by therapists to have significantly lower level of psychological functioning (GAS). There were no other significant differences between the groups at baseline.

The CBT/ PT participants reported significantly greater improvement on severe partner violence ($p<0.05$, eta squared=0.94). The CBT/ PT participants were found to have a significantly lower rate of recidivism (22% vs. 50% in the CBT group, $p<0.05$). The CBT/ PT participants reported significantly greater improvement on the intrusive-socially avoidant scale ($p<0.01$, eta squared=0.14) at post-treatment, compared to the CBT groups. However, the CBT participants reported significantly greater improvement on measures of psychological/ behavioural functioning (measured by GAS, $p<0.05$, eta squared=0.12) and general symptom and relationship distress (measured by the OQ-45, $p<0.05$, eta squared=0.10).

In sum, the treatment conditions were associated with significantly different improvements on certain psychological and behavioural measures, and the integrated CBT/ PT group demonstrated lower rates of recidivism. Weaknesses of the study include the use of a small sample size, lack of follow-up, lack of random assignment and potential for socially desirable responding. Due to the small sample size and fact that the sample was approximately half African American men, findings may not be generalisable to other sub-populations of men.

Lee et al., 2004

A US-based before and after study by Lee et al., 2004 [+] examined the effectiveness of a solution-based DV group therapy treatment for male and female DV offenders. The study included a total of 87 male and female DV offenders who had been court ordered to receive treatment but were offered the chance to avoid prosecution by completing a group treatment programme and not committing further violence. The study excluded offenders who were either court mandated for treatment or opted for treatment. Participants were: 86% male and 14%

female, and primarily: White (84%), aged 31-50 years (74%), high school educated (49%), employed as labourers (55%), and married (47%).

The Plumas Project is a solution and goal-focused DV group treatment programme. The treatment included 1 hour group sessions over 3 months, co-led by a female and male therapist. Perpetrators are held accountable for solutions, encouraging solution-talk rather than problem talk. The programme focuses on the solutions, strengths and competencies of offenders, while not minimizing the impact of their abusive behaviour. The aim of the programme is for offenders to recognize and reconnect with their strengths and abilities, and to develop a personal goal (e.g. self improvement, improved relationships or fostering a helpful attitude).

Recidivism rates were collected from the victim witness office, the probation office, and the district attorney's office. As well, reports of violence from participants and their partners were collected during telephone interviews at follow-up. The Index of Self-esteem (ISE) was used to measure self-reported degree and severity of self-esteem problems; and the Solution Identification Scale (SIS), assessed spouse' evaluation of relational behaviours in intimate relationships. Assessment was conducted at pre- and post- treatment and 6-month follow-up and official records were tracked for 6 years.

The rate of recidivism was 16.7% by counting cases from all sources (district attorney's office=6.7%, probation office=4.4%, and victim witness office=15.5%). Perceived level of violence by partners decreased significantly from 5 at pre-treatment to 0.3 at follow-up ($t(21)=6.7$, $p<0.001$). No significant differences in recidivism rates were found between genders. There were improvements in offenders' relational skills as reported by their partners at post-treatment ($t(33)=3.6$, $p<0.001$) and during follow-up ($t(21)=4.1$, $p<0.001$). There was also an increase in offenders' self-esteem at both post-treatment ($t(81)=-2.2$, $p<0.5$) and follow-up ($t(47)=-3.1$, $p<0.01$).

Findings suggest that a solution and goal focused group treatment programme may decrease violence and improve relational skills and self-esteem among male and female offenders. Limitations of the study include: small sample size, lack of a control group, lack of control of external factors (including divorce, relocation, incarceration) that may have impacted outcomes, low response rates among offenders and partners (55%), potential for under-reporting due to reliance on self-report, and limited description of the source population and setting. While the study included men and women, most participants were White men and therefore findings may not be applicable to women or ethnically diverse men.

Lee et al., 2007

A US-based before and after study by Lee et al., 2007 [+] evaluated the effectiveness of a solution-based DV group treatment, examining the influence of self-determined goals in predicting recidivism. The study included a total of 88 male and female DV offenders who were court ordered into treatment yet offered an opportunity to avoid prosecution by completing treatment and not permitting further violence. The study excluded offenders who chose treatment or who were court mandated to treatment. Participants in the study were 80% male, and 20% female; primarily White (88%); primarily ages 31-50 (74%); high school educated (49%); nearly half were labourers (49%); and half were married (50%). The setting of the intervention was not described.

The Plumas Project is a solution and goal-focused DV group treatment programme. The treatment included 1 hour group sessions over 3 months, co-led by a female and male therapist. Perpetrators are held accountable for solutions, encouraging solution-talk rather than problem talk. The programme focuses on the solutions, strengths and competencies of offenders, while not minimizing the impact of their abusive behaviour. The aim of the programme is for offenders to recognize and reconnect with their strengths and abilities, and to develop a self-determined treatment goal (e.g. self-improvement, improved relationships or fostering a helpful attitude.

Annual follow-up of recidivism rates were collected from the victim witness office, the probation office, and the district attorney's office. Goal commitment (commitment to achieving identified goal during treatment), goal agreement (goal mutually agreed upon by offender and therapist), and goal specificity (goal is: behaviourally described, positively stated, and identified in small steps) were measured on a three point scale by the therapist at post-test. Confidence to continue working on their goals following completion of the programme was self-reported on a 10 point scale at post-test.

For those participants who completed the programme the recidivism rate was 10.2%. A total of 58% of variance in recidivism was accounted for in the final model. Goal specificity and goal agreement were found to positively predict confidence to work on goals (r=0.45 and 0.20, respectively), which negatively predicted recidivism (probit coefficient=-0.08, SE=0.04). A probit coefficient of -0.08 meant that one unit increase in the confidence to work on goals resulted in a decrease of 0.08 standard deviation in the predicted Z score of cumulative normal probability distribution of recidivism. As well, goal specificity directly and negatively predicted recidivism (probit coefficient=-0.82, SE=0.28). No significant differences in recidivism rates were found between the genders.

Findings suggest that the development of goal specificity and goal agreement in a solution focused treatment programme was associated with decreased recidivism. Limitations of the study include: small sample size, lack of control group, use of self-report measures on process variables, limited description of the source population and setting, potential for relationship between therapist and participant to shape therapist reports of goal specificity and agreement, and lack of partner reports of recidivism. While the study included men and women, most participants were White men and therefore may not be applicable to women or ethnically diverse men.

Maxwell et al., 2010

A US-based RCT by Maxwell et al., 2010 [++], a re-analysis of an earlier RCT (Davis et al., 2000), examined the timing and trends of new arrests to address whether the intervention temporarily suppressed abusive behaviours or whether the group therapy treatment programme produced sustained changed. The study included male criminal court defendants (n=376) charged with assaulting their intimate female partner. When the judge prosecutor and defendant all agreed to send the defendant to batterer treatment, they were included in the study. Participants were: African American (36%), Hispanic (28%) or West Indian (20%); one-third completed either no high school (33%) or high school (33%); most were employed (64%); and earning a mean income of $16, 000. The setting of the intervention was New York City Victim Services, Alternative to Violence (ATV) programme.

Group assignments were made during sentencing after the judge, prosecutor, and defendant had agreed to batterer treatment based on the random assignment process. If there was agreement, the prosecutor contacted the ATV office to request an interview of the offender for intake. Participants were randomly assigned to either treatment (group therapy) or control (community services). However, judges could overrule the allocation and did so in 28% of control cases, requiring the offender to attend batterer treatment. Those randomly allocated to treatment were divided into either one group that completed the programme in 26 weekly sessions (n=129), and another group that completed the programme in 8 weeks (by doing longer sessions biweekly) (n=61). Group treatment entailed 39 hours of psycho-educational therapy based on the Duluth model, delivered by co-therapists in either English or Spanish. The curriculum included: defining DV, understanding historical and cultural dimensions of domestic abuse, and reviewing criminal issues. Participants received instruction and participated in discussions, and were encouraged to take responsibility for their anger, actions, and reactions. The control group (n=186) completed 40-hours of community service, typically over a 2-week. Duties included: renovating housing units, clearing vacant lots for community gardens, painting senior citizen centres, and cleaning playgrounds. None of the activities were expected to influence abusive behaviour. Participants

were also provided with education on drugs and HIV, and if interested were referred to drug, HIV, or employment counselling programs.

Recidivism rates were collected via the New York's official records system (Criminal Justice Agency and the NYC Police Department). The computer database of the district attorney was also searched to verify if the victim in the new incident matched the victim in the original incident. Recidivism rates were measured continuously for the 15 months post-treatment (compared to the original study which measured at discrete periods- 6 and 12 months follow-up).

They found that men assigned to the 26-week treatment group had a longer period of non-violence (if violence re-occurred at all) compared to men in the control condition ($b=0.55$, $p<0.05$). Assignment of an offender to treatment (in either the 8- or 26-week group) revealed a significant preventative effect ($b=-0.87$, $p=0.01$) during the period of treatment. On average, the hazard rate (time independent effect) was almost 70% lower when an offender attended treatment. During any period of follow-up observed, quantity of treatment was no longer significantly related to amount of violence ($b=-0.02$, $p>0.05$). Therefore, by the end of observation (15 months follow-up), all participants demonstrated the same average of criminal incidents regardless of amount of treatment. This suggests that the act of a judge's assignment of an offender to treatment is protective, yet if an offender actually attends the treatment programme this positive effect is somewhat reduced.

While the findings support the finding by Davis et al., 2000 [++] that the 26-week group had a longer reduction in the number of violent incidents, their findings also reveal that the impact of treatment was not sustained and therefore outcomes may be an effect of suppression or supervision rather than treatment. The study used a robust analysis, but as this was a re-analysis, is somewhat limited by the data collection of the previous study (in particular high attrition rates). The study was conducted with an ethnically diverse (African American, Latino and West Indian) sample of men court mandated for treatment, and therefore may be most applicable to similar groups of male batterers.

McGregor et al., 2000

A Canadian before and after study by McGregor et al., 2000 [+] evaluated the effectiveness of a group counselling programme for men who are abusive towards their intimate partners, which focused on belief-system change. The study included a total of 76 men who were either self- or court- referred to treatment. Men who did not attend at least 9 sessions were excluded from the study. All participants were also attending individual counselling sessions, and had achieved at minimum the contemplation stage of the trans-theoretical model of change. Men who participated were a mean age of 34.5 years; 46% were high school educated and 47% post-secondary educated; the average length of their intimate relationship was 7.6 years; and 40% were referred by probation. The intervention was held in a counselling centre. Only 22 men completed follow-up; these men were slightly older (mean age 37 years), were less likely to be referred by probation and were more likely to report a psychiatric history.

The intervention, 'Responsible Choices for Men,' is a group programme targeting belief-system change. The format is 2 hour weekly sessions for duration of 14 weeks, facilitated by male-female co-therapists. The key goals of the treatment include: decreasing all types of abusive behaviour (including also abuse of children); accepting responsibility for one's actions; improving self-esteem and assertive behaviours; improving family relations; reducing stress; improving empathy. The four key components of the programme are: challenging the victim-blaming stance, challenging belief system, reconnecting with emotions, and encouraging the experience of empathy. Partner checks were performed at three points to assess women's safety and track men's progress.

Outcome measures at pre- and post-intervention were: Physical Abuse of Partner Scale (PAPS); and Non-Physical Abuse of Partner Scale (NPAPS); Index of Clinical Stress (ICS), to measure

personal stress; Index of Family Relations (IFR), to measure severity of family problems; Generalized Contentment Scale (GCS) to identify non-psychotic depression; Adult Self-Expression Scale (ASES) to measure assertiveness; Sex Role Ideology Scale (SRIS) to measure respondent's attitudes about roles and behaviour for women and men. All 76 men completed the pre- and post- test measures, while 22 men completed the same measures at follow-up, between 5-28 months post-intervention (average of 14 months).

There were significant differences post-intervention among the mean scores on all scales ($F=10.8$, $p<0.001$). The follow-up data (n=22) revealed continued improvement; the pre-, post-, and follow-up measures were significantly different, demonstrating improvement across time for all 8 scales ($F=6.7$, $p<0.001$). On average, participants reported a 41% improvement on self-esteem, a 59% improvement on family relations and a 68% improvement on measures of depression. The follow-up scores maintained significance even after accounting for length of follow-up ($F=1.9$, $p<0.05$).

Findings suggest that a group counselling programme focused on changing belief systems was associated with improvements on measures of physical and non physical abuse, and stress, depression, understanding of gender roles, and emotional and relational outcomes, and improvement was sustained in the follow up group. Key weaknesses of the study include: the lack of a control group and randomization, low follow-up rate, potential for under-reporting by abusers, and omission of measures of recidivism. They do not report ethnic composition of participants, and therefore it is difficult to determine applicability to diverse groups of men.

Milner and Singleton, 2008

An English before and after study by Milner and Singleton, 2008 [+] examined the effectiveness of a solution-focused brief therapy programme for male and female abusers. The study included 50 men and women (46 cases) who abused their intimate partners in Huddersfield, England, and received counselling by the lead author. Participants were a mean age of 37 years, 76% male and 24% female, primarily White (aside from 3 participants who were Black men, 1 Asian man and 1 Black woman), heterosexual (aside from 3 lesbian women) and primarily working class and unemployed.

The intervention was solution focused brief therapy. The therapy does not provide explanations for violence but does hold the perpetrator responsible for identifying solutions to their behaviour. The intervention uses a “signs of safety approach” encouraging offenders to identify signs of safety which can be measured, and to implement and expand these signs to create a safety care plan. Therapy sessions were initially held with individual male and female abusers, with the option of bringing the partner or family members into later sessions (further details on how many participants chose these options were not reported). The number and timing of sessions also varied based on participant's needs and the homework provided. The average number of sessions was 4.3, lasting approximately one hour each. Recidivism was measured by: self reports, partner reports and police reports. Successful completion of the programme was also assessed. Period of follow-up was not reported, although presumably this occurred post-treatment.

A total of 68 participants started the programme, and 50 completed the programme; four participants were asked to leave and fourteen dropped out. Of these 50 completers, a total of 30 men completed the programme, in addition to four men who attended with their partners. All 16 women who began the programme, including four who attended as couples completed the programme. They report that all participants who successfully completed the programme were violence-free; 57% of participants who dropped out had continued to be violent, three non-violent, and the outcome was unknown for three; and 75% of those that were asked to leave remained violent. The proportion of participants who successfully completed the programme was 73.5% (78% counting the men who were asked to leave the programme).

Findings suggest that a brief solution focused therapy may reduce partner violence. Limitations of the study include: lack of a comparison group, lack of follow up (not reported), lack of description of the source population, and potential for under-reporting of cases of DV by participants and partners. While the study was conducted in the UK, and therefore should be directly applicable, demographic information is not provided for participants so it is not possible to ascertain for whom this intervention may be successful.

Morgan et al., 2001

A New Zealand-based qualitative study by Morgan et al., 2001 [+] provided a discursive analysis of an educational programme for men who had physically assaulted their partner. The study included men ages 24- 45 (mean age of 31 years) who had physically assaulted their partner attending the Men for Non-Violence (MFNV) stopping violence course. Six of the men had been ordered by the courts to attend the programme. A total of 13 men completed the pre-intervention interview; 11 men completed the follow-up interview.

The intervention was a 9- session educational programme using a Liberal Humanist perspective. Liberal Humanist discourse locates subjects as agents, who are rational and in control of their free-willed, goal-directed behaviour. The education programme integrates understanding of choice, awareness and personal responsibility with anger management skills and socio-cultural consciousness raising. Key to the anger management portion was recognizing emotions underlying anger. Data collection involved semi-structured interviews conducted at pre- and 3 months post-intervention. No additional information was provided on the methods or setting for data collection. Transcripts were reviewed and coded for patterns of meaning, variations and contradictions in the men's responses. The research team identified cultural discourses used in men's construction of violent events. The analysis analysed the ways of speaking, and categorized (where appropriate) narratives using a post-structuralist taxonomy including: medical pathology, romantic expressive-tension, liberal humanist instrumentalism, structuralist social systematic constraints and learned behaviour.

Analysis of interviews revealed that the intervention influenced men's understanding of their violence and improved accountability. In the first interview men often spoke about their violence as a form of "expressive tension" or "pathological"- their violence was framed as a manifestation of the tension they were unable to cope with. For example, one participant noted: “a lot of pressure.. built up and up and all of a sudden I snapped.” This framing of their behaviour as unusual and a reaction to stress, prevented men from accepting responsibility for their behaviour. For example, another participant explained: "I wasn't really conscious of what I was doing, it just happened." Following the intervention, men continue to utilize the "expressive tension" model of violence to recount violence. However, many participants began to discuss their violence using a Liberal Humanist "instrumental" discourse, noting intention in their actions. Men more often identified the intent of their behaviour and the control they had over their actions. For example, one participant noted: "I choose how I react.. at the end of the day the decision's mine." The authors also note that men were more emotionally expressive during the second interview.

Participation in the educational programme appeared to improve men’s accountability for their actions during interviews. Limitations of the study include: lack of measure of partner/ victim experiences, short period of follow-up, lack of link to recidivism, limited details on data collection and lack of triangulation of data. Aside from age, they do not provide participant characteristics so it is difficult to determine wider applicability.

Morrel et al., 2003

A US-based quasi-randomized control study [+] compared the effectiveness of a cognitive behavioural therapy (CBT) intervention with supportive group therapy in a group of court mandated partner violent men. The study included 86 men presenting for intake at a community DV agency. To be included: men had to be 18 years or older, partner consent was required, men on psychiatric medications required therapist approval and men using substances were required

to be involved in substance abuse treatment. Participants were an average age of 34 years, primarily Caucasian (60%) followed by African American (30%), with a mean education of 13 years and average monthly income of $1, 800.

Participants were not randomly assigned to either cognitive behavioural group therapy (CBT) (n=48) or supportive group therapy (ST) (n=38), but were assigned to the next available treatment group that alternated. Both groups were 2 hours per session for 16 weekly sessions, comprised of 7-10 men, and led by a trained and supervised female and male co-therapists. The CBT programme included structured sessions focused on: ending abusive behaviours, developing non-violent relationships, crisis- management (time out, managing triggers and anger), and communication skills, along with unstructured discussions of ongoing issues. The ST group was unstructured, with minimal therapist direction, but focused on supporting the partner violent men to develop a personal plan for change by providing support, offering an opportunity to express feelings, improve communication, reduce isolation and improve their relationship with their partner as well as other men. Participants determined the agenda and did not engage in skill training. No significant differences were found between the two groups at baseline.

Outcome measures included: the Revised Conflict Tactics Scales (CTS2) to measure partner aggression; state criminal records (at 22-36 months post-intervention for 63 of 86 participants) to assess criminal recidivism; partner reports of physical violence using a structured interview on physical abuse and arrests; partner reports of the Global Impression of Change to measure perceived treatment outcome; the Safe at Home instrument to measure participant readiness to change; the Rosenburg Self-Esteem Scale to measure participant self-esteem; a 15-item self-efficacy interview to measure participants' confidence to manage relationship conflict; and partner reports of communication problems using the Verbal Problem Checklist. Follow up was conducted at baseline, post-treatment and 6-months post-treatment.

An overall significant reduction was found between pre- treatment and follow-up on: physical assault ($p<0.001$), psychological aggression ($p<0.001$), injuries ($p<0.001$) and sexual coercion ($p<0.01$). No significant differences were found between the two groups on partner aggression and re-arrests. However, the ST group demonstrated greater self-efficacy for abstaining from verbal aggression ($p<0.05$), and negotiation ($p<0.05$). Both groups demonstrated significant improvements from pre- to post-intervention on: self-esteem ($p<0.01$), efficacy to abstain from verbal abuse ($p<0.001$), and stage of change scales including preparation/ action ($p<0.01$).

Overall, findings suggest that both structured CBT and unstructured supportive group therapy for partner violent men are associated with improvements in physical assault, psychological aggression, injuries and sexual coercion, although there were no differences between groups on partner aggression and re-arrests, and the unstructured group demonstrated greater self-efficacy for abstaining from verbal aggression, and negotiation. However, the authors note difficulties in delivering the intervention (issues with anger-control and communication of participants) that may have impacted outcomes.

Muftic and Bouffard, 2007

A US-based cross-sectional study by Muftic & Bouffard, 2007 [+] examined the effectiveness of a coordinated community response intervention for male and female DV offenders. The study included 201 heterosexual male (n=131) and female (n=70) DV offenders from a small urban community. Data collected for male offenders was from January 2003 to the end of December 2003, while data for female offenders was from January 2001 to the end of December 2003. Males were an average age of 31 years; primarily White (88%); high school (47%) or college educated (36%); and most were employed (78%). Male offenders were either: married (28%), divorced/ separated (24%), cohabiting (28%) or dating (20%) the victim; and some men had a previous DV related offence (31%). Female offenders were an average age of 30 years; primarily White (83%); high school (42%) or college (32%) educated; and employed (57%). Most female

offenders were either cohabiting (35%) or dating (33%) the victim; and 16% had a previous DV related offence.

The first component of this coordinated community response intervention is a probably cause arrest police, in which the police would file an incident report regardless of whether or not an arrest was made. This report would be submitted to the state's attorney's office and a victim advocacy agency. In instances of arrest, a victim advocate would contact the victim; in cases where an arrest did not occur, a letter would be sent to the victim providing a list of community resources including shelter and counselling services. If an offender is prosecuted, the victim advocate would support the victim by attending meetings with the prosecutor and court hearings. A criminal 'no-contact' or protection order would also be made, prohibiting contact between the offender and victim for a specific time period (typically one year), which could be changed if the offender completes an assessment and recommended treatment. The authors report that in terms of the outcomes of court proceedings, a more lenient sentence was imposed significantly more often for female than male offenders (46% vs. 22%, $\chi 2=9.903$, $p<0.001$). A no-contact order was provided to male offenders 83% of the time, compared to 70% of female offender cases ($\chi 2=5.42$, $p<0.05$). If the offender was convicted, they would be required to report to an independent non-profit community corrections agency that would complete an intake and monitor their compliance with a clinical DV assessment and recommended treatment at a local treatment agency. If treatment is recommended, this becomes part of court judgement. The most common treatments in this community are: a 24 week DV treatment for male offenders, a 5 hour anger management seminar for men and women, individual counselling, chemical dependency evaluation and treatment, or other recommendations (e.g., meeting with police, completing a psychiatric evaluation). In about 25% of cases, no treatment is recommended.

A variety of dichotomous yes/ no variables representing completion of different stages of the intervention were collected from a variety of sources, including: whether the offender appeared at the community corrections agency as required, whether an intake interview was completed for those offenders who appeared at the community corrections agency, and whether the offender completed whatever was included in their court order. These were added up to measure the components of the intervention that the offender completed. Recidivism (general and DV-related) was measured using official police arrest records after the date of sentencing. The average time-at-risk for recidivism (i.e. post-intervention follow-up time) was 10.4 months for the entire sample. Females had an average time-at-risk of 14.9 months compared to 8.1 months for males, due to the longer time frame used to gather a sufficiently large sample of female offenders.

Overall, female offenders completed more intervention components (2.3 vs. 2.0) than did male offenders ($t=–1.765$, $p<0.05$). Female offenders were significantly more likely to complete their court order regardless of the order content (46%) than male offenders (17%, $\chi 2=8.4$, $p<0.01$). Regarding recommendations for treatment, female offenders were more likely to be referred to either anger management (29% vs. 16%) or another form of treatment, such as individual counselling (39% vs. 17%). In contrast, male offenders were more likely to be sent to a DV treatment group (37% vs. 2%). These differences in recommendations for treatment were statistically significant ($\chi 2=25.750$, $p<0.001$), though note that in this community there were no DV treatment programs for female offenders. However, when treatment of any form was recommended, female offenders were significantly more likely to complete it (47%) than males (19%, $\chi 2=7.539$, $p<0.01$). Although recidivism among female offenders was slightly higher compared to male offenders (29% vs. 24% for any rearrest charge; 80% vs. 66% for DV rearrests only), this was not statistically significant. To examine whether the intervention impacted recidivism differently for men and women, logistic regression models (one for any rearrest, and one for DV-related rearrests only) were conducted, including the following predictor variables: relationship between the victim and offender, dual-arrest status, race, prior arrests, age, time at risk, total number of intervention components completed, and gender. Findings revealed that offenders who had a prior arrest (any arrest) ($exp(b)=3.416$, $p<0.01$) and greater time at risk ($exp(b)=1.058$, $p<0.05$) had a higher likelihood of recidivating. Offenders involved in a dual arrest were less likely to recidivate ($exp(b)=0.196$, $p<0.01$). For the logistic regression model predicting

any DV-related rearrest, the likelihood of recidivism was lower for offenders who were married to the victim compared to those offenders dating the victim (exp(b)=0.183, p<0.05) and for offenders in dual-arrest incidents (exp(b)=0.122, p<0.01), but higher when the offender had a prior arrest record (exp(b)=3.792, p<0.01). Neither gender nor the number of intervention components significantly impacted either recidivism measure.

In sum, although women were more likely to complete treatment recommendations and fulfill their court order, their recidivism rates were not lower. Furthermore, the intervention did not appear to reduce recidivism (general crime or DV) for either women or men. Limitations include: the inclusion of only those offenders who were arrested and successfully prosecuted and the potential for under-reporting of incidents due to reliance on official records. The sample was predominantly White and therefore findings may not be applicable to diverse groups of male and female offenders.

Musser et al., 2008

A US-based non-RCT by Musser et al., 2008 [+] examined the use of motivational interviewing (MI) as a preparatory intervention (prior to participation in a group CBT intervention) for partner-violent men. The study included a total of 108 men presenting for treatment at a DV centre; 79% of the men were court-ordered to treatment. Cases not related to DV or referred for individual therapy were not included. Participants were a mean age of 35.7 years; primarily White (50%) or African American (44%); had a mean education of 13 years; the majority was full-time employed (82%); and the mean income was $25-30, 000.

At intake assessment, in the MI group (n=55) individual 45 minute sessions of MI were used (expression of empathy, develop discrepancy, avoid argumentation, support of self-efficacy) to collect demographic information and discuss the clinic procedures for the 16-week group CBT sessions. During the second session (2 weeks later), feedback was provided based on men's self-report assessments, again applying MI principles. The self-report assessment included questions from: the State Trait Anger Expression Inventory, the Dyadic Adjustment Scale, and the Conflict Tactics Scale. Those with drug or alcohol issues received further feedback for these issues. Trained male and female doctoral students conducted the interviews. During the standard intake (control) condition (n=53), participants completed the assessment and reviewed clinic policies for the CBT group, but did not apply MI principles to elicit cooperation.

Abusive behaviour was measured via telephone interview using the Conflict Tactics Scale (CTS), at 6 months following participation in the CBT treatment; 34 men in the MI condition completed follow-up, and 31 men in the control. They found no significant changes in partner report of physical assault, injury, and psychological aggression between the intervention and control groups. However, physical assault approached significance (p=0.07), with control participants being more than twice as likely to physically assault or injure their partners, compared to the intervention group. However, they do note greater compliance with CBT homework, more help seeking outside of the programme and higher therapist ratings of the working alliance (late in treatment, but not early in treatment) for those in the MI intake group (all p's<0.05).

This study found no significant differences in partner violence for men who participated in an MI intake versus standard intake prior to engagement in a CBT group, but did find that the MI intake improved some measures of men's receptivity to the CBT intervention. Improvements in readiness to change may improve participation in treatment interventions. Limitations of the study include: lack of data or analysis of men who dropped out the programme and low follow up rates. The study was conducted with primarily White and African American men accessing a DV centre, and therefore may be most applicable to similar populations and context.

Price et al., 2008

A UK based before and after study by Price et al., 2008 [+] examined the outcomes of the first 18 months of the Domestic Violence Intervention Project (DVIP), which included an intervention for

male perpetrators of DV. The programme also included interventions for victims, the findings of which are reported in that section. The programme was aimed at men perpetrating DV in the London boroughs of Barking & Dagenham, Newham and Waltham Forest. No demographic details were provided for participants. Out of 168 referrals deemed appropriate for assessment, a total of 97 perpetrators completed the assessment, 76 entered treatment, 33 completed the violence prevention modules and 14 completed 60 hours or more of treatment. The authors note that at the time of publishing, there were 20 men still receiving treatment.

The programme is based on the philosophy that violence is learned and can therefore be unlearned, that a perpetrator is responsible for his behaviour, and that it is possible to improve the behaviours of perpetrators for themselves and their relationship with partners and children. The programme is grounded in cognitive behavioural, social learning theory, psychodrama, psychotherapeutic and relationship skills training approaches. The intervention is a group treatment programme aimed at supporting men to take responsibility for their actions and change their behaviour. Prior to treatment, an assessment 2-4 hours in length, plus 2 hours conducted with their partner if Children's Services was involved, was conducted. This assessment covered the history and risk of violence, as well as motivational and attitudinal issues (e.g. perpetrator's level of empathy and denial). An assessment report along with recommendations was then provided to social workers. The intervention was delivered over 32 weeks, with a total of 60 hours of programming in 2 1/2 hour weekly group sessions. The programme sought to help men understand the reasons for their abusive behaviour, strategies to change this, and how to develop respectful relationships with their partner. Men were encouraged to take responsibility for their actions rather than blaming their partners or external factors, and were taught to critically examine gender-based expectations of their partners and themselves. One- third of the sessions focused on ending violence, while the rest focused on parenting and relationship skills.

Participants were re-assessed again at week 12 and at the end of treatment (week 32). Repeat victimization was measured by examination of police reports and women's reports of their partner's behaviour. Findings revealed that 70% of women reported no further violence, while 78% reported that abusive behaviour had been reduced or eliminated. Repeat victimisation was found to be reduced by between 87.5% and 89.3% based on case reports.

In sum, findings suggest that participation in the perpetrator programme was associated with a reduction in partner reported violence and police reports of repeat victimization. Limitations of the study include: the relatively low participation/ completion rate (out of 168 eligible for assessment, 71 did not attend at all; of the 97 that completed assessment, 21 did not participate further), and lack of analysis of drop outs or non-participants. It is possible that those who participated were more interested or likely to change their abusive behaviour. While the study was conducted in the UK, the authors do not provide demographic information on perpetrators and therefore it is difficult to ascertain wider applicability.

Rosenberg 2003

A US-based qualitative study by Rosenberg 2003 [+] examined the effectiveness of group interventions from the perspective of probationers. This qualitative study reports on interviews conducted with men and women court-mandated to DV treatment, and was part of a study on recidivism outcomes for DV offenders in a probation department. A total of 70 interviews were completed (male n=57; female n=13). Participants were primarily male (81%) (no further details provided) .

The study included men and women from multiple treatment programs (rather than a single intervention). The programs discussed involved one year of 2 hour weekly group sessions, delivered in one of six certified DV intervention programs. The authors note that programs differed somewhat in theoretical approaches, and that the content was determined by state law, but was primarily based on process-oriented, cognitive- behavioural and educational approaches. Typical components included: time outs, identifying triggers to anger, emotional regulation and

developing communication skills. The setting of the programs is not reported, though they indicate that this was part of a coordinated community response.

The first 224 probationer files were included in the total sample. The total sample of probationers and victims was then asked to participate in either telephone or face-to-face interviews on trauma history, quality of life, post-treatment violence (physical and psychological), and perceptions of the treatment programs (one question asked whether participants were currently using information they had learned from the programme). These were conducted one-year post-treatment. A total of 70 interviews were completed. They created a table of responses to interview questions and a simple tally of participants reporting an item. Further details on method of analysis (coding process, determining categories) were not provided.

At follow-up, 84% of participants reported continuing to use the “time-out” method when encountering stressful situations at work or at home. For example, some participants spoke about how they dealt with angry customers by not engaging or becoming angry and defensive. A further 30% reported that they had an improved ability to communicate with their partners and co-workers, rather than repressing their thoughts and emotions. Finally, 14% reported an improvement in their ability to consider consequences of their actions, identify anger triggers, create boundaries, and take responsibility for their behaviours.

Findings suggest improved skills and tools related to managing anger and conflict, and communication behaviours, for participants who attended court mandated group treatment. Limitations of the study include: lack of analysis of non-completers of the programme, the inclusion of multiple treatment programs (with limited details on the contexts), the lack of analysis of differences between women and men in the sample, and limited information on data collection and analysis (how categories were determined and how coding occurred). They do not provide demographic characteristics of participants, and therefore it is difficult to determine applicability.

Schrock et al., 2007

A US-based qualitative study by Schrock et al., 2007 [+] examined how male batterers who attended a Duluth model-based therapy programme negotiate masculinity and if the treatment was effective in its goal of transforming masculinity. The number of participants involved in the treatment was not noted, although they state that the analysis was based on 3 years of weekly groups. The study included court mandated men and excluded men who missed more than 3 sessions. Participants were 50% African American, 40% White, and 10% Latino; and the majority (75%) was working class. The setting of the intervention was a community service centre.

Each session was 2 hours, held weekly with 10-18 participants per group for a period of 26 weeks per group, and led by male and female co-facilitators. The focus of the Duluth model is to transform men into non-abusive, non-judgmental listeners, to encourage empathy, honesty and accountability, and egalitarian family relationships. The programme may also include skill-building and anger management sessions, with the goal of improving assertiveness, communication and management of conflict. At the beginning of each session, men would check in and provide a responsibility statement, followed by the facilitator lead session. If participants brought up childhood violence, the conversation was diverted. Data was collected via ethnographic methods including: group observations from a one-way mirror, note-taking and sit in observation. Data analysis was conducted concurrently with data collection, with emerging themes noted and hypotheses developed. Notes were coded by interaction, and were reviewed by a second researcher to identify interactional tactics. The study was based on symbolic interactionist perspective and Goffman’s principles of self-presentation, and grounded theory.

They note that completers of the programme were less likely than dropouts to be recharged (11% vs. 42%) and more likely to be living with their victims (42% vs. 14%). The authors note that there was success in having men take responsibility for their actions, use egalitarian language, control anger and choose non-violence, but men also demonstrated resistance in taking on the victims’

perspective and being emotionally vulnerable, and positioned themselves as hardworking men deserving of a patriarchal divide. However, the authors do not provide qualitative data to support the positive changes they note. Rather they provide examples of how facilitator interactions failed to produce meaningful changes in participants. For example, they describe how participants were shamed into assuming 'pseudo-responsibility' or using egalitarian language: (Facilitator): "What did you say?! Did I hear you say my woman?" (Participant): "What's the big deal? What's wrong with saying 'my woman'? Tonya always calls me 'my man.'" (Facilitator): "[It's] like saying 'my bitch,'" said Bev, who added, "I'd much rather you call her by her name." (Participant): "I think this is just silly. I'm trying to talk about things that I usually wouldn't talk about, and you're worried about how I'm saying things more than what I'm saying! It's like I can't just talk naturally." They also note how vulnerability and empathy were resisted by diversion (making jokes) or disengagement (being quiet/ inexpressive), and how participants who did express empathy were shunned by other participants. Finally, the authors note how participants valued themselves as hard-workers during sessions.

While programme completers were less likely to be re-charged, the intervention appeared to have limited impact in creating meaningful changes regarding notions of masculinity, responsibility, empathy and egalitarian behaviours. Limitations of the study include: lack of analysis of post-treatment behaviour or violence outcomes, lack of population data, and lack of qualitative data to support the positive improvements noted in the abstract and discussion. Due to the lack of population data (including number of participants) it is difficult to ascertain applicability.

Schumacher et al., 2011

A US-based individual RCT by Schumacher et al., 2011 [+] examined the impact of a brief motivational enhancement intervention in an alcohol treatment setting on IPV treatment outcomes. The study included a total of 23 men recruited from two residential substance abuse treatment facilities (28-30 days in length), who self-reported IPV in the past year, were married or cohabiting and consented to partner participation. Of the men who participated, 16 were White and 7 Black; 12 had a high school (or equivalent) education, and 6 reported some college or trade education; 7 were currently employed. Men reported a mean of 64.9 acts of psychological aggression, 11.6 of moderate physical assault, and 4.8 of severe physical assault in the past year.

Men were urn randomized to either the intervention (n=11) or control (n=12) condition, using the following variables: recruitment site, dependence severity, antisocial personality disorder symptoms, frequency of physical partner violence, and readiness to change IPV. The authors note that there were significantly more White men in the intervention group (p=0.03); there were no other significant differences in baseline measures. Following completion of the assessment, men in the intervention were engaged in a 90-minute motivational interviewing intervention, in which a trained doctoral therapist provided written personal feedback on the assessment and discussed this feedback, ending with development of a plan (completed on a worksheet) to make behavioural change/s if the man demonstrated readiness to change. Men were also provided with self-help handouts and a list of treatment resources. In the control condition, men received only the list of treatment resources. The assessment included the following scales: CTS2, Personal Assessment of Intimacy in Relationships, Personal Assessment of Intimacy in Relationships, Change Questionnaire Version 1.2 (to measure motivation to change a behaviour); the University of Rhode Island Change Assessment (URICA); and help-seeking behaviours. Post-treatment, participants completed the Change Questionnaire Version 1.2. One week following treatment, participants were contacted over the phone to assess motivation and help-seeking. Further follow-up assessments were conducted at 3- and 6- month follow-up. Female participants were also contacted following enrollment to measure partner abuse using the CTS2, and completed assessment again at 3- and 6- month follow up by phone.

At 2 weeks post-treatment, the intervention condition reported greater help-seeking compared to the control condition (p=0.04, Cohen's d=0.90). At 3- and 6-month follow-up, both groups showed improvement over time in self-reported alcohol outcomes (p<0.000), anger (p<0.000), and CTS2

measures of psychological aggression (p<0.000) and physical aggression (p=0.036 for male partner's report, and p=0.024 for female partner's report). There was also a significant group main effect for intimacy (p=0.049) and a marginally significant group x time interaction effect (p=0.065), reflecting an increase in intimacy over the six-month follow-up among the intervention group participants, but no change for the control group.

Both conditions demonstrated improvements in abuse outcomes, with the intervention only demonstrating greater improvement in short-term measures of help-seeking. Limitations of the study include: small sample size, potential for socially desirable reporting, loss of participants at follow up (only 52% completed 3 or 6 month follow up assessments), the potential for ethnic and educational differences between intervention and control groups, and lack of description or analysis of the two recruitment sites. The study was conducted with White and Black alcohol dependent men and therefore may be limited in applicability to a similar sub-population of abusers.

Schwartz et al., 2003

A US-based non-RCT by Schwartz et al., 2003 [+] examined the effectiveness of a group therapy intervention in reducing gender role conflict in men who had abused their intimate partner. The study included a total of 21 men attending an abuse prevention programme at a DV shelter; the authors note that the majority of men were mandated to treatment (proportion not provided). In the intervention condition (n=14), participants were a mean age of 31 years; 12 were Mexican American, 2 White, and 1 African American. In the comparison condition (n=7), participants were a mean age of 33 years; 6 were Mexican American, and 1 was White.

Participants were not randomized; a group facilitator volunteered for the group to act as the comparison. The intervention (2 groups of 7 men each) involved 8 sessions 2hours in length, facilitated by two trained psychologists. The group sessions addressed: conflicts between work and family, issues with emotionality, relationships between men, and success, power, and competition. Participants were required to reflect on their fathers and grandfathers behaviour by producing geno-grams. Men were also taught positive non-verbal communication skills. Other sessions included: discussing feelings by using an awareness wheel, learning expressive speaking skills and listening skills, and finally confrontation skills. The comparison condition (1 group of 7 men) received the standard Duluth model of treatment, a socio-cultural and feminist model to educate men on abuse and confrontation as connected to male power and comparison. A male psychologist facilitated this group.

The outcome measure used was the Gender Role Conflict Scale (GRCS) to assess gender role conflict related to: success, power, and competition; restrictive emotionality; restrictive affectionate behaviour between men; and conflict between work and family relations. Assessment was conducted at pre- and post- intervention. No significant differences were found between the intervention and comparison groups at baseline.

The intervention group reported a significantly greater reduction over time for restrictive emotionality (p<0.016) and restrictive affective behaviour between men (F(1,19)=12.77, p=0.002). There was not a significant change for "success, power, and competition" or "conflict between work and family" over time for the intervention or control groups.

Limitations of the study include: small sample size, lack of randomization, lack of follow-up assessment, and lack of measure of violence outcomes. The study was conducted with predominantly Latino men and therefore may be limited in applicability to this sub-population of abusers.

Smith, 2011

A UK-based qualitative study by Smith, 2011 [++] examined perpetrators' perception of change following involvement in abuser schema therapy. The study included a total of 18 men with abuse

problems that had not been through the justice system but had self-referred to the community based service providing the therapy. Men were notified of the programme by their GP but were required to self-refer to be considered for inclusion. Men who were under 18, who had spent time in prison or who had completed prior CBT therapy for anger were excluded from the study. The mean age of participants was 34 years (no other participant characteristics provided).

Abuser Schema Therapy is based on person-centred theory, attachment theory and cognitive behavioural psychotherapy principles. The intervention was manualized and included planned sessions supported by participant handouts and homework assignments. Participants engaged in weekly one-hour sessions for a period of 20 weeks, during which time partners were also provided access to other clinic counsellors. Following pre-assessment, the content of the intervention was as follows: two sessions providing an introduction to the therapy intervention, two sessions on self-monitoring for triggers in a journal, three sessions addressing coping strategies, five sessions addressing automatic thoughts and situational behaviours, one session focused on consolidating therapy components and problem solving, four sessions exploring critical life events and relation to core beliefs, and three sessions devoted to developing maintenance strategies. Follow-up sessions were conducted at 3-, 6-, 9-, and 12- months post-treatment. Interviews were semi-structured and conducted by the researcher in a private room. Full consent was provided and participants were offered additional counselling if required following the interview. The interviews were recorded and transcribed, and were analysed against a set of pre-coded variables drawn from Scott and Wolfe 2000 [+]. These variables were revised, deleted or added to based on manual analysis of the transcripts, resulting in 107 endorsements of the variables that were quantified and ranked.

The four highest ranked variables based on men's narratives were: reduced anger (n=18), increased ability to communicate and assertiveness (n=17), reduced reaction to anger-provoking events (n=10), and perception of responsibility for personal power (n=9). Regarding reduced anger, one man reported: "I don't lose my temper all the time and I know it's not specific to me all the time. I'm not afraid of anger any more. I feel happier, freer than before. I don't feel guilty anymore and the baggage seems smaller- before it was like dragging rocks now they're pebbles. I'm now able to say things in small bits rather than take it out on X (partner). I feel calmer." In regards to communication skills, one man said: "I can be verbally assertive rather than verbally aggressive. I am able to listen to other people's arguments and constructive criticisms. I don't feel hostile to anyone anymore. They have their own point of view." Supporting the theme of reduced reaction to anger-provoking events, one participant noted: "I think a lot more. The aggression isn't there even when I feel angry. I know it's up to me to sort things out for myself." Finally, in support of the theme of responsibility for personal power, a participant stated: "I feel I could handle things differently than before...therapy has helped me to be more assertive, calmed me down. I used to be influenced by outside influences."

Overall, this qualitative study found that men expressed positive changes in regards to anger, communication, negative reactions and personal responsibility, following involvement in abuser schema therapy. The study was well-designed and analysed, including reflexivity, strong theoretical background, methods to reduce bias (external audit of coding and analysis) and providing rich data from the interviews with men (including context of the cases and supporting statements). A weakness of the study is the inclusion of a purposeful sample, and therefore potential for self-selection. Due to the small, qualitative nature of this study, findings may not be generalisable. Further, the study included only men who self-refer and were likely more motivated to change and therefore may not be applicable to men who are court mandated to treatment. Further study is also required to examine the benefit of this therapy for partners/ victims of the participants.

Taft et al., 2001

A US-based non-RCT by Taft et al., 2001 [+] examined the effectiveness of treatment retention procedures during group counselling for male domestic abuse perpetrators. The study included

189 men attending a group counselling programme at an urban DV centre. Participants were a mean age of 34.2 years, primarily Caucasian (60%) followed by African American (33%), primarily court referred (69%), full time employed (89%), not married (70%), had a mean education of 12.8 years and mean monthly income of $1, 593.

Participants were either assigned to the treatment retention cohort (TRC) (n=83) or the control cohort (CC) (n=83). All participants completed 16 weekly 2-hours sessions of group counselling (with 8-9 men per group) delivered by co-therapists. Those in the control group received a CBT programme focused on improving readiness to change, anger and stress management and communication skills, and encouraging non-violence. Participants in the TRC participated in a comparison of the CBT programme with a supportive therapy (ST) alternative. TRC participants were assigned to either CBT or ST depending upon order of entry to the programme. The ST group was unstructured, with minimal therapist direction, but focused on providing a supportive group setting to facilitate emotional expression, improve communication, and improve their relationship with their partner as well as other men. Despite receiving either CBT or ST, all TRC participants received retention procedures which consisted of: written and verbal (via telephone) expression of interest in working with the participant, delivered by the therapist, and a mailed follow up note to clients who missed sessions (including either an expression of concern or desire to see them at the following session). Missed homework assignments were sometimes included with the mailed note. In comparison, CC participants did not receive the retention intervention, but were only contacted if they did not attend their first session or if they did not attend two consecutive sessions (to determine if they were planning to continue/ attend).

Therapists noted session attendance/ dropout. Associations between session attendance and treatment outcome were assessed for the TRC group only, while in the CC, self report data were collected only at post-treatment by completers. Other outcome measures included: relationship abuse assessed by the Revised Conflict Tactics Scale (CTS-2), and criminal recidivism through assessment of state criminal histories 22 to 36 months post-completion. Assessments were conducted at baseline and 6-months follow-up. Monthly income was significantly higher in the TRC group ($p=0.045$) at baseline. There were no significant differences between ST and CBT conditions of the CC in session attendance.

Participants in the TRC attended more counselling sessions than those in the CC ($F(l, 188)=7.313$, $p=0.007$). Participants in the TRC attended a mean 12.89 sessions (SD=3.35), compared to 11.22 sessions in the CC (SD=4.80). The TRC participants also had lower drop out rates (15%) compared to the CC (30%) (chi squared $(1,N=189)=6.45$, $p=0.011$). Multiple regression analysis demonstrated a significant interaction by race and cohort regarding session attendance ($F(l, 179)=4.384$, $p=0.038$). In the CC group, attendance was greater for Caucasians (M=12.16) compared to minority individuals (M=9.93); while in the TRC, ethnic minority participants demonstrated greater attendance (Af=13.42) than Caucasians (M=12.58). There was a negative correlation direction between attendance and victim reports of the following outcomes: physical assault (-0.31, $p<0.05$) and injuries (-0.46, $p<0.01$) at post-treatment and injuries at 6-month follow-up (-0.47, $p<0.01$), suggesting higher attendance was associated with improvements in problem behaviours. No significant associations were reported between session attendance and psychological aggression. State records also suggested that higher attendance was associated with reduced recidivism ($r=-0.49$, $df=57$, $p<0.001$). Of the participants who dropped out of the programme (n=11), 54% had criminal charges at follow-up, compared to a recidivism rate of 10% in those who completed treatment (n=50) (chi squared $(l, N=61)=9.3$, $p=0.002$).

Findings suggest that retention procedures may reduce counselling treatment drop out, particularly for ethnic minority participants; programme attendance was associated with greater reductions in physical assault and injuries but not psychological aggression. Limitations of the study include: lack of randomization, the potential that increases in attendance were due to improvements in the programme or therapist over the course of treatment, and the potential for unknown differences between the groups that may have impacted findings.

Tutty et al., 2001

A Canadian before and after study by Tutty et al., 2001 [+] evaluated the effectiveness of a family-of-origin group therapy treatment approach (reflecting on early experiences of trauma) for male batterers. The study included a total of 104 self-referred and court mandated male batterers, and excluded men with substance use problems, psychosis, or who were denying responsibility for their violent behaviour. The mean age of participants was 34 years; 53% were living with their partner; 87% had children; the mean monthly income was $1,948. Over half of the men (56%) had experienced some form of childhood violence; 8% had observed DV and 23% had been abused as a child. The setting of the intervention was 3 DV agencies belonging to a network that provides support groups for battered women.

The key elements of the intervention were a: feminist examination of gender roles, reflecting on and working with early experiences of violence and childhood traumas, and developing new problem solving strategies with a goal of ending abusive behaviours. Groups (6-8 men in each) were either held for 12 weeks with each session lasting 2 hours, or for 10 weeks with each session lasting 3 hours. A male and female pair of social workers with training in treating family violence delivered the intervention. The goal of the programme is to encourage men to empathize with their partners by identifying and reflecting on their own early traumas, and expressing vulnerable emotions connected to these experiences. Partners are also contacted throughout the treatment, and any controlling or abusive behaviours are identified and addressed. The authors note that these groups are part of a community response to woman abuse, and that support groups for abused women were also offered. No differences were found between programme completers (68%) and non-completers.

Written self-report on the Index of Spouse Abuse (ISA) was used to assess physical and non-physical abuse. Therapists also rated client functioning in 11 areas (including: physical and verbal abuse, controlling behaviours, self-esteem, emotional expression, coping, accepting responsibility, decision making, views of women, social desirability, marital communication).
Psychological, attitudinal and interpersonal measures included the following written self-report assessments: the Interpersonal Support Evaluation List (ISEL) to assess level of social supports; the Internal-External Control Scale to measure locus of control; Perceived Stress Scale; and the Family Assessment Measure-Dyadic Relationship (FAM-DR) to assess marital functioning. Therapists also rated client functioning in 11 areas (including: physical and verbal abuse, controlling behaviours, self-esteem, emotional expression, coping, accepting responsibility, decision making, views of women, social desirability, marital communication). Follow up was conducted at 6 months by mail in assessment.

Statistically significant improvements were found (all $p<0.000$) for adjusted scores (for social desirability) on: physical and nonphysical abuse. Statistically significant improvements were found (all $p<0.000$) for adjusted scores (for social desirability) on: appraisal support, perceived stress, locus of control, and marital relationships functions (FAM-DR) scales of: roles, affective expression, and communication. Improvements in self-esteem ($p=0.024$) and attitudes towards marriage and family ($p=0.059$) were also reported as significant after adjusting for social desirability. Therapists reported significant change for all areas ($p<0.05$) except for social desirability and decision making. No significant differences were found between men court-mandated to treatment compared to voluntary participants.

The study demonstrated significant improvements in psychological, attitudinal and interpersonal measures and a significant reduction in physical and non-physical abuse following involvement in a family-of-origin group therapy treatment. Limitations of the study include: lack of a control group and lack of partner reports to confirm abuse outcomes. The study excluded men using substances and therefore may not be applicable to men who use substances. Due to the non-experimental nature of the study, findings may not be generalisable.

Tutty et al., 2006

A Canadian before and after study by Tutty et al., 2006 [+] examined the effectiveness of a group intervention ("Responsible Choices for Women") for female batterers. The study included 33 women (at final analysis) who had participated in the programme. Demographic characteristics provided were based on 51 initial participants. The mean age was 32 years; half (50%) were married; most (72%) had children; average income was $15,000; most (68%) had a psychiatric history and had received prior counselling (84%). Five of the women (10% of participants) were in a lesbian relationship. The intervention took place in an urban counselling centre.

The treatment involved 2-hour sessions of group therapy (6-12 women per group) for 15 weeks, delivered by a male-female team of therapists. The key goal of the programme is to support women in becoming violence free. Primary objectives include: decreasing abusive behaviour, accepting responsibility for actions, improving self-esteem, increasing assertiveness, decreasing stress, improving relationships, and fostering empathy. Before beginning the programme, women must engage with a primary therapist from the counselling centre who assesses violence, readiness for change, treatment goals, and to determine whether women are acting in self-defence versus perpetrating violence. If women have a current partner, the therapist will also meet with him or her during assessment. The intervention was based on social learning and cognitive behavioural therapy. Techniques include: cognitive restructuring, relaxation techniques, communication skills and sex role socialization strategies, modeling appropriate behaviour monitoring, time-outs, role-playing, and audio-visual support materials. Participants also complete homework assignments in a workbook. Partners are contacted at 3 time-points to assess women's progress and partner safety. Assessment of participants was conducted at pre-, mid- and post- intervention.

Outcome measures included: Abuse of Partner Scales (physical and non-physical violence). Psychological and interpersonal outcome measures included: Hudson Index of Self-Esteem; Generalized Contentment Scale (severity of depression); Index of Clinical Stress (severity of perceived stress); and the Adult Self-Expression Scale (to assess verbal assertiveness).

They found statistically significant improvements on non-physical abuse of partner (p=0.000), but no significant improvement on physical abuse. They found statistically significant improvements on: self-esteem (p=0.001), general contentment (p=0.001), clinical stress (p=0.000), and adult self-expression (p=0.004). There were no significant improvements on other outcome measures.

Findings suggest that the group treatment programme for women batterers was associated with a reduction in non-physical abuse, yet had no association with a reduction in physical abuse, and improvements on several psychological measures. Limitations of the study include: lack of follow up, small sample size, lack of comparison group, and lack of completion (resulting in exclusion of data). While 10% of participants reported being in a lesbian relationship, no further analysis is provided. Findings may not be generalisable due to the small, pilot nature of the study and lack of comparison group.

Tutty et al., 2009

A Canadian before and after study by Tutty et al., 2009 [+] examined the effectiveness of a group treatment programme ("Responsible Choices for Women") for female batterers. The evaluation included all women who had completed the programme since 1995 (n=293), who were clients of a primary therapist in the counselling centre. The mean age of participants was 31 years; women were primarily single (32%), married (21%) or common law (21%); the majority had children (65%); and the mean annual income was $16, 937. The majority of women had engaged in prior counselling (79%), and had experienced family violence in childhood (62%); nearly one-third reported psychiatric problems (29%), while a minority of women reported sexual abuse (8%) and substance use problems (10%).

The treatment involved 2-hour sessions (except for the first and last sessions which were 3 hours) of group therapy (6-12 women per group) for 15 weeks, delivered by a male-female team of therapists. The key goal of the programme is to support women in becoming violence free. Primary objectives include: decreasing abusive behaviour, accepting responsibility for actions, improving self-esteem, increasing assertiveness, decreasing stress, improving relationships, and fostering empathy. Before beginning the programme, women must engage with a primary therapist from the counselling centre who assesses violence, readiness for change, treatment goals, and to determine whether women are acting in self-defence versus perpetrating violence. If women have a current partner, the therapist will also meet with him or her during assessment. The intervention was based on social learning and cognitive behavioural therapy. Techniques include: cognitive restructuring, relaxation techniques, communication skills and sex role socialization strategies, modelling appropriate behaviour monitoring, time-outs, role-playing, and audio-visual support materials. Participants also complete homework assignments in a workbook. Partners are contacted at 3 time-points to assess women's progress and partner safety. Assessment of participants was conducted at pre- and post- intervention. A total of 154 women completed the pre- and post- assessment. No significant differences were found between the original sample and the completers.

Outcome measures related to abuse included: the Abuse of Partner Scales (physical and non-physical abuse); Partner Abuse Scales: Physical and Nonphysical (PASPH) (degree of experience of abuse by partner). Psychological outcome measures included: the Generalized Contentment Scale (severity of depression); Index of Clinical Stress (severity of perceived stress); Rosenberg Self-Esteem Index (self-esteem); and Marlowe-Crowne Social Desirability Test Short Form (assess potential biasing of self-report). The study measured both abuse and psychological outcomes at post-treatment.

The 154 women who completed both pre- and post-tests reported statistically significant improvements on (all p's=0.001): nonphysical abuse of partner, partner nonphysical abuse of the woman, and partner physical abuse of the woman. Partner physical abuse and nonphysical abuse against partner scores moved from the clinical into the nonclinical range. However, these scores should be viewed descriptively only, as these are outside of the women's control and. The only variable that differentiated for the mandated and non-mandated women was nonphysical abuse of partner, with the mandated women reporting use of fewer abusive behaviours at pre-test (p=0.006). There was a non-significant increase in partner physical abuse. However, the authors note that this is likely related to increased honesty regarding abusive behaviours following engagement in the programme. The authors note that 9 relationships were lesbian (4% of sample), and 10% were using substances, although they do not provide an analysis for these sub-groups.

For women who completed pre- and post- tests (n=154), there was a significant improvement in generalized contentment (depression), and clinical stress (all p values<0.009). However, self-esteem significantly decreased (worsened) (p=0.001) and remained at clinical levels. In terms of clinically significant change, the generalized contentment scales and clinical stress scales moved from the clinical into the nonclinical range.

Completion of group treatment programme for women batterers was associated with improvements in non- physical abuse, but no significant change in physical abuse. Limitations of the study include: lack of a control group, lack of follow-up, analysis of completers only, and discrepancies in the reporting of outcomes (some outcomes described as significant, although the statistics provided for only one outcome which demonstrated significance). Finally, the lack of a comparison group limits generalisability.

Waldo, 2007

A US-based cluster RCT by Waldo, 2007 [+] examined the effectiveness of a group counselling approach within a guidance based group programme for male abusers. The study included 99

men court mandated to DV treatment. Participants were a mean age of 30 years; primarily Hispanic (75%); primarily married (48%) or single (37%); less than high school (29%), high school (31%) or college (29%) educated. The setting of the intervention was an urban DV treatment centre.

A total of 6 group programs were included in the data collection and analysis. Guidance sessions were held in groups led by one trained group facilitator and based on the Duluth model. The Duluth model addresses nine topics: nonviolence, non-threatening behaviour, sexual respect, honesty and accountability, support and trust, partnership, respect, negotiation and fairness, and effects of violence on children. Participants were asked to reflect on, define and discuss violence and non-violence. Group leaders provided lectures and handouts to educate participants on violent behaviours, providing the message that violence is a choice and is about trying to gain control of a situation of person/ partner. Group sessions were randomly assigned to either usual treatment (n=72, although n=61 were rateable and therefore analysed) or the intervention (n=60, though n=47 were rateable and therefore analysed). Usual treatment received only the guidance sessions. The intervention group received a counselling session. Prior to the counselling session, intervention group participants had attended a mean of 12 guidance sessions. Leaders of guidance sessions randomly exchanged one counselling session for a guidance session. The counselling intervention was grounded in Yalom's "here and now" processing, which includes participant-to-participant feedback, and participant self-disclosure to facilitate group learning. Facilitators guided the exploration of relationship problems or successes that participants were experiencing.

The following factors from the 'Group Therapeutic Factors Impact on the Dynamics of Abuse' were assessed: universality (realizing that they are not alone in their engagement in abuse); hope (learning that it is possible to change); cohesion (feeling closeness to other group participants); interpersonal learning (openness to feedback from other participants); information (learning about DV); and existential (realizing that they do not control many things). The measurement instrument used was the Critical Incident Questionnaire, conducted post-treatment.

Participants in the guidance sessions reported greater: hope (3% difference) and information (6% difference), while intervention participants reported greater: universality (12% difference), cohesion (7% difference) and interpersonal learning (3% difference). The authors note that because the guidance sessions were not focused on relationships between participants, but rather on providing information, it is less likely that these sessions would foster universality, cohesion and interpersonal learning. No significant differences were found between the groups in their perception that the treatment approach was worthwhile.

This study found differences between a guidance session and guidance session including counselling condition in participants' experiences of therapeutic factors. Limitations of the study include: the use of only one counselling session (may have minimal impact due to low intensity), small (pilot study) sample size, exclusion of responses due to illegible hand-writing (n=24), lack of statistical analysis and use of three different facilitators. The study was small and conducted with predominantly Latino men, and therefore may not be generalisable to other groups of men.

Interventions for Addressing Elder Abuse or Maltreatment

Nahmiash and Reis, 2008

A Canadian based qualitative study by Nahmiash, 2008 [+] compared, through content analysis, the success of a variety of interdisciplinary elder abuse intervention strategies. The study sample included 83 older adults identified as victims of abuse and neglect who had received/ were receiving a home based intervention. One-third of the victims were males and two-thirds females. All types of abuse (physical, psychological, financial, and neglect) were included. Only abuse and

neglect cases in which the abuser is the caregiver were included, and the authors note that this was typically a family member (data not provided).

The intervention model examined was led by multidisciplinary home care professional, including a home care intervention team offering home assessment visits to identify abuse and provide services, and an intervention team who confirms abuse cases using the Indicators of Abuse checklist (IOA). Individual and group intervention strategies are planned based on analysis of the IOA (for example, to address specific problems such as isolation, substance abuse, etc.). Case discussions and intervention strategies are developed using the Abuse Intervention Description (AID) to identify intervention priorities and evaluate the progress of strategies implemented, client acceptability and success in resolving abuse. Other intervention elements included: a team of expert consultants who provide professional information and advice (including criminal justice, financial, psychological, and public guardianship professionals); non-professional volunteer 'buddies' who meet with elders to help reduce isolation and offer advise and support; weekly empowerment support group for abused elders; a family support group for abusive caregivers; and a community Senior Abuse Committee focuses on prevention of abuse, raising community awareness and advocacy.

Following a 2-3 hour home assessment, a trained intervener completed the IOA. Following 3-4 months of an intervention, strategies were rated on an AID form by a multidisciplinary group (3-5 members including e.g. nurse, social maker, intervention consultant, day centre coordinator and home maker), with each intervention rated as: accepted or refused, and successful, partially successful, in progress or not available. Success is measured according to effect on reducing or stopping abuse or solving the issue identified (e.g. isolation). The 83 AID intervention plans were coded by two independent raters, with 473 intervention strategies categorized into10 mutually exclusive activities.

A total of 8% of intervention strategies were successfully or partially successfully rated, with 20% rated unsuccessful. However, 23% of the intervention strategies were still in progress and could not be rated as successful or non-successful. Categories that were most successful included: general medical, nursing and rehabilitation strategies (22.5%). Second to these were abuser caregiver strategies, including individual counselling to reduce anxiety, depression and stress (17.3%). Third, was intervention home making services (15.1%), while the fourth most successful category of intervention strategies was support groups, including: the empowerment group, volunteer buddies, self care counselling, and educational and informational strategies (12.9%). In contrast, intervention strategies most refused included those aimed at improving patient socialization, for example in day centre or community activity programs (only 9.9% successful).

Findings reveal that tailored home-based, multidisciplinary intervention strategies for abused elders were successful (reduced/ stopped violence or improved identified problem) in 8% of cases analyses; and general medical, nursing and rehabilitation strategies were most successful. Limitations of the study include: inability to rate the 23% of interventions in progress, and lack of distinction in analysis between family and non-family member abusers, and limited qualitative analysis (findings limited to presentation of percentages). They do not provide demographic characteristics of the sample, so it is difficult to determine applicability.

Phillips, 2008

A US-based RCT by Phillips, 2008 [+] evaluated the effectiveness of a psycho-educative nursing intervention to decrease physical and psychological aggression by care recipients towards older care-giving wives and sisters, and the impact on specific abuse outcomes (including anger, depression, confusion, anxiety and care-giving burden). The study included a total of 83 women 50 years and older who provided care to elders over 55, and who had experienced a minimum of 1 form of verbal/ psychological aggression once a month, or physical aggression once per year. Hispanic women who identified a country of origin other than Mexico were excluded. Demographics were provided by: intervention (I) and control (C). Caregivers for male elders (who

were a mean age of 76 (I); 74 (C)) were a mean age of 65 (I) or 67 (C) years, White (I: 19%; C: 21%, married (I: 19%; C: 22%, employed (I: 8%; C: 5%), and had known the elder for a mean age of 45 (I) or 43 (C) years. Caregivers for female elders (who were a mean age of 83 (I); 85 (C)) were a mean age of 56 (I) or 59 (C) years, White (I: 13%; C: 23%, married (I: 16%; C: 18%, employed (I: 17%; C: 23%), and had known the elder for a mean age of 54 (I) or 57 (C) years. There were no significant differences between intervention and control on demographic characteristics. The intervention was conducted in the home of participants and by telephone.

Participants were randomly assigned to either intervention (n=38) or control (n=45) by coin flip. The intervention included lessons on: pattern identification, advocacy counselling, re-framing of the caring situation and discussion of non-confrontational care-giving techniques. The intervention was individualized, interactive and included collaborative problem solving and planning. During each session, caregivers presented problems they had encountered and the interventionist facilitated a discussion of the problem, triggers and relationship patterns associated with aggression, along with new strategies for managing the problem. The key message was to “stop, plan, and practice,” which was also provided on a magnet as a reminder. The goal was to recognize tension, analyse the problem, plan a different strategy and rehearse their response before they spoke or acted. The control group received no intervention.

Outcome measures included: the Revised Conflict Tactic Scale (CTS-R) to assess past and current aggression (modified using a scale specific to elder abuse and abuse against caregivers); Profile of Mood States Scale (POMS) to measure negative mood; and the Care-giving Burden Scale to measure social function and disruptive behaviour burden associated with caregiving. Assessments were conducted at baseline and 3-month follow- up. A total of 15 participants were lost before baseline data collection due to a change in the mind of the caregiver, death of the elder or relocation of the elder to a nursing home.

Findings revealed no significant differences for groups for physical aggression between baseline and follow up. No significant effect was found for the intervention on mood states or the 2 types of measured care-giving burden. For depression, there was a significant main effect × time interaction, with both intervention and control participants demonstrating a reduction over time ($F=4.22$, $p=0.04$). Caregivers of men in the intervention demonstrated a significant reduction in anger over time ($F=3.99$, $p=0.05$) and confusion over time ($F=4.74$, $p=0.03$).

Findings reveal a lack of effect of the psycho-educational on physical aggression, mood states or care-giving burden, although caregivers of men in the intervention did report a significant reduction in anger and confusion over time. Limitations of the study include: reliance on self-report of caregivers, lack of information on the perspective of elders regarding abuse, limited description of the source population, and under-powered for analysis. The author does not provide a full description of the sample, including ethnic composition of all participants, and therefore it is difficult to determine applicability.

Reay and Browne, 2002

A UK-based interrupted time series by Reay & Browne, 2002 [+] examined the effectiveness of a psychological educational and anger management intervention for individuals who neglect or abuse their elderly dependents. A total of 19 participants were referred to the intervention by their GP or psychiatrist. In most cases, the perpetrator of neglect (n=5) or abuse (n=7) was the elderly spouse of the victim, followed by the adult child of the victim (32%; abuse n=2, neglect n=4), and in one case of neglect the perpetrator was the elderly sister of the victim (5%). Participants had already admitted abuse, were living with the victim, were retired, in good physical health and living in adequate housing. Victims were not suffering from dementia. Participants were divided into two groups based on admittance of either physical abuse (Group 1, n=9) or neglect (Group 2, n=10). Group 1 included 6 males and 3 females aged 65-72 years; Group 2 included 3 males and 7 females aged 67- 74 years. No further demographic data was provided.

Following completion of initial history intake and assessment measures, participants engaged in the educational component of the intervention. This component was 90 minutes, delivered by a clinical psychologist, and involved a semi-structured interview regarding the victims' illnesses, local services (e.g. support groups for caregivers, day care) and resources available, and issues with caring for the elderly (including: stress, loss of control and isolation). One week following completion of this component, the assessment measures were completed again. Four weeks later, participants were re-engaged in a 90-minute individual therapeutic anger management programme focused on identifying and managing stages of anger. Assessments were again completed one week later. The final follow-up was conducted at a 6-month follow up appointment. Outcome measures included: the Conflict Tactics Scale (CTS) to assess behaviours during conflict situations; Machin's Strain Scale (SS) to measure caregiver stress; Beck Depression Inventory (BDI); Beck Anxiety Inventory (BAI); Cost of Care Index (CCI) to measure personal, social, emotional, physical and economic costs associated with care-giving.

No significant differences were found at pre-intervention between participants who physically abused or neglected their elderly dependent based on age and gender of the caregiver or victim. For physical abusers, they found a trend for reduction on the CTS between baseline to post-treatment, and 6 month follow up ($z=4.8$, $p<0.09$, Friedman test, two-tail). This trend was not found for neglecters. A significant change in the reduction of conflict occurred after the anger management intervention ($p<0.05$, Wilcoxon's test), but not the education component. A significant difference was found in the mean score on the CTS when comparing physical abusers to neglecters at each assessment point ($p<0.01$, Mann Whitney U test). There was also a significant reduction in reported strain by both abusers and neglecters overall ($z=17.2$, $p<0.001$; $z=19.2$, $p<0.001$, Friedman test; respectively), with a significant change after each intervention (Wilcoxon's tests, $p<0.01$), that was greatest for the neglect group post-education intervention. Level of depression also significantly reduced for both groups overall ($z=16.2$, $p<0.001$; $z=20.0$, $p<0.001$, Friedman test; respectively), with changes following each intervention (Wilcoxon's tests, $p<0.01$). A greater reduction was observed in the neglect group following the education intervention, whereas a greater reduction was observed in the abuser group following the anger management intervention. Significant changes were found for reduction in anxiety in both groups ($z=15.2$, $p<0.0005$; $z=20.0$, $p<0.0001$, Friedman test; respectively), at each intervention stage (Wilcoxon's tests, $p<0.05$), with the physical abuse group demonstrating greater changes post–anger management and the neglect group post-education. Participants in the neglect group had higher anxiety scores than those in the physical abuser group at baseline, post-intervention, and follow-up (p's $< .01$, Mann Whitney U test). Finally, cost of care was significantly reduced in both groups overall ($z=16.2$, $p<0.001$; $z=10.4$, $p<0.001$, Friedman test; respectively), with no significant differences between the two groups. Although CCI scores significantly reduced overall, for the physical abuse group, CCI scores significantly increased following the education intervention (Wilcoxon's test, $p<0.01$) before dropping again post-anger-management.

Findings reveal an overall reduction in strain, depression, anxiety and cost of care for both groups; greater reductions were observed for the neglect group on strain, depression and anxiety following the education component, and greater improvements for the physical abusers on depression and anxiety following the anger management component. The anger management intervention was associated with significant reduction in conflict among the physical abusers, but not neglect group. Limitations of the study include the use of a small sample size, lack of a control group, poor description of sample and potential for self-report bias. While the study was conducted in the UK, limited demographic data is provided, and therefore it is difficult to determine for whom these findings are most applicable. These findings cannot be generalized due to the small sample size.

Interventions for Couples

Babcock et al., 2011

A US-based RCT by Babcock et al., 2011 [+] examined the impact of two communication skills training exercises for couples on men's emotional change during arguments with their partners. The study included married or cohabiting English speaking couples that had experienced at least two incidents of male-to-female aggression in the past year, or no relationship violence but low female-partner satisfaction with the relationship. Eligible couples that agreed to participate, were classified using the Conflict Tactics Scale-2 (CTS2), and completed both days of data collection. Couples classified as "distressed nonviolent", those with incomplete data, and those where the female partner anticipated increased violence from their partner if they participated were excluded. A total of 100 men and their partners were included in the study. Men were a mean age of 31.6 years, had a mean annual family income of $30,769, a mean level of college education, had been in the relationship for a mean of 3.8 years, and had a mean of 19.1 acts of physical violence reported by female partners in the past year. Participants were primarily African American (48%), followed by Caucasian (26%) and Hispanic (18%).

Men were randomly assigned to one of three conditions: editing- out- the- negative (n=39); accepting-influence (n=30), and a placebo/ time- out condition for the control (n=31). There were no differences at baseline between the groups. Couples discussed an area of conflict twice, interrupted by a brief intervention or placebo/ time-out. First, couples were separated to complete a questionnaire and then rejoined for the videotaped conflict discussions. The aim of the interview was to identify conflict area in their relationship. Couples were requested to sit quietly for a 4-minute eyes-open baseline, then to engage in two 7.5-minute conflict discussions. These discussions were interrupted by either the intervention (either editing out the negative or accepting influence) or time-out/ placebo task, where men received instruction according to treatment group and women listened to music on headphones. Both partners completed an "About That Discussion" (ATD) questionnaire (designed for the project) after each conflict discussion. Finally, participants were interviewed individually and debriefed. In the editing-out-the-negative exercise, a grad student taught men to substitute their immediate negative response with a more neutral one. In the accepting-influence condition, a grad student taught men to search for the "kernel of truth" of their partner's argument with which they could agree, recognizing some validity in their partner's statements. In both intervention conditions, men were instructed to practice the skill in the upcoming argument without informing his partner what he was doing or why. In the placebo/ time-out condition, men listened to music for 8 minutes and received instructions to relax.

The discussions were videotaped and coded by a team of 10 trained coders, who were blinded to treatment condition. The Specific Affect Coding System (SPAFF) was used and codes were collapsed into global "verbal aggression" and "positive" categories. Men and women completed the ATD questionnaire to assess self-report of positive and aggressive affect. Follow-up was conducted with female partners one week after participation to check that no violent incidents occurred. However, there was no follow-up for outcome measures.

Men in both of the skills-training conditions demonstrated a greater decreases in aggressive feelings than men in the time-out condition based on self-report ($F(2,97)=3.37$, $p<0.05$, eta square=0.71) and observed affective behaviour (positive affect $F(2,97)=3.38$, $p<0.05$, eta squared=0.014; aggressive affect $F(2,97)=3.37$, $p<0.05$, eta squared=0.054). Women also reported feeling less aggressive when their husbands were assigned to one of the skills-training conditions, compared to the control (time-out) condition ($F(2,97)=3.44$, $p<0.05$, eta squared=0.056).

This study reveals that teaching abusers communication skills can improve men's emotional reactions during arguments with a partner. Limitations include: the use of a voluntary sample of men (may not be representative of court-mandated men or women seeking shelter), the use of a

small sample size (could not test for four-way interactions), and lack of follow-up outside of the laboratory setting. The authors note that the ethnic composition of the sample differed from the larger population. Differences between intervention procedures and real life interactions (e.g. music used during time-out, men not allowed to leave room) may limit generalisability outside of the intervention setting.

Cleary-Bradley et al., 2011

A US-based RCT by Cleary-Bradley et al., 2011 [+] evaluated the efficacy of Creating Healthy Relationships Programme (CHRP), a couple and relationship education programme for low-income parenting couples who exhibit situational violence. They define situational violence as reciprocal violence, with each partner engaging in low levels of violence. To participate, couples had to be in a relationship for a minimum of one year, be over 18 years and speak English, have at least one child under 12 years, have a combined income below the county median for a family of 3 ($73, 000) and be experiencing situational violence. A total of 115 couples participated in the study. Male participants were between ages 27-43; primarily Caucasian (79%); most had a high school (35%), some college (19%), or a professional degree; and the majority was full-time employed (70%). Female participants ranged in age from 26 to 42 years old; were primarily Caucasian (87%); and most had a college (33%) or high school education (27%).

The intervention was psycho-educational and based on 'house theory', which describes relationship characteristics associated with relationship satisfaction and longevity. The 'sound relationship house' is comprised of seven levels or 'floors' of the house, each representing a different relationship aspect that contributes to a healthy relationship. The foundation of the house includes: friendship, fondness and admiration; other levels include: conflict management and creating shared meaning (skills associated with building shared: values, beliefs and goals). The focus of the intervention is largely on strengthening these relationship domains by building skills related to: conflict management, emotional intimacy, friendships, and a culture of appreciation, fondness and respect. The CHRP includes five content areas: Managing Stress; Establishing Emotional Connections in the Family with Partners and Children; Maintaining Intimacy; Creating Shared Meaning; and Managing Conflict. The intervention content was designed for a lower literacy level and pilot tested with low income couples.

Surveys assessing relationship status (whether couples were together or not), relationship skills (including communication and interaction patterns), relationship satisfaction (measuring contentment with relationship) and relationship conflict, were completed at baseline and post-intervention (between 0 to 6 months following the intervention). Couples were randomly assigned to either the treatment (n=62) or control group (n=53). The intervention was held weekly for 2 hours per session, for a period of 22 weeks (44 hours of total programming). Sessions were co-facilitated by male/ female clinicians and held with groups of 6-8 couples. Each session began with a video showing diverse couples participating in a talk show focused on the session topic. Following the video, couples engaged in a discussion of their thoughts and feelings about the topic, which was followed by an educational component taught by the facilitators. Sessions also included skill building exercises that allowed participants to practice relationship skills. Couples in the control group did not receive the intervention but were referred to community resources.

The majority of couples (73%) were found to have remained together throughout both assessment periods. The control group included more couples that dissolved their relationship (57%) compared to the intervention (43%), although this difference was not significant, ($\chi 2(1)=0.01$, $p=0.94$). Regarding relationship satisfaction, for male reported satisfaction, there were no main effects; however, for female reported satisfaction, the interaction model revealed no significant differences across time for controls but a significant difference between baseline and follow-up for couples in the intervention ($t=-2.18$, $p=0.04$), with satisfaction reportedly higher at post-test. For male reported relationship skills, the interaction model revealed no significant differences across time for controls and a difference that trended toward significance for couples in the intervention yet was not significant ($t=-2.02$, $p=0.06$). For female reported relationship skills,

there was no significant difference for controls, and a difference that trended toward significance for treatment couples (t=−1.87, p=0.08), with skills somewhat higher at post-test. For male-reported relationship conflict, there was a significant difference across time for the treatment group (t=4.18, p=0.001), with conflict lower at post-test assessment. There was no main effect for female-reported conflict.

Overall, findings reveal that in the intervention group there was: increased female-reported relationship satisfaction, a trend towards improved male-reported and female-reported relationship skills, and reduced male-reported conflict. Limitations of the study include the high attrition rate (between baseline and post-intervention assessment, 41 subjects withdrew from the study), potential for self-report bias and variability in timing of post-test assessments due to difficulties in reaching participants. The study was conducted with situationally violent (low level of reciprocal violence) parenting couples and therefore may not be applicable to other types of DV or other populations.

Fals-Stewart et al., 2002

A US-based individual RCT by Fals-Stewart et al., 2002 [+] conducted a secondary data evaluation (using data from a prior 1996 study) comparing the impact of a behavioural couples therapy and individually based treatment for substance abusing men, on male to female partner violence. The study included a total of 86 couples. To be eligible, men had to be 20-60 years old, married for one year or living together for 2 years, and met DSM-IV criteria for a substance use disorder. Men were required to agree to abstain from substances during treatment and not be seeking treatment elsewhere (aside from self-help meetings). Couples were excluded if the female partner met DSM–IV criteria for a psychoactive substance use disorder in the past 6 months or if either partner met DSM–IV criteria for mental or psychotic disorders. The setting of the intervention was two community-based outpatient clinics. Participants were a mean age of 34 years, primarily Caucasian (84%), had a mean education of 11.9 years, a mean relationship length of 6 years, and an average of 2 children. Most men were court mandated to attend treatment (85%). Men were primarily cocaine (63%) or alcohol (40%) dependent, followed by opiates (38%) and cannabis (35%).

The total 86 couples were randomized to either: intervention (BCT) (n=43 couples), or comparison (IBT) (n=43 couples). There were no significant differences between the groups at baseline. In both conditions, participants were to receive 56 sessions. In the behavioural couples therapy (BCT), following 4 weeks of orientation, men engaged in 12 weeks of one individual 60-minute session and one 90-minute group session per week, in addition to 60 minute BCT treatment conjoint sessions. The individual sessions and group sessions for men focused on developing coping skills to abstain from drugs or alcohol. In the couple's sessions, the non–substance-abusing partner was actively involved in the intervention, with sessions focused on: supporting male partners to abstain from alcohol and other substances, teach communication skills, improve relationship satisfaction and encourage positive behavioural exchanges between partners. Couples in the intervention were also required to verbally agree to refrain from engaging in any form of angry touching. Following these 12 weeks, men engaged in 8 weeks of weekly 60-minute sessions dedicated to discharge planning. The IBT condition (n=43 couples) was identical, except the couples session was omitted and replaced with an additional 60-minute individual session per week. Trained substance abuse counsellors delivered both interventions. Men who attended less than half of the sessions (IBT n=3) were excluded from the analysis.

The focus of this analysis was women's reports of partner violence in the past year using the Conflict Tactics Scale (CTS). This measurement was completed at programme entry and one-year post treatment. Prior to treatment, there was no significant difference in male to female physical aggression for couples in the BCT (n=17, 43%) and IBT (n=19, 48%) conditions. At one-year post-treatment, couples who participated in the BCT group reported significantly lower aggression (n=7, 18%, p< 0.01), compared to those couples in the IBT group who demonstrated no significant reduction in aggression (n=17, 43%).

Findings reveal a significant reduction in aggression in couples attending the BCT that was not observed among men attending the IBT sessions. Limitations of the study include: post hoc analysis, and lack of examination of violence frequency measures or female-to make aggression. Further research is also needed to investigate if the effectiveness of the BCT intervention was due to the violence reduction strategies learned by female partners. The sample was primarily White, court mandated men with all men using substances so may not be applicable to other sub-groups of couples in which the men are not using substances.

Fals-Stewart et al., 2009

A US-based RCT by Fals-Stewart et al., 2009 [++] examined whether participation in couples therapy, compared with individual therapy, had a differential effect on the day-to-day relationship between substance use and IPV among married or cohabiting substance-abusing men. The study included a total of 207 heterosexual couples where the male partner had perpetrated IPV against the female partner. To be eligible, participants had to be 20-60 years old, married for one year or living together for 2 years, and meet DSM-IV criteria for a substance use disorder. They were also required to agree to abstain from substances during treatment and not be seeking treatment elsewhere (aside from self-help meetings). Couples were excluded if the female partner met DSM–IV criteria for a psychoactive substance use disorder in the past 6 months or if either partner met DSM–IV criteria for mental or psychotic disorders. The setting of the intervention was a community-based outpatient clinic.

In the intervention (BCT), male participants were a mean age of 32.8 years, primarily White (67%), had a mean education of 14.5 years, and an average of 9.8 years of problematic substance use. Their female partners were a mean age of 31.6 years, primarily White (70%), with a mean education of 14.8 years. The mean number of years married or cohabiting was 5.2 years, and they had an average of 1.8 children, and income of $44, 127. Substances for which male participants met DSM-IV substance dependence criteria were: 72% alcohol, 17% cannabis, 50% cocaine, 34% opiates, 20% other. Most male participants were referred by a physician or provider (33%), followed by self- (19%) or probation- referred (19%). In the comparison group (IBT), male participants were a mean age of 33.3 years, primarily White (69%) had a mean education of 14.9 years. The mean age of female partner was 32 years, they were primarily White (70%), with a mean education of 15 years, and had an average of 10.1 years of problematic substance use. The mean number of years married or cohabiting was 5.4 years, and they had an average of 1.6 children, and income of $45,924. Substances for which male partners met DSM-IV substance dependence criteria were: 76% alcohol, 15% cannabis, 46% cocaine, 31% opiates, 23% other. Most men were referred by a physician or provider (32%), followed by self- (21%) or probation-referred (17%).

The total 207 couples were randomized to either: intervention (BCT) (n=103 couples), or comparison (IBT) (n=104 couples). There were no significant differences between the groups at baseline. The manualized intervention was 32 sessions of 60minute behavioural couples therapy (BCT). Both partners attended 12 BCT treatment sessions together during which the non–substance-abusing partner was actively involved in the intervention. The BCT sessions were aimed at supporting male partners to abstain from alcohol and other substances, teach communication skills, improve relationship satisfaction and encourage positive behavioural exchanges between partners. Couples in the intervention were also required to verbally agree to refrain from engaging in any form of angry touching. In the case of relapse, women were taught not to engage with their partner in discussion or conflict resolution, but to use time-outs, develop a safety plan, and avoid using abusive retaliate behaviours. In the next 20 sessions, men participated in individual, 12-step substance use treatment sessions based on the Individual Drug Counselling manual. This treatment conceptualizes alcoholism as a spiritual and medical disease, and is aligned with the Alcoholics Anonymous philosophy. Abstinence from alcohol and other substances was encouraged and participants were requested to attend Alcoholics' Anonymous self-help groups. The comparison group was a 32 session, 60minute individual-based treatment

(IBT). Partners did not attend the sessions. Participants received the same 20 individual-based sessions as substance-abusing participants in the BCT condition plus an additional 12 sessions with a 12-step facilitation focus. Therapists (n=6) providing the interventions (both BCT and IBT) were all trained substance-abuse counsellors.

Substance use was assessed using: the Timeline Follow-back Interview (a calendar and memory prompts to assess substance use, and percentage of days abstinent (PDA)), and partner interviews to assess substance use using the Structured Clinical Interview for DSM–IV. IPV was assessed using the Timeline Follow-back Interview–Spousal Violence, (event history calendar (using violence measures from the Conflict Tactics Scale) to track male-to-female percentage of days with any violence (MFPD-AV) and male-to-female percentage of days with severe violence (MFPD-SV)). Assessments were conducted every 3 months until 1 year post-treatment. Attrition was low (81% of couples completed assessments).

Both groups reported more substance-abstinent days and a decrease in IPV at post-treatment and at the 12-month follow-up (all p's<0.05). Couples in the BCT condition reported lower levels of IPV and substance use at a 12-month follow-up compared with couples with male partners in IBT (all p's<0.05). Treatment assignment was a significant moderator of the reported relationship between substance use and IPV. Likelihood of non-severe ($p<0.01$) and severe ($p<0.05$) male-to-female partner violence on days of male substance use was lower among couples that received BCT compared with IBT. On days of no substance use, there was no difference in the likelihood of male-to-female IPV for those in BCT or IBT; both were equally effective.

Couples in the intervention reported lower levels of IPV and substance use and also on days of drinking or drug use, reported significantly lower levels of IPV compared to the comparison group. The study was robust in design and analysis. The study could have been further strengthened by the inclusion of data collection on violence-reduction strategies used by female partners. Further research is needed to investigate if the effectiveness of the BCT intervention was due to the violence reduction strategies learned by female partners. The sample was primarily White and middle income, with all men using alcohol or substances so may not be applicable to other ethnic groups or lower income couples in for whom men are not using alcohol or substances.

O'Farrell et al., 2004

A US-based before and after study by O'Farrell et al., 2004 [++] examined the impact of behavioural couples therapy (BCT) on IPV in couples where the male partner abuses alcohol. The study included heterosexual couples with an alcoholic male partner, who entered the Counselling for Alcoholics' marriages (CALM) Project at one of four addictions treatment programs between Feb 1992 and Jun 1998. To be included, participants must be 21- 65 years old, married or living together for at least one year, and meet DSM–III–R criteria for alcohol abuse/ dependence. Patients were required to be abstinent for the duration of treatment and to consider taking Antabuse (if medically cleared), and could not be involved in other treatment. Patients were excluded if they met DSM–III–R criteria for a current psychotic disorder, or if the female partner met criteria for current alcohol or drug abuse or dependence. The study included a total of 303 couples. Male alcoholics were a mean age of 43.3 years, were predominantly White (95%), had a mean income of $40-50, 000, had been in the relationships for a mean of 13.2 years, and most were married (88%). Female partners were a mean age of 41.1 years, and were primarily White (96%). In the non-alcoholic comparison sample, men were a mean age of 43.3 years, were predominantly White (94%), had a mean income of $40-50, 000, had been in the relationships for a mean of 14.4 years, and most were married (96%). Female partners were a mean age of 41.1 years, and were primarily White (96%). The setting of the intervention was a treatment centre.

The BCT programme involved 20–22 weekly sessions over a period of 5-6 months by trained therapists following a treatment manual: 10-2, 1 hour initial conjoint pre-group sessions were held with each couple followed by 10, 2 hour couples group sessions. Participants completed a daily sobriety contract (for most participants this also included daily use of Antabuse, witnessed by the

partner), and engaged in positive couple and family activities, and training related to communication and negotiation skills. Willing patients also participated in 12-step meetings as part of the sobriety contract, along with urine drug screens for those with a co-occurring drug use problem. Violence was addressed during couples' sessions, and forms of non-violence and positive communication and interaction patterns were taught. While there was no random allocation, a demographically matched non-alcoholic comparison sample was recruited (from participants of the1985 National Family Violence Re-Survey) to act as a comparison group (n=303). The treatment and comparison group did not differ on matching variables (all p's>0.15) aside from marital status, with the alcoholic sample had more cohabiting and less married couples than the comparison group.

Outcome measures for IPV included: the verbal and violence subscales of the Conflict Tactics Scale (CTS). Alcohol use and abstinence was tracked using the Timeline Follow-Back Interview (to assess number of days drinking in the year before and 2 years following the BCT). An attendance log was used to track sessions attended by couples. The use of BCT-targeted behaviours was measured within the past 90-days using two scales (to measure amount of desired changes in a partner, and measures of overall relationship adjustment) from the Couples Behaviours Questionnaire (CBQ). Quarterly follow-ups were conducted for two years post-treatment.

In the year prior to involvement in BCT, 60% of alcoholic patients had been violent toward their female partner, compared to12% in the matched comparison group. In the one and two years following BCT, violence and verbal aggression both decreased significantly (in both prevalence and frequency, all p's<0.001; Year 2 male-perpetrated effect sizes were: verbal aggression prevalence r=0.62, overall violence prevalence r=0.61, severe violence prevalence r=0.36, verbal aggression frequency=0.44, overall violence frequency r=0.38, severe violence frequency=0.19). At the 2-year follow-up, there were no significant differences between the treatment and comparison groups on overall or severe violence, yet the comparison group reported significantly higher rates of verbal aggression; relative risks for men were: verbal aggression=2.2, overall violence=1.2, severe violence=1.1. Patients who abstained from alcohol after BCT had clinically significant violence reductions; by the 2-year follow-up, there were no significant differences between this group and the comparison sample on male violence. Relapsed patients demonstrated improvement but by the 2-year follow-up, continued to report significantly greater verbal aggression than the comparison group (p's<0.001). Days-with-drinking was significantly correlated with male-to-female aggression on: violence prevalence and frequency and verbal aggression frequency, (all p's<0.05, r's ranging from 0.13-0.20) but not for: verbal aggression prevalence and frequency, or severe violence prevalence and frequency. Structural equation modeling revealed that greater treatment involvement (both attending BCT sessions and using BCT-targeted behaviours) was associated with lower violence following BCT (p's<0.05 for parameter estimates in the model), which was mediated by reduced problem drinking and enhanced relationship functioning (p's<0.01 when *either* reduced problem drinking or enhanced relationship functioning was the sole mediator, but not significant when both were included as mediators in the model).

This study revealed that involvement in a BCT intervention was associated with reduced violence outcomes, and that abstinence from alcohol was associated with more sustained (2 year) improvements in violence reduction. While the study was robust, limitations of the study include the lack of a randomized control group, and inability to infer causation between continued drinking and continued violence. The study was conducted with White, middle class men using alcohol, and therefore may not be applicable to other groups of male abusers.

Schumm et al., 2009

A US-based before and after study by Schumm et al., 2009 [+] investigated the impact of women's alcoholism treatment on partner aggression to examine if IPV decreases after women receive alcoholism treatment, similar as it does among men. The study included 103 heterosexual

couples with an alcoholic female partner, who were beginning the Counselling for Alcoholics' Marriages programme (total n=412; intervention n=103 couples; matched with non-alcoholic comparison n=103 couples). To be included, participants were required to be age 21-65 years, married or living together for one year, could not be involved in other counselling for alcoholism and be willing to abstain from alcohol during treatment and take Antabuse medication if cleared, and not presenting with a psychotic disorder. Participants entering the programme had previously completed inpatient alcoholism treatment (41%), outpatient alcoholism treatment (25%) or were responding to a recruitment flyer or other referral (34%). Intervention participants were a mean age of 39.96 years, were primarily White (92%), and had a high school education. Male partners were a mean age of 42.23 years, primarily White (90%), and college educated. The mean length of the relationship was 11.17 years, the majority was married (86%), and the mean family income was $45-50, 000. The study was non-randomized, with treatment participants compared with a demographically matched group of non-alcoholic females and their partners who had completed a survey several years prior to this study. Comparison group participants had been in slightly longer relationships (mean length12.64 years) and a greater proportion were married (99%), but otherwise did not differ. The setting of the intervention was an urban community counselling programme.

The intervention was a Behavioural Couples Therapy (BCT) programme, involving 20-22 weekly sessions for a period of up to 6 months conducted by master's or pre-doctoral level trained therapists, following a treatment manual. Participants received an average of 16.7 sessions. The programme included daily recovery contracts (for most, with Antabuse ingestion witnessed by the partner), positive family and couple activities, training in non-violence and communication and negotiation skills training. Recovery contracts included 12-step meetings for willing patients, along with drug testing for those with co-occurring substance use issues.

Outcome measures included: the verbal aggression and violence scales of the Conflict Tactics Scale (CTS); and the Timeline Follow-Back interview (TLFB) to measure female alcohol use (via self-report) in the year before and 2 years following the intervention. Based on TLFB responses, women were classified as either "remitted" or "relapsed." In the intervention group, the CTS was completed by both the female alcoholic and partner, while in the comparison group only the male partner reported. Follow up on alcohol use was conducted pre- and post- programme, and at quarterly intervals for 2 years post-programme. Partner aggression was measured at pre- and post- programme, and 1- and 2- years post-programme.

When comparing the year before and 2-years post intervention, significant reductions were found on each prevalence of aggression measure (female-to-male: elevated verbal aggression ($Q=53.39$, $p<0.001$, $r=0.63$); overall violence ($Q=41.27$, $p<0.001$, $r=0.58$); severe violence ($Q=35.45$, $p<0.001$, $r=0.55$); male-to-female: elevated verbal aggression ($Q=42.17$, $p<0.001$, $r=0.58$); overall violence ($Q=44.74$, $p<0.001$, $r=0.59$), severe violence ($Q=8.72$, $p<0.01$, $r=0.31$). In the 1-year following BCT, 45% of participated were remitted and 55% relapsed. In the 2nd year, 49% of participated were remitted and 51% relapsed (no data provided on significance). In the year prior to BCT, 68% of female alcoholic patients reported violence toward their male partner, compared to 15% in the non-alcoholic comparison group. When comparing remitted female alcoholic patients (following the intervention) with the non-alcoholic comparison sample, no significant differences were found.

Findings reveal a significant reduction in aggression for female alcoholic couples that attended the behavioural counselling intervention. The study did not include a control group, and therefore findings cannot be causally linked to the intervention. Other limitations include: limited description of the treatment programme, potential for cohort effects (due to collection of comparison sample data years prior to the study), and lack of self-report on aggression measures in the comparison sample. Given the lack of control group, it is not possible to generalize findings. The study was conducted with predominantly White heterosexual women, and therefore findings may not be applicable to diverse groups of women and their partners.

Woodin et al., 2012

A US-based before and after study by Woodin et al., 2009 [+] examined how brief motivational interviewing behaviours impact changes in male-to-female partner aggression for men and women in a couple's intervention. The study included 25 couples recruited from a University setting, who were experiencing physically aggressive dating behaviours. To participate, individuals had to be aged 18-25, dating for a minimum of 3 months, had no prior marriage or cohabitation, and had experienced a minimum of one act of male to female partner aggression in the past 3 months. Female participants were an average age of 19 years, and primarily Caucasian (48%) or Asian American (44%). Male participants were an average age of 20 years, and primarily Caucasian (60%) or Asian American (42%). The men length of the relationship was 24 months, and the mean family income was $70,000 - $79,999. The setting of the intervention was a university counselling programme.

The intervention began with a conjoint 2-hour assessment and interview of couples, led by a trained female therapist. This was followed with a 45 minute feedback session completed several weeks after the assessment. The treatment was manualized, all sessions were videotaped and therapists were supervised and assessed for treatment fidelity. During the feedback session, therapists met with men and women individually, and using motivational interviewing principles (empathic, non-confrontational, client-centred approach), discussed with the participant the potential impacts of the aggression on the individual and the relationship, and facilitated a discussion of potential behaviour change and risk factors for aggression. The therapist reinforced any participant statements indicative of motivation change. Following this feedback session, couples were brought back together for a 15-minute conjoint session (details not provided or assessed in this study).

Therapist behaviours by assessing videotapes sessions using the Motivational Interviewing Treatment Integrity Code: Version 2.0 (MITI) which assesses global therapist characteristics of MI (including spirit, empathy) and behaviour frequencies (for close-ended/ open-ended questions, reflections, and MI adherent (asking permission, affirm, emphasize control, support); and MI non-adherent behaviours (advise, confront, direct). Participant physical aggression was assessed by using the Revised Conflict Tactics Scales (CTS2). Assessment was completed via online questionnaires at 3-, 6- and 9- months post-intervention.

Their analysis revealed that higher levels of global empathy were related to marginally greater aggression reductions for women (effect size [r]=0.14), but not for men, though this finding was not significant. Greater use of reflection to question ratio was associated with greater aggression reductions for both men ($r=0.30$, $p<0.001$) and women ($r=0.19$, $p<0.05$). As well, a higher percentage of open-ended questions were related to significantly greater reductions in aggression for women ($r=0.19$, $p<0.05$), but not for men. Global MI spirit, the use of complex reflections and MI adherent behaviours were not found to significantly impact aggressive behaviours.

Findings suggest that some of the therapist behaviours consistent with MI principles were associated with reductions in aggression in a brief intervention for couples, with some variations in outcomes for women and men. Limitations of the study include the use of a small sample size, low follow-up rates for men in general (62% follow up at 3 months; 40% by 9 months) and at 9 month follow-up (62% overall follow up at 9 months), and lack of analysis of non-completers. Participants were largely high income, Caucasian or Asian American University students, and therefore findings may not be applicable to other couples that experience aggression or violence.

6.5. Evidence Statements

We have organized the findings using the following categories:

1) Advocacy interventions

2) Skill-building interventions
3) Counselling and brief interventions
4) Therapy interventions
5) Individual interventions for abusers
6) Short duration group interventions measuring recidivism/ abuse outcomes
7) Short duration group interventions measuring attitudinal, psychological and interpersonal outcomes
8) Long duration group interventions measuring recidivism/ abuse outcomes
9) Long duration group interventions measuring attitudinal, interpersonal and psychological outcomes
10) Couple interventions including substance use treatment
11) Couples interventions not including substance use treatment
12) Interventions addressing elder abuse

Advocacy interventions are those that inform, guide and help victims of DV to access a range of services and supports, and ensure their rights and entitlements are achieved. Skill-building interventions include training and educational interventions aimed at improving various skills among victims of abuse (including relaxation, decision making, and financial skills). Counselling/ brief interventions promote a range of outcomes, such as reducing depression and increasing empowerment among those who have experienced DV, through interventions based on psycho-educational, cognitive-behavioural, and motivational interviewing approaches. Therapeutic interventions promote improvement in posttraumatic stress symptoms, depressive symptoms and related mental health impacts of violence, through more intensive treatments than counselling interventions such as group therapy.

For group interventions for abusers, note that short duration interventions were those that were 16 weeks or less in duration, while long duration interventions were those that were over 16 weeks in duration. Recidivism and abuse outcomes include: recidivism rates (measured by official criminal/ legal records), self- or partner- reports of aggression or various forms of abuse (psychological, physical, verbal, etc.). Attitudinal outcomes include measures of changes in attitudes, including: motivation/ readiness to change, accountability for abuse, and demonstrating empathy. Examples of psychological outcomes include measures of: anxiety, self-esteem, depression, and stress. Finally, interpersonal outcomes include: improved relationships, communication skills, relational skills, affective expression and marital satisfaction.

Evidence Statement 11- Advocacy interventions for victims

There is moderate evidence from ten studies that advocacy services may improve women's access to community resources, reduce rates of IPV, improve safety, decrease depression, reduce various stressors, and improve parenting stress and children's well-being. A cluster-RCT (Taft et al., 2011 [++]) revealed a significant decrease in IPV before adjustment for propensity score for pregnant and postpartum women involved in a community-based mentorship programme. A RCT (Sullivan et al., 2002 [++]) reported improvements in mother's depression and self-esteem and children's well-being following participation in home visitation advocacy services. A before and after study (Howarth et al., 2009 [+]) evaluated the effect of Independent DV advisor services (IDVA), demonstrating improvements in women's safety and a decrease in abuse. A RCT (Bair-Merritt et al., 2010 [+]) found a decrease in IPV rates for mothers involved in a home visitation programme. A cluster RCT (Coker et al., 2012 [+]) observed a decrease in depressive symptoms and suicidal thoughts for rural women receiving advocate services, but found no difference in self-perceived mental health or accessing of hot-line services. A cross-sectional study (Kendall et al., 2009 [+]) reported improvements in: perceived safety and safety planning for participants provided with emergency department advocacy counselling services. A RCT (Allen et al., 2004 [+]) revealed improvements in women's access to community resources regardless of presenting need, following post-shelter advocacy services. A before and after study (Poole et al., 2008 [+]) found a decrease in various stressors (partner, housing, mental health, legal and

physical health) for women using substances who were accessing shelter services. A before and after study (Price et al., 2008 [+]) found that women receiving support services reported improvements in their safety and quality of life and their children's safety, and caseworkers also reported improvements in women and children's safety. Finally, a qualitative study (Cath Gregory Consulting, 2008 [+]) revealed that a 24 hour helpline service facilitated abused women in understanding abuse and making changes to their lives, and provided links to available supports and services.

Taft et al., 2011 (cluster-RCT [++], Australia, n=174 women (intervention n=113; control n=61) (mean age of 32, majority using health-care card (indicative of low income), majority experiencing IPV and depression, primarily married with 2 or more children), 12-months) *[Community-based mentorship from non professionals for pregnant and postpartum women, including: advocacy, parenting support, referrals, legal and self-care support. Control received clinician care only with no mentoring]* Greater difference in IPV (measured by CAS) in intervention (Adj Diff=-8.67, 95%CI -16.2 to -1.15, p=0.03), but weaker after propensity score (PS) adjustment (Adj Diff=-8.75, 95%CI -18.2 to 0.70, p=0.07). Difference in mean depression scores in the intervention was -1.90 (95%CI -4.12, 0.32, p=0.09), or -1.92 (95%CI -4.25, 0.41, p=0.11) after PS adjustment. Total parenting stress (%) was OR=1.0 (CI 0.45, 1.49, p=0.9) or 0.86 (CI 0.32, 2.33, p=0.8) after PS adjustment.

Sullivan et al., 2002 (RCT [++], USA, n=78 mothers (intervention n=45; control n=33) (mean age 31 years, primarily White or African American, low income; mean age of children 8.3 years) post-, 4-months) *[16 weeks free services by paraprofessional advocate via home visitation twice/ week. Forms of assistance included: housing, education, social support, childcare, transportation, and material goods. Plus 10 week educational programme for children including sessions on: safety, emotional expression, self-worth and physical activities]* Non-significant improvement in mother's well-being over time ($F(10, 63)=1.81, p<0.08$). Intervention reported higher self-esteem and lower depression (both p values<0.05). Children in intervention reported significant improvements in well-being over time ($F(16, 57)=2.30$, $p<0.01$), were less likely to be contacted by the abuser at 4-month follow-up (11.1% vs. 27.3%), (one-tailed $\chi^2=0.04$), and reported improvements in global self-worth, self-confidence, physical appearance, and athletic subscales (all $p<0.05$).

Howarth et al., 2009 (before and after [+], UK, n=2,567 women at intake to IDVA services, 1,247 at 4 months, 411 at 9 months, 34 at 6 month follow-up (Primarily White, half employed; age 21-30, 37% and age 31-40, 31%, all meeting high risk criteria for violence at intake), 4 mo., 9 mo. (exit) and 6 mo. post) *[Independent domestic violence advisor (IDVA) services consisting of provision of multiple forms of assistance such as safety planning, support in relation to criminal court cases, housing, child contact, benefits, immigration issues, access to GP, etc.]* Following IDVA services (regardless of time or type of service), 57% of all victims experienced a cessation in the abuse they were suffering, 76% reported improved feelings of safety. Positive outcomes increased with the number of intervention received; 37% of women felt safer after 0-1 forms of support compared to 77% of those receiving 2-5 forms and 88% of those receiving 6-10 forms of support. At 6-month following case closure, the majority of women surveyed (82%) reported no further abuse.

Bair-Merritt et al., 2010 (RCT [+], USA, n=643 women, intervention=373, control=270 (primarily 19-25 years of age, Native Hawaiian/ Pacific Islander, poor mental health, employed in past year, both victims and perpetrators of IPV) post-, annually when the child was age 1-3, and annually when the child was 7-9 years) *[3 years of home visits (initially weekly) by paraprofessional providing advocacy, education on child development, role-modeling and problem-solving*, *and emotional support.]* Lower unadjusted rates of IPV victimization (21%) and lower rates of IPV perpetration (34%) in intervention compared with women in the control condition, across all IPV types. In adjusted analyses, women in the intervention group demonstrated significantly lower rates of physical assault victimization (IRR, 0.85; 95% CI, 0.71- 1.00) and perpetration (IRR, 0.82; 95% CI, 0.70-0.96).

Kendall et al., 2009 (cross-sectional [+], USA, n=350 female n=10 male (mean age 32 years, primarily African American, mean length of abusive relationship 5 years), post 2 days, 2-weeks, 6-weeks and 12-weeks) *[IPV advocacy counsellor in emergency department provided assessment, assistance with a 5–point safety plan, information on community resources and help to arrange shelter stay if requested]* 96% of participants perceived improved safety following the intervention. Of the 157 who provided feedback, 133 had developed a safety plan and completed between 49% and 59% of their safety plan at the various follow-up intervals.

Coker et al., 2012 (cluster RCT [+], USA, n=231 (intervention=138; control=93) (Intervention: mean age 42.6 years; Control: mean age 38 years, Both samples primarily African American, less than high school educated and experiencing IPV by a current partner), 2 weeks- and 6-, 12-, 18- and 24- months) *[Women accessing rural health clinics who identified IPV in the past 5 years were offered either an advocate intervention in the intervention clinic or external referral in the usual care clinics]* No differences in calls to a hotline, or in self-perceived mental health between intervention and usual care groups. Scores for depressive symptoms and suicidal thoughts decreased over time among women in the intervention, compared to usual care (Intervention x Time interaction, F=3.10, p=0.01).

Allen et al., 2004 (RCT [+], USA, n=278 women (intervention n=143; control n=135) (mean age 29 years, African American and White, majority low income, who had accessed services at urban refuge) post-, 10 week) *[4-6 hours advocacy for 10 weeks post shelter stay, including connection to appropriate community resources and skill building towards self advocacy]* Women in the intervention group were more effective overall at accessing necessary community resources (F (1, 261)=42.90, p<0.001): engaging in a greater number of activities to address education needs, (F(1, 254)=19.41, p<0.001), legal issues, (F(1, 254)=5.72, p<0.05), and acquiring material goods and services, (F(1, 254)=47.07, p<0.001). Intervention improved women's' effectiveness in accessing needed community resources regardless of the particular needs women presented.

Poole et al., 2008 (before and after [+], Canada, n=125 women (T1); n=74 women (T2) (mean age 35 years, majority Caucasian ethnicity, heterosexual orientation, using one or more substances 3 times/ week, completed some high school, and had children), 3 months post intervention) *[Shelter, emotional support, crisis intervention, parenting support and childcare, information on resources, referrals to services, accompaniment to appointments, transportation and clothing]* Significant decreases in the following stressors: partner stress (p <0.001), housing (p=0.012), mental health (p=0.001), legal issues (p=0 .002), physical health (p=0.021).

Price et al., 2008 (before and after [+], UK, n=47 female victims (completers) (demographic characteristics NR), 3-, 6-, 18- month follow-up *[Integrated women's support services provided to women with a partner in the DV Intervention Project. Varied, women-focused, ongoing support service including: safety planning, one on one programmes, telephone support, outreach meetings at the children's centre and social work offices]* Caseworker assessments revealed that 88% and 78% of referring social workers rated women and children, respectively, as 'much safer' or 'safer'. Based on the women's assessment across all three evaluations, 65% of women reported feeling 'safer' or 'much safer,' 69% assessed their children's level of safety as 'safer' or 'much safer,' and 93% reported that their quality of life was 'much improved' or 'improved.'

Cath Gregory Consulting, 2008 (qualitative [+], UK, n=47 women (no demographic details; n=12 had experienced severe violence, n=8 had mental health concerns, n=5 experienced violence in front of children, n=4 homeless from abuse), NR *[24hr telephone service for support related to DV. Focus on: supporting safety, offering risk awareness and avoidance support, referrals to refuges and services, practical support. Length of support varies from brief to ongoing]* 83% of women reported a change in their situation and 70% had moved to a refuge or ended their relationship. Qualitative analysis revealed that the helpline: assisted women in making positive changes, provided support, helped women understand DV, and provided important links to refuges and support services. A minority of women reported unfriendly interactions with helpline workers or feeling confused by the advice offered.

Applicability

Three studies were conducted in the UK (Howarth et al., 2009 [+]; Cath Gregory Consulting, 2008 [+]; Price et al., 2008 [+]) and are therefore applicable to the UK context. One study was conducted in Canada (Poole et al., 2008 [+]), one in Australia (Taft et al., 2011 [++]) and the remaining five studies were conducted in the USA (Allen et al., 2011 [+]; Bair-Merritt et al., 2010 [+]; Coker et al., 2012 [+]; Kendall et al., 2009 [+]; Sullivan et al., 2002 [++]). The applicability of some findings may be limited to the specific sub-populations targeted, including: women using shelter services (Allen et al., 2011), rural African American women (Coker et al., 2012 [+]), pregnant and postpartum women (Taft et al., 2011 [+]) and mothers and children (Sullivan et al., 2002 [++]). The study by Poole et al., 2008 included women using substances that were accessing shelter services, and therefore may be applicable to women with these co-occurring issues. The study by Bair-Merritt et al., 2010 [+] included young Native Hawaiian/ Pacific Islander mothers in Hawaii and therefore may be less applicable to the UK context.

Evidence Statement 12- Skill building interventions for victims

There is moderate evidence from six studies that skill building (teaching, training, experiential or group learning) on a range of topics with victims of partner violence has positive effects on victims' coping, well-being, decision-making abilities, safety and reduction of coercive and violent behaviour toward them. A cluster RCT (Rychtarik & McGillicuddy, 2005 [++]) found that coping skills training reduced physical violence against women in relationships with men with untreated problem drinking. A RCT (Miller et al, 2011 [+]) found that educating women about forms of reproductive coercion and how to do harm-reduction in the reproductive context resulted in a reduction in the odds of pregnancy coercion, compared to women in the control groups. A before and after study (Glass et al, 2009 [+]) found that a computerized danger assessment and a decisional aid tool resulted in women feeling more supported and less conflicted about improving their safety. A quasi-experimental design (Sanders, 2007 [+]) found that an educational programme on economic issues improves financial efficacy or the ability to make financial decisions among abused women. A RCT (Sullivan et al, 2004 [+]) found that a 9-week CB group intervention improved anxious, depressive and internalizing/ externalizing behaviours in children and improved women's sense of isolation and health. Finally, a RCT (Hernandez-Ruiz et al., 2005 [+]) found that music therapy decreased anxiety in women in shelters.

Rychtarik and McGillicuddy, 2005 (cluster RCT [++], USA, n=171 women (with partners with untreated problem drinking, mean age 42, 13.44 years education primarily: White, employed, married, 47% reported partner physical violence during previous year, and 59% reported being violent to their partner), post-treatment, 3-, 6-, 9-, 12 months) [*8-week group interventions delivered by alcohol rehab counsellors, using manuals and situations. One using Coping Skills Training (CST) (n=55) and one using 12-Step programme (TSP) (n=58), and delayed treatment (n=58) used as control and then randomized into treatment. The CST included stress and coping information and problem solving. TST focused on Al Anon steps 1-5: enabling, detachment, codependency].* Partner violence in the CST condition declined significantly from 50% violence at baseline to 37% ($p<0.05$, proportion of variance (PV)=0.14); non-significant increase from 44% to 51% in TST group.

Miller et al., 2011 (RCT [+], USA, n=906 women (aged 16-49, majority under 24 years, non-White, attending family planning clinics), 3 time points (not specified)) *[2-question IPV screening followed by teaching about reproductive coercion, forms of IPV, its effects on reproductive health, pregnancy choice and contraceptive choice, followed by eliciting harm reducing strategies for dealing with these issues] Women* in intervention clinics showed a 71% reduction in the odds of pregnancy coercion compared to control clinics (adjusted odds ratio [AOR]=0.29; 95% confidence interval [CI], 0.09-0.91). More women in intervention reported that they stopped dating a partner within past 3 months because relationship was unsafe (AOR=1.63; 95% CI, 1.01-2.63).

Glass et al., 2009 (before and after study [+] USA, n=90 women (mean age 34, primarily White or Latina, high school or college educated, majority in extreme danger in relationship in past year),

not reported) *[Computerized Decisional Conflict skill building tool to ascertain a woman's priorities, decision making steps by measuring her goals and priorities and suggesting strategies for increasing safety]* After using the safety decision aid, the women felt more supported in their decision (baseline score 39.44 improved to 31.3, p=0.012) and reported less total decisional conflict (baseline score 39.35 improved to 33.01, p=0.014).

Sanders et al., 2007 (Quasi-experimental design [+], USA, n=67 women in DV shelters (intervention=32; control=35), majority African American, high school educated, 51% age 18-35, 48% age 36-50; majority income < $500/ month), 2 weeks post-intervention) *[REAP (Realizing your Economic Action Plan), a 12-hour individual and group, shelter-based curriculum providing economic education, including money and power, credit, banking and investing and cost of living planning].* Experimental group significantly increased financial literacy (p<0.05), and financial efficacy (p<0.05), but only efficacy remained after controlling for length of relationship.

Sullivan et al., 2004 (Before and after study [+], USA, n=46 help-seeking women and 79 children (no demographic information provided), post-intervention) *[9 week concurrent and conjoint cognitive behavioural intervention on safety planning, trauma resolution, reducing self-blame, and conflict resolution skills, with additional mothers' group focus on parenting skills and social support]* Significant reductions in children's anxious or depressive behaviours (t (76)=1.99, p=0.05); internalizing behaviours, (t(76)=2.41, p=0.02); and externalizing behaviours, (t(76)=1.95, p=0.05). Mothers, isolation, life stress, and health significantly improved at post-test (p<0.05).

Hernandez-Ruiz et al., 2005 (RCT [+], USA, n=28 women (intervention=14; control=14) (mean age 35.36 years, 2 children, average 7.94 years in abusive relationship, abuse lasting an average of 4.23 years), one-month) [*5 sessions of daily sleep therapy for abused women in shelters, using a Progressive Music Relaxation (PMR) for 20 minutes in duration].* A significant improvement in sleep quality was found in the experimental condition (p=0.007) but not in the control group (p=0.105). Statistically significant reduction of anxiety was found in the experimental group (p<0.001).

Applicability

All six studies were conducted in the USA (Miller et al., 2011 [+], Glass et al., 2009 [+]; Hernandez-Ruiz et al., 2005 [+]; Rychtarik & McGillicuddy, 2005 [++]; Sanders et al., 2007 [+]; Sullivan et al., 2004 [+]). The study by Rychtarik and McGillicuddy, 2005 [++] was conducted primarily with educated, White women who had partners with problem drinking but did not have a substance use problem, and therefore may not be applicable to other sub-populations. The study by Sanders et al., 2007 [+] included primarily African American women accessing shelter services and therefore may not be generalisable to other groups of women. The remaining studies were conducted with women accessing shelter services (Glass et al., 2009; Hernandez-Ruiz et al., 2005), pregnant women (Miller et al., 2011) and mothers and children (Sullivan et al., 2004) and therefore findings may be most applicable to similar settings and populations in the UK.

Evidence Statement 13- Counselling and brief intervention for victims

There is moderate evidence from nine studies that counselling interventions may improve: PTSD symptoms, depression, anxiety, self-esteem, stress management, independence, support, re-occurrence of violence, birth outcomes for pregnant women, motivational level, readiness to change, and/ or forgiveness. A RCT (Kiely et al., 2011 [+]) demonstrated a decrease in re-occurrence of violence (that differed by severity of violence) and some birth outcomes (birth weight, preterm delivery and gestational age) for pregnant African American women following a cognitive behavioural intervention. A RCT (Johnson et al., 2011) revealed reductions in PTSD severity and specific symptoms, and re-abuse for women who completed a shelter-based cognitive behavioural intervention. A RCT (Zlotnick et al., 2011 [+]) found no significant reduction in PTSD or IPV from an interpersonal psychotherapy intervention for pregnant and postpartum women at follow-up, although there was a moderate reduction in PTSD and depression symptoms during pregnancy. A RCT (Koopman et al., 2005 [+]) did not find differences between

an expressive writing and neutral writing intervention for PTSD symptoms, but did find that women with depression at baseline benefited from the expressive writing condition. A qualitative study (Morales Campo et al., 2009 [+]) found that Hispanic immigrant women attending support groups for abuse reported improvements in self-esteem, stress management, independence and feelings of support. A non-RCT (Rasmussen et al., 2008 [+]) found that motivational interviewing (MI) enhanced shelter counselling was associated with greater motivational level and readiness to change. A RCT (Reed et al., 2006 [+]) reported improvements in: women's forgiveness, self-esteem and several emotional and recovery outcomes, following participation in forgiveness therapy. A before and after study (Laughon et al., 2011 [+]) revealed that women who participated in a brief educational intervention reported a decrease in several forms of violence. Finally, in a before and after study (Hassija et al., 2011 [+]) rural women's PTSD and depressive symptoms improved following participation in video-conference counselling.

Kiely et al., 2011 (RCT [+], USA, n=1,044 pregnant women (intervention=521; control=523) (mean age 24.5 years, all African American, primarily: single, high school educated and receiving Medicaid), 2nd and 3rd trimester and 8-10 weeks postpartum) *[Integrated cognitive behavioural intervention, provided by social workers/ psychologists during routine visits, for reducing smoking, depression and IPV during pregnancy. 4-8, 20-50 min sessions tailored to risk women were concerned with plus two booster sessions. IPV intervention included: safety planning, education on IPV, risk assessment and preventive options]* Intervention less likely to report recurrent episodes of IPV (adjusted OR 0.48, 95% CI 0.29–0.80). Women in the intervention reporting minor intimate violence were less likely to experience additional cases of violence during pregnancy (OR 0.48, 95% CI 0.26–0.86, OR 0.53, 95% CI 0.28–0.99) and postpartum (OR 0.56, 95% CI 0.34–0.93); and for women with severe IPV at postpartum (OR 0.39, 95% CI 0.18–0.82). Very low birth weight was lower among women in the intervention group (intervention: 0.8%, usual care: 4.6%, p .052) as was very preterm delivery (1.5% compared with 6.6%, P .030). Mean gestational age was greater in the intervention condition (38.2 weeks compared with 36.9 weeks, p=0.016).

Johnson et al., 2011 (RCT, [+], USA, n=71 women (mean age 32.55 years, African American and Caucasian, with some college education, and children, with PTSD or sub-threshold PTSD) 1-, 3- and 6-months). *[Cognitive behavioural intervention (n=35) compared to control (n=35). Both received standard shelter services (case management, support, education). Intervention received12, 60-90min in-shelter individual cognitive behavioural sessions including psycho-education, safety planning, empowerment skills, cognitive skills training, and optional modules to address co-occurring issues]* PTSD severity decreased over time (χ^2 (67, N=70)=118.75, p< .0001). In the ITT sample, women in intervention (46.9%) were less likely to report re-abuse compared to control participants (81.8%), (OR=5.1, 95% CIs [1.66, 15.70], RR=1.75, 95% CIs [1.17, 2.61]). In the ITT sample, significant effect for emotional numbing symptom severity (t (67)=-2.046, p<0.05), depression severity (t (67)=-3.13 p<0.01), empowerment (t (67)=2.09, p < .05), and social support (t (67)=2.11, p< .05); and effortful avoidance symptom severity, (t (49)=-2.50, p<0.05), and arousal symptom severity, (t (49)=-2.04, p<0.05), in the MA sample.

Zlotnick et al., 2011 (RCT [+], USA, n=54 pregnant women (mean age of 23.8 years, primarily Hispanic, single, high school educated, all low income, majority experienced severe abuse) 5–6 weeks after intake, 2 weeks post-partum, 3-month postpartum) *[Interpersonal Psychotherapy intervention (n=28): 4, 60min individual sessions pre-delivery plus one 60min session post-delivery to improve interpersonal relationship skills, social support & support transition to motherhood. Control (n=26) received standard medical care for pregnant women at clinic plus educational material and list of IPV resources]* No significant reduction in depressive episodes, PTSD, or IPV during pregnancy or at 3-month follow-up. Moderate effects for intervention in reducing PTSD symptoms (F (1, 44)=7.50, p=0.009) and depression (F (1, 34)=4.07, p=0.05) during pregnancy. Larger overall effect size for PTSD symptom reduction found after controlling for childhood sexual trauma (F (1, 42)=5.67, p=0.022), from d=0.59 to d=0.69.

Koopman et al., 2005 (RCT [+], USA, n=47 women (mean age 36.5, primarily: single, White, heterosexual, high school educated, income less than $40, 000, with no children) 4-months post-intervention *[Expressive writing (n=25) of traumatic event, compared to neutral writing (n=22) of daily schedule. Instructed to write privately for 20min for 4 weekly sessions, without discussion]* No significant differences between groups in reduction of symptoms of depression, PTSD or pain. Women who were more depressed at baseline demonstrated significantly greater reduction in depression in the expressive writing condition (p=0.05).

Morales-Campos et al., 2009 (qualitative study [+], USA, n=30 women (Mexican/ Mexican American, mean age 41 years, half were married, 43% US citizens), NR (involvement in groups ranged from 2-96 months) *[Support group provided in community organization for immigrant Hispanic women who have experienced DV. Conducted in Spanish by Mexican psychologist. No further details reported]* Qualitative analysis reveals support groups improved women's self-esteem and independence, stress management and coping skills, and provided a sense of community and support.

Rasmussen et al., 2008 (non-RCT [+], USA, n=20 women (mean age 37 years, primarily: Caucasian or Latina, married, high school educated, unemployed; half receiving income assistance) post-intervention *[Control (n=10) provided regular shelter services including individual counselling 1/ week for 4 weeks from shelter counsellors, and experimental (n=10) received regular shelter services plus individual therapy sessions from shelter counsellors trained in motivational interviewing (MI)]* Post-test improvements in motivational level in the intervention group (increase to 90%, p=0.029); number of women identified as high motivational decreased in control group from pre- (n=5) to post- (n=4) test. Intervention also demonstrated higher readiness to change at post-test (mean at post-test=11.1, compared to 9.9 for the control, p-values NR).

Reed et al., 2006 (RCT [+], USA, n=20 (mean age 44.95, primarily Caucasian and employed, mixed education level) post- intervention, 7 months) *[Forgiveness therapy (n=10: 1hr weekly individual support women in forgiveness process, compared to standard therapeutic procedure (AT) (n=10): discussion of participant-initiated current life concerns. Each 5-12 months in length & specific to emotional abuse]* FT group significantly greater increase in: forgiving the former abusive partner, (t (9)=5.80, p <0.0001); self-esteem, (t (9)=2.12, p<0.05); environmental mastery (t (9)=1.84, p<0.05); finding meaning in suffering (t (9)=2.34, p<0.05); and new stories (survivor status), (t (9)=3.58, p<0.01), and greater decrease in: trait anxiety, (t (9)=-2.43, p<0.05); depression, (t (9)=-1.88, p<0.05); posttraumatic stress symptoms, (t (9)=-2.54, p<0.05); and old stories (victim status), (t(9)=-5.01, p<0.001).

Laughon et al., 2011 (before and after [+], USA, n=18 pregnant women (mean age 28 years, primarily White, rural, high school educated) 3-months *[10 minute one-on-one educational intervention delivered by trained nurse in prenatal clinic; including brochure, safety planning, danger assessment, consciousness raising, list of resources, plus STI/ safe sex education]* Decrease in physical violence (p=0.02) and threats of violence (p=0.04). Decrease in sexual violence and increased number of safety behaviours and safer sex strategies, but these differences were not statistically significant.

Hassija et al., 2011 (before and after [+], USA, n=15 women (rural, mean age of 30.20, primarily Caucasian) every 4 sessions during treatment) *[Weekly 90min trauma focused, therapist-led, video-conferencing (based on cognitive processing therapy and prolonged exposure) provided to rural women (in groups and individually) at DV centres; mean number of 13.3 sessions. Motivational interviewing also used to help facilitate decision-making]* Women reported a large decrease in PTSD symptoms (d=1.17) and depressive symptoms (d=1.24) from pre- to post-treatment.

Applicability

All nine studies were conducted in the USA (Hassija et al., 2011 [+]; Johnson et al., 2011 [+]; Kiely et al., 2011 [+]; Koopman et al., 2005 [+]; Laughon et al., 2011 [+]; Rasmussen et al., 2008 [+]; Reed et al., 2006 [+]; Zlotnick et al., 2011 [+]). The study by Hassija et al., 2011 [+] was conducted with rural women and therefore findings may be limited to a comparable sub-population of women in the UK. Several studies included sub-populations of pregnant women, such as: African women with multiple risk factors (Kiely et al., 2011 [+]), rural women (Laughon et al., 2011 [+]) and low income women (Zlotnick et al., 2011 [+]), and therefore findings may not translate to other groups of women. The study by Koopman et al., 2011 [+] included primarily White women who had left an abusive relationship and therefore findings may not be generalisable to diverse women currently in an abusive relationship. The study by Morales-Campo et al., 2009 [+] included Hispanic immigrant women and therefore may not be applicable to other groups of women. A small pilot study by Rasmussen et al., 2008 [+] included primarily Caucasian and Hispanic women residing in a shelter and therefore may not translate to other settings and populations. Finally, the study by Reed et al., 2006 [+] included women who had only experienced emotional abuse and therefore findings may not be relevant to women who have experienced other forms of abuse. All studies, aside from Kiely et al., 2011, included very small sample sizes and therefore may have limited applicability.

Evidence Statement 14- Therapy interventions for victims

There is moderate evidence from eight studies that therapy interventions may be effective for improving various PTSD symptoms, depression, trauma symptoms, psychological and social outcomes, parenting/ family-related outcomes and in some cases may reduce likelihood of future IPV or re-abuse. An individual RCT (Resick et al., 2008 [++]) found improvements in PTSD and depression among women in all conditions (cognitive processing alone, with writing account, or writing alone); however, women in the cognitive processing alone group demonstrated a greater reduction on PTSD measures. A RCT (Iverson et al., 2011 [+]) demonstrated reductions in PTSD and depressive symptoms that were associated with reductions in physical IPV at 6-months following either cognitive processing or written account therapies. A non-RCT (McWhirter, 2006 [+]) found improvements in social support measures for women attending a professional development intervention, and improvements in self-efficacy for women in a homeless shelter involved in CBT. A RCT (Crespo et al., 2010 [+]) compared cognitive behavioural therapies (CBT), including either exposure or communication components; they found reductions in post-traumatic stress, anxiety, anger and depression in both conditions, but greater effects for the exposure condition. An individual RCT (McWhirter et al., 2011 [+]) reported improvements in various emotional, family and change-related outcomes for mothers and children participating in emotion-focused and goal-focused group therapies; women in the goal-focused intervention reported greater improvements in family conflict and decreased alcohol use, and women in the emotion-focused condition reported greater improvements in social support. A before and after study (Grip et al., 2011 [+]) found improvements in mothers' psychological and trauma symptoms, and sense of coherence following psychosocial group therapy. A before and after study (Iverson et al., 2009 [+]) found improvements in women's: depressive symptoms, hopelessness, distress and social adjustment following dialectical behavioural therapy. Finally, a before and after study (Allen et al., 2011 [+]) demonstrated significant improvements in PTSD symptoms, and women's reports of healing, following a holistic group therapy.

Resick et al., 2008 (individual RCT [++], USA, n=150 women (mean age of 35.4 years; mean education of 13.8 years; primarily White, currently not in abusive relationship) 2-weeks, 6-months post-treatment) *[12 hours individual therapy in each. Cognitive processing therapy (CPT) (n=56): cognitive therapy (confronting and challenging beliefs) and writing traumatic events. CPT-C (n=51): identical to CPT minus writing component. Written account (WA) condition (n=55): only writing of and re-reading traumatic experiences during therapy and at home]* All groups demonstrated improvements on PTSD and depression, anger, state and trait anxiety and guilt cognitions; no significant difference between groups on total therapeutic outcome, or post-traumatic diagnostic scale (PDS). CPT-C group reported greater improvements on the PDS post-

treatment than the WA group, but not significant at 6-month follow-up. For ITT analysis the Clinician-Administered PTSD Scale (CAPS) score of PTSD decreased 36.1 points on average from baseline ($p<0.001$) for CPT, 31.9 points ($p<0.001$) for WA, and 40.8 points ($p<0.001$) for CPT-C group. On completer analyses (all p values < .001), the CPT group decreased 37.7 points, the WA group decreased 36.5 points, and the CPT-C decreased 42.1 points. No significant differences between groups for measures of major depressive disorder or panic disorder.

Iverson et al., 2011 (RCT [+], USA, n=150 women (mean age 35.4 years, primarily Caucasian, mean education of 13.8 years, over half with income less than $20, 000) every 6 weeks during treatment, 6-months post-treatment) *[12 hours of individual therapy over 6 weeks to address IPV (including physical IPV and child abuse). Compared cognitive processing therapy (CPT) (n=53) with CPT-C (n=47) and Written Account condition (WA)(n=50). CPT focused on identifying and challenging cognitive distortions plus written accounts of traumatic events. CPT-C identical to CPT, except omitted written accounts. WA expanded on writing component, with no cognitive therapy]* Neither amount of treatment or treatment condition were a significant predictor of IPV victimization, and therefore not reported by authors. Overall, significant mean-level decrease from pre- to post- test in PTSD ($b1=-.17$, $t=-12.38$, $p<0.001$, $\Delta\sigma2=0.56$) and depressive symptoms ($b1=-.16$, $t=-12.16$, $p<0.001$, $\Delta\sigma2=0.50$). Significant associations between change in PTSD ($b=3.37$, $t=3.06$, $p<0.05$, $pr2=0.07$) and depressive symptoms ($b=3.49$, $t=2.93$, $p<0.05$, $pr2=0.07$) over the course of therapy and reductions in IPV at 6-month follow-up.

McWhirter, 2006 (non-RCT [+], USA, n=68 women (Intervention: mean age 32 years, primarily Caucasian or Latina, high school educated; Control: mean age 51 years, primarily Caucasian and college educated) week one and five of treatment) *[Included women experiencing major life transitions (not all victims but all vulnerable to abuse, numbers NR); in the group therapy (n=37), women were living in a homeless shelter; in the alternative group (n=31), women were in mentoring programme. Intervention=5 session, 90 minute weekly group therapy using CBT (psycho-education, exploring thoughts and behaviours) and Gestalt therapies (group processing), and discussion of alcohol and drugs. Alternative therapy included professional development skills training with mentor]* Significantly greater improvement in social support measure for alternative group, ($p<0.05$), and self-efficacy for intervention ($p<0.05$). No significant treatment effects for financial stress, family conflict, or family bonding.

Crespo et al., 2010 (RCT [+], Spain, n=53 women (mean age of 41 years, middle-class, half separated from abuser) post-, 1-, 3-, 6-months) *[8, 90min group cognitive behavioural therapy modules: six common to both the exposure condition (n=28) and communication skills condition (n=25); one including either exposure therapy/ communication skills; plus one on relapse prevention]* Significant improvements in anger expression ($F (1, 36)=5.49$, $p<0.01$ at 6-months), posttraumatic stress ($F (1, 36)=4.41$, $p<0.05$ at 1-month), depression ($F(1, 36)=7.81$, $p<0.01$ at 1-month), and anxiety ($F(1,3\ 7)=4.52$, $p<0.05$ at post-treatment) for both groups, with greater effects for the exposure condition.

McWhirter et al., 2011 (individual RCT [+], USA, n=46 women and 48 children (mean age 30 years, primarily White) post intervention) *[Compared 5 weekly, 60min emotion-focused (n=22) and goal-focused (n=24) shelter based group therapies. Both included concurrent 45min sessions for children plus 60min conjoint therapy. Women's emotion-focused included Gestalt techniques plus CBT psycho-education; children's groups included emotional awareness and expression. Women's goal-focused included CBT approach with motivational interviewing to identify and achieve goal; children's group included art and visual aids to select and work towards goals]* Significant improvements in both women's groups ($p<0.05$) for depression, family bonding, self-efficacy, readiness to decrease violence, readiness for therapeutic change, and facilitators' report of readiness to change. Significantly greater decrease in family conflict in the goal-focused intervention ($F (1, 44)=28.75$, $p<0.05$, $\eta2=0.40$ (main); $F (1, 44)=4.10$, $p<0.05$, $\eta2=0.09$ (interaction), and greater increase in the quality of social support in the emotion-focused intervention ($F (1, 44)=18.68$, $p<0.05$, $\eta2=0.30$ (main); $F (1, 44)=5.88$, $p<0.05$, $\eta2=0.12$ (interaction)). For children, significant improvements in both intervention groups (all $p<0.05$) for:

emotional well-being (F (1,46)=7.00, η^2=0.13), peer conflict (F (1,46)=4.97, η^2=0.16), family conflict (F (1,46)=22.27, η^2=0.43), and self-esteem (F (1,46)=7.87, η^2=0.24). Women in goal-focused group reported a decrease in use of alcohol (mean pre-treatment score for alcohol use out of five=2.03 (SD 0.58), mean post-treatment score=0.55 (SD 0.74)), not found in emotion-focused group.

Grip et al., 2011 (before and after [+], Sweden, n=42 mothers (mean age 38.8 years, primarily single mothers, 54% Swedish born, 11 years min. education, low SES, not living with perpetrator) post-, 12-months) *[Psychosocial group therapy for mothers for 15 weeks, including: information on IPV, reactions to IPV, the effect of IPV on personality, family interactions and communication]* Significantly improvements in psychological symptoms (F (2, 36)=9.97, p<0.001), sense of coherence (F (2, 36)=6.88, p>0.01 [sic]), and a reduction in trauma symptoms (F(2, 36)=17.273, p<0.001) post- intervention and at 1-year follow-up. No significant change in parental locus of control.

Iverson et al., 2009 (before and after [+], USA, n=31 women (mean age of 40.7, primarily Caucasian, income less than $30, 000, high school or college education) post-intervention) *[12, 2hr weekly group dialectical behavioural therapy sessions including: cognitive skills training and application, problem-solving and ongoing support by therapists and participants]* Significant improvements on all outcomes: reduced depressive symptoms (F (1, 30)=12.97, p< .001, d=0.54), hopelessness (F (1, 30)=5.88, p<0.05, d=0.42), and psychiatric distress (F(1, 30)=14.82, p<0.001, d=0.78) and increased social adjustment (F(1,30)=7.67, p< .01, d=0.53).

Allen et al., 2011 (before and after [+], USA, n=11 women (mean age 35 years, primarily college educated, half low-income, all separated from abuser) post-intervention, 6 weeks) *[10 week semi-structured holistic group therapy (for women not currently in crises), for healing from trauma via transition through 3 stages: 'separation', 'liminality' and 'incorporation'. Includes storytelling, meditation, day dreaming exercises, and avoids recounting of abuse]* Significant improvements on 8 of 17 PTSD assessment measures including: repeated disturbing thoughts, reliving stressful experience, avoidance of thoughts/ feelings, feeling emotionally numb, feeling as if the future will be cut short, trouble sleeping, being super alert, and feeling easily startled (all p<0.05). Qualitative analysis revealed healing themes: creating a safe place, establishing autonomy, pride in appearance, reclaiming self, developing inner peace, and rejoining community.

Applicability

One study was conducted in Spain (Crespo et al., 2010) [+]; one was conducted in Sweden (Grip et al., 2011) [+]; and the remaining six studies were conducted in the USA (Allen et al., 2011 [+]; Iverson et al., 2009 [+]; Iverson et al., 2011 [+]; McWhirter, 2006 [+]; McWhirter et al., 2011 [+]; Resick et al., 2008 [++]). The specific sample populations used in some studies may limit findings to: women who are not in crises (Allen et al., 2011 [+]) or women using shelter services (McWhirter, 2006 [+]; McWhirter et al., 2011 [+]). The study by Iverson et al., 2011 [+] only measured physical IPV so may not be applicable to women experiencing other forms of violence. The Resick et al., 2008 [++] study excluded women using alcohol and other substances, so may not be applicable to women with these co-occurring issues. Outside of these specific limitations, there is no particular reason to think that there may be barriers in applicability to the UK context.

Evidence Statement 15- Individual interventions for abusers

There is moderate evidence from eight studies that individual interventions for abusers may improve: aggressive feelings towards partner, attitudinal change, understandings of violence and accountability, or short-term help seeking. Some interventions also reported improvements in violent behaviours or recidivism, while others demonstrated no effect. The types of individual interventions employed varied. A non-RCT (Gondolf, 2008 [+]) found that individual case management did not significantly improve batterer programme dropout, re-assault, and re-arrests, or women's perceptions of safety. A before and after study (Gondolf & Jones, 2001 [+]) examined batterer interventions in 3 sites found that programme completion was associated with a

reduction in re-assault, and programme length was not significantly associated with programme completion. A non-RCT (DeLeon-Granados et al., 2005 [+]) found that an individual level intervention on its own was less effective in reducing recidivism among male offenders than when combined with indirect community outreach services. In a before and after study (Milner and Singleton, 2008 [+]), all male and female abusers who completed a brief solution focused therapy were reported to be violence free. Evidence from several studies suggests that motivational interviewing (MI)-based feedback may not impact aggression or violence, but may impact some attitudinal outcomes. A non-RCT (Musser et al., 2008) found no significant differences in partner violence among men who received MI based feedback at intake, compared to those who did not, although the intervention did improve men's receptivity to the intervention. An RCT (Kistenmacher et al., 2008 [+]) demonstrated improvements on some (action and external attributions of violence when outliers were excluded) but not all (pre-contemplation and contemplation) attitudinal outcomes for a small sample of male abusers following MI based assessment feedback. In an individual RCT (Shumacher et al., 2011 [+]) that also compared MI based feedback at assessment with a control, a significant difference was found among a small sample of alcohol dependent men for short term help seeking, with no differences in anger, reports of aggression or alcohol outcomes. Finally, in a qualitative study (Morgan et al., 2001 [+]) a small sample of male physical abusers demonstrated changes in understandings of violence and accountability, following involvement in an educational intervention.

Gondolf, 2008 (non-RCT [+], USA, n=684 male batterers (African American) every 3-months up until 12 months post-intervention) *[Case management intervention (n=202): One-on-one case management services (assessment of need, referrals to community resources and telephone follow-up) embedded in a cognitive behavioural counselling programme. This was compared with a group of men who did not complete case management (n=482) but had previously completed the counselling programme]* No significant differences between case management and non-case management group on: batterer programme dropout, re-assault, and re-arrests, or women's perceptions of safety. Case management group reported significantly higher on seeking of additional assistance (44 vs. 29%; $p<0.01$; n=419).

Gondolf & Jones, 2001 (before and after [+], USA, n=640 batterers; n=480 partner reports (batterers were a mean age of 32 years, primarily court referred, 55% belonged to an ethnic minority, half living with partner, length of abuse mean of 3.5 years) *[Batterer programs in 3 urban sites: 1] Denver: 9 months; included: individual evaluations, alcohol treatment, individual psychotherapy, and case management for victims. 2) Dallas: 3 months; included: individual evaluations, individual counselling and a women's group. 3) Houston: 5 ½ months; included: referrals for substance use problems in batterers and counselling for battered women]* Based on women's reports, 42% of programme drop-outs re-assaulted, while only 26% of completers re-assaulted ($p<0.0001$). Programme completion reduced probability of re-assault by 44% (bivariate probit) to 64% (two-stage specification) ($p<0.005$). The length of the programme (3, 5 ½ or 9 months) was not found to be significantly associated with dropout rate.

DeLeon-Granados et al., 2005 (non-RCT, [+], USA, n=474 male DV offenders (Anglo, Latino and African American men, no other details), 6-month recidivism, and variable survivor analysis (recidivism for entire time period in the study). *[Compared: arrest only (control group) (n=138); arrest and treatment 1 (individual-level treatment=30 minute jail-based meeting with former DV offender who provided information on community resources and a support group) (n=78); arrest and treatment 2 (community-based treatment=community outreach related to DV, not targeting offender, but analysed offender outcomes if outreach occurred in offender's area of living) (n=138), and arrest plus treatments 1 and 2 (n=120)]* 6-month recidivism lowest for arrest combined with both individual level and community level treatments (2%), compared to arrest combined with individual treatment (14%), arrest combined with community level treatment (4%) or arrest only (8%). Survival analysis revealed that combined treatments were more effective than arrest only or arrest combined with individual treatment, and arrest combined with community level treatment was better than arrest combined with individual level treatment (all p values<0.05).

Musser et al., 2008 (non-RCT, [+], USA, n=108 partner violent men presenting for treatment at DV centre (mean age 35.7 years, White or African American, mean 13 years education, primarily full time employed, mean income $25-30, 000, most court-ordered to treatment), 6- month) *[MI as preparatory intervention (prior to CBT) (n=55): 45min individual sessions using MI principles to conduct assessment and discuss CBT intervention procedures, with a later MI feedback session to discuss assessment. Compared to control (n=53) who completed assessment and reviewed clinic policies but without MI principles]* No significant differences between groups in partner reports of injury, physical assault or psychological aggression, although a non-significant trend was reported for physical assault (p=0.07). The MI group reported greater compliance with CBT homework, more help seeking outside the programme and higher therapist ratings of the working alliance (all p's<0.05).

Milner and Singleton, 2008 (before and after, [+], England, n=50 male and female abusers (76% male, 24% female, mean age 37 years, primarily White, working class, unemployed and heterosexual (aside from 3 lesbian women), post-treatment) *[Solution focused brief therapy using 'signs of safety' approach to encourage identification, implementation and expansion of safety care planning (setting NR). Individual sessions, although partner or family members able to join later sessions if desired (numbers NR); variable timing and number of sessions based on need, with average of 4.3, 1hr sessions]* All participants who completed programme (73.5%) were violence free. Over half of participants (57%) who dropped out continued to be violent.

Kistenmacher et al., 2008 (RCT, [+], USA, n=33 men (mean age of 37.3 years, Euro American, mean of 11.2 years education and $1, 381 monthly income, mandated for treatment, nearly half had committed one or more acts of severe IPV, majority referred to drug or alcohol treatment), post treatment) *[Intervention (n=16): 50-60 minute individual follow up with therapist on violence questionnaire and discussion of treatment based on MI (aimed at facilitating motivation to change) in a university outpatient clinic; compared to control (n=17): no meeting with therapist]* There were significant improvements in the MI group from pre- to post- test in action (regarding readiness to change) (Wilks's λ=0.70, F (3, 22)=3.3, p=0.04), and a significant decrease from pre-to-post test in external attributions (t(11.68)=–1.9, p=0.04). However, neither of these effects was significant when outliers were included. There was a trend for pre-contemplation and contemplation, though not statistically significant.

Schumacher et al., 2011 (individual- RCT, [+], USA, n=23 men in alcohol treatment (White and Black, high school or college/ trade educated, high rates of psychological aggression; mean of 4.8 acts of severe physical assault in past year) one- week, 3-month, 6-month) *[(Residential alcohol treatment setting) Intervention (n=11): 90min MI-based individual feedback on assessment, followed by development of behavioural change plan if demonstrating readiness to change, along with self-help handouts and list of resources; compared to control (n=12): men received only list of resources]* The MI intervention demonstrated significantly greater improvements in short term help seeking (p=0.04, Cohen's d=0.90). At 3- and 6- months follow up, both groups demonstrated improvements over time in self-reported anger (p<0.000), CTS2 measures of psychological aggression (p=0.000), and physical aggression (p=0.036 for male partner and p=0.024 for female partner) and alcohol outcomes (p<0.000).

Morgan et al., 2001 (qualitative, [+], New Zealand, n=11 male physical abusers (completers included in analysis) (mean age of 31 years), 3-months) *[Men for Non-Violence (MFNV) stopping violence course (setting NR): a 9 session individual education intervention focused on choice, awareness, personal responsibility, anger-management skills and socio-cultural consciousness raising]* Narrative analysis revealed an impact on men's understanding of violence and improved accountability, with a shift among some men from violence as 'expressive tension' (reaction to stress) to 'instrumental' (intention for one's actions).

Applicability

One study was conducted in England (Milner and Singleton, 2008 [+]), one in New Zealand (Morgan et al., 2001 [+]), and the remaining six studies were conducted in the USA (Gondolf & Jones, 2001 [+]; Gondolf, 2008 [+]; DeLeon-Granados et al., 2005 [+]; Kistenmacher et al., 2008 [+]; Musser et al., 2008 [+]; Schumacher et al., 2011 [+]). The UK study (Milner and Singleton, 2008 [+]) was conducted with primarily White working class, unemployed men and women, and therefore will be applicable to this sub-population. In some studies, the sub-groups of abusers included may limit applicability; for example, to: African American men (Gondolf, 2008 [+]; Anglo, Latino and African American men (DeLeon-Granados et al., 2005 [+]); White and African American men (Musser et al., 2008 [+]); or White and Black alcohol dependent men (Schumacher et al., 2011 [+]). Other studies have limited applicability due to study design or methodological limitations, including: small sample sizes (Kistenmacher et al., 2008 [+]) and/ or lack of demographic data (Morgan et al., 2001 [+]).

Evidence Statement 16- Short duration group interventions for abusers measuring recidivism/ abuse outcomes

There is inconsistent evidence from 10 studies that short duration (16 weeks or less) group interventions reduce recidivism/ abuse outcomes. Multiple studies reported a reduction in recidivism or other abuse measures. A non-RCT (Taft et al., 2001 [+]) found that retention procedures for a group counselling programme for male abusers improved attendance and completion; greater attendance was associated with reductions in physical assault and injuries, and completers had lower recidivism rates. A before and after study (Tutty et al., 2001 [+]) reported a significant reduction in men's physical and non-physical abuse (after adjusting for social desirability), following involvement in a family-of-origin group therapy treatment. Two before and after studies examined a solution and goal focused treatment for male and female batters (Lee et al., 2007 [+]; Lee et al., 2004 [+]); one found that the development of goal specificity and goal agreement was associated with decreased recidivism (Lee et al., 2007 [+]), while the other reported a decrease in partner's perceived level of violence (Lee et al., 2004 [+]). A quasi-RCT study by Morrel et al., 2003 [+] compared structured CBT with unstructured supportive group therapy for partner violent men, and found improvements for both groups in physical assault, psychological aggression, injuries and sexual coercion; there were no differences between groups on partner aggression and re-arrests, although the unstructured group demonstrated greater self-efficacy for abstaining from verbal aggression, and negotiation. Findings from a before and after study (McGregor et al., 2000 [+]) showed that a group counselling programme for male abusers was associated with improvements on physical and non-physical abuse, that were sustained in the follow up group. A before and after study (Lawson et al., 2001 [+]) examined a group therapy programme for male abusers and found reductions in physical and psychological aggression and injury. In contrast, a few studies reported improvements in some, but not all abuse measures or no improvement at all. Findings from two before and after studies (Tutty et al., 2006 [+]; Tutty et al., 2009 [+]) revealed that a group treatment programme for female batterers was associated with a reduction in non-physical abuse but not physical abuse. Finally, a cross-sectional study (Gondolf et al., 2009 [+]) found that men participating in cognitive behavioural group counselling and referral to mental health treatment did not demonstrate improvements in re-assault, re-arrest for DV or partner reports of safety.

Tutty et al., 2009 (before and after [+], Canada, n=293 female batterers (mean age 31 years, most had children, mean annual income of $16, 937, most had engaged in prior counselling and experienced family violence in childhood), post-treatment) *[15 weekly, 2hr sessions of group therapy based on social learning and cognitive behavioural therapy, delivered in a counselling centre. Key focus: decrease abusive behaviour and stress; improve relationships, accountability, self-esteem, assertiveness and empathy. Women met individually with therapist prior to group sessions to assess violence & treatment goals. Groups included: cognitive restructuring, time outs, modelling, skill building, and role-playing]* Significant improvement in non-physical abuse against a partner, and partner physical and non-physical abuse of the woman ($p<0.009$). There was a non-significant increase in partner physical abuse.

Taft et al., 2001 (non-RCT [+], USA, n=189 male DV perpetrators (mean age 34.2 years, primarily Caucasian, followed by African American, most court referred, employed, not married, mean education of 12.8 years and monthly income of $1, 593), 6-months) *[16 weekly, 2hr sessions of group counselling at a DV centre. Treatment retention control (TRC n=83): Received either CBT (similar to control) or supportive therapy (ST) (unstructured, focused on emotional expression and relationship building). All in TRC received retention procedures (written & verbal follow-ups by therapist to encourage involvement/ return to group. Control cohort (CC n=83): CBT programme aimed at improving readiness to change, skill building (communication, anger and stress management) and non-violence)* TRC participants attended more counselling sessions than CC (F (l, 188)=7.313, p=0.007), and had lower drop out rates (15% vs. 30%) (Chi squared (1,N=189)=6.45, p=0.011). Negative correlation between attendance and victim reports of: physical assault (-0.31, p<0.05) and injuries (-0.46, p<0.01) at post-treatment and injuries at 6-month follow-up (-0.47, p<0.01). Significant interaction by race and cohort regarding session attendance (F (l, 179)=4.384, p=0.038). Of programme drop-outs (n=11), recidivism was 54%, compared to 10% of completers at follow-up (n=50) (chi squared (l, N=61)=9.3, p=0.002).

Gondolf et al., 2009 (cross-sectional, [+], USA, n=148 male batterers (to test impact of receiving mental health treatment on batterer outcome, compared: men receiving clinical evaluation (n=48) to men who did not (n=100); and men who received mental health treatment and clinical evaluation (n=28) to men who did not receive mental health treatment (n=120)); n=479 male batterers (to test effect of referral to mental health treatment, compared: men court mandated to receive mental health treatment (n=148), men under partially implemented mandate (n=149), and voluntarily referred (n=182) (44% less than 30 years old, 51% African American), 3-, 6-, 9-, 12-months (with female partners) *[Mental health treatment involved an initial appointment, and a 30-50min individual clinical evaluation including a treatment plan. DV treatment was 16 weekly, 1.5 hour group counselling sessions at counselling outpatient clinic, using instructional, gender based cognitive behavioural approach]* No significant differences in re-assaults across referral stages at 12 month follow up, or for the batterer programme at 3- and 12- month follow up. Female partners of men in mandated referral group reported significantly lower safety between 9 and 12 month follow up, in likelihood to be hit ("'very unlikely': no referral: 67% vs. partial: 66% vs. mandated: 50%; p<0.05), and feelings of safety ('very' safe": no referral: 73% vs. partial: 69% vs. mandated: 54%; p<0.05).

Tutty et al., 2001 (before and after, [+], Canada, n=104 male batterers (mean age 34 years, most with children, half living with partner, mean monthly income $1, 948, over half had experienced childhood violence, self-referred and court mandated), 6-months) *[12 week, 2hr group sessions or 10 week, 3hr sessions in 3 DV agencies. Include: feminist examination of gender roles, early experiences of violence and trauma, and developing new problem solving strategies. Partners contacted to ensure safety and offer access to support groups]* Significant improvements after adjusting for social desirability on: physical and nonphysical abuse (p<0.000). No significant differences between court-mandated and self-referred men.

Lee et al., 2007 (before and after [+], USA, n=88 male and female DV offenders (80% male, and 20% female, age 31-50, primarily White, high school educated), one-year) *[1hr group sessions over 3 months. Solution and goal-focused DV treatment (setting NR) focused on accountability, identifying strengths and developing solutions including personal goal/ plan for improvement]* Recidivism rate for completers was 10.2%, with no significant differences between men and women. Goal specificity and goal agreement positively predicted confidence to work on goals (r=0.45 and 0.20, respectively), which negatively predicted recidivism (probit coefficient=-0.08, SE=0.04). Goal specificity directly and negatively predicted recidivism (probit coefficient=-0.82, SE=0.28).

Lee et al., 2004 (before and after [+], USA, n=87 male and female DV offenders (86% male and 14% female, ages 31-50, primarily White, high school educated), post-, 6-months; 6 years (criminal records) *[1hr group sessions over 3 months. Solution and goal-focused DV treatment*

(setting NR) focused on accountability, identifying strengths and developing solutions including personal goal/ plan for improvement] Overall rate of recidivism at follow-up was 16.7%, with no significant differences between men and women. Significant decrease in partner's perceived level of violence at follow-up (t (21)=6.7, p<0.001).

Morrel et al., 2003 (quasi-randomized control study [+], USA, n=86 court mandated partner violent men (mean age 34 years, primarily Caucasian, mean education 13 years, mean monthly income $1, 800), post- treatment, 6-months) *[16 weekly, 2hr sessions in each condition. Group CBT (n=48): focused on non-violence, conflict management and communication skills and discussion of ongoing issues. Supportive group therapy (ST) (n=38): unstructured participant driven groups; focused on supporting men to develop a personal plan for change, expression of feelings, reduction of isolation and improvement of relationships]* Overall significant reduction between pre- treatment and follow-up on: physical assault (p<0.001), psychological aggression (p<0.001), injuries (p<0.001) and sexual coercion (p<0.01). No significant differences were found between the two groups on partner aggression and re-arrests, although ST group demonstrated greater self-efficacy for abstaining from verbal aggression (p<0.05), and negotiation (p<0.05).

McGregor et al., 2000 (before and after [+], USA, n=76 abusive men (mean age 34.5 years, 40% probation referred, high school or post-secondary education), post-treatment, -28 month follow up (average 14 months) *[All men were also attending individual counselling, and in contemplation stage. Intervention: 14 weekly, 2hr session, group counselling programme targeting belief system change (setting: counselling centre). 4 key components: challenging victim blaming, challenging belief system, reconnecting with emotions and encouraging empathy]* Significant differences at post-intervention for physical and non-physical abuse (F=10.8, p<0.001). Continued improvement at follow-up (n=22); pre-, post-, and follow-up measures were significantly different, with improvement across time (F=6.7, p<0.001).

Tutty et al., 2006 (before and after, [+], Canada, n=33 female batterers (mean age 32 years, mean income $15, 000, most had children, most with psychiatric history and prior counselling, 10% in a lesbian relationship), mid- and post intervention) *[15 weekly, 2hr sessions of group therapy based on social learning and cognitive behavioural therapy, delivered in a counselling centre. Key focus: decrease abusive behaviour and stress; improve relationships, accountability, self-esteem, assertiveness and empathy. Women met individually with therapist prior to group sessions to assess violence & treatment goals. Groups included: cognitive restructuring, time outs, modelling, skill building, and role-playing]* Statistically significant improvements on non-physical abuse of partner (p=0.000). No significant improvements on physical abuse.

Lawson et al., 2001 (before and after [+], USA, n=21 men on probation for partner abuse (mean age 33 years, primarily Hispanic or African American, followed by Caucasian), post-treatment) *[15 weekly, 2.5hr group therapy sessions focused on relaxation training, cognitive restriction and self-instructional training related to abuse and gender issues (setting NR)]* Significant reduction in reports on CTS-2 measures of: physical assault (F (l, 40)=9.72, p=0.003), psychological aggression (F (l, 40)=8.81, p=0.005), and injury (F(l,40)=6.5, p=0.015). Aggression, as measured by the marital satisfaction scale significantly reduced (F (l, 40)=53.33, p=0.000). Frequency of violence significantly reduced from pre- to during group (p <0.05) and from pre- to post-group (p=0.05).

Applicability

Three studies were conducted in Canada (Tutty et al., 2001 [+]; Tutty et al., 2006 [+]; Tutty et al., 2009 [+]) and seven in the USA (Taft et al., 2001 [+]; Gondolf et al., 2009 [+]; Lee et al., 2007 [+]; Lee et al., 2004 [+]; Morrel et al., 2003 [+]; McGregor et al., 2000 [+]; Lawson et al., 2001). Some studies may be limited in applicability due to the samples used, such as: men who do not have substance use issues (Tutty et al., 2001 [+]), White men (Taft et al., 2001 [+]; Morrel et al., 2003 [+]), or male batterers with mental health issues (Gondolf et al., 2009). Two studies examined programs for female batterers (Tutty et al., 2006 [+]; Tutty et al., 2009 [+]), although ethnicity of

participants was not provided. Two studies included male and female batterers, yet note that the majority of participants were White men, and therefore may not be applicable to diverse women and men (Lee et al., 2004 [+]; Lee et al., 2007 [+]). Few demographic characteristics are provided in McGregor et al., 2000 [+], making it difficult to determine applicability.

Evidence Statement 17- Short duration group interventions for abusers measuring attitudinal, psychological and interpersonal outcomes

There is moderate evidence from nine studies that short duration (16 weeks or less) group interventions improve attitudinal, psychological and interpersonal outcomes among abusers. The majority of studies reported improvements on various measured outcomes. A before and after study (Tutty et al., 2001 [+]) which examined a family-of-origin group therapy treatment, reported improvements among male batterers on all psychological, attitudinal and interpersonal measures. A cluster RCT (Waldo et al., 2007 [+]), which compared a guidance session (based on Duluth model) and guidance session including counselling treatment for male abusers, reported differences in the attitudinal and interpersonal improvements achieved by each group. Findings from a before and after study (Lee et al., 2004 [+]) revealed that a solution and goal focused group treatment programme was associated with improved relational skills and self-esteem among male and female offenders. A quasi-RCT study by Morrel et al., 2003 [+] compared structured CBT with unstructured supportive group therapy for partner violent men, and found improvements for both groups in self-esteem, efficacy to abstain from verbal abuse and stage of change. A before and after study (McGregor et al., 2000 [+]) found that a group counselling programme was associated with improvements on all psychological, interpersonal and attitudinal outcomes, and improvement was sustained in the follow up group. A before and after study (Carney et al., 2006 [+]) found that a cognitive behavioural intervention resulted in improvements in passive aggressiveness and likelihood to use force, with similar effects for African American and White participants. A non-RCT (Schwartz et al., 2003 [+]) reported that group therapy for abusive men was associated with improvements in restrictive emotionality and restrictive affectionate behaviour. Two studies found improvements on some, but not all psychological measures. A before and after study (Tutty et al., 2006 [+]) revealed that a group treatment programme for women batterers was associated with improvements in self-esteem, general contentment, stress, and adult self-expression, but no improvements on depression. In a later study of the same programme (Tutty et al., 2009 [+]), improvements were found among female batterers in measures of depression and stress, but there was a reduction in self-esteem.

Tutty et al., 2009 (before and after [+], Canada, n=293 female batterers (mean age 31 years, most had children, mean annual income of $16, 937, most had engaged in prior counselling and experienced family violence in childhood), post-treatment) *[15 weekly, 2hr sessions of group therapy based on social learning and cognitive behavioural therapy, delivered in a counselling centre. Key focus: decrease abusive behaviour and stress; improve relationships, accountability, self-esteem, assertiveness and empathy. Women met individually with therapist prior to group sessions to assess violence & treatment goals. Groups included: cognitive restructuring, time outs, modeling, skill building, and role-playing]* Significant improvement in: generalized contentment (depression) and clinical stress ($p<0.009$). Self-esteem significantly decreased (worsened) ($p=0.001$).

Tutty et al., 2001 (before and after, [+], Canada, n=104 male batterers (mean age 34 years, most with children, half living with partner, mean monthly income $1, 948, over half had experienced childhood violence, self-referred and court mandated), 6-months) *[12 week, 2hr group sessions or 10 week, 3hr sessions in 3 DV agencies. Include: feminist examination of gender roles, early experiences of violence and trauma, and developing new problem solving strategies. Partners contacted to ensure safety and offer access to support groups]* Significant improvements after adjusting for social desirability on: appraisal support, perceived stress, locus of control, marital relationships functions, and roles, affective expression, and communication (all $p<0.000$). Significant improvements after adjustment for: self-esteem ($p=0.024$) and attitudes towards marriage and family ($p=0.059$). Therapists reported significant change for all areas ($p< 0.05$)

except social desirability and decision making. No significant differences between court-mandated and self-referred men.

Waldo et al., 2007 (cluster-RCT, USA, n=99 male abusers (mean age 30 years, primarily Hispanic), post-treatment) *[Usual treatment (n=72): Received only weekly group guidance sessions based on Duluth model, focused on: non-violence, accountability, non-threatening behaviour, sexual respect, partnership, negotiation and effects of violence on children. Intervention (n=60): After attending a mean of 12 guidance sessions, one counselling session exchanged for a guidance session; using participant-to-participant feedback to facilitate group learning. Setting: DV treatment centre]* Usual treatment participants reported greater: hope (3% difference) and information (6% difference); intervention participants reported greater: universality (12% difference), cohesion (7% difference) and interpersonal learning (3% difference). No significant differences were found between the groups in their perception that the treatment approach was worthwhile.

Lee et al., 2004 (before and after [+], USA, n=87 male and female DV offenders (86% male and 14% female, ages 31-50, primarily White, high school educated), post-, 6-months; 6 years (criminal records) *[1hr group sessions over 3 months. Solution and goal-focused DV treatment (setting NR) focused on accountability, identifying strengths and developing solutions including personal goal/ plan for improvement]* Significant increase in partner's reports of offenders' relational skills at post-treatment ($t(33)=3.6$, $p<0.001$) and follow-up ($t(21)=4.1$, $p<0.001$) and offenders' self-esteem at post-treatment ($t(81)=-2.2$, $p<0.5$) and follow-up ($t(47)=-3.1$, $p<0.01$).

Morrel et al., 2003 (quasi-randomized control study [+], USA, n=86 court mandated partner violent men (mean age 34 years, primarily Caucasian, mean education 13 years, mean monthly income $1, 800), post- treatment, 6-months) *[16 weekly, 2hr sessions in each condition. Group CBT (n=48): focused on non-violence, conflict management and communication skills and discussion of ongoing issues. Supportive group therapy (ST) (n=38): unstructured participant driven groups; focused on supporting men to develop a personal plan for change, expression of feelings, reduction of isolation and improvement of relationships]* Both groups demonstrated significant improvements from pre- to post-intervention on: self-esteem ($p<0.01$), efficacy to abstain from verbal abuse ($p<0.001$), and stage of change scales including preparation/ action ($p<0.01$).

McGregor et al., 2000 (before and after [+], USA, n=76 abusive men (mean age 34.5 years, 40% probation referred, high school or post-secondary education), post-treatment, -28 month follow up (average 14 months) *[All men were also attending individual counselling, and in contemplation stage. Intervention: 14 weekly, 2hr session, group counselling programme targeting belief system change (setting: counselling centre). 4 key components: challenging victim blaming, challenging belief system, reconnecting with emotions and encouraging empathy]* Significant differences at post-intervention for all measures: self-esteem, personal stress, severity of family problems, non-psychotic depression, assertiveness, attitudes about roles and behaviours for women ($F=10.8$, $p<0.001$). Continued improvement at follow-up (n=22); pre-, post-, and follow-up measures were significantly different, with improvement across time for all measures ($F=6.7$, $p<0.001$).

Carney et al., 2006 (before and after, [+], USA, n=59 female batterers (mean age 32.7 years, African American or White, mean education 12.8 years, mean monthly income $1, 412, most arrested prior to programme, used alcohol, and were still with victim), post-treatment) *[2hr, 16wk feminist informed, group cognitive behavioural programme including psycho-educational and therapy sessions aimed at anger management and skills development; delivered in a DV agency]* Scores of passive/ aggressiveness ($t=3.64$, $p=0.001$, effect size $d=0.44$), measures of use of controlling behaviours ($t=2.30$, $p=0.025$, $d=0.30$) and likelihood to use physical force ($t=2.49$, $p=0.013$, $d=0.23$) decreased from pre- to post-treatment. There were no significant differences between African American and White participants from pre- to post- treatment.

Tutty et al., 2006 (before and after, [+], Canada, n=33 female batterers (mean age 32 years, mean income $15, 000, most had children, most with psychiatric history and prior counselling, 10% in a lesbian relationship), mid- and post intervention) *[15 weekly, 2hr sessions of group therapy based on social learning and cognitive behavioural therapy, delivered in a counselling centre. Key focus: decrease abusive behaviour and stress; improve relationships, accountability, self-esteem, assertiveness and empathy. Women met individually with therapist prior to group sessions to assess violence & treatment goals. Groups included: cognitive restructuring, time outs, modeling, skill building, and role-playing]* Statistically significant improvements on: self-esteem (p=0.001), general contentment (p=0.001), clinical stress (p=0.000), and adult self-expression (p=0.004). No significant improvements on depression.

Schwartz et al., 2003 (non-RCT [+], USA, n=21 abusive men (mean age of 31 (intervention) or 33 (comparison) years, primarily Mexican American and White, most mandated to treatment), post-intervention) *[Intervention (n=14): 8, 2hr group therapy sessions, addressing: conflict between work and family, emotionality, relationships between men, success, power and competition. The intervention included reflection on father and grandfather behaviours, communication, listening and confrontation skills. Comparison (n=7): standard Duluth model, a feminist socio-cultural model to educate men on abuse as connected to male power and control. Setting: DV shelter]* Significantly greater reduction over time for intervention on restrictive emotionality ($p<0.016$) and restrictive affective behaviour between men ($F(1,19)=12.77$, $p=0.002$). No significant change for "success, power, and competition" or "conflict between work and family" over time for the intervention or control.

Applicability

Three studies were conducted in Canada (Tutty et al., 2001 [+]; Tutty et al., 2006 [+]; Tutty et al., 2009 [+]), and the remaining five studies were conducted in the USA (Waldo et al., 2007 [+]; Lee et al., 2004 [+]; Morrel et al., 2003 [+]; McGregor et al., 2000 [+]; Carney et al., 2006 [+]; Schwartz et al., 2003 [+]). Some studies may be limited in applicability due to the samples used, such as: men who do not have substance use issues (Tutty et al., 2001 [+]), or Latino men (Waldo et al., 2007 [+]; Schwartz et al., 2003 [+]). Three studies also examined programs for female batterers (Tutty et al., 2006 [+]; Tutty et al., 2009 [+]); Carney et al., 2006 [+]). One study included male and female batterers, yet the majority of participants were White men, and therefore may not be applicable to diverse women and men (Lee et al., 2004 [+]). Few demographic characteristics are provided in McGregor et al., 2000 [+], making it difficult to determine applicability. The non-experimental nature of many of the studies and small sample size of several studies may limit generalisability.

Evidence Statement 18- Long duration group interventions for abusers measuring recidivism/ abuse outcomes

There is inconsistent evidence from eight studies regarding the effect of long duration (over 16 weeks) group interventions for male abusers on recidivism or abuse outcomes. Some studies noted temporary reductions in violence or improvements in select measures of violence/ aggression. For example, an RCT (Maxwell et al., 2010 [++]) found a reduction in violence for men during psycho-educational group treatment, but this was not sustained beyond the treatment period. Another RCT (Alexander et al., 2010 [+]) found improvements in victim reports of partner physical aggression for men receiving a stages of change MI approach, but no difference in self-reported physical aggression or self- or victim- reported psychological aggression. Other studies reported a reduction in recidivism/ abuse outcomes. A before and after study (Price et al., 2008 [+]) found that partner reports of violence and police reports of repeat victimization were reduced following involvement of male perpetrators in a cognitive behavioural treatment programme. One non-RCT (Lawson, 2010 [+]) found a lower rate of recidivism and severe partner violence for men attending a CBT programme combined with a psycho-educational component, compared to CBT alone. A before and after study (Lawson and Barnes, 2006 [+]) examining a cognitive behavioural approach reported significant reductions in partner violence. Finally, a qualitative study (Schrock et al., 2007 [+]) reported that men who completed a Duluth model group therapy programme were

less likely than non-completers to be re-charged. In contrast, two studies demonstrated no intervention impact on recidivism. A cross-sectional study (Muftic & Bouffard, 2007 [+]) examining differences between male and female offenders involved in a coordinated community response intervention found that while women were more likely to complete treatment recommendations and fulfill their court order, their recidivism rates were not lower; and overall, the intervention did not appear to reduce recidivism (general crime or DV) for either women or men.
A before and after study (Bowen et al., 2008 [+]) demonstrated limited psychological change for male abusers following a psycho-educational treatment programme, that was not associated with re-offense.

Maxwell et al., 2010 (RCT, [++], USA, n=376 male DV offenders (18 years or over (mean age not provided); African American, Hispanic or West Indian, primarily no high school or high school education; employed; mean income of $16, 000), continuous for 15-month period) *[Assigned to 26 week, weekly group therapy programme (n=129) or 8wk, bi-weekly group therapy (n=61). Both 39hrs of psycho-educational therapy based on Duluth model (address definitions of DV, historical and cultural dimensions of DV, criminal issues; encourage accountability) delivered at victim services agency. Control group (n=186): 40hr community service over 2 weeks, plus education on HIV, drugs and employment counselling services].* Men in 26-week treatment demonstrated significantly longer period of non-violence compared to control ($b=0.55$, $p<0.05$). Assignment to either the 8- or 26-week group revealed a significant preventative effect ($b=-0.87$, $p=0.01$) during treatment. The hazard rate (time independent effect) was 70% lower when an offender attended treatment. Yet at follow-up, quantity of treatment no longer significantly related to amount of violence ($b=-0.02$, $p>0.05$).

Alexander et al., 2010 (RCT, [+], USA, n=528 male batterers (mean age of 31-36 years; Spanish speaking immigrant Latino men, and English speaking African American and White men, most with children; under one-third (Spanish) to one-half (English) employed; primarily court mandated; mean of 8-9 years (Spanish) or 12-13 years (English) education), post-treatment (batterers); 6-, 12- months (partners) *[Compared two 26 week group sessions (session length & setting NR). Stages-of-change motivational interviewing (SOCMI) (n=247 (200 English; 47 Spanish): using MI principles, 12 sessions targeted to pre-contemplation and contemplation, and 12 to behavioural change. Cognitive behavioural therapy gender re-education (CBTGR) (n=281 (175 English; 106 Spanish): behavioural techniques (time-out, anger journal) and acknowledgement of DV and pros/ cons of abuse]* No outcome differences between language groups. Significant reduction for SOCMI in victim-reported physical aggression at follow-up ($p<0.05$) but no significant difference in self-reported physical aggression or self- or victim- reported psychological aggression. For victim reported physical aggression, men less ready to change benefited more from SOCMI, while men more ready to change benefited more from the CBTGR ($p<0.05$).

Muftic & Bouffard, 2007 (cross-sectional [+], USA, n=201 heterosexual DV offenders (male n=131; female n=70) (Males mean age of 31 years, primarily White; Females mean age of 30 years, primarily White), post-intervention (mean of 10.4 months for entire sample; mean of 14.9 months for females and 8.1 months for males) *[Coordinated community response intervention for male and female offenders. After a court judgement, offenders must participate in: an intake interview and DVI screening; clinical assessment and development of treatment recommendations; and follow-through and completion of treatment recommendations (including: 24 week DV treatment programme for men, 5 hour anger management, counselling, substance use treatment)]* Overall, female offenders completed more intervention components (2.3 vs. 2.0) than did male offenders ($t=-1.765$, $p<0.05$). Female offenders were significantly more likely than male offenders to complete their court order regardless of the order content (46% vs. 17%, $\chi2=8.4$, $p<0.01$) and were also significantly more likely to complete treatment recommendations (47% vs19%, $\chi2=7.539$, $p<0.01$). Recidivism among female offenders was slightly higher (29% vs. 24% for any re-arrest charge; 80% vs. 66% for DV rearrests only), although this was not statistically significant. Findings from logistic regression models revealed that neither gender nor the number of intervention components significantly impacted either recidivism measure (any re-arrest or DV related re-arrest).

Bowen et al., 2008 (before and after, [+], UK, n=84 men (n=32 DV offenders; n=52 non-offenders) (mean age 35 (offenders) or 40 years (non-offenders); primarily White British; offenders had much greater rate of previous convictions, lower education and employment rate, and greater rate of alcohol abuse than non-offenders), 11-months) *[Domestic Violence Perpetrator Programme (setting NR): 24, 2-2.5hr weekly/ bi-weekly sessions plus 5 monthly, 2.5hr follow up sessions. Pro-feminist, psycho-educational, focus on: nature of violence, male socialization, empathy, sexual respect and accountability]* Levels of clinically significant psychological change had no association with re-offending (all tests non-significant).

Price et al., 2008 (before and after [+], UK, n=97 male perpetrators (demographics NR), pre-intervention, week 12, post-intervention (week 32) *[2.5hr weekly groupwork sessions delivered over 32 weeks (setting NR). Focused on understanding reasons for abuse, taking responsibility for actions, critical examination of gender expectations, and parenting and relational skills training]* Partner reports revealed that 70% of women reported no further violence, while 78% reported that abusive behaviour had been reduced or eliminated. Police reports revealed that repeat victimisation reduced by between 87.5% and 89.3%.

Lawson, 2010 (non-RCT, [+], USA, n=45 partner violent men (mean age of 30.1 (CBT/ PT) or 35.8 (CBT) years, African American, Hispanic and Caucasian, mean of 10 years education), post-treatment) *[Both 17 weekly, 2.5 hour sessions of group therapy (setting NR). CBT (n=18): motivation to change, non-violence, identifying triggers and time-outs, changing attitudes, skill-building (anger & stress management, relaxation, communication, assertiveness). CBT/ PT (n=27): CBT components plus psychodynamic component focused on identifying maladaptive interpersonal behaviours learned in childhood]* Lower rate of recidivism for CBT/ PT (22% vs. 50% in the CBT, $p<0.05$), and greater reduction in severe partner violence ($p<0.05$, eta squared=0.94).

Lawson and Barnes, 2006 (before and after, [+], USA, n=33 men on probation for DV offense (mean age 32.8 years; primarily African American, followed by White and Hispanic; low to lower middle class, 11.8 years mean education) post-treatment) *[17 weeks integrated cognitive-behavioural, feminist, psychodynamic group treatment (setting NR). Addressed: social influences, cognitive-behavioural processes and maladaptive relationships]* Significant reduction in partner violence ($F (1, 30)=6.06$, $p<0.05$).

Schrock et al., 2007 (qualitative, [+], USA, n=NR (3 years of weekly groups) (court mandated men, primarily African American or White, working class), NR) *[2hr, 26 weekly group sessions in community service centre. Based on Duluth model, the programme focus is on transforming men to non-violence, empathy, accountability, and egalitarian relationships using skill building (communication, assertiveness) and anger management sessions. Men provide responsibility statement at initial check in, and conversation of childhood trauma is avoided]* Completers were less likely than dropouts to be re-charged (11% vs. 42%) and more likely to be living with their victims (42% vs. 14%).

Applicability

Two studies were conducted in the UK (Bowen et al., 2006 [+]; Price et al., 2008 [+]) and the remaining six studies were conducted in the USA (Maxwell et al., 2010 [++]; Alexander et al., 2010 [+]; Muftic & Bouffard, 2007 [+]; Lawson, 2010 [+]; Lawson and Barnes, 2006 [+]; Schrock et al., 2007). One of the UK studies (Bowen et al., 2008 [+]) was conducted with predominantly White British men, and one of the US studies (Muftic & Bouffard, 2007 [+]) was conducted with primarily White male and female offenders, and therefore may have limited applicability to diverse groups. The other UK study does not provide demographic information of participants and therefore it is difficult to determine wider applicability (Price et al., 2008 [+]). In contrast, some studies were conducted with ethnically diverse samples of court mandated men (Maxwell et al., 2010 [++]; Alexander et al., 2010 [+]). The remaining studies were conducted with very small

samples of men (Lawson, 2010 [+]; Lawson and Barnes, 2006 [+]) or an unreported sample size (Schrock et al., 2007 [+]) and therefore may not be generalisable.

Evidence Statement 19- Long duration group interventions for abusers measuring attitudinal, interpersonal and psychological outcomes

There is inconsistent evidence from 8 studies that longer duration group interventions improve attitudinal, psychological and interpersonal outcomes among abusers. A qualitative study (Smith, 2011 [++]) found that men reported reduced anger and improved communication, assertiveness and perceived responsibility of personal power following involvement in abuser schema therapy. One before and after study (Connors et al., 2011 [+]) found that interpersonal outcomes improved following men's participation in a group counselling intervention, and that men reporting greater motivation to change demonstrated more pronounced improvements. A before and after study (Cranwell Schmidt et al., 2007 [+]) found improvements in men's attitudes regarding abusive behaviours and motivation to change following engagement in a pro-feminist CBT- based group treatment. One qualitative study (Rosenberg 2003 [+]) found that male and female probationers who attended a group therapy intervention reported improvements in communication and conflict management skills. A non-RCT (Lawson, 2010 [+]) found that a CBT intervention and a CBT intervention including a psycho-educational component demonstrated different psychological and behavioural improvements for men in each group. A before and after study (Lawson and Barnes, 2006 [+]) examined a cognitive behavioural group treatment and found improvements on men's psychological and interpersonal outcomes based on attachment patterns. In contrast to those studies demonstrating improvements, some studies revealed little positive effect. One before and after study (Bowen et al., 2008 [+]) examining a psycho-educational intervention reported limited (non-significant) psychological change for men. A qualitative study (Schrock et al., 2007 [+]) reported limited changes in men's: notions of masculinity, responsibility, empathy and egalitarian behaviours following participation in a Duluth-model intervention.

Smith, 2011 (qualitative [++], UK, n=18 men (mean age 34 years), 3-, 6-, 9- and 12 months post-treatment) *[20 weekly one-hour sessions of abuser schema therapy in a clinic setting, plus partner access to clinic counsellors. Included: self-monitoring for triggers, coping strategies, problem solving, changing abuse-related beliefs, exploring critical life events related to beliefs, and developing maintenance strategies for non-violence]* The four highest ranked variables based on men's narratives were: reduced anger (n=18), increased ability to communicate and assertiveness (n=17), reduced reaction to anger-provoking events (n=10), and perception of responsibility for personal power (n=9).

Connors et al., 2011 (before and after, [+], Canada, n=298 male DV offenders (mean age 36.6 years, White or Aboriginal, married, with children, most reported committing one or two assaults), post-treatment) *[29, 3hr sessions including min. of 3 individual counselling sessions & group sessions in security institutions/ community, using adult learning and cognitive behavioural approach and mixed formats (skill-building, role-playing, relapse planning, autobiography). Topics covered: motivational enhancement, awareness and education (using Duluth Model), managing abuse-related thoughts and emotions, social skills, self- management/ relapse prevention, and healthy relationships. Quiz following each session, with remedial sessions provided as needed. Includes assignments & relapse prevention plan prior to completion]* Significant improvements in: self-report jealousy outcomes (IRS), anger outcomes (AQ-R), measures of the Abusive Relationship Inventory (ARI), facilitator reports of programme treatment targets (FSR) (partner violence, motivation to change, participation and overall performance) and participant reactions to risk situations (DVV) (all p's<0.001). Mean changes in readiness to change were in the positive direction on both self-report and facilitator ratings (p<0.001 for both). All participants improved over time, but those rated as motivated improved at a higher rate (p's<0.05).

Cranwell Schmidt et al., 2007 (before and after, [+], USA, n=278 male batterers (mean age 33 years, Caucasian, mean monthly income of $1, 291) post-treatment) *[27 session group pro-feminist cognitive behavioural programme based on Duluth model; setting NR. Topics focus on:*

understanding DV & impacts of abuse, accountability, motivation to change and safety planning] Positive change in attitudes regarding abusive behaviours (all p values ≤0.01) and 6 of 8 survey items regarding support of a non-violent relationship (all p values <0.01). Greater motivation to change behaviour based on the effect of abuse on family relationships (p values <0.05).

Bowen et al., 2008 (before and after, [+], UK, n=84 men (n=32 DV offenders; n=52 non-offenders) (mean age 35 (offenders) or 40 years (non-offenders); primarily White British; offenders had much greater rate of previous convictions, lower education and employment rate, and greater rate of alcohol abuse than non-offenders), 11-months) *[Domestic Violence Perpetrator Programme (setting NR): 24 weekly/ bi-weekly, 2-2.5hr sessions plus 5 monthly, 2.5hr follow up sessions. Pro-feminist, psycho-educational, focus on: nature of violence, male socialization, empathy, sexual respect and accountability]* Limited significant psychological change was found for programme completers; changes were found for sympathy for battered women and locus of control (p's<0.05), but these were not found following adjustment for social desirability.

Rosenberg 2003 (qualitative, [+], USA, n=70 male and female probationers court-mandated to DV treatment (male n=57; female n=13, no further demographic data provided), 1-year) *[One year of 2 hour weekly group therapy sessions delivered in 6 DV intervention programs (setting NR). Content varied but based on process-oriented, CBT and educational approaches, including: time outs, identifying triggers, emotional regulation and communication skills]* At one-year post-treatment, 84% of participants reported continuing to use "time-outs" at work and home, 30% reported improved communication with their partners and co-workers, and 14% reported improvement in their ability to consider consequences of actions, identify anger triggers, create boundaries, and take responsibility for their behaviours.

Lawson, 2010 (non-RCT, [+], USA, n=45 partner violent men (mean age of 30.1 (CBT/ PT) or 35.8 (CBT) years, African American, Hispanic and Caucasian, mean of 10 years education), post-treatment) *[Both 17 weekly, 2.5 hour sessions of group therapy (setting NR). CBT (n=18): motivation to change, non-violence, identifying triggers and time-outs, changing attitudes, skill-building (anger & stress management, relaxation, communication, assertiveness). CBT/ PT (n=27): CBT components plus psychodynamic component focused on identifying maladaptive interpersonal behaviours learned in childhood]* Greater improvements for CBT/ PV in avoidance attachment (p<0.05, eta squared=0.11) and intrusive-socially avoidant scale (p<0.01, eta squared=0.14), but greater improvement for CBT on psychological/ behavioural functioning (p<0.05, eta squared=0.12) and general symptom and relationship distress (p<0.05, eta squared=0.10).

Lawson and Barnes, 2006 (before and after, [+], USA, n=33 men on probation for DV offense (mean age 32.8 years; primarily African American, followed by White and Hispanic; low to lower middle class, 11.8 years mean education) post-treatment *[17 weeks integrated cognitive-behavioural, feminist, psychodynamic group treatment (setting NR). Addressed: social influences, cognitive-behavioural processes and maladaptive relationships]* Significant increase in reporting of secure attachment (Chi square=5.06, p=0.024). Secure-changed men reported increase in comfort with closeness & depending on others at follow-up (t (13)=4.88, p<0.001), and lower anxiety and depression than insecure men at follow-up (p <0.05); insecure and secure-unchanged men reported increase in avoidance of closeness at follow-up (t (12)=2.33, p <0.05 and t (6)=2.43, p<0.05, respectively).

Schrock et al., 2007 (qualitative, [+], USA, n=NR (3 years of weekly groups) (court mandated men, primarily African American or White, working class), NR) *[2hr, 26 weekly group sessions in community service centre. Based on Duluth model, the programme focus is on transforming men to non-violence, empathy, accountability, and egalitarian relationships using skill building (communication, assertiveness) and anger management sessions. Men provide responsibility statement at initial check in, and conversation of childhood trauma is avoided]* The authors claim some success in men's accountability and egalitarian language, yet findings reported focus on participant resistance and failed facilitator interactions.

Applicability

Two studies were conducted in the UK (Bowen et al., 2008 [+]; Smith et al., 2011 [++]), one in Canada (Connors et al., 2011 [+]) and the remaining five studies were conducted in the USA (Cranwell Schmidt et al., 2007 [+]; Rosenberg 2003 [+]; Lawson, 2010 [+]; Lawson and Barnes, 2006 [+]; Schrock et al., 2007 [+]). Several studies were conducted with predominantly White men (Bowen et al., 2008 [+]; Connors et al., 2011 [+]; Cranwell Schmidt et al., 2007 [+]), and therefore may have limited applicability to diverse groups of men. The remaining studies were conducted with very small samples of men (Lawson, 2010 [+]; Lawson and Barnes, 2006 [+]) or an unreported sample size (Schrock et al., 2007 [+]; Rosenberg 2003 [+]) and therefore may not be generalisable.

Evidence Statement 20- Couple interventions including substance use treatment

There is moderate evidence from four studies that behavioural couples therapy (BCT) included within substance use treatment is associated with improved abuse outcomes, and in some studies with improved substance use measures. One before and after study (O'Farrell et al., 2004 [++]) found that male to female violence and verbal aggression decreased for couples with a male alcoholic partner who attended a BCT intervention, and abstinence from alcohol was associated with more sustained improvements. A RCT (Fals-Stewart et al., 2009 [++]) found that BCT with a substance using male partner reported lower levels of IPV (male to female) and of substance use; and even on days using drugs or alcohol reported lower levels of IPV than the comparison group. A before and after study (Schumm et al., 2009 [+]) reported a significant reduction in both female-to-male and male-to-female aggression for couples with a female alcoholic partner who attended a BCT intervention. Finally, an individual RCT (Fals-Stewart et al., 2002 [+]) found a significant reduction in male to female aggression for couples with a substance using male partner who were attending a BCT that was not observed among men attending individual substance use treatment sessions.

O'Farrell et al., 2004 (before and after [++], USA, n=303 couples with alcoholic male partner (Mean age of 43.3 years (men) and 41 years (female partner), White, mean income $40-50, 000, married), quarterly follow-ups for 2 years post-treatment) *[Behavioural couples therapy (BCT): 20-22 weekly, 1hr sessions over 5-6 months. Including: 10-12 individual conjoint sessions and 10, 2hr conjoint group sessions: taught non-violence, communication and interpersonal skills. Also completed daily sobriety contract, and if willing 12-step meetings with drug testing (for those with co-occurring drug problem). Setting: alcohol treatment centre. BCT compared with a demographically matched non-alcoholic sample of couples)* In year before treatment, 60% of BCT had been partner violent vs. 12% in matched comparison group. Years 1 and 2 post-BCT, violence and verbal aggression decreased significantly (in prevalence and frequency, all p's<0.001). No significant differences between the treatment and comparison groups on overall or severe violence, or between alcohol abstainers (in the BCT) and comparison at 2-year follow up. Days-with-drinking significantly correlated with violence prevalence and frequency and verbal aggression frequency, (all p's<0.05, r's ranging from 0.13-0.20) but not for: verbal aggression or severe violence prevalence and frequency.

Fals-Stewart et al., 2009 (RCT [++], USA, n=207 couples with substance using male partner (mean age of 33 (men) or 32 years (female partner), primarily White, mean education 14-15 years, primarily alcohol dependent men, most physician/ provider referred), every 3-months up to 1 year post-treatment) *[Both groups received 32 sessions; delivered in community based outpatient clinics. Behavioural Couples therapy (BCT) (n=103 couples): 12 weekly 60 min conjoint sessions (focused on supporting abstinence, communication and relational skills) plus 20 weekly, 60min individual sessions of 12-step substance abuse treatment. Individual Based Treatment (IBT) (n=104 couples): all 32 weekly sessions were 60min individual 12-step substance abuse treatment]* Both groups reported decrease in substance use and IPV at post-treatment and 1-year follow up (all p's<0.05). BCT couples reported lower levels of IPV and substance use at 12-month follow up than IBT (all p values <0.05). Likelihood of non-severe

(p<0.01) and severe (p<0.05) partner violence on days of male substance use was lower among BCT couples compared with IBT; on days of no substance use, there was no significant difference.

Schumm et al., 2009 (before and after [+], USA, n=103 couples with an alcoholic female partner (mean age 40 (women) or 42 (male partners) years, White, high school (women) or college (male partners) educated, married, mean income $45-50, 000), 1-, 2- years post-treatment) *[Behavioural Couples Therapy (BCT): 20-22 weekly sessions for up to 6 months including daily recovery contracts, involvement in 12-step groups if willing, and drug testing (if also using other substances); along with training in non-violence, communication and interpersonal skills. Setting: urban community counselling programme. Compared with demographically matched non-alcoholic couples sample]* Significant reduction between year before and 2-years post intervention on: each female-to-male and male-to-female prevalence of aggression measure (verbal aggression, overall violence and severe violence) (all p values <0.001). Prior to BCT, 68% of female alcoholic patients reported violence toward their male partner vs. 15% in the non-alcoholic comparison group; comparing remitted female alcoholic patients with non-alcoholic comparison, there were no significant differences in violence at follow up.

Fals-Stewart et al., 2002 (individual RCT [+], USA, n=86 couples with substance using male partner (Mean age 34 years, primarily Caucasian, married or living together, mean education 11.9 years, mean of 2 children, most men court mandated to treatment), one year post treatment) *[Both groups received 56 sessions; delivered in community based outpatient clinics. Behavioural couples therapy (BCT) (n=43 couples): weekly individual 60min sessions and 90 minute group sessions (focused on developing coping skills to abstain from substances), and 60 min conjoint sessions (focused on supporting abstinence, communication and relational skills). Individual Based Treatment (IBT) (n=43 couples): Identical except weekly conjoint session replaced with additional 60min individual session (focused only on substance use)]* Significant reduction in physical aggression for BCT from pre- (n=17, 43%) to post-treatment (n=7, 18%, p<0.01). No significant reduction in aggression for IBT.

Applicability

All four studies were conducted in the USA. All studies included a male substance-using partner, except for Schumm et al., 2009 [+] that included couples with an alcohol female partner. Findings therefore will not be applicable to couples experiencing violence in which the male/ female partner is not using substances. All studies included predominantly White participants and therefore may not be applicable to diverse men and women.

Evidence Statement 21- Couples interventions (not including substance use treatment)

There is weak evidence from three studies that couples interventions (which do not include treatment for substance users) are associated with a reduction in aggression outcomes or improvements in relationship skills, satisfaction and conflict. A RCT (Cleary-Bradley et al., 2011 [+]) which examined a psycho-educational intervention for parenting couples exhibiting situational violence found increased female-reported relationship satisfaction, a trend towards improved male-reported and female-reported relationship skills, and reduced male-reported conflict in the intervention group. Another RCT (Babcock et al., 2011 [+]) communication skills training was associated with improvements in men's and women's aggressive feelings towards their partner during conflict discussions. One before and after study (Woodin et al., 2012 [+]) found that the appropriate use of some, but not all, MI principles during feedback on assessment was associated with reductions in aggression, and differences were found between women and men.

Cleary-Bradley et al., 2011 (RCT [+], USA, n=115 parenting couples exhibiting situational violence (low income, primarily White, men aged 27-43, women aged 26- 42, child under 12 years old), pre-, post-intervention (0-6 months post-completion) *[Psycho-educational intervention (n=62): weekly 2hr group sessions for 22 weeks, with 6-8 couples focused on strengthening*

relationships by building skills related to: conflict management, emotional intimacy, friendships, and developing a culture of appreciation, fondness and respect. Sessions were co-facilitated by a male and female clinical and included a video related to the session topic, group discussion, an educational component and skill-building exercises. Control group (n=53) received community resources] In the intervention group there was: increased female-reported relationship satisfaction (t=−2.18, p=0.04); a trend towards improved male-reported (t=−2.02, p=0.06) and female-reported relationship skills (t=−1.87, p=0.08); and reduced male-reported conflict (t=4.18, p=0.001); there were no significant changes in the control group.

Babcock et al., 2011 (RCT, [+], USA, n=100 men and their female partners (men: mean age of 31.6 years, primarily African American or White, college educated, mean annual family income of $30,769; male to female aggression or low relationship satisfaction reported by female partner) post-treatment (men), 1- week (women). *[Couples discussed conflict area twice (7.5 minutes each) interrupted by either: 'editing out the negative' (n=39) (men taught to replace negative with neutral response), or accepting influence (n=30) (men taught to recognize validity in partner statements), compared to placebo/ time out (n=31) (men listened to relaxation music)]* Compared to the placebo/ time-out, men in both communication skills training conditions demonstrated significant reduction in self reported aggressive feelings (F (2,97)=3.37, p<0.05, eta square=0.71) and observed affective behaviour (positive affect F (2,97)=3.38, p<0.05, eta squared=0.014; aggressive affect F (2,97)=3.37, p<0.05, eta squared=0.054), and women reported feeling less aggressive towards their partner (F (2,97)=3.44, p<0.05, eta squared=0.056).

Woodin et al., 2012 (before and after [+], USA, n=25 couples experiencing physically aggressive male-to female dating behaviours (mean age of 19 (women) or 20 (men) years, Caucasian and Asian American, mean length of relationship: 24 months, mean family income $70-79, 999), 3-, 6-, 9- months post-intervention) *[Conjoint 2 hour assessment and interview and 45min individual feedback session using MI principles (empathic, non-confrontational, client-centred approach), including discussion of impact of and risk factors for aggression, and potential for behaviour change. Setting: university counselling programme]* Use of certain MI principles by the therapist was associated with improvements, including: greater reflection to question ration with aggression reduction for men (r=0.30, p<0.001) and women (r=0.19, p<0.05), and use of more open-ended questions was related to greater reductions in aggression for women (r=0.19, p<0.05), but not men. Global MI spirit, the use of complex reflections and MI adherent behaviours did not significantly impact aggressive behaviours.

Applicability

The studies included partners voluntarily seeking treatment (Babcock et al., 2011 [+]), situationally violent parenting couples (Cleary-Bradley et al., 2011 [+]), and a small sample of primarily high income White and Asian American university students experiencing dating violence (Woodin et al., 2012 [+]), and therefore may be limited in applicability to other groups.

Evidence Statement 22- Interventions addressing elder abuse

There is weak evidence from three studies that interventions addressing elder abuse (either against elders or against caregivers) may be associated with improvements in psychological and abuse outcomes. Two studies reported limited or mixed effects. One RCT (Phillips, 2008 [+]) reported a lack of effect of a psycho-educational intervention on physical aggression, mood states or care-giving burden for caregivers who had experienced abuse, although caregivers of men reported a reduction in anger and confusion over time. A qualitative study (Nahmiash, 2008 [+]) rated only a small minority of tailored home-based, multidisciplinary intervention strategies for abused elders as successful. One study noted several improved outcomes. This interrupted time series (Reay & Browne, 2002 [+]) found an overall reduction in strain, depression and cost of care for caregivers who had abused an elderly care recipient and had participated in a two-part educational and anger management intervention, with greater improvements noted for physical abusers following the anger management component, and for the neglect group following the education component.

Phillips, 2008 (RCT [+], USA, n=83 female caregivers who had experienced verbal/ psychological or physical aggression by care recipient (mean age of 56-65 years, 13-21% White (other ethnic composition not reported), 5-23% employed, 13-23% married, known elder for mean of 43-57 years), 3-months) *[Intervention (n=38): individual, educative intervention including collaborative problem solving on: pattern identification, counselling, and non-confrontational care-giving. Discussion of specific problems, triggers and problem solving strategies; key message: "stop, plan, practice.' Control (n=45): no intervention. Setting: home of participants and by telephone]* No significant effect for intervention on: mood states or care-giving burden. There was significant reduction over time for depression among both intervention and control participants (F=4.22, p=0.04). Caregivers of men in the intervention demonstrated a significant reduction in anger (F=3.99, p=0.05) and confusion over time (F=4.74, p=0.03).

Nahmiash, 2008 (qualitative [+], Canada, n=83 older adults identified as victims of abuse and neglect (1/3: males; 2/3: females, no other details), following 3-4 months of the intervention) *[Multi-disciplinary intervention delivered in the home. Includes screening for abuse by home care professional, followed by tailored individual and group intervention strategies, including: professional advice/ support, volunteer buddies to reduce isolation, empowerment support groups, family support, and community awareness]* 8% rated as successful and 20% unsuccessful (23% not rated because in-progress), based on reduction or elimination of violence or improved identification of problem. General medical, nursing and rehabilitation strategies were identified as most successful.

Reay & Browne, 2002 (interrupted time series [+], UK, n=19 caregivers (neglect n=9 (6 males; 3 females); abuse n=10 (3 males; 7 females)) (Primarily elderly spouse or adult child of victim, living with victim), 6-months) *[90min educational intervention providing information on available services and resources, and issues with caring for elderly. Follow up assessment was conducted, and then 4 weeks later, participants received a 90min individual anger management intervention. Setting: NR]* Findings reveal an overall reduction in strain ($p<0.001$), depression ($p<0.001$), anxiety ($p<0.0001$) and cost of care ($p<0.001$) for both groups (neglect and abuse) at follow-up. The anger management intervention was associated with a significant reduction in conflict ($p<0.05$); greater reductions were observed for the neglect group on: strain, depression and anxiety following the education component, and greater improvements for the physical abusers on: depression and anxiety following the anger management component. A trend for improvements regarding behaviours during conflict was found for physical abusers ($p<0.09$) but not the neglect group.

Applicability

One study was conducted in the UK (Reay & Browne, 2002 [+]), one in the USA (Phillips, 2008 [+]) and one in Canada (Nahmiash, 2008 [+]). The UK based study (Reay & Browne, 2002 [+]) was conducted with a very small sample size and therefore lacks generalisability. All studies provided limited demographic characteristics of participants and therefore it is difficult to determine applicability.

6.6. Discussion

A total of 76 articles were identified on interventions and approaches used in health and social care settings for responding to violence among victims (33), abusers (33), elders (3) and couples (7), informing 12 evidence statements on: advocacy interventions; skill-building interventions; counselling and brief interventions; therapy interventions; individual interventions for abusers; short duration group interventions measuring recidivism/ abuse outcomes; short duration group interventions measuring attitudinal, psychological and interpersonal outcomes; long duration group interventions measuring recidivism/ abuse outcomes; long duration group interventions measuring attitudinal, interpersonal and psychological outcomes; couple interventions including

substance use treatment; couples interventions not including substance use treatment; interventions addressing elder abuse.

6.6.1. Findings

Interventions for Victims of Domestic Violence

Settings of the interventions for victims included: shelters, community programs (including in some cases, in women's homes), clinical settings, perinatal services and DV services.

There is moderate evidence from 10 studies that advocacy services may improve women's access to community resources, reduce rates of IPV, improve safety, decrease depression, reduce various stressors, and improve parenting stress and children's well-being. Advocacy interventions are those that inform, guide and help victims of DV to access a range of services and supports, and ensure their rights and entitlements are achieved. Interventions included: community based mentorship, home visitation advocacy services, Independent Domestic Violence Advisor Services (IDVA), emergency department advocacy services, advocacy services for rural women, shelter and post-shelter advocacy services, and a 24 hour helpline services. Several studies included mothers, while others were aimed at pregnant, rural-dwelling, substance using women, and women using refuge services. While the majority of studies received a moderate quality rating, all studies reported improvements for women, suggesting that advocacy services delivered in a variety of contexts may be a promising approach for responding to DV.

There is moderate evidence from six studies that skill building (teaching, training, experiential or group learning) on a range of topics with victims of partner violence has positive effects on victims' coping, well-being, decision-making abilities, safety and reduction of coercive and violent behaviour toward them. Skill-building interventions include training and educational interventions aimed at improving various skills among victims of abuse. Women in these studies included: women with alcoholic partners, non-White women attending family planning clinics, women using refuge services, and mothers and children. While all studies reported improvements, these interventions varied widely focusing on building skills such as: coping skills, safety planning and conflict resolution skills, knowledge of reproductive coercion and harm reduction in a reproductive context, decision-making and danger-assessment skills, economic education, and sleep training.

There is moderate evidence from nine studies that counselling interventions may improve: PTSD symptoms, depression, anxiety, self-esteem, stress management, independence, support, re-occurrence of violence, birth outcomes for pregnant women, motivational level, readiness to change, and/ or forgiveness. Counselling/ brief interventions promote a range of outcomes, such as reducing depression and increasing empowerment among those who have experienced DV, through interventions based on brief educational, cognitive-behavioural, and motivational interviewing approaches. Sub-groups of women that were addressed included: pregnant African American women, pregnant and postpartum women, women in shelters, Hispanic immigrant women and rural women. The majority of interventions reported improvements on the various outcomes measured, yet some reported only modest improvements or improvements on some but not all measures.

There is moderate evidence from eight studies that therapy interventions may be effective for improving various PTSD symptoms, depression, trauma symptoms, psychological and social outcomes, parenting/ family-related outcomes and in some cases may reduce likelihood of future IPV or re-abuse. Therapeutic interventions promote improvement in mental health impacts of violence, through more intensive treatments than counselling interventions such as group therapy. Interventions included: cognitive processing and written account therapies, cognitive behavioural therapy, emotion- and goal- focused group therapy, psychosocial group therapy, dialectical behavioural therapy and holistic group therapy. Several studies were conducted with low-income women, and the majority of women captured in these interventions were Caucasian. All studies

reported improvements on the various outcomes measured; some studies that compared interventions reported differences in the type and level of effect.

Interventions for Perpetrators of Domestic Violence

Settings of the interventions for batterers included: DV intervention programs, shelters, outpatient clinics, community based services (in some cases linked with probation or security institutions), alcohol treatment clinics and counselling clinics.

There is moderate evidence from eight studies that individual interventions for abusers may improve: aggressive feelings towards partner, attitudinal change, understandings of violence and accountability, or short-term help seeking. Some interventions also reported improvements in violent behaviours or recidivism, while others demonstrated no effect. One study included White male and female batterers (Milner and Singleton, 2008 [+]), while all other studies targeted male batterers (sub-groups included: African American men, Hispanic men and alcohol dependent men); study samples were a mix of court mandated and non-mandated participants. The types of individual interventions employed varied, including: individual case management, an individual level intervention combined with community outreach services, solution focused therapy, educational interventions, and motivational interviewing. Overall, interventions appeared to have a greater effect on attitudinal outcomes than recidivism/ violence outcomes (which, when measured improved in some but not all studies).

There is inconsistent evidence from 10 studies that short duration (16 weeks or less) group interventions reduce recidivism/ abuse outcomes. Two studies examined programs for female batterers (Tutty et al., 2006 [+]; Tutty et al., 2009 [+]), and two studies included male and female batterers (Lee et al., 2004 [+]; Lee et al., 2007 [+]), while the remaining studies focused on male batterers. Study samples were a mix of court mandated and non-mandated participants, and were primarily White or demographics were not provided. Approaches included: group counselling, family of origin group therapy, solution and goal- focused treatment for male and female batterers, structured cognitive behavioural therapy and supportive group therapy. Multiple studies reported a reduction in recidivism or other abuse measures. In contrast, a few studies reported improvements in some, but not all abuse measures or no improvement at all, including a group treatment programme for female batterers and a cognitive behavioural group counselling intervention.

There is moderate evidence from nine studies that short duration (16 weeks or less) group interventions improve attitudinal, psychological and interpersonal outcomes among abusers. Three studies examined programs for female batterers (Tutty et al., 2006 [+]; Tutty et al., 2009 [+]); Carney et al., 2006 [+]) and one study included male and female batterers (Lee et al., 2004 [+]), while the remaining studies included only male batterers. Study samples included both court mandated and non-mandated participants. The majority of studies were conducted with primarily White participants, although several included diverse participants (Latino and African American participants). Approaches included: family of origin group therapy, a solution and goal focused group treatment programme, CBT, unstructured supportive group therapy, group counselling, and group sessions based on the Duluth model. The majority of studies reported improvements on the various outcomes measured. However, two studies examining a group treatment programme for female batterers, found improvements on some, but not all psychological measures.

There is inconsistent evidence from eight studies regarding the effect of long duration (over 16 weeks) group interventions for male abusers on recidivism or abuse outcomes. Some studies reported a reduction in recidivism/ abuse outcomes. Other studies reported reductions in violence or improvements in select measures of violence/ aggression (e.g. physical versus psychological aggression). One study included male and female offenders (Muftic & Bouffard, 2007 [+]), while the remaining studies included only male abusers. The majority of studies were conducted with primarily White samples of court mandated or non-mandated participants; only two were conducted with ethnically diverse samples of court-mandated men (Maxwell et al., 2010 [++];

Alexander et al., 2010 [+]). Approaches included: CBT programs, psycho-educational components, Duluth-based group therapy, and a stages of change MI approach. Evidence of effectiveness was mixed with some studies reporting a reduction in recidivism/ abuse outcomes, some reporting only temporary reductions or improvements in select measures of violence/ aggression, and some studies demonstrating no impact on recidivism.

There is inconsistent evidence from eight studies that longer duration group interventions improve attitudinal, psychological and interpersonal outcomes among abusers. Examples of outcomes measured include: communication, assertiveness, attitudes regarding violence, motivation to change, conflict management skills, psychological outcomes, responsibility for behaviours, empathy and egalitarian behaviours. One study included male and female probationers (Rosenberg 2003 [+]), while the remaining studies included only males. Several were conducted with ethnically diverse samples, though the majority included primarily White participants. Study samples include court mandated and non-mandated participants. Approaches included: abuser schema therapy, group counselling, CBT- based group treatment, group therapy intervention for male and female probationers, Duluth model based interventions and psycho-educational components. Evidence of effectiveness was inconsistent, with most studies demonstrating improvements, but some studies revealing little positive effect.

Interventions for Adressing Elder Abuse or Maltreatment

There is weak evidence from three studies that interventions addressing elder abuse (either against elders or against caregivers) may be associated with improvements in psychological and abuse outcomes. One study noted several improved outcomes (Reay & Browne, 2002 [+]), while the other studies reported limited or mixed effects. Interventions included: educational and anger management intervention for caregivers who had abused an elder, psycho-educational intervention for caregivers who had experienced abuse, and a tailored home-based, multidisciplinary intervention for abused elders. The lack of studies in this area, and differences in approaches used in the available studies, makes it difficult to determine the effectiveness of interventions to address elder abuse.

Interventions for Couples

There is moderate evidence from four studies that behavioural couples therapy (BCT) included within substance use treatment is associated with improved abuse outcomes, and in some studies with improved substance use measures. One study measured female-to-male and male-to-female aggression for couples with a female alcoholic partner (Schumm et al., 2009 [+]), while the remaining studies focused exclusively on male-to-female violence among partners with a substance using male partner. In general, studies reported improvements in partner violence/ aggression, although samples were all primarily White and therefore findings may not be meaningful for ethnically diverse couples who are experiencing violence.

There is weak evidence from three studies that couples interventions (which do not include treatment for substance users) are associated with a reduction in aggression outcomes or improvements in relationship skills, satisfaction and conflict. Interventions included: communication skills training, psycho-educational group sessions for parenting couples, and MI principles during assessment feedback. Given the lack of interventions for non-substance using couples, and diversity of approaches, samples used and outcomes measured in the available studies, it is difficult to form overall conclusions on the effectiveness of couples-based approaches.

6.6.2. Gaps in the Literature

There are a number of significant gaps in the literature. In particular, there is a lack of research among several populations relevant to the scope of our review. No studies were located that examined interventions to address ‘honour’ based violence or forced marriage. Other reports have identified women who experience ‘honour’-based violence or forced marriages as a key

understudied group of victims (House of Commons Home Affairs Committee, 2008). Elements of a response to forced marriage and 'honour'-based violence are being developed, including individual assessment and support in multiple settings to identify services required, such as employment and financial needs; reassurance for the victim that going against forced marriage is not going against their religion or culture; and/ or encouragement and help with continuing education as needed (Kazimirski et al., 2009). However studies of such interventions are not yet available in the academic literature.

In the literature on interventions for victims, there was an overall lack of evidence on tailored approaches for diverse women and women at different levels of risk. In addition, many studies included samples of women who were already accessing shelter services, and therefore findings may not be applicable to women who are not using these services. Only 3 articles included women who were separated or in the process of separating (Crespo et al., 2010; Allen et al., 2004; Reed & Enright, 2006). This group of women may be difficult to include, due to concerns over safety during this period. Other researchers have noted the lack of tailored interventions available for diverse victims. For example access to temporary and overall accommodation has been highlighted as a key issue for abuse survivors with disabilities (Hague, Thiara, & Magowan, 2007; McClain, 2011). However, there is some evidence from the grey literature (from studies that were not eligible for inclusion) of promising work to identify and address barriers to accessing help by Black, Asian, minority ethnic and refugee women who have experienced DV (Against Violence and Abuse, 2010; Smith, Burchess, & Bright, 2009). Further research with more diverse groups and evaluations of tailored approaches are required.

For interventions for abusers, very few studies examined the impact of interventions or approaches for diverse sub-populations of men or women, and no culturally specific programs were identified. Most interventions were directed at heterosexual men who abuse their partners. Some exceptions include: several studies which evaluated programs for female batterers (Tutty et al., 2006 [+]; Tutty et al., 2009 [+]; Carney et al., 2006 [+]); and two studies that included male and female batterers, although notably, the majority of participants were White male batterers (Lee et al., 2004 [+]; Lee et al., 2007 [+]). Overall, further research is required to investigate potential differences in approaches for diverse groups of women and men.

Currently, studies do not clarify how differential types of intervention intensity fit together into a response continuum, nor do they clarify directions for improving service access. The studies identified in the search related to this review did not address the spectrum of services recognized as key to a continuum of interventions for those who have experienced DV. The Taskforce on the Health Aspects of Violence Against Women and Children noted there is a great deal of useful information in the public domain already, yet in this review it can be seen that there remains room for more work to be done to clarify the continuum of services needed; to study modes of recognizing emergent health and social needs, to identify common comparable outcomes, and understand the effectiveness of responses (Taskforce on the health aspects of violence against women and children, 2010).

No quality studies (either [+] or [++]) were found that evaluated family intervention responses to DV, although several poor quality studies [-] were assessed and excluded from the report of findings. There was also a lack of interventions delivered within or linked to the health sector. However, partnership approaches (including those linked with health-care or with legal and criminal sectors) will be discussed in the final section. Additional evidence for advocacy approaches will also be included in the partnership section. In the grey literature (studies that did not meet inclusion criteria), there is some evidence for interventions linking DV and substance use services. The three year Embrace Project (2008-2011) was set up to develop and evaluate a new model of good practice for alcohol services, to raise awareness of these overlapping issues at a national level in the UK, and to develop resources and learning which can be disseminated across alcohol and domestic abuse services (Templeton & Galvani, 2011). In addition, the Stella Project recommended that staff training include pilots of brief alcohol intervention on how to work

with men who are abusive and identify clear referral pathways into appropriate services, as well as to promote the safety of partners (Stella Project, 2008).

There was moderate evidence for advocacy and various approaches to skill development, counselling and therapeutic approaches for victims of abuse. However, many studies, particularly within the counselling/ brief intervention and therapeutic intervention approach sections, included small sample sizes. Many studies also reported high rates of attrition, and lacked follow-up beyond programme completion. These methodological limitations make it difficult to generalize many of the findings reported. Larger, more robust studies are required to determine effective approaches to responding to DV among victims.

Intervention approaches for abusers were generally quite uniform, often employing psycho-educational, broad skill development, or cognitive behavioural approaches, including the Duluth Model from the USA (Domestic Abuse Intervention Programs, 2011). Batterer intervention programs typically utilize a range of psycho-educational techniques to increase understanding of coercive control, challenge abusive behaviour and teach alternatives. Approaches such as education, cognitive behavioural techniques, group participatory exercises and skills training and practice were used, and referrals to other treatment settings made for individuals with co-existing mental health or substance use problems, or who have experienced untreated childhood trauma.

However, there were variations in how programmes for abusers were implemented. The duration of interventions varied widely, as did counsellors' training experiences, the sample composition, administration, sponsoring agency, referral sources, and sources of funding (Gondolf, 2009). Edelson points to the challenges in bringing evidence into practice related to batterers programmes, such as need for evidence that supports understanding of why something works or does not work, linkage to broader research related to cognitive behavioural approaches and community building, and greater involvement of practitioners in preparing for and interpreting research (Edleson, 2012).

The majority of studies addressing interventions for abusers were non-experimental (primarily before and after studies). Often, studies did not include a comparison group, included relatively small sample sizes, reported high rates of attrition, and lacked follow up beyond programme completion. Therefore, it is not possible to generalize many of the findings reported. Larger, more robust studies are required to determine effective approaches to responding to DV among these groups. In studies measuring violence outcomes for batterer interventions official records of the police or court, such as restraining orders, records of arrest or conviction, are often used to capture recidivism rates and to indicate the effectiveness of interventions. Determining programme effectiveness using such measures is complicated by such issues as under-reporting, low rates of re-arrests for domestic abuse (Bennett & Williams, 2001), low response rates in follow-up, varying follow-up periods, and lack of control and comparison groups (Laing, 2003).

In the couples' section, the majority of studies examined behavioural couples therapy for heterosexual partners with a substance using male partner, although one did examine female alcoholic partners (Schumm et al., 2009 [+]). While these show moderate effectiveness for perpetrators of violence struggling with substance use disorders, weaknesses of these approaches include a lack of grounding in a theoretical framework or acknowledgement of the gendered nature of violence. In addition, the effectiveness of these approaches for non-substance using couples has not been identified in this review.

Only three studies were found that addressed elder abuse, and all of these studies lacked demographic details for participants. Research describing the needs of diverse older people experiencing maltreatment is lacking, however a study conducted recently in Canada describes the needs of older immigrant women experiencing abuse (Guruge & Kanthasamy, 2010). Some of the culturally relevant issues identified by women in that this study included were: children's and grandchildren's welfare, community expectations, unfamiliarity with Canadian ways, financial and immigration concerns, and limitations in accessing health, social, and settlement services.

Further research is required to examine interventions for diverse groups of elders experiencing abuse.

7. Research Question 4: Effectiveness Review of Interventions for Children who are Exposed to Domestic Violence

7.1. Background

Definitional Issues

There is a lack of standardized terminology within the research on DV. For example, the term "exposure" may be used in different ways, ranging from a description of children who witness violence to children who are directly abused (Kracke & Hahn, 2008). Furthermore, "exposure" captures varying levels of severity ranging from single incidences to chronic exposure (Kracke & Hahn, 2008). This creates challenges in accurately measuring the outcomes of exposure. Different types of exposure have also been identified in the literature based on the level of the child's presence and involvement in the context of abuse. For example, children may observe the violent incident, overhear the violence, witness or be aware of the outcome or effects of the violence, intervene during the incidence of abuse, or be used as "hostages" by the perpetrator of the violence (Fowler & Chanmugam, 2007; Humphreys, Houghton, & Ellis, 2008; Stanley, 2011). Different types of exposure may influence a child's response to and coping with DV, and therefore interventions for children may benefit from identifying the context of violence experienced.

Impact of Children's Exposure to Domestic Violence

Researchers have examined the effects of exposure to DV on behavioural and developmental outcomes among children and young people. Stanley notes several limitations of this research including: the need to separate exposure to violence from other forms of direct abuse or neglect and a reliance on data collected from convenience samples of women and children living in shelters, or accounts from mothers rather than children themselves (Stanley, 2011). In particular, the outcomes from studies conducted in shelter situations may be impacted by the particular characteristics of the shelter situation (some may be very stressful/ chaotic, while others provide a supportive refuge), and the additional stress that a child may experience from being placed in a foreign environment (Guille, 2004).

Age-specific differences in outcomes to exposure to DV have been examined. For example, infants respond with symptoms of poor health and sleeping, and excessive crying and screaming (Humphreys, et al., 2008). Children who have experienced abuse report: greater levels of fear, anxiety, stigma, aggressive behaviours, sleeping problems and poorer social competence, verbal skills and school performance issues (Edleson, 2011; Fowler & Chanmugam, 2007; Guille, 2004; Stanley, 2011). A meta-analyses by Kitzman et al. found that children who had been exposed to violence exhibited poorer outcomes on 21 behavioural and developmental measures when compared to children who had not witnessed abuse (Kitzmann, Gaylord, Holt, & Kenny, 2003). Furthermore, these outcomes were similar to those reported by children who had been directly physically abused (Kitzmann, et al., 2003). During adolescence, mental health issues including anger, depression, fear, and suicidal thoughts have been found among those who were exposed to DV during childhood (Olaya, Ezpeleta, de la Osa, Granero, & DomÃnech, 2010).

During adulthood, greater rates of depression and experiences of being either a victim or perpetrator of DV are greater among those who were exposed to DV during childhood (Stanley, 2011). Post-traumatic stress disorder (PTSD) has been observed both among children who have witnessed single episodes of violence, as well as chronic exposure to DV (Guille, 2004). One US study with 2,798 children and women participating in the Safe Start Initiative found that 25% of children exposed to violence reported clinical symptoms of PTSD, and 12% reported sub-clinical

levels (Kaufman, Ortega, Schewe, Kracke, & Safe Start Demonstration Project Communities, 2011). In addition, nearly half (47%) of mothers reported clinical levels of stress related to parenting following abuse, suggesting that mother-child interventions are required.

There is mixed evidence regarding differences in the outcomes of exposure to DV between boys and girls (Fowler & Chanmugam, 2007; Stanley, 2011). Several meta-analyses have revealed no differences between girls and boys (Kitzmann, et al., 2003; Sternberg, Lamb, Guterman, & Abbott, 2006; Wolfe et al., 2003). However, Evans and Davies' meta-analyses found that boys who were exposed to violence demonstrated more externalizing behavioural problems (e.g. aggression, socially disruptive behaviours) (Evans, Davies, & DiLillo, 2008).

There is fear and anxiety associated with the prospect of revealing experiences of domestic abuse. For example, children report feeling insecure and being worried about the potential of being taken into care, or causing further harm to their mother or to themselves, if they reveal abuse to a professional (Humphreys & Thiara, 2002). In England and Wales, children's services are most often notified about children's exposure to DV through police notifications (Stanley, 2011). Despite an increase in notifications, police referrals have been found to be the least likely to advance to an initial assessment among child services. This may prevent children and mothers from getting support and is an issue that needs to be considered when responding to children who have been exposed to DV (Cleaver, Nicholson, Tarr, & Cleaver, 2006). Stanley notes that this finding raises questions about the best methods both for identifying children at risk, and for intervening with children who are not prioritized for assessment by child services in the UK (Stanley, 2011).

A meta-analysis examining the behavioural effects of children's exposure to DV revealed that 63% who had experienced DV exhibited worse outcomes than children who had never experienced DV (Kitzmann, et al., 2003). However, the remaining portion (37%) of children appeared to be doing as well as other children, suggesting a resiliency to the effects of exposure to violence. Humphreys et al. (2008) argue that it is important therefore not to over-pathologise children who have been exposed to DV, and to recognize the ability of children and mothers to recover when they have access to a safe space. Stanley (2011) reviews a variety of potentially protective factors, including: self-esteem, self-efficacy, the availability of a supportive adult/ parent, and friendships or other forms of community social support. Yet, several factors may present additional risk for children who are exposed to violence, including: co-existing mental health issues of one or more parents, parental substance misuse, and the co-occurrence of direct abuse or neglect (Edleson, 2011). Researchers have not identified the specific effects of protective or risk factors on health outcomes, due largely to the complexity of factors and difficulties in examining the effect of these factors in isolation (Fowler & Chanmugam, 2007).

It is clear that children exposed to violence are a heterogeneous group and diverse responses are therefore needed that account for these variances and complexities. A US-based review of programs for children exposed to violence suggests that incorporating the following principles are key to the development of effective responses to children's exposure to DV: facilitating safety of the victim and child and reducing risk for further violence, employing trauma-informed care to children and families who have been exposed to violence (also supported by: (Fowler & Chanmugam, 2007), and improved training and delivery of culturally and developmentally appropriate services for children and families (US Department of Justice & US Department of Health and Human Services, 2011). Furthermore, research demonstrates that it is important to honour the voices of children when responding to DV (Humphreys, et al., 2008). A discussion forum held with children who had experienced DV in the UK, reveals that children are often more aware of incidents of abuse than their parents imagine, and are frustrated by service providers who don't ask for their input, suggesting that it is important to listen to children when deciding upon or developing appropriate responses, rather than relying solely on the accounts of mothers or parents (Barron, 2007).

7.2. Summary of the Literature

A total of 69 full-text study reports were retrieved. An additional 11 reports relevant to Q4 were collected through the grey literature search (a breakdown is provided in the flow-charts in *Appendix G*), including: web-searches and the OpenGrey database. In addition, 10 papers suggested by the PDG were deemed relevant to Q4 and considered for full text review.

A total of 90 reports were retrieved for full text review. Of these, 54 papers were excluded at the full text screening stage. One systematic review (Rizo et al., 2011) was identified. An additional 22 papers were captured by this review, and were therefore not individually rated. One quantitative study that received both a [-] internal and [-] external quality rating, and one qualitative study with an overall [-] rating are included in the report of findings. No papers were excluded from Q4 due to quality rating. A total of 13 studies are included and reported on in this review. A summary of the studies included in see *Appendix I.*

7.2.1. Systematic Reviews

One systematic review was identified which met the inclusion criteria (Rizo et al., 2011). This review was included in this review. We did not include/ individually assess the individual studies covered by this review. The scope of this review was similar to the scope of the present review- to examine interventions that either directly or indirectly target children exposed to intimate partner violence. More details on this review are included in the Findings section of this report.

While the review by Rizo et al. (2011) is comprehensive and directly relevant to this particular review question, there are a number of differences between their review strategy and the methods used in our review that must be noted. In particular, they do not indicate how they conducted a quality assessment for each study. Yet they do critically analyse the empirical literature and provide information on strengths and limitations for each study, including issues with study design and methods. They also note studies that are particularly rigorous in design. They do not provide effect sizes and p-values for outcomes, but rather discuss findings more generally. However, we have gathered additional details on: country of study, study design, and reported outcomes with effect sizes and p-values, which are presented in *Appendix L*. While the lack of assessment of these studies using NICE methods is a limitation of our review, the collection of these additional details helps present a more complete picture of the literature.

We summarized the findings from 25 out of 31 studies covered by this review. We have excluded two studies that focused exclusively on intervening with parents/ caregivers and did not examine outcomes for children who are exposed to violence (Peled, Davidson-Arad, & Perel, 2010; Scott & Crooks, 2007), as well as four studies that were published prior to 2000 and are therefore outside of our review scope (Gibson & Gutierrez, 1991; Kot, Landreth, & Giordano, 1998; Marshall, Miller, Miller-Hewitt, Sudermann, & Watson, 1995). As per NICE advice, we did not assess the individual studies covered by Rizo et al. (Rizo, Macy, Ermentrout, & Johns, 2011) that are relevant to our research question

The 25 studies from Rizo are discussed within the following categories: Four studies evaluated the effectiveness of a single component therapeutic intervention that was delivered to both mother and child (Lieberman, Ippen, & Van Horn, 2006; Lieberman, Van Horn, & Ghosh Ippen, 2005; Smith & Landreth, 2003; Timmer, Ware, Urquiza, & Zebell, 2010); two studies evaluated single component psycho-educational interventions delivered to mothers and children (Becker, Mathis, Mueller, Issari, & Atta, 2008; Ducharme, Atkinson, & Poulton, 2000); one study evaluated a single component therapeutic intervention for children (Tyndall-Lind, Landreth, & Giordano, 2001); four studies examining the effectiveness of a single component psycho-educational intervention delivered only to children (Johnston, 2003; McWhirter, 2008; Pepler, Catallo, & Moore, 2000; Sudermann, Marshall, & Loosely, 2000); four studies evaluated multi-component interventions focused on advocacy (Blodgett et al., 2008; Crusto et al., 2008; McFarlane, Groff, O'Brien, & Watson, 2005); two studies evaluated multi - component interventions focused on advocacy and therapy (Ernst, Weiss, Enright-Smith, & Hansen, 2008; C. M. Sullivan, Bybee, &

Allen, 2002).; and eight studies evaluated multi-component interventions focused on therapy and parenting (Carter, et al., 2003; Dodd, 2009; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; E. N. Jouriles et al., 2009; E.N. Jouriles et al., 2001; MacMillan & Harpur, 2003; McDonald, Jouriles, & Skopp, 2006; M. Sullivan, Egan, & Gooch, 2004).

7.2.2. Included Studies

The results of quality assessment are presented in *Appendix K*. Of the studies reviewed, for internal validity, two were judged to be of high quality [++], and 9 of medium quality [+], and one of low quality [-]. For external validity, eight studies were judged to be of medium quality [+] and three of low quality [-], while two were qualitative studies and did not receive an external validity rating

Applicability

Two studies were conducted in Australia; two in the UK; one in Sweden; and eight studies were conducted in the USA. However, for the majority of the interventions there is no reason to believe that the approach could not be applied to the UK context. Potential applicability issues that pertain to specific intervention formats are discussed within the findings of the report and provided in the evidence statements.

The main source of potential barriers to applicability is the sampling procedures used in the majority of studies. Many of the studies relied on non-random convenience sampling. This may limit the generalisability of the results to the population of children who are exposed to violence as a whole. This issue is further noted in the findings section.

7.3. Findings

We will report on evidence in two categories. First, from a systematic review conducted by Rizo et al. (2011), which examined interventions for children exposed to intimate partner violence (IPV), and second from the additional studies that were collected through our search process, and were quality assessed using NICE tools. The search methods and exclusion criteria used by Rizo et al. differed somewhat from our methods and therefore we identified 13 additional articles that were not covered by their review.

We have organized our findings using the following categories:

1) Single component therapeutic interventions delivered to mother and child
2) Single component psycho-education interventions delivered to mother and child
3) Single component therapeutic interventions delivered to child only
4) Single component psycho-education interventions delivered to child-only
5) Multi-component interventions focused on advocacy
6) Multi - component interventions focused on advocacy and therapy
7) Multi - component interventions focused on therapy and parenting

See *Appendix M* for a summary of the framework used for reporting evidence for research question 4.

Overview of Rizo et al., 2011 [+]

Rizo et al. (2011) undertook a systematic review and a critical analysis of the literature concerned with interventions that either directly or indirectly target children exposed to DV, published between 1990 and 2010.

The authors conducted a systematic search of the: PubMed, PsychInfo, ASSIA, Social Service Abstracts, Sociological Abstracts, and Social Work Abstracts, from 1990- fall 2010. Keyword searches included: DV, intimate partner violence, partner violence, partner abuse, wife abuse, battered women, battered, batter, mother, parent, father, child, exposure, witness, intervention, service, treatment, programme, and therapy. They also conducted reference searching of all

included articles to identify additional relevant studies. In total, these search methods resulted in over 14,000 articles. To identify those most relevant, the authors screened for articles that were: 1) empirical; 2) interventions or programs for helping children exposed to IPV. These include parenting interventions, interventions for survivors or perpetrators that assess child outcomes, and direct interventions for children who have witnessed IPV; 3) used quantitative methodologies; 4) written in English.

They identified, and describe, 31 studies including the intervention's aim, description, sample, and key findings. The authors carefully consider strengths and limitations of the studies individually and provide their assessment in tables. By and large, the populations targeted when addressing the needs of children exposed to DV in these studies have been the children directly, and/ or caregivers who are mothers.

They organized the studies into 4 types of intervention programs:

1) Counselling/ therapy programs,
2) Crisis/ outreach programs,
3) Parenting programs, and
4) Multi - component intervention programs.

They note that the intervention goals *for children* across these four types of programming were often similar and included: Learning about and dealing with IPV; developing and enhancing coping skills; developing and enhancing communication skills; developing and enhancing conflict resolution and problem-solving skills; exploring attitudes and beliefs about family violence; increasing personal safety; improving trauma symptoms and overall psychological well-being; increasing self-esteem and self-efficacy; increasing social skills and social support; decreasing self-blame; understanding and expressing feelings; improving emotion-regulation; and changing maladaptive behaviours.

Similarly intervention goals *for caregivers and parents* across all studies included: Developing and enhancing their knowledge of child development and the impact of IPV on children; developing and enhancing parenting and disciplining skills; decreasing parenting stress; increasing self-esteem and parenting self-efficacy; increasing emotional and psychological well-being; helping caregivers/ parents develop safety plans; developing and enhancing social support; developing and enhancing self-advocacy skills; developing and enhancing communication and problem-solving skills; developing caregivers'/ parents' knowledge of and connections with community resources; improving caregiver/ parent–child interactions and activities; and improving the caregiver/ parent–child relationship.

Given the commonalities across studies for both groups reached by these interventions, the authors suggest that these may be helpful intervention strategies for providers working with parents/ caregivers and with children who are exposed to violence. They suggest that multi-component programs (which often included intervention strategies from the other 3 categories) may be most helpful, but encourage further research examining the effects of single-focused approaches in order to determine the specific effects of each approach.

Due to the relatively small number of studies on this important topic and methodological weaknesses identified, they indicate that, as such, it is not yet possible to determine which of these four approaches holds the most promise, or make firm conclusions on whether or not interventions/ programs result in a positive difference for children exposed to DV. However, they do make note of 10 studies with significant rigor; and recommend to increase rigor overall, that researchers who are conducting future intervention studies: 1) recruit, include, and intervene with large samples participants; 2) conduct an intent-to-treat analyses; 3) perform follow-up, and data collection following the intervention; 4) use experimental randomized study designs; and 5) use robust statistical methods to account for nested, correlated data (e.g., hierarchal liner modeling).

While the four categories mentioned form the basis of the Rizo et al. review paper, we have categorized the studies in this review using a different framework.

7.3.1. Single component therapeutic interventions for mother and child

The [+] review by Rizo et al. (2011) included four studies which evaluate effectiveness of a single component therapeutic intervention that was delivered to both mother and child, either together or in concurrent but separate interventions (Lieberman, et al., 2006; Lieberman, et al., 2005; Smith & Landreth, 2003; Timmer, et al., 2010).

Rizo et al. (2011)

Quantitative Studies

Two studies included in this section were identified by Rizo et al. (2011) as some of the most rigorous studies in their review (Lieberman et al., 2005; Lieberman et al., 2006). These US-based RCT studies reported on the same intervention: a weekly mother-child psychotherapy intervention delivered over a period of 50 weeks in a clinical setting. The intervention was aimed at improving maladaptive behaviours and parent-child interactions through individual and joint sessions and the use of play. The 2005 study evaluated the intervention among an ethnically diverse sample of 75 mother-child dyads (39 girls; 36 boys) ranging in age from 3-5 years. The 2006 study was a final 6-month follow-up among a smaller sample of 22 girls and 28 boys and their mothers, ranging in age from 3-6 years. Both studies demonstrated improvements in children's behaviour problems and traumatic stress symptoms, and improvements among mothers in PTSD symptoms. Strengths included the use of theory (cognitive behavioural, attachment and ecological theories) to inform the intervention, the inclusion of information on providers, inclusion of an ethnically diverse, community based sample, the use of a comparison group, the inclusion of an ITT analysis, follow up, standardized measures and monitoring of treatment fidelity. Limitations include the use of a small sample, reliance on mothers reporting of outcomes, lack of follow-up and use of a non-random convenience sample.

The US-based experimental interrupted time series study by Smith and Landreth (2003) examined a shelter-based filial therapy parent training group intervention. In this intervention, mother participated in 12, 1.5 hour training sessions and then engaged in 10 to 12 play sessions with the children, conducted over a period of 2-3 weeks. They included an ethnically diverse sample of 11 mothers and 11 children (4 girls, 7 boys) aged 4-10 years in a sample drawn from a DV and homeless shelter. Both interventions included modeling and play sessions and parent training/ coaching in parent-child play. Children in the intervention group demonstrated significant improvements compared to the non-treatment group on all measures. Involvement in greater intensity individual therapy was associated with higher behavioural scores than children in less intensive experimental group. Mothers in the experimental group also demonstrated improvement in empathy and communication skills, and allowing child self-direction. While this study included multiple comparison groups, use of multiple reporters (children, mothers and raters), standardized measures and information on providers, key limitations noted include: small sample size, no discussion of manual used or theory, a lack of randomization and follow up, the use of experimental and control groups from different time periods and lack of control in the comparison group.

A US-based non-RCT by Timmer et al. (2010) examined a parent-child interaction therapy intervention delivered in a clinical setting. The intervention was 14-20 weeks in length and focused on teaching parents praise behaviours, use of appropriate discipline techniques, and mother-child play using training, coaching and feedback, mother-child play and homework assignments. They included an ethnically diverse sample of 129 mother-child dyads (62 who were exposed to IPV and 67 non-exposed) ranging in age from 2-8 years (66.7% male; 33.3% female. They found significant improvements in children's behaviour problems with no significant differences between IPV-exposed and non-IPV exposed groups, as well as improvements in mothers' psychological distress. Completion of the intervention was associated with greater

improvements. Strengths included the use of theory (social learning and attachment) and a manualized intervention, inclusion of an ethnically diverse, community-based sample, inclusion of feasibility data, use of standardized measures and a comparison group and reporting of power and effect sizes. Limitations included: mothers acted as the sole reporters of outcomes, no information provided on mother's age, no systematic measurement of IPV, no information on providers, lack of randomization, no follow up, the use of a non-random convenience sample, and lack of generalisability due to children's involvement in child welfare.

Additional Studies

Two additional studies were assessed which evaluated effectiveness of a single component therapeutic intervention that was delivered to both mother and child (Addressing Family Violence Programs, 2011, before and after [+]; Ghosh Ippen et al., 2011, RCT [++].

Quantitative Studies

A before and after study by the Royal Children's Hospital Melbourne, Australia (2011) [+] looked at outcomes related to attachment between mother and child dyads who participated in a 10 week Peek a Boo Club group. Although the setting of the intervention is not reported, it is assumed given the nature of the authoring institution that this was conducted in a clinical setting. The group used an experiential, activity based and interactive approach to provide a therapeutic venue to facilitate healthy infant and mother attachment. This group treatment is founded on the idea that exposure to IPV can inhibit a mother's capacity to effectively focus on her child's attachment needs. Participants included mothers and children exposed to DV in Melbourne, Tasmania and rural Victoria. Ages of the infants were: 42% under 12 months, 33% 12-24 months, and 21% 24 months or older. The infants were diverse in ethnicity, with 12% Aboriginal or Torres Strait Islander.

Attachment was measured at the end of the programme using the 19 item Maternal Postnatal Attachment Scale (MPAS), with 103 of 172 mothers of mother-infant dyads who participated between 2005 to 2010. Toddler social-emotional and behavioural problems were measured with 27 toddlers using the Brief Infant and Toddler Social and Emotional Assessment (BITSEA).

A positive shift in mother's attachment was found: an increase of around 2 points in the Global Attachment Scale mean (from 75.3 to 77.6), as well as an increase in the mother's acceptance and tolerance of her infant (from 17.9 to 18.4) and her pleasure in interaction with her infant (from 20.9 to 22.1). However, the post-group scores do fall outside the range for normal postnatal mothers. There was a decrease in reporting of significant social and emotional problems in toddlers by mothers from pre group (52% reported significant problems) to post (26% significant problems), and possible deficits/ delays in competence were reported pre (11%) to post group (7%).

The methods are not fully reported: there is not full information on the 172 participants and no report of statistical significance for attachment scores is given. However standardized scales were used. The authors include only outcomes from testing at the end of the programming and no long-term outcomes. The findings are based on self report and the authors note that mothers may idealise attachment with their infants pre-intervention, and therefore the increase in attachment may be greater than that reflected in the scores.

The groups were led by a maternal and child health nurse, a social worker with experience running women's DV support groups, and a family therapist with many years experience working with children affected by family violence. The intervention team had weekly supervision with an infant mental health specialist employed at Royal Children's Hospital Mental Health Service. The involvement of the hospital is an important aspect of this intervention, not seen in other interventions. This intervention has been awarded: a commendation in 2005 in the National Child Abuse Awards for Responding to Child Abuse and Neglect, a Gold Award, Mental Health Services FisT Programme in 2009, and a Certificate of Merit, Australian Government Crime & Violence Prevention Awards in 2010.

Ghosh Ippen et al. (2011) [++] re-analysed data from a RCT of an evidence-based clinical intervention (Child Parent Psychotherapy (CPP) that has the therapeutic goal of enhancing the parent's capacity to provide safety and developmentally appropriate caregiving to the child (Ghosh Ippen, Harris, Van Horn, & Lieberman, 2011). The child and the mother participated together in the sessions. The CPP intervention has been found to promote in young children: secure attachment, improved cognitive performance, decreased traumatic stress symptoms and behavioural problems, and reduced PTSD symptoms. While the mothers' individual psychological status is not a direct target of the treatment, mothers who participate in CPP have been found to demonstrate decreased PTSD avoidance symptoms as well as improvements in global symptoms. This study utilized a reanalysis of data from previous studies, to investigate whether CPP is effective for intervening with preschoolers exposed to multiple traumatic and stressful events (TSEs) and whether the level of child's risk impacts treatment effects for mothers. The previous studies involved 39 girls and 36 boys aged 3-5 years and their mothers. The prevalence of exposure to the 8 TSEs was: 29.3% physical abuse, 12% sexual abuse, 97.3% witnessing DV, 5% neglect, 100% separation from caregiver, 5.3% caregiver criminal history, 16% caregiver substance abuse and 88% caregiver mental illness. The intervention included weekly child-parent psychotherapy session, 60 minutes each over 50 weeks, with a mean attendance of 32 sessions (SD 15). Treatment fidelity was monitored through progress notes. The control group received case management and resource referrals.

They found that the high-risk CPP children (with 4 or more TSEs) showed significantly greater improvements in reductions in PTSD and depression symptoms, number of co-occurring diagnoses, and total behaviour problems. The lower risk CPP group (with <4 TSEs) also showed significant improvement in PTSD symptom reduction, whereas the comparison group did not. In the low risk group, both treatment and comparison group mothers showed significant improvements in PTSD, but only CPP mothers showed significant post treatment reductions in depression. In the high-risk group, CPP mothers showed significant reduction in PTSD and depression, whereas comparison group mothers showed no improvements in any of these domains. At intake, children with 4+ TSEs showed significantly greater impairment across all child symptom domains. They had a greater number of PTSD symptoms ($t(73)=-3.24$, $p<0.01$, $d=0.75$) and depression symptoms ($t(73)=-2.21$, $p<0.05$, $d=0.42$), met criteria for more DC: 0-3 diagnoses ($t(73)=-3.92$, $p<0.001$, $d=0.91$), and had significantly greater behaviour problems ($t(73)=-2.12$, $p<0.05$, $d=0.49$). At post-test, there were statistically significant group differences for 4+ children in both ITT and TC samples (ITT: $x^2(1)=10.48$, $p<0.01$, $\phi=0.55$; TC: $x^2(1)=12.38$, $p<0.001$, $\phi=0.65$) with CPP children showing significantly lower rates of PTSD (ITT: 5%; TC: 0%) than comparison group children (ITT: 53%; TC: 55%). For the <4 group, chi-square tests were not significant for ITT or TC samples. At post-test, in the ITT sample, CPP 4+ mothers were significantly less likely to have a diagnosis of PTSD ($x^2=7.70$, $p=0.01$, $\phi=0.47$), with 15% of CPP mothers and 60% of comparison group mothers meeting PTSD criteria. In the TC sample, although fewer CPP 4+ mothers met criteria for PTSD (CPP=17% versus comparison=44%), this difference was not statistically significant. No significant treatment differences for maternal PTSD were found for the <4 group. Only CPP mothers showed significant post treatment reductions in depression. Within-group effect sizes were moderate to large for the CPP group. In the 4+ TSE group, CPP mothers showed significant reduction in PTSD and depression, with large effects in all these areas ($d>0.90$), whereas comparison group mothers showed no improvements in any of these domains.

The authors conclude that, by strengthening the parent-child relationship, CPP has significant positive effects not only for the child's psychological functioning but for the mother's as well. CPP treatment may provide both direct and indirect benefits for mothers. By actively engaging in their child's treatment, mothers may better understand, recognize, and manage trauma related behaviours. Mothers may also indirectly benefit from reductions in stress and enhanced self-efficacy as their children's symptoms improve, and their engagement in their child's treatment.

The study design and analysis were robust, although sample size was small. Sex and gender differences were not reported on. The intervention in this study was intensive: weekly one-hour sessions for 50 weeks. It is of note that the comparison group mothers received individual therapy and case management, underlining the importance of relational interventions involving both mother and child. The families were ethnically diverse and low income, and the authors see this as demonstrating that CPP may be effective in addressing the gap between clinical need and availability of culturally informed treatment. The study confirms other evidence of benefits of involving mothers in relationship-based treatment with their children, as benefits are accrued for both.

7.3.2. Single component psycho-educational interventions for mother and child

Rizo et al. (2011)

Rizo et al. (2011) [+] reviewed two single component psycho-educational interventions delivered to mothers and children (Becker, et al., 2008; Ducharme, et al., 2000)

Quantitative Studies

A US-based before and after study by Becker et al. (2008) evaluated a 12-week, 90-minute community-based psychoeducational and support group session for children and caregivers. Groups were gender and age-specific; topics were similar across groups but delivered in an age-appropriate format. The goals of the psychoeducational groups for children were to: provide a safe setting for learning about DV, to explore beliefs and knowledge about violence, and to build coping skills. Parenting support groups were also provided to children's caregivers. A total of 106 ethnically diverse children ranging in age from 3 to 17 years participated in the study (69 girls; 37 boys). In addition, 104 non-offending parents participated, who were all mothers. They found that children and mothers who completed the group were rated as more improved on coping skills, and there were significant improvements in children's internalizing and externalizing behaviours and psychopathology. Mothers also reported significant improvements in parenting skills. Strengths noted by Rizo et al. (2011) include the use of a community based and ethnically diverse sample, and multiple reporters for both child and parent outcomes (from both mother and counsellor). However, several limitations were provided, including: no systematic collection of information on family violence, lack of comparison group, high attrition rate, lack of information on providers of the intervention, lack of follow-up, no discussion of theory or the manual used, use of a non-random convenience sample, and the statistical analyses did not account for nested/ correlational data.

A Canadian cluster-RCT study by Ducharme et al. (2000) examined a parenting intervention. This community-based intervention included 5 group sessions for mothers along with ongoing parent-conducted treatment sessions in the home. Parents were taught Errorless Compliance Training, which involved training to treat children's non-compliance as errors rather than disobedience. The intervention involved 15 children (10 boys; 5 girls) ranging from 4-10 years old and 9 mothers 28-37 years old. The intervention lasted between 14 weeks- 28.7 weeks on both children and caregivers, and revealed significant improvements in children's behaviour problems and maternal stress and perception of child cooperation, as well as significant improvements in children's externalizing and internalizing problem behaviours. They also found consumer satisfaction with the treatment (Ducharme, et al., 2000). Strengths noted include use or multiple reporters (mothers and research assistants) and standardized measures, follow up, analysis of effect size, and use of a manualised intervention. Limitations include a lack of experimental design, no discussion of theory or information on providers of the intervention, small sample sizes, high attrition, no true comparison group, lack of measures to assess parent-child relationship (despite this being identified as a programme goal), use of non-random convenience samples, and failure to statistically account for nested and correlated data.

Additional Studies

We identified an additional 2 studies covering single-component psycho-educational interventions delivered to children and mothers who are exposed to violence (Grip et al., 2011, before and after [+]; Humphreys et al, 2006, qualitative, [-]

Quantitative Studies

A before and after study by Grip et al. (2012) [++] assessed a group programme for children exposed to IPV and their mothers in a community service setting in Sweden. The programme consisted of 15 weekly structured 90-min sessions based on the “Children are people too” programme, which is focused on education about violence, safety planning, feelings, defences, risks and choices and parent/ child communication, using multiple modalities (play, drawing, discussions and lessons). The groups were composed of six to eight children of similar age, led by two female social workers.

The sample for the study was 46 children and their 34 mothers who were seeking help for intimate partner violence and were not living with the perpetrator. Children ranged in age from 5 to 14 years (mean 9, sd=2.4), and included 25 girls and 21 boys. Mothers were of low SES and lived in abusive relationship for a mean of 6.8 years.

Two methods were used to collect child outcomes: the Strengths and Difficulties Questionnaire (total problem scale, prosocial and impact subcales), Cronbach's alphas ranged from 0.70-0.74; and a semi-structured interview covering child and mother history and current life situation, child violence exposure, and presence of trauma symptoms (intrusion, avoidance, arousal, worries and psychosomatic complaints). The mothers’ trauma symptoms were also collected using the Impact of Event Scale, Cronbach's alpha=0.98. Follow up periods were at end of programme, and one-year post.

From the SDQ total problem scale it was found that the children’s behavioural problems were significantly reduced ($t(23)=2.96$, $p<0.05$) from pre- to post-assessment and the effect size (Cohen’ s d) was in the medium range (0.60, CI:0.16-1.04). There was no effect from pre- to the 1-year follow- up assessment ($t(23)=1.73$, $p>0.05$) and the effect size confidence interval covered zero (0.35, CI:-0.06-0.76). Analyses with the LOCF sample from pre- to post-assessment also revealed a reduction in behavioural problems ($t(45)=2.83$, $p<0.05$) but no change between pre- and the 1-year follow-up assessment. The SDQ impact scale indicated that the effect of the children’s behavioural problems on their daily activities also decreased ($t(23)=2.09$, $p>0.05$), but there was no change from pre- to the 1-year follow-up assessment. Effect sizes pre- to post-assessment were small (0.43, CI:0.00-0.84). The LOCF sample decreased from pre- to post-assessment ($t(45)=2.42$, $p<0.05$) but not from pre- to the 1-year follow-up assessment ($t(45)=1.30$, $p>0.05$). No changes were found in children’s pro social behaviour, in either analysis.

Mothers’ initial trauma symptoms accounted significantly for the variance in the children’s change scores from pre to 1-year follow-up assessment (20.0% of the variance): the higher the mother’s initial trauma symptoms, the greater the reduction in SDQ total. Children’s violence exposure did not explain changes in SDQ over and above mothers’ initial trauma scores. No association was found between mother’s self reported changes in trauma symptoms following her participation in the conjoint group for mothers, with her rating of her child’s change in symptom level on SDQ.

There are several strengths to this study. They employed standardized validated instruments, included 6-month post assessment (rather than end of group) and follow-up at one year. The application of statistical analyses is well described, including Pearson correlations, multiple regression and t tests. However, limitations include: lack of comparison group, high attrition, use of only the mothers as informants, and the potential that this study may not be properly powered due to use of a small sample size.

While this study took place in Sweden, it was conducted with a group of mothers and children comparable to those who experience violence in UK. The setting for this study is a new form of community-based service for children affected by IPV and their mothers, which the authors describe as a complement to child and adolescent psychiatric services. This type of setting is described as arising directly from policy change towards recognizing children exposed to violence as victims of crime with mandated rights to support by municipal services. This type of service is likely to reach more women and children affected by violence than refuges, and as such the findings are important. While this study does not have a large sample size, it is important for the potential scope of mothers and children reached through such accessible community-based services, which are positioned as legally compensatory.

While overall positive effects were seen on behavioural problems and social impairment in children, these were not sustained at the one year follow up. It may suggest the need for more intensive individualized work with the most traumatized children. It is of note that the mothers with higher trauma symptoms at the start of treatment noted the greatest reduction in their children's behaviour problems post treatment; this underlines the importance of mother and child interventions.

Qualitative Studies

A qualitative study by Humphreys et al. (2006) [-] involved the development and testing of age-appropriate 'activity packs' designed to promote communication between mothers living in refuges in the UK, and their children who have been exposed to violence. Activity packs included various activities for addressing self-esteem, relationship between mother-child, and exploring emotions and experiences related to DV. Fourteen mothers and children, and their child workers were interviewed separately in the shelter by researchers after completing the activity packs.

The self reported outcomes for mothers show the activities were well received overall, provided opportunities to talk about feelings and experiences, encouraged readiness to consider their children's needs, and increased mutual understanding of their situation. Many children were enthusiastic about spending time with their mothers and having activities to work on together.

While a qualitative approach is warranted to solicit feedback on content of interventions such as this, the overall design of the research, the methods, and approach to analysis were not fully described, and therefore the study received a poor quality rating. The scale of the evaluation is very small and reported very informally and as such recommendations cannot be made at this point. When other cycles of assessment are complete, it is hoped the authors would report more fully on the assessment methods and findings.

Input from mothers and children themselves on materials is an important aspect of development of interventions affecting them. Promoting such mother-child communication is being identified as an important intervention goal in other studies, and this intervention may be well received by shelters working from a comparable strengths-based and anti-oppressive stance.

7.3.3. Single component therapeutic interventions for children

Rizo et al. (2011)

Quantitative Studies

Rizo et al. (2011) [+] reviewed one study that evaluated a single component therapeutic intervention for children.

A US based experimental interrupted time series study by Tyndall et al. (2001) compared outcomes of sibling group play therapy and individual play therapy in a community services setting. The goal was to empower children and build coping skills through participation in 12, 45-minute sessions of sibling play therapy over a period of 12 days to 3 weeks while living in a

shelter. The intervention was delivered to an ethnically diverse sample of 10 children (6 girls; 4 boys) aged 4-9. Outcomes measured included child behaviour and child self-concept. Children exhibited improvements in externalizing and internalizing behaviour problems, aggression, anxiety, depression and self-esteem, and sibling group play therapy was found to be equally effective when compared to individual play therapy. Strengths included the use of a comparison group and multiple reporters (from both mother and child), inclusion of information on providers and use of standardized questionnaires. Limitations included a small sample size, the use of a non-random convenience sample, the use of intervention and comparison groups from two different studies and time periods, no randomization, no follow-up, and lack of theoretical backing and information on the manual.

Additional Studies

An additional two studies evaluated single component therapeutic interventions for children (Parker et al., 2006, before and after [-]; Schultz et al., before and after [+]).

A before and after study conducted by Parker et al. (2006) [-] examined an intervention involving Expressive Writing (EW) therapy for adolescent girls exposed to DV in a community based setting (Parker, Steward, & Gantt, 2006). There were 15 girls, average age 14.3 years, exposed to the EW (9 in the experimental and 6 girls in the control group). The control group did not have the added intervention of Positive Points (PP), a list of positive points to incorporate in their writing, given to the girls before writing a piece about a traumatic event in their lives. There was a baseline self-assessment of emotional state using the HIG ("How's it Going?") measure. There were several measures of emotional state, anger, self-concept and depression administered pre and post treatment. The data from the expressive writing were analysed in a programme called Linguistic Inquiry and Word Count.

The sample was very small, recruited from a social services/ child welfare agency in South Carolina in the USA. The girls were either in foster care or group homes, but no other inclusion criteria were specified. The directors of the homes gave consent to the experiment. 11 of the girls were White, and 4 were African American.

They found a 67% increase in positive emotions for the experimental and the control conditions. There was a significant increase in the number of words related to *self* in the experimental group ($F(1,13)=13.46$, $p<0.003$). No differences were detected in pre and post measures of anger, self-concept, or dating attitudes. There was a greater reduction in measures of depression among the treatment group. Also, post-test indicated less sadness among the treatment group, though this was not significant ($F(1,3)=3.27$, $p<0.09$). This approach appears to have at least short-term positive effects on mood and self-esteem among the experimental group and control groups but there was no follow up reported. The sampling approach was not fully described, and no males were in the sample recruited. The sample was all receiving service from child welfare and living in state run facilities.

Schultz et al. (2007) [+] conducted a pilot before and after study to measure the effectiveness of providing equine assisted psychotherapy (EAP) to an unselected consecutive sample of 63 children referred by community sources in New Mexico in a clinical setting. The children had various behavioural and mental health issues and were exposed to an average of 19 EAP sessions. They were scored on the Global Assessment of Functioning Scale (GAF) pre and post treatment. Of these children, 40% had a history of inter parental violence, 20% a history of sexual abuse and 27% a history of abuse and/ or neglect.

All children showed an improvement in GAF scores, and there was a statistically significant correlation between the percentage improvement of the GAF scores and the number of sessions given ($r=0.73$, $p<0.001$). The mean (±SD) pre and post-treatment scores were 54.1 ± 3.2 and 61.7 ± 5.0 (paired $t=9.06$, $p<0.001$). Females had a significantly greater improvement in GAF scores than males (15.0% versus 10.3%; $t=2.46$, $p=0.02$). When children were divided into age

categories, univariate analysis showed that the greatest improvement in the GAF scores occurred in the youngest of the subjects (F=4.9, p=0.01). The data did not show any statistically significant differences in pre- and post-treatment scores between those with and without histories of intra-family violence. However, in the group of children who had a history of physical abuse and neglect, there was a statistically significant greater percentage improvement in the GAF scores after treatment than in those who did not have a history of abuse and neglect.

There are a number of limitations with this study. Specifically, this study utilized a self-selected sampling approach that was biased. In addition, the pre and post treatment study design prevents attribution of change to any one factor in the intervention. The availability of equine-based psychotherapy may also be limited in some areas, and cultural affinity for equine therapy and outdoor activities may differ across sub-populations. Further research is required to assess impact by age, gender and presenting problem, and to examine the potential for other forms of animal-based therapies for children who are exposed to violence.

7.3.4. Single component psycho-educational interventions for children

Rizo et al., 2011

Rizo et al. (2011) [+] reviewed four studies examining the effectiveness of a single component psycho-educational intervention delivered only to children (Johnston, 2003; McWhirter, 2008; Pepler, et al., 2000; Sudermann, et al., 2000).

Quantitative Studies

A US-based before and after study by Johnston (2003) examined a group programme delivered to 223 ethnically diverse children (106 girls and 117 boys), ranging in age from 5-14 years. The intervention was a one hour- 90 minute session delivered over 10-15 weeks in schools and agencies and used games and activities to improve problem solving and build relationship skills. Psycho-educational therapy sessions were also held with parents/ caregivers. The key outcomes measured were family well-being and child-behaviour. The study found positive outcomes (improvements in emotional and behavioural problems) at 6-months follow up based on clinicians, teachers and parents ratings. There were significant improvements in children's behaviour problems, emotional and behavioural difficulties and social competence; effects were moderate to substantial in size. Strengths included: use of multiple reporters (parents, teachers and clinicians) and standardized measures, information on providers, follow up, theoretical bases (ecological model), multi-site study, and a community sample. However, Rizo et al. (2011) note that the study did not include a comparison group, used a non-random convenience sample, did not clearly discuss attrition or the caregiver component of the intervention, revealed inconsistencies in programme implementation across sites, lacked details on intervention or tailoring, and the statistical analyses did not account for correlated data.

A US-based before and after study by McWhirter (2008) evaluated a community based group intervention to improve stress management, coping and relationship skills, through a 5-week group intervention for an ethnically diverse sample of 46 children ages 6- 12. The intervention was informed by an ecologically based perspective and included play and therapeutic activities including: art, movement and role-playing and safety planning exercises, along with sessions to understand and express feelings associated with violence. The study demonstrated significant improvements in children's psychological well-being. The majority of children also reported learning new information, were interested in returning to the group, and enjoyed the other children in the group and the opportunity to discuss important topics. Strengths noted include: the use of multiple reporters (children and mothers), inclusion of an ethnically diverse sample, and theoretical bases (ecological model) for the intervention. However, Rizo et al. (2011) note a number of limitations including: small sample size, scant information on intervention format, lack of a comparison group, the use of a non-random convenience sample, a lack of follow-up, and the statistical analyses did not account for nested/ correlated data.

A Canadian before and after study by Pepler et al. (2000) evaluated a shelter-based child peer group and mother's counselling programme. However, the component and outcomes for mothers are not described. This intervention aimed to improve children's understanding of violence (including a discussion of gender roles), build coping and safety skills and improve self-esteem through a series of 10 small (7 person) weekly group sessions. The intervention was delivered within shelters to 46 children from 12 support groups (27 boys and 19 girls) ranging in age from 6-13 years. Outcomes were measured through questionnaires completed by both mothers and children to examine attitudes towards violence, anxiety and behaviour. Findings revealed significant improvements in understandings of violence, depression and anxiety and behavioural adjustment. Mothers also reported fewer behavioural problems in children following the intervention. However, counselling mothers was not found to impact children's behavioural adjustment. Strengths noted include theoretical bases (risk and resilience, and systemic perspective), and use of standardized measures and multiple reporters (mothers and children). However, limitations included a small sample size, high attrition rates, no discussion of manual used or information on providers, no comparison group, limited information of the mother's component, lack of statistical information, lack of follow-up, use of a non-random convenience sample, and the statistical analyses did not account for nested/ correlated data.

A Canadian before and after study evaluated a community-based group therapy intervention intended to increase understandings of violence, improve coping and conflict resolution skills, improve safety planning and teach about/ prevent sexualized violence (Suderman et al., 2000). The intervention was delivered in 10-12 group sessions among 31 children (17 girls and 14 boys) aged 7-15 divided by gender and developmental level. Outcomes measured included: participant satisfaction, understanding of violence, attitudes towards woman-abuse and knowledge of alternatives to violence. They found that young people demonstrated improvements in attitudes, beliefs and knowledge about community resources for violence, as well as improved responses to peers in conflict situations, and that mothers also reported positive changes in their children. Both children and mothers rated the group positively. Strengths reported by Rizo et al. (2011) include the use of multiple reporters (children and caregivers), a community based sample, the use of a manualized intervention, and tailored questionnaire. However, numerous limitations are also noted such as: lack of information on theory, providers who delivered the intervention or racial/ ethnic composition of the sample, small sample size, lack of validation of the questionnaire used, lack of comparison group, limited statistical power, no follow up, use of a non-random convenience sample, and the statistical analyses did not account for nested/ correlated data.

Additional Studies

Quantitative Studies

In addition to those reported in Rizo et al. (2011), two additional studies on single-component psycho-educational interventions delivered to children-only were assessed (Bunston & Dileo, 2005, before and after [+]; Miller et al., 2012, RCT [+]).

A before and after study by Bunston, W. & Dileo, J. (2005) [+] reports on a 12 month evaluation of an 8 week mental health group intervention for children 8 to 12 years of age. The intervention was offered collaboratively by mental health and school based professionals, predominantly in school settings. The group aims to provide an environment that will help children develop skills to resolve conflict and to interact better with others using cognitive behavioural interventions in a group setting.

The participants were Australian children who experience problems in expressing strong feelings, have difficulties in interpersonal relationships and who have lived, or are still living with family violence. Participants ranged from 8 to 12 years of age (M=9.79, SD=1.07); 22 (25%) were female and 66 (75%) were male. Referrals were made from mental health services and schools in suburbs of Melbourne, Australia. Three validated questionnaires were used: the Strengths and Difficulties Questionnaire, The Social Skills Rating Scale and the Children's Inventory of Anger scales.

On the Strengths and Difficulties Questionnaire, teachers reported statistically significant improvement in prosocial behaviour (t (61)=4.31, p<0.01, d'=0.45), total difficulties (t (61)=4.02, p<0.01, d'=0.52), peer problems (t (61)=3.97, p<0.01, d'=0.42), conduct problems (t (61)=2.93, p<0.01, d'=0.38), hyperactivity (t (61)=2.89, p=0.01, d'=0.36), and emotion symptoms (t (61)=2.36, p=0.02, d'=0.45). Parents reported slight but less significant improvement. Female participants reported significantly reduced peer problems following the programme, while no change was noted for males. Females reported higher levels of anger whilst males reported lower levels of anger. On the Social Skills Rating Scale *parents* reported statistically significant improvement in cooperation (F (1,37)=2.72, p=0.01, d'=0.37), and overall social skills (F (1,37)=2.21, p=0.02, d'=0.30). Improvement on all other scales was also reported, but not at statistically significant levels. *Teachers* reported statistically significant improvements in cooperation (F (1,34)=2.72, p=0.03, d'=0.26), self-control (F (1,34)=1.99, p=0.05, d'=0.26), externalising problems (F (1,34)=2.54, p=0.02, d'=0.36), internalising problems (F (1,34)=2.42, p=0.02, d'=0.25), hyperactivity (F (1,34)=2.93, p<0.01, d'=0.34), and problem behaviours (F (1,34)=3.78, p<0.01, d'=0.44).

Limited sample size and poor statistical power are reported by the authors, and they suggest there may be expectancy bias due to the fact that measures were collected by clinicians. Only before and after, not long-term outcomes were collected, and randomization was not done. This programme appears to have wide applicability: the programme has been run by the hospital team in a variety of locations, by others who participated in their 'train the trainer' programme, and by still others who simply purchased the manual.

A US-based RCT study by Miller et al. (2012) [+] examined baseline knowledge about safety planning in preschoolers exposed to DV and the impact of a ten-session intervention (Preschool Kids Club) that teaches children specific and adaptive safety-planning strategies. It involved 110 ethnically diverse children aged 4 to 6 years, exposed to violence in the previous two years, whose mothers were recruited from community settings. Families were recruited using flyers distributed to low-income housing units, stores, churches, DV shelters, and local mental health agencies with a toll-free number for the programme offices.

The group intervention involved twice weekly sessions over 5 weeks. In the sessions, preschoolers engaged in activities such as role playing designed to help them identify and express emotions, learn safety planning and conflict resolution strategies, and consider gender roles in an age appropriate way. The focus of this study was the impact of the session on safety planning, which was introduced in session five and reinforced, in the subsequent sessions. The safety planning session taught children safety planning strategies that encourage removal of themselves from the violence and seeking help from adults.

The children were interviewed at baseline and post-intervention. The children were asked open ended questions about safety planning and these responses were categorized into 10 subcategories, grouped into adaptive and maladaptive. At baseline, only 27 children (25% of the overall sample) were able to identify an adaptive safety plan for family violence, and twenty-six children (24% of the overall sample) identified a maladaptive safety-planning strategy. Overall, non-response was high. The qualitative analysis of the changes in safety planning strategies from baseline to post intervention showed that 10 children (26% of the group) from the intervention group reported active-help seeking strategies post intervention, compared with just two children at baseline (4% of the group). Three children from the control condition reported active help-seeking strategies at baseline, with no additional active help-seeking strategies at post-intervention follow-up.

There are several strengths to this study. The study used a randomised controlled design; families were randomized 5 to waitlist and 5 to intervention as they contacted the researchers. Analysis involved 3 coders who completed the entire set of transcripts to determine categories with an IRR of 89%. However, in spite of short follow-up time (1 week) the authors note a large

number of ‘no responses’ from children. Of the 90 at the post intervention follow-up, approximately two thirds of children (62.7% of controls and 64.1 % of the intervention children) had no response.

In spite of the large number of children who were not able to name any kind of safety plan post intervention; the authors see that many preschool-aged children are capable of learning and remembering information about safety planning. Safety planning can help protect the physical and emotional health of young children exposed to violence, particularly in helping preschoolers seek help from others during incidents of family violence. It is less intensive than therapeutic interventions and might be applied in a range of contexts.

7.3.5. Multi-component advocacy interventions

Rizo et al., 2011

Four studies reviewed by Rizo et al. (2011) [+] evaluated multicomponent interventions with advocacy as a primary intervention focus (Blodgett, et al., 2008; Crusto, et al., 2008; McFarlane, et al., 2005a, 2005b).

Quantitative Studies

The US-based non-comparative study by Blodgett et al. (2008) evaluated crisis-response services available to/ delivered to the whole family in a community setting. The aim of the intervention was to provide service planning and care coordination to families at the time of, or shortly after an incident of DV. Referrals were provided by multiple sources (though primarily police), and then services were provided to the whole family (Masters-level clinicians met with family at the time of incident, or shortly after depending upon family wishes), which focused on engaging, supporting, and facilitating problem solving for the family. Links were also provided to other professional support services. This descriptive report of findings included information from 270 children from 144 families, ranging in age from 0-19 years. They note that 13% of crises intervention cases were beneficial to the child or family and that benefits increase with a longer duration of support (5 or more direct contacts from crises support workers). The strengths of this study include the use of multiple raters and included detailed coding protocols. Limitations include small sample for subanalyses, limited and incomplete data, no comparison group or randomization or use a standardized intervention.

A US-based before and after study by Crusto et al. (2008) evaluated an advocacy-based programme focused on care coordination and service planning within a community setting. The wraparound programme included: assessment, caregiver-child services, individual treatment plans, and care coordination service (Crusto, et al., 2008). The goal of this intervention was to decrease: incidents of violence, trauma symptoms and parenting stress and increase participants’ connection to community based resources. Their sample included 82 ethnically diverse children (56% male and 44% female) ranging from 1-6 years in age. They found significant improvements in traumatic events, parenting stress, and children’s intrusive and avoidance behaviours. They also found improvements in children’s depressive symptoms, dissociative symptoms, hyperarousal, angry feelings and overall post-traumatic stress symptoms, yet these were not statistically significant. Finally, they found that children’s improvements were associated with hours of service and duration in the programme. Strengths noted by Rizo et al. (2011) include: a focus on young children, inclusion of an ethnically diverse sample, the use of theory (child-parent psychotherapy and attachment theory) to inform intervention, and the administration of instruments in families’ preferred language. Limitations include: lack of comparison group, reliance on parents as the sole reporter of data, no follow up, lack of information on providers, collection of data by the programme staff who delivered services, use of a non-random convenience sample, and no discussion of manual used or specific services delivered.

Two US-based studies directed at mothers used a cluster-RCT design to compare the effectiveness of a referral care intervention and nurse case management for improving children’s

behaviour (McFarlane et al., 2005a,b). The two studies report on the same intervention that was delivered to mothers but aimed at improving children's behaviour. The referral card included information on safety planning, a list of resources, and prompted the mother to schedule an interview at the clinic. The case management intervention included screening, a safety plan brochure, and case management services. In the McFarlane 2005a study, a sample of 206 ethnically diverse children (46.6% males; 53.4% females) participated and follow up was conducted to examine child behaviour outcomes at baseline and 1 year follow up. They found significant improvements in children's behaviour in both treatment groups at 1 year follow up, with boys aged 6-11 years and girls aged 12-18 showing the least improvement. At 1-year follow-up the scores of children with treated mothers were significantly lower than those children with mothers who received referral. Strengths noted by Rizo et al. (2011) include the inclusion of an ethnically diverse sample, follow up, use of theory (developmental psychology) to inform intervention, standardized measures, and information on providers. Limitations include focus on reports of mothers, small sample size in some age and sex-groups, limited discussion of the manual used and use of a non-random convenience sample.

In the McFarlane 2005b study, 258 ethnically diverse mothers participated and follow up was conducted at 6, 12, 18 and 24 months (McFarlane, 2005b). They found significant improvements in behaviour problems between intake and 24 months in both treatment groups, with children aged 18 months to 5 years showing the most improvement and teenagers demonstrating the least improvement. Strengths noted include the inclusion of an ethnically diverse sample, follow up, use of theory (developmental psychology) to inform intervention, standardized measures, and information on providers. Limitations include focus on reports of mothers, small sample size in some age and sex-groups, limited generalisability due to public clinic setting of the study, limited discussion of the manual used, use of a non-random convenience sample, and the statistical analyses did not account for correlated data. Rizo indicates that these studies are some of the most rigorous included in the review.

Additional Studies

Quantitative Studies

In addition to the studies reviewed by Rizo et al. (2011), we assessed one additional evaluation of a multi-component intervention with advocacy as a primary focus (Whiteside-Mansell et al., 2009, RCT, [+].

A US-based RCT study by Whiteside-Mansell et al. (2009) [+] examined whether attending Early Head Start (EHS) child care during the first 3 years of life protects children from the expected negative impact of witnessing family conflict with respect to maladaptive and aggressive behaviour at the end of the programme (age 3) and before starting school (age 5). The study included 610 low-income children from 4 sites (child care centers offering EHS programming), 305 controls and 305 who received EHS services. Children were enrolled at 14 months, and follow up was done at 3 and 5 years. Participants were 51% male 49% female (control); 54% male 46% female (treatment). Ethnicity of participants (control/ intervention) was as follows: 36/39% black, 28/26% Hispanic. 7/4% other race; in addition, the average income as a percentage of the poverty line for families was 66%/67%.

Head Start has broad goals to enhance the cognitive, socioemotional, health, and nutritional status of families living in poverty in the US. This study shows it has a role as part of a multifaceted approach to supporting children exposed to violence, but is not achieving the outcomes of more specific interventions.

Early Head Start is a non-parental child care for low-income families. The child to staff ratio is 4-1 and there is a maximum group size of 8 children. Staff members have a Child Development Associate credential. The intervention was not described, and is presumably early childhood programming with broad scope. How frequently children attended the programming was also not

described. These are major weaknesses limiting the usefulness of this study to informing recommendations.

Methods of analysis were externally validated standardized tools, and internal consistency was reported:

- Child Behaviour Checklist - 19 items reflecting problems with aggression (e.g. child has temper tantrums, child hits others) filled out by the parent. Cronbach's alpha 0.88 (3 years) and 0.89 (5 years).
- Child Bayley Behavioural Rating Scale (conducted at age 3 by assessor) - Assessor rated the child's behaviour observed throughout the testing session, 7 items related to child's ability to change tasks, handle frustration and self-regulate, Cronbach's alpha 0.92.
- Head Start National Evaluation's Child Aggression Scale (conducted at age 5) - 4 item parent reported scale targeting specific aggressive behaviour (e.g. hits and fights), Cronbach's alpha 0.64.
- Leiter-R Examiner Rating Scales (age 5)- A subscale was used to assess affective and emotional self-regulatory aspects of performance in challenging tasks, Cronbach's alpha 0.93 for emotional regulation subscale

Findings from the study suggest that EHS may assist children in not developing aggressive behaviours as a result of being in an environment of 'family conflict.' At age three follow-up, there was a significant treatment effect such that children in the intervention group had lower aggression (beta=-0.53, $p<0.05$). At age 3 the comparison group had a positive link between family conflict and aggressive behaviour (unstandardized beta=5.7, $p<0.05$), EHS group (when model inverted) had non-significant results indicating no link between family conflict and aggressive behaviour (beta=1.55, $p>0.05$). R-square for model=0.25 (25% of variation in child aggression can be explained by model). At age 5, the treatment effect was no longer significant. Aggression was still positively related to family conflict, but did not differ significantly between the treatment and control. When they used emotion regulation as an outcome, the interaction term was not significant; EHS treatment status did not appear to moderate the impact of family conflict on children's emotional regulation at 3 or 5 years.

A number of strengths and limitations should be noted. Method of allocation to the intervention was done by random assignment. The control group was similar at baseline. Missing values in outcomes were estimated using FIML. However, the programming offered by Head Start is not described, and the mechanisms by which the EHS centre-based services may moderate the negative impact of family conflict on child behaviour could not be determined. The authors report that 93.7% of families enrolled their children in the EHS programme, within 26 months after entering the research study. However, it is not clear how they were recruited if not already enrolled at the centers. An unstandardised regression coefficient was reported, not an odds ratio. Most measures were reported by the mothers, and the authors report that these did not converge with outcomes observed by the assessors during interviews. Finally, for the purposes of this review, it is unclear if "family conflict" as indicated in the subscales is an adequate measure of DV.

7.3.6. Multi-component therapy and advocacy interventions

Rizo et al. (2011)

Two studies reviewed by Rizo et al. (2011) [+] evaluated multi-component interventions including therapy and advocacy components (Ernst, et al., 2008; Sullivan, et al., 2002).

Quantitative Studies

A US-based before and after study by Ernst et al. (2008), examined children's understanding of DV and safety planning following a clinically-based intervention. When police responded to IPV, children received immediate treatment services and an individual treatment plan delivered once per week in family, group or individual counselling. Sessions included safety planning, group

therapy and other strategies based upon the child's unique situation. The intervention included 58 children ranging in age from 3-17 years, 51% female, 49% male. They found significant improvements in children's understanding of DV, awareness that violence is not their fault and improved understanding of a safety plan. Strengths of this study noted include: the use of multiple reporters (both children and social workers), information on providers and theoretical bases (informed by strengths- model). Limitations include: lack of comparison group, independent evaluation, and standardised measures and follow up, use of a non-random convenience sample, variations in treatment modalities utilized and reliance on police reports. Findings suggest that tailoring is important, but because the programs varied from child to child and details are not provided, it is not possible to determine the specific programme components required to improve effectiveness.

Rizo et al. (2011) identified the US-based RCT study by Sullivan et al. (2002) as rigorous. These authors conducted an experimental pre-post and 4-month follow up study with a no-treatment comparison group, to evaluate a strengths-based intervention for children and caregivers in a community setting. The intervention involved 16 weeks of free advocacy (to teach mothers self-advocacy skills and connect them with additional resources and support services) and a 10-week group therapy for children (to teach children about safety, physical activity and empowerment principles). A total of 80 ethnically diverse mothers and children participated in the study (77% of mothers were under 35 years old). They found a decrease in mothers' depression and increase in self-esteem and reported quality of life; children reported improvements in self-confidence and physical abilities. Some strengths noted by Rizo et al. (2011) include: randomization, use of standardized measures, reporting of effect size, follow up and inclusion of a comparison group. Some key limitations noted include unclear randomization methods, lack of accounting for nested-correlated data in statistical analyses, and use of a convenience sample.

Additional Studies

Two additional studies evaluated multi-component interventions including therapy and advocacy components (Finkelstein et al., 2005, before and after [+]; Noether et al., 2007, non-RCT [+]).

Quantitative Studies

Finkelstein et al. (2005) [+] report on a mixed methods (cross-sectional and qualitative) study with 115 children of mothers who have co occurring issues of substance use and violence. The intervention aimed to understand the benefits for children of providing coordinated services for mothers and children, to increase resiliency and fortify resistance to violence among the children. The study employed a strengths-based, trauma-informed approach in the form of a clinical assessment of the child, service coordination and advocacy, and a developmentally matched 10 session skills-building group based on Peled and Davis' manual (*Group Work With Children of Battered Women)*. Children were in two groups, divided by age (5-7; 8-10) and approximately half were female.

Analysis of 69 comments provided in response to the question: "What did you like about your child's participation in the group?" revealed that more than 1 in 3 mentioned learning (including about issues such as safety and violence, coping and communication skills). One in 5 comments detailed positive child outcomes from the group (e.g., improvement in child communication/ expression, more positive attitude). In addition, 17% of mothers/ caretakers indicated that they valued the group process, in particular connecting with other children who shared similar experiences. Only 6% of the comments suggested doubts about the value of the group.

When mothers were asked, "How much do you think the group helped your child?" almost half of the mothers answered that the group helped their children "a lot" or "very much"; one-third replied "somewhat"; and 1 in 5 responded "a little" or "not at all". 77% percent (n=35) reported observing positive changes in their children, including: improved communication (43%); improved attitude and behaviour (31%); and increased knowledge and skills related to safety, coping, addiction and recovery (20%).

The study had no control group, and effectiveness was based on mothers' self reports and evaluations of the child's experience in the group. There was a high attrition rate and clinicians, peer support staff and mothers identified key barriers such as transport issues, mothers left treatment, or mother working on self and couldn't focus on child. There was no distinct follow up measures provided at 3, 6 and 9 months, rather all were consolidated. There was no intent to treat measure in this study, although the authors report one in the parent study on which this was based.

This intervention is labour intensive and geared to situations where mothers are in treatment for co occuring substance use and violence. The attrition rate was mainly a result of access issues, and steps to improve access by paying for transport, food and child-care were deemed important. The children in this study were all young, so these data do not apply to adolescents. The women were involved in the design of the intervention and its evaluation, which enhances its real life applicability. The sample was derived from women already in treatment for co-occurring issues of substance use, mental illness and where violence was present and children had likely been exposed.

This study addresses an important gap in the literature (children of women with co-occurring substance use and violence). However, there was no control group in this study and the study is based on the evaluations of mothers about effectiveness, with no follow up of those who dropped out.

A US-based non-RCT conducted by Noether et al. (2007) [+] aimed to examine the effectiveness of a resiliency-building intervention for children of mothers who were engaged in treatment for co-occurring mental health, violence and substance use issues. The study used convenience sampling, drawing from a subset of a sample from the Women, Co-Occurring Disorders and Violence Study (WCDVS). The larger WCDVS was conducted at 9 sites across the United States, included 2,729 women, and was designed to examine the effectiveness of integrated, trauma-informed treatment services for women with histories of violence and co-occurring issues. Two of the four study sites from which women and children were recruited were residential treatment facilities (Los Angeles, CA and Denver, CO) and two were outpatient treatment facilities (Cambridge, MA, and Stockton, CA). To be eligible to participate, women had to be enrolled in the larger study and be the mother/ caretaker of a child aged 5-10 years old.

The 253 children who participated in the study were a mean age of 7.28 years, with 52.6% boys and 47.4% girls. Participants were Hispanic/ Latino (34.0%), White or Caucasian (40.3%), Black/ African American (18.6%), other race (21.3%), or multiracial (19.8%) (Percentages add to more than 100% since the Hispanic/ Latino category overlapped with the other categories). Of the children, 10.4% had experienced physical abuse, 6.5% had experienced sexual abuse, and 68.0% had witnessed violence in their home.

Women were non-randomly assigned via aggregate matching, based on the location of the programme. Children of mothers recruited to the experimental group (n=115) were delivered a trauma-informed intervention model consisting of three components: clinical assessment of child and mother, service coordination and advocacy from a dedicated case manager, and a psycho-educational group intervention focused on skill-building. The 12-session weekly group intervention was based on Peled and Davis' manual (*Group Work With Children of Battered Women)* and designed to provide a safe and respectful space to build resilience, enhancing emotional and behavioural skills of children by increasing knowledge of safety planning and interpersonal skills. The intervention was age-specific, involving age-appropriate activities for younger (5-7 years) and older (8-10 years) participants. Participants in the comparison group (n=138) received services as usual. For the children's study, as well as for the WCDVS for women, a baseline interview and four follow-up interviews at 3, 6, 9, and 12 months were conducted. The purpose of 3- and 9-month follow-up interviews was to assess service utilization, while the 6- and 12-month follow-up interviews were designed to assess outcomes.

Mothers reported on emotional and behavioural characteristics of children at 6 and 12 months, using the standardized Behavioural and Emotional Rating Scale (BERS) to assess: interpersonal strengths, family involvement, school functioning and affective strengths. Changes in level of safety knowledge were also assessed using a 4-point Likert scale. Mothers' mental health, substance use and trauma outcomes were also measured at 6 and 12 months using the Brief Symptom Inventory (BSI), the Posttraumatic Stress Disorder Symptom Scale (PSS) and The Addiction Severity Index (ASI). Mothers' outcomes were measured and analysed to assess impact on children's outcomes.

The authors found that at 6 months, children with mothers who had positive outcomes, scored better on the BERS overall, regardless of treatment (effect size=0.363, p=0.048). Children in the intervention condition (Groups 1 and 2) demonstrated some improvement regardless of mother's 6-month outcomes, although this was not significant (effect size and p-value not reported). Children in the comparison group with mothers that had negative outcomes (Group 4) performed significantly worse than all other groups, with a negative mean change score of 2.68 between baseline and 6 months. Having been exposed to violence was the strongest predictor of improved safety knowledge at 6-month follow-up (effect size=0.340, p=0.027). Gender, age and race/ ethnicity of the child were not significant predictors of any outcomes at 6-month follow up (effect size and p-values not reported). In sum, at 6-month follow up, mothers' improvement was the greatest predictor of improvement among children on the BERS strength quotient.

At 12 months, mothers' outcomes no longer significantly impacted children's overall positive outcomes (effect size=0.054, p=0.949). At 12-months, participation in the intervention group was the strongest predictor of improvement (effect size=0.462, p=0.004). At 12-month follow-up, witnessing of household violence was a significant predictor of improvement for: positive self-identity (effect size=0.276, p=0.016), relationship tools (effect size=0.168, p=0.056), family involvement (effect size=0.332, p=0.025), and capacity for closeness (effect size=0.270, p=0.048). This was in contrast to the expectations of the authors, yet they note that this may be due to the fact that the standardized group intervention was originally designed to address issues for children exposed to violence and therefore may have been more helpful for this group.

At 12-months, child's gender, race/ ethnicity other than being non-Hispanic black, were not significant predictors of any outcomes (effect size and p-values not reported). Younger children (5-7 years) showed better improvement than older children (8-10 years) on overall scores (effect size not reported, p=0.032). The authors note that this is consistent with other research, and that further research is required to examine this effect.

Being of non-Hispanic Black race was a significant predictor of poorer outcomes in positive self-identity (-0.448, p=0.022), family involvement (-0.325, p=0.045), and capacity for closeness (-0.479, p=0.006). However, the authors indicate that non-Hispanic Black children exhibited more behavioural problems prior to the intervention, and while they did show improvements following intervention, they did not reach the same level of improvement as other races/ ethnicities of children.

While the study was relatively robust, (+) there were several notable limitations. Primarily, the outcomes were based on mother's report, rather than child reporting which may bias the results in favour of the mothers' experiences in her own treatment. Additionally, there was no standardized 6-month follow up period, although 12-month follow-up was consistently measured after completion. The 6-month follow-up was dependent upon mother's period of involvement in the programme and therefore the timing of interviews with children's completion of treatment varied. It is therefore possible, as noted by the authors, that children with mothers who had the most significant issues may not have received a sufficient amount of intervention at the 6-month follow up period. Because the study was not randomized, it is impossible to establish a causal effect between intervention and children's outcomes. The authors recommend a RCT of the intervention.

Findings from this study suggest that trauma-informed and age-specific intervention, which includes concurrent treatment, services for both mothers and children increase children's behavioural and emotional health and interpersonal skills. Mothers' improvement in mental health, substance use and trauma related outcomes impacted children's behavioural skills at short-term (6 month) follow up, while the benefits of intervention regardless of mothers' outcomes were demonstrated at longer-term follow-up (12 months). Younger children and children who are exposed to violence may experience greater emotional and behavioural benefits from involvement in a group intervention to build resiliency skills.

7.3.7. Multi-component parenting and therapy interventions

Rizo et al. (2011)

Rizo et al. (2011) [+] reported on 8 studies that evaluated multi - component interventions focused on therapy and parenting (Carter, Kay, George, & King, 2003; Dodd, 2009; Graham-Bermann, Lynch, Banyard, DeVoe, & Halabu, 2007; Jouriles et al., 2009; MacMillan & Harpur, 2003; McDonald, Jouriles et al., 2001; Sullivan, Egan, & Gooch, 2004).

Quantitative Studies

The US based cluster-RCT study by Graham-Bermann et al. (2007) was identified as being one of the most rigorous papers included in the review. They compared a child-only component with a child- plus-mother combined intervention. The child intervention included 10 weekly group sessions for 221 children (110 boys; 111 girls), aged 6-12 years. The goal of the group sessions was to address knowledge and beliefs about violence, and support emotional and behavioural improvements. In the child-plus-mother intervention, a total of 221 mothers also participated in a 10-week empowerment focused intervention to improve parenting skills and self-efficacy. They found that the child-plus-mother intervention demonstrated significant improvements in behaviour problems and attitudes about violence, which were maintained at follow-up. Both the child-only and child-plus-mother groups showed significant reductions in internalizing and externalizing problems compared to the no-treatment group. Strengths noted include: use of a manualised intervention, use of social desirability scale, discussion of theoretical bases (ecological approach, social-cognitive, social learning, and trauma theories) examination of effective intervention components, use of multiple reporters (mothers, children and teachers) and rigorous statistical analyses, follow up, standardized measures and relatively large sample size. Limitations noted include a self-selected convenience sample that was not ethnically diverse, lack of treatment fidelity measures or analysis on meditational risk, lack of information on providers, use of a non-random convenience sample, no randomization.

Two US-based RCT studies by Jouriles (2001; 2009) and one US-based RCT study by McDonald et al. (2006) were also identified as rigorous by Rizo et al. (2011). These studies reported on the same intervention, which was a parenting and therapy intervention delivered to children and caregivers. Therapists met with mothers in their home to teach problem solving and child management skills and provide emotional and practical support (including referrals for additional care support, and assistance with food and transportation needs). Therapists worked with mothers, but included children in sessions to evaluate mothers' child management skills and to examine children's reactions to these skills. The intervention included 1-1.5 hour weekly sessions delivered 8 months after leaving a shelter.

The earlier study by Jouriles (2001) included an ethnically diverse sample of 36 mothers and children with a mean age of 5.67 years. Data was collected at 5 points, every 4 months over a 16-month period. They found that improvements in externalizing behaviours and management skills were faster among children in the treatment group. There was a clinically significant reduction in externalizing behaviours for the treatment group. They also found a statistically significant improvement in mothers' management skills in the treatment group. Finally, mothers' distress and children's internalizing behaviours improved over time for both groups at similar rates. Strengths noted include the use of an experimental design, multiple reporters (mothers and research

assistants), theoretical bases (Patterson's model of antisocial behaviour), standardized measures, follow-up, inclusion of information on providers, use of a manualized intervention, and the examination of clinical significance. Limitations include: small sample size, limited assessment of parenting, a sample limited to families leaving shelters, use of a non-random convenience sample, they did not investigate individual components, and statistical analyses did not account for correlated data.

The later study by Jouriles (2009) included an ethnically diverse sample of 66 mothers and their children with 32 in treatment (58.8% male; 41.2% female) and 34 in comparison (41.2% male; 58.8% female). Data was collected at 6 time points, very 4-months over a 20-month period. They found greater improvements in children's conduct problems and mothers' parenting in the treatment group that were maintained at follow up, and changes in mothers' parenting accounted for a sizable portion of the treatment effect on children's behaviour problems. They report medium to large effect sizes for children's outcomes and small to medium effect sizes for mothers' outcomes. Strengths noted include the use of an experimental design, multiple reporters (mothers and research assistants), theoretical bases (Patterson's model of antisocial behaviour), standardized measures, follow-up, rigorous statistical analyses, use of a manualized intervention, reporting of effect sizes, clinical significance and outcomes, the inclusion of information on providers, use of a multi-method assessment approach, and the examination of meditational processes. Limitations include: small sample, use of a non-random convenience sample, screening out of many families due to stringent criteria, and the study design did not investigate individual components.

McDonald, Jouriles et al. (2006) included 30 ethnically diverse families in their study (13 in treatment; 17 in comparison) with 9 girls and 21 boys with a mean age of 5.5 years. They compared services as usual with experimental design, and collected 2-year follow up data from mothers only. They found at follow up that more children in the comparison group demonstrated significant conduct problems, while children in the treatment group were reported to have better social relationships, and lower levels of internalizing problems. Mothers in the treatment group reported improved child management strategies and to have returned to their partners during follow-up. Strengths noted include: use of a manualized intervention, randomization, use of theory (Patterson's model of antisocial behaviour), follow-up, standardized measures, inclusion of information on providers, and examination of clinical significance. Limitations include: use of a small sample that was limited to families leaving shelters, use of a non-random convenience sample, and reliance on mothers as sole reporters.

A Canadian before and after study by MacMillan and Harpur (2003) evaluated the well-being of families accessing treatment for children exposed to DV. The intervention included parenting groups and group therapy for children. A total of 47 children (24 boys and 23 girls) from 35 families participated in the study. Parenting groups were delivered in 10 weekly 90-minute sessions and focused on improving parent-child relationships and promoting positive forms of discipline. Children's groups were delivered in 10 weekly 90minute sessions to small groups (6-8), and aimed to provide a safe space for children to share their experiences and feelings through psychoeducation and relaxation exercises. They found improvements in children's knowledge of DV and improvements in children's externalizing behaviours. Parents also demonstrated significant improvements in stress. Strengths noted include: use of a community sample and multiple reporters (parents and children), use of standardized measures, the use of an instrument developed for children exposed to violence, and examination of clinical significance. Limitations include: lack of comparison group or follow up, lack of information on providers and the manual or theory used, small sample size and high attrition rates, use of a non-random convenience sample, and statistical analyses did not account for correlated data.

A US-based before and after study by Carter et al. (2003) evaluated a pilot treatment programme for children exposed to DV. The intervention included individual, group and family therapy delivered over 10-12 weekly 90-minute sessions facilitated by licensed therapists. The sample included an ethnically diverse sample of 192 children and 64 parents, with children ranging in age

from 4-18 years. Children's groups focused on psychoeducational and play therapy and building safety and conflict resolution skills. Parents groups focused on improving parenting skills, and learning about child development and the effects of DV, and supporting children's healing. They found significant improvements in children's stress, somatic symptoms, interpersonal conflict and social problems. Children reported improved emotional expression, understanding of violence, and ability to create a safety plan. Parents reported lower stress and fewer behavioural problems with children following treatment. Strengths noted include: use of multiple reporters (mothers and children) and multiple sites, relatively large and ethnically diverse sample size, use of standardized information and information on providers. Limitations include: lack of comparison group and follow up, use of a non-random convenience sample, lack of information on providers or manual used, and the statistical analyses did not account for correlated data.

A US-based experimental time-interrupted study by Sullivan et al. (2004) evaluated a group intervention programme for mothers and children exposed to DV. The intervention was a 9-week group intervention with each session beginning with concurrent mother and child groups and ending with a conjoint component. The focus of the mothers' group was to learn about safety planning, improve parenting skills and provide social support. The children's groups focused on learning about safety planning, reducing blame and enhancing trauma and conflict resolution. The conjoint component focused on improving mother-child communication. The sample included 79 children and 46 mothers; the mean age of children was 8.51 years. They found significant improvement in children's mood disorder and trauma symptoms, self blame and behaviour problems, and anger. They also found significant improvements in child adaptability, mood and distractibility or hyperactivity. Mothers reported significant improvements in isolation, life stress and health. Strengths noted by Rizo et al. (2011) include: the examination of clinical significance, use of standardized measures and theory (feminist principles, cognitive behavioural theory, and systemic approaches) and use of multiple reporters (mother and child). Limitations include: small sample size, high attrition rate, lack of a true comparison group, no measures on parenting skills although this was a treatment goal, no discussion of manual, limited information on the intervention and sample or study procedures, lack of information on providers, use of a non-random convenience sample, lack of follow-up, and the statistical analyses did not account for correlated data.

A UK-based before and after study by Dodd (2009) evaluated a community-based group therapy intervention delivered to mothers and their children who have experienced DV. The goal of the intervention was to promote positive mother-child relationships and improve the psychological well-being of mothers and children. Mothers participated in support groups that focused on building confidence and social support and taught parenting skills. Children attended therapeutic play groups, which focused on building self-esteem and emotional well-being and providing fun activities. Both mothers and children also participated in "Theraplay" which focused on improving relationships, developing secure attachments and improving parental sensitivity. Qualitative research methods (interviews and focus groups) were held with mothers and facilitators; however, no information was provided on the study sample. They found that mothers and children were satisfied with the programme and enjoyed both separate and joint components. Mothers reported improvements in parenting hassles and self-esteem, and group leaders felt positive about the success of the group. Rizo et al. (2011) note the following study strengths: detailed description of intervention and the inclusion of process data. Limitations include: lack of sample information, limited information on data analysis methods, study design or procedures, lack of comparison group and follow up, lack of information on providers of the intervention or the manual or theory used, use of a non-random convenience sample, and the statistical analyses did not account for correlated data.

Additional Studies

Two additional studies evaluated a multi-component intervention including parenting and therapy components (Puccia et al., 2012, before and after [+]; Sharp et al, 2011, qualitative [+]).

A US-based before and after study by Puccia et al., 2012 [+] examined if a trauma focused cognitive behavioural therapy (TF-CBT) intervention improved trauma symptoms in children who had witnessed DV. The study included 45 child clients of a community counselling centre who had witnessed DV. Children were an average age of 11 years; 84% Caucasian; 58% female and 42% male; and the majority were living with their parents (78%). Almost all (98%) of children had additional traumas, including: emotional abuse (84%) and physical abuse (64%). The majority also had an impaired caregiver (71%) and had PTSD as a primary diagnosis (62%). The majority of children reported: behaviour problems (n=32), academic problems (n=24) and attachment problems (n=25).

The trauma-focused cognitive behavioural therapy (TF-CBT) integrates cognitive behavioural, interpersonal, and family therapy principles within a trauma sensitive intervention. At the first session, the clinician assesses whether or not treatment is appropriate, and may require additional sessions to collect history. The intervention components include: conjoint parent-child sessions, psycho-education, relaxation techniques, affective expression and regulation, cognitive coping and processing, parenting skills, trauma narrative, in vivo exposure, and safety skills and safety planning. The aim is to provide a supportive space for children to discuss their traumatic experiences, and to allow parents and children to communicate about the traumatic events. A total of 27 clients completed treatment as planned. Four clients completed treatment at 3 months, 15 completed treatment at 6 months, 6 completed treatment at 9 months, 1 completed treatment at 12 months, and one completed treatment at 15 months.

Outcome measures included the: Post Traumatic Stress Disorder Reaction Index (PTSD-RI) for children aged 7–18, the Trauma Symptom Checklist for Children alternate version (TSCC-A) for children aged 8–16, and the Child Behaviour Checklist (CBCL) for children ages 1.5 to 18, completed by the client's parent or guardian. Follow-up was conducted every 3 months and at the end of treatment. At baseline, 38 clients were of age to complete the PTSD-RI; 26% of the children's scores on this were in the clinical range, yet subscales on this index were higher: 87% re-experiencing, 55% avoidance, 84% arousal. At baseline, 26 clients were of age to complete the TSCC-A; 23% were measured as having clinical PTSD, 46% as borderline, and 31% as normal.

Of the participants who completed treatment (n=27), 22 were of age to complete the PTSD-RI, and 15 were of age to complete the TSCC-A. The number of participants who completed the CBCL and findings from this measure are not provided. On the PTSD-RI (n=22) at completion, no participants were found to be in the clinical range for total PTSD score; re-experiencing at completion dropped from 18 (64%) to 8 (36%), avoidance from 8 (36%) to 2 (1%), and arousal from 19 (86%) to 14 (64%). On the TSCC-A, all clients were found to be in the normal range upon completion.

Overall, findings suggest that clients who have witnessed DV have symptoms of posttraumatic stress, and those who completed TF–CBT treatment demonstrated significant progress with symptoms. Limitations of the study include the inclusion of dropouts in baseline scores, high attrition, the lack of analysis of drop-outs versus completers, and limited details on the intervention (such as time devoted to specific components). The study was primarily conducted with White children and parents and therefore may not be applicable to diverse groups of children who have witnessed violence.

Qualitative Studies

Sharp (2011) [+] conducted a qualitative evaluation of the Cedar project in Scotland for children and their mothers recovering from domestic abuse who were referred by agencies. It is based on an action research model, and involves interviews with 27 children and 25 mothers who were participants in the psycho-educational programme, an adaptation of an Ontario programme that engages multi-agencies, children and their mothers. The programme included assessment of and group therapeutic interventions for both mother and children, focused primarily on safety planning, skill-building and improving parenting. There is a detailed evaluation framework described on

which the interviews were based. There are five main guiding principles which work in combination: the Cedar core of the curriculum, structure and strengths-based approach; peer learning; concurrent groups to support mutual recovery and learning for children, young people and mothers; assessment as engagement and multi-agency professional learning and integration. The programme was seen as broadly positive for raising awareness of abuse, reducing isolation and developing strengths-based responses among children and mothers. Facilitators report broadly positive results from groups about reducing isolation and building understanding of abuse among children, but less clear about behavioural changes.

A number of study limitations were found. In particular, there is no description of who did the interviews, or what analytic approach was taken to interpret the interview data. However, there are long excerpts and discrepant findings are reported. Nonetheless, this is a moderate evaluation offering insightful comments on the nature of the intervention. There is a chapter addressing cost-effectiveness of the programme, and sections addressing the multi-agency partnership model embedded in Cedar.

7.4. Evidence Statements

Evidence Statement 23- Single component therapeutic interventions for mother and child

The [+] review by Rizo et al. (2011) included four studies which evaluated effectiveness of a single component therapeutic intervention, delivered to both mother and child, either together or in concurrent but separate interventions(Lieberman, et al., 2006; Lieberman, et al., 2005; Smith & Landreth, 2003; Timmer, et al., 2010). Two additional studies were assessed which evaluated effectiveness of a single component therapeutic intervention, delivered to both mother and child (Ghosh Ippen et al., 2011, RCT [++]; Addressing Family Violence Programs, 2011, before and after [+]).

From Rizo et al., 2011, systematic review [+]:

- Lieberman et al, 2005 (RCT, USA, n=75 mother-child dyads, 6 months)
- Lieberman et al., 2006 (RCT, USA, n=50 mother-child dyads, 6 months)
- Smith and Landreth, 2003 (experimental interrupted time series study, USA, n=11 mother-child dyads, end of programme)
- Timmer et al., 2010 (non-RCT, USA, n=129 mother-child dyads, end of programme)

Additional Studies:

- Ghosh Ippen et al., 2011 (RCT [++], USA, n=75 mother-child dyads, 6 months)
- Addressing Family Violence Programs, 2011 (before and after [+], Australia, n=103 mother-child dyads, end of programme).

There is moderate to strong evidence that single component therapeutic interventions aimed at both mother and child are effective with diverse samples in improving child behaviour, mother-child attachment and stress and trauma-related symptoms in mothers.

Two US-based RCT studies by Lieberman et al, (2005; 2006) evaluated a mother-child psychotherapy intervention delivered in weekly one-hour sessions over a period of 50 weeks with an ethnically diverse sample of 39 girls and 36 boys age 3-5 years and their mothers in the earlier study (2005); and 22 girls and 28 boys age 3-6 years and their mothers in the follow up study (2006). At 6 month follow up, they found significant improvements in total behaviour problems and traumatic stress symptoms for children and mothers. These studies were identified as rigorous (e.g. strengths noted: included comparison group, manualized intervention) by Rizo et al. (2011).

The US-based experimental interrupted time series study by Smith and Landreth (2003) examined a shelter-based filial therapy parent training group intervention (including: modelling and play sessions and parent training) delivered to mothers in 12, 1.5 hour training sessions and then 10 to 12 play sessions with children, over 2-3 weeks with an ethnically diverse sample of 11 children (4 girls; 7 boys) aged 4-10 years and their mothers living in a shelter. Children in the intervention group demonstrated significant improvements compared to the non-treatment group on all measures (behavioural outcomes, self-concept, child-parent interaction), and greater intensity individual therapy was associated with higher behavioural scores. Methodological weaknesses (e.g. lack of randomization and follow up) limit the formation of strong conclusions regarding effectiveness.

A US-based non-RCT by Timmer et al, 2010) examined a parent-child interaction therapy (including mother-child play, teaching of praise and discipline techniques) delivered over 14-20 weeks to an ethnically diverse sample of 129 mother-child dyads (62 who were exposed to IPV and 67 non-exposed) ranging in age from 2-8 years (66.7% male; 33.3% female). They found significant improvements in children's behaviour problems with no significant differences between IPV-exposed and non-IPV exposed groups, as well as improvements in mothers' psychological distress. Completion of the intervention was associated with greater improvements. Methodological weaknesses (e.g. lack of randomization and follow up) limit the formation of strong conclusions regarding effectiveness.

A US-based RCT by Ghosh Ippen et al. (2011) [++] examined an intensive mother-child psychotherapy intervention aimed to improve trauma and stress symptoms among children by enhancing safety and care-giving, through one- hour weekly sessions held over 50 weeks with an ethnically diverse sample of 39 girls and 36 boys aged 3-5 years. Note that this was a re-analysis of data from the Lieberman study (2005). They found significantly lower rates of PTSD (ITT: 5%; TC: 0%) in child-parent psychotherapy groups than comparison group children (ITT: 53%; TC: 55%).

An Australian before and after study by the Royal Children's Hospital Melbourne (2011) [+] evaluated a 10 week experiential, activity based and interactive therapy intervention for 103 mother and child dyads (56% Non-indigenous Australians, 12% Aboriginal or Torres Strait Islander, 32% other; 44% female; 83% unemployed). They found a positive shift in mother's attachment: a shift from 75.3 to 77.6 on the Global Attachment Scale mean, as well as an increase in the mother's acceptance and tolerance of their infant (from 17.9 to 18.4) and her pleasure in interaction with her infant (from 20.9 to 22.1). However, the post-group scores do fall outside the range for normal postnatal mothers, and no reports of statistical significance for attachment scores are provided.

Applicability

One study was conducted in Australia, and the remaining studies covered were US-based. However, there is no particular reason to think that there may be barriers to applicability of the non-UK findings.

Evidence Statement 24- Single component psycho-educational interventions for mother and child

Rizo et al. (2011) [+] reviewed two single component psycho-educational interventions delivered to mothers and children (Becker, et al., 2008; Ducharme, et al., 2000). We identified an additional 2 studies covering single-component psycho-educational interventions delivered to children and mothers who are exposed to violence (Grip et al., 2012, before and after [++]; Humphreys et al, 2006, qualitative, [-]).

From Rizo et al., 2011, systematic review [+]:

- Becker et al., 2008, (before and after, USA, n=106 children; n=104 mothers, end of programme)
- Ducharme et al., 2000, (cluster-RCT, Canada, n=15 children; n=9 mothers, 6-month)

Additional Studies:

- Grip et al., 2012 (before and after [++], Sweden, n=46 children; n=34 mothers, 1 year)
- Humphreys et al, 2006 (qualitative [-], UK, n=14 mother-child dyads, follow up not reported)

There is inconsistent evidence that single-component psycho-educational interventions aimed at mothers and children are effective in building coping skills and increasing knowledge and improving children's behaviour and mothers' parenting skills.

A US-based (Hawaii) before and after study by Becker et al. (2008) evaluated a 12-week, 90-minute community-based psycho-educational and support group (goals: increase knowledge about DV, build coping skills) for 106 ethnically diverse children ranging in age from 3 to 17 years (69 girls; 37 boys) and their mothers. Children and mothers who completed the group were rated as more improved on coping skills, and there were significant improvements in children's internalizing and externalizing behaviours and psychopathology; mothers also reported significant improvements in parenting skills. Methodological weaknesses (e.g. lack of information on intervention, and no follow up) limit the formation of strong conclusions regarding effectiveness.

A Canadian cluster-RCT study by Ducharme et al. (2000) examined a 14-28 weekly-session group parenting intervention (focus was errorless compliance training), along with ongoing parent-conducted treatment sessions delivered in the home to 15 children (10 boys; 5 girls) ranging from 4-10 years old and 9 mothers 28-37 years old. They found significant improvements in children's behaviour problems and maternal stress and perception of child cooperation, as well as significant improvements in children's externalizing and internalizing problem behaviours. Methodological weaknesses (e.g. lack of experimental design, small sample size) limit the formation of strong conclusions regarding effectiveness.

A Swedish before and after study by Grip et al. (2012) [++] assessed 15 weekly, 90-min group sessions (including: education about violence, safety planning, and parent/ child communication, using play, drawing, discussions and lessons) involving 34 low-income mothers and 46 children (25 girls, 21 boys) aged 5-14 years. They found that children's behavioural problems were significantly reduced ($t(23)=2.96$, $p<0.05$) from pre- to post-assessment and the effect size (Cohen' s d) was in the medium range (0.60, CI:0.16-1.04), but there was no effect from pre- to the 1-year follow- up assessment ($t(23)=1.73$, $p>0.05$).

A UK based qualitative study by Humphreys et al., 2006 [-] examined the development and testing of age-appropriate 'activity packs' designed to build self-esteem and promote communication between 14 mothers living in refuges in the UK, and their children. While the self reported outcomes for mothers were positive (increased understanding of violence, satisfaction with the groups), the study design and analysis was weak and therefore does not provide strong findings.

Applicability

One study was conducted in the UK (Humphreys et al., 2006) [-]; one was conducted in Sweden (Grip et al., 2012) [++]; one in Canada (Ducharme et al., 2000) and one in the US (Becker et al., 2008). The Grip et al. (2012) study examined a community based service that arose from policy changes in Sweden (mandating that children exposed to violence have rights to municipal services). However, there is no reason to believe this would differ from community based services offered in the UK. There is also no particular reason to think that there may be barriers to

applicability of the Canadian-based study to UK context. However, the US-based study was conducted in Hawaii and therefore findings may be less relevant to the UK-context.

Evidence Statement 25- Single component therapeutic interventions for children

Rizo et al. (2011) [+] reviewed one study that evaluated a single component therapeutic intervention for children (Tyndall-Lind, et al., 2001). An additional two studies evaluated single component therapeutic interventions for children (Parker et al., 2006, before and after [-]; Schultz et al., 2007, before and after [+]).

From Rizo et al., 2011, systematic review [+]:

- Tyndall et al. 2001 (before and after, USA, n=10, end of programme)

Additional Studies:

- Parker et al., 2006 (before and after [-], USA, n=15, end of programme)
- Schultz et al., 2007 (before and after [+], USA, n=63, 3 months)

There is weak evidence regarding effectiveness of single component therapeutic interventions. Play therapy and equine therapy both show some improvements with diverse groups of children in behaviour, aggression and self-esteem, but the interventions are difficult to compare.

A US based experimental interrupted time series study by Tyndall et al. (2001) compared a 12, 45-minute sibling play therapy intervention (focused on empowerment and skill-building) delivered over a period of 12 days to 3 weeks, with individual play therapy in a shelter setting.
The intervention was delivered to an ethnically diverse sample of 10 children (6 girls; 4 boys) aged 4-9. Children exhibited improvements in externalizing and internalizing behaviour problems, aggression, anxiety, depression and self-esteem, and sibling group play therapy was found to be equally effective when compared to individual play therapy. Methodological weaknesses (e.g. small sample size, no randomization) limit the formation of strong conclusions regarding effectiveness.

A US-based before and after study by Parker et al. (2006) [-] evaluated an expressive writing therapy intervention delivered in four 90-minute sessions to 15 adolescent girls aged 12-17 (11 Caucasian, 4 African American) exposed to DV. They found a 67% increase in positive emotions for both the experimental and the control conditions at the end of programme, and there was a significant increase in the number of words related to self in the experimental group ($F(1,13)=13.46$, $p<0.003$). However, the study included a small sample size and no follow up was conducted.

A US-based before and after study (Schultz et al., 2007) [+] evaluated an equine assisted psychotherapy (EAP) intervention (goals to improve psychological and social well-being) delivered to a sample of 63 young people aged 4-16 years (26 girls; 37 boys; 51% non-Hispanic White, 46% Hispanic; 3% Black) who had been referred to a psychotherapist for behavioural or mental health issues. At 3 month follow-up, they found improvement in Global Assessment of Functioning (GAF) scores, and there was a statistically significant correlation between the percentage improvement in GAF scores and the number of sessions given ($r=0.73$, $p<0.001$).

Applicability

All studies were US-based. However, there is no particular reason to think that there may be barriers to applicability of the non-UK findings.

Evidence Statement 26- Single component psycho-educational interventions for children

Rizo et al. (2011) [+] reviewed four studies examining the effectiveness of a single component psycho-educational intervention for children (Johnston, 2003; McWhirter, 2008; Pepler, et al., 2000; Sudermann, et al., 2000), and two individually assessed studies (Bunston & Dileo, 2005, before and after [+]; Miller et al., 2012, RCT [+]).

From Rizo et al., 2011, systematic review [+]:

- Johnston, 2003 (before and after, USA, n=223, 6 month)
- McWhirter, 2008 (before and after, USA, n=46, end of programme)
- Pepler et al., 2000 (before and after, Canada, n=4 time points up to 6 month)
- Suderman et al., 2000 (before and after, Canada, n=31, end of programme)

Additional Studies:

- Bunston & Dileo, 2005 (before and after [+], Australia, n=88, end of programme)
- Miller et al., RCT (RCT [+], USA, n=110, 1-week post intervention)

There is moderate evidence that single-component psycho-educational interventions aimed at children are effective in improving children's coping skills, behaviour, emotional regulation, conflict resolution skills and knowledge about violence.

A US-based before and after study by Johnston (2003) examined a 10-15 weekly, 60-90 minute session psycho-educational intervention (focused on problem solving and skill building) delivered to 223 ethnically diverse children (106 girls and 117 boys), ranging in age from 5-14 years. They found improvements in emotional and behavioural problems at 6-months follow up based on clinicians, teachers and parents' ratings, as well as significant improvements in children's behaviour problems, emotional and behavioural difficulties and social competence; effects were moderate to substantial in size. Methodological weaknesses (e.g. lack of details on intervention, inconsistencies in implementation) limit the formation of strong conclusions regarding effectiveness.

A US-based before and after study by McWhirter (2008) evaluated a community based group intervention to improve stress management, coping and relationship skills (through art, play, expression-based activities), delivered over 5-weeks to an ethnically diverse sample of 46 children ages 6- 12. They found significant improvements in children's psychological well-being. Methodological weaknesses (e.g. lack of details on intervention, lack of follow up) limit the formation of strong conclusions regarding effectiveness.

A Canadian before and after study by Pepler et al. (2000) evaluated a shelter-based child peer group and mother's counselling programme (components and outcomes for mothers are not described) aimed at improving children's understanding of violence, coping and safety skills and improving self-esteem through a series of 10 small (7 person) weekly group sessions. The intervention was delivered within shelters to 46 children from 12 support groups (27 boys and 19 girls) ranging in age from 6-13 years. Findings revealed significant improvements in understandings of violence, depression and anxiety and behavioural adjustment. Mothers also reported fewer behavioural problems in children following the intervention, but counselling mothers was not found to impact children's behavioural adjustment. Methodological weaknesses (e.g. small sample size, lack of follow up) limit the formation of strong conclusions regarding effectiveness.

A Canadian before and after study evaluated a community-based group therapy intervention intended to increase understandings of violence and build coping and conflict resolution skills (Suderman et al., 2000). The intervention was delivered in 10-12 group sessions among 31

children (17 girls and 14 boys) aged 7-15 divided by gender and developmental level. They found that young people demonstrated improvements in attitudes, beliefs and knowledge about community resources for violence, as well as improved responses to peers in conflict situations, and that mothers also reported positive changes in their children. Methodological weaknesses (e.g. small sample size, lack of follow up) limit the formation of strong conclusions regarding effectiveness.

An Australian before and after study by Bunston, W. & Dileo, J. (2005) [+] reports the findings from a 12-month evaluation of a 90-minute/ week, 8 week mental health group intervention for a sample of 88 children 8 to 12 years of age. On the Strengths and Difficulties Questionnaire teachers reported statistically significant improvement in pro-social behaviour ($t(61)=4.31$, $p<0.01$, $d'=0.45$), total difficulties ($t(61)=4.02$, $p<0.01$, $d'=0.52$), peer problems ($t(61)=3.97$, $p<0.01$, $d'=0.42$), conduct problems ($t(61)=2.93$, $p<0.01$, $d'=0.38$), hyperactivity ($t(61)=2.89$, $p=0.01$, $d'=0.36$), and emotion symptoms ($t(61)=2.36$, $p=0.02$, $d'=0.45$). However, no long term outcomes were collected, and randomization was not done.

A US based RCT by Miller et al. (2012) [+] examined the impact of a ten session intervention (Preschool Kids Club) that teaches children specific and adaptive safety-planning strategies, conflict resolution skills, and education on gender relations (via activities such as role playing). The intervention was delivered in twice weekly sessions over 5 weeks with a sample of 110 children. The qualitative analysis of the changes in safety planning strategies from baseline to post intervention showed that 10 children (26% of the group) from the intervention group reported active-help seeking strategies post intervention, compared with just two children at baseline (4% of the group).

Applicability

Two studies were from Canada and one from Australia, while the remaining studies were US-based. However, there is no particular reason to think that there may be barriers to applicability of the non-UK findings.

Evidence Statement 27- Multi-component advocacy interventions

Four studies reviewed by Rizo et al. (2011) [+] evaluated multi-component interventions with advocacy as a primary intervention focus (Blodgett, et al., 2008; Crusto, et al., 2008; McFarlane, et al., 2005a, 2005b). One individually assessed study also evaluated a multi-component advocacy-based intervention (Whiteside-Mansell et al., 2009, RCT, [+]).

From Rizo et al., 2011, systematic review [+]:

- Blodgett, et al., 2008 (non comparative, USA, n=270, chart review)
- Crusto, et al., 2008; (before and after, USA, n=82, end of programme)
- McFarlane, et al., 2005a, 2005b, (cluster RCT, USA, n=206, 12 months, n=258,6,12,18 and 24 month)

Additional Studies:

- Whiteside-Mansell et al. 2009 (RCT [+], USA, n=610, end of programme, 24 months)

There is moderate evidence that multi component interventions with a focus on advocacy are effective in reducing the trauma symptoms and stress in both children and families, and in improving child behaviours such as aggression.

A US-based non-comparative study by Blodgett et al. (2008) examined a community-based family crisis-response services intervention, providing service planning and care coordination to families at the time of, or shortly after an incident of DV. The descriptive report included information from 270 children (age 9-19 years) from 144 families and found that 13% of crisis interventions benefited the child or family and that benefits increase with longer duration of support (5 or more

direct contacts from crises support workers). This study offers promising findings, but due to methodological limitations (e.g. small sample for subanalysis, limited and incomplete data), further research is required in order to make strong conclusions.

A US-based before and after study by Crusto et al. (2008) evaluated a wraparound programme focused on care coordination and service planning within a community setting that had the goal of decreasing incidents of violence, trauma symptoms and parenting stress while increasing participants' connection to community based resources. Their sample included 82 ethnically diverse children ranging from 1-6 years in age. They found significant improvements in traumatic events, parenting stress, and children's intrusive and avoidance behaviours, with children's improvements associated with hours of service and duration in the programme. Methodological weaknesses (e.g. lack of comparison group, reliance on parents as the sole reporter of data, no follow up, use of a non-random convenience sample) limit the formation of strong conclusions regarding effectiveness.

Two US-based cluster-RCTs compared the effectiveness of nurse case management and a referral care intervention for improving children's behaviour (McFarlane et al., 2005a,b). The referral care included information on safety planning, a list of resources, and prompted the mother to schedule an interview at the clinic; the case management intervention included screening, a safety plan brochure, and case management services. The McFarlane 2005a study examined child behaviour outcomes in a sample of 206 ethnically diverse children at baseline and at 1 year follow up. They found significant improvements in children's behaviour in both treatment groups at 1 year follow up, with boys aged 6-11 years and girls aged 12-18 showing the least improvement. At 1-year follow-up the scores of children with nurse case management treated mothers were significantly lower than those children with mothers who received referral. In the McFarlane 2005b study, 258 ethnically diverse mothers participated and follow up was conducted at 6, 12, 18 and 24 months. They found significant improvements in behaviour problems between intake and 24 months in both treatment groups, with children aged 18 months to 5 years showing the most improvement and teenagers demonstrating the least improvement. Rizo et al. (2011) identified both studies as rigorous (e.g. strengths noted include: follow up, use of theory (developmental psychology) to inform intervention, standardized measures).

A US-based RCT by Whiteside-Mansell et al. (2009) [+] compared the outcomes of children enrolled at 14 months old to the Early Head Start (EHS) programme, a non-parental childcare, for an ethnically diverse sample (in treatment group: 39% Black; 26% Hispanic; 4% other race) of low-income families with control children receiving usual care. At the end of the programme (3 years in age) EHS had moderated the effect of family conflict on child's aggression measured by the Child Behaviour Checklist; the EHS group had no link between family conflict and aggressive behaviour, but the comparison group had a positive link between family conflict and aggressive behaviour. At the age 5 follow-up no significant differences between the treatment and the control group were measured. However, the intervention is not described and it is unclear if "family conflict" as indicated in the subscale is an adequate measure of exposure to DV.

Applicability

All studies covered were US-based. However, there is no particular reason to think that there may be barrier to applicability of the non-UK findings.

Evidence Statement 28- Multi-component therapy and advocacy interventions

Two studies reviewed by Rizo et al. (2011) [+] evaluated multi-component interventions including therapy and advocacy components (Ernst, et al., 2008; C. M. Sullivan, et al., 2002), in addition to two individually assessed studies (Finkelstein et al., 2005, before and after [+]; Noether et al., 2007, non-RCT [+]).

From Rizo et al. (2011), systematic review [+]

- Ernst et al, 2005 (before and after, USA, n=58 children, end of programme)
- Sullivan et al., 2002 (individualized RCT, USA, n=80 mothers and children, pre, post and 4 month)

Additional Studies:

- Finkelstein et al., 2005 (before and after [+], USA, n=115, 6 and 12 month)
- Noether et al., 2007 (non RCT [+], USA, n=253, 6 and 12 month)

There is moderate evidence of effectiveness of multi component interventions including both therapy and advocacy among diverse populations of women and children, some with co occurring issues of substance use and mental health issues. These interventions increased knowledge and awareness about violence and safety planning, improved self-esteem and self competence and improved interpersonal relationships.

A US based before and after study by Ernst et al. (2005) evaluated an intervention for children who witnessed violence that involved identification through a child advocate dispatched to the home following police calls, individual therapy sessions over a period of 2 to 12 months, and psycho-educational component for younger children which used a colouring book format. While the intervention involved individual therapy, the outcomes reported on from progress reports retrospectively were related to increased awareness and use of safety plans. The children ranged from 3 to 17 years (mean age 8.5) who lived in a largely Hispanic city. On 15 of 16 evaluation questions, they found a statistically significant improvement from pre-intervention to post intervention $p<0.01$ in increased knowledge and skills such as children's understanding of IPV, children's awareness that violence is not their fault and use of a safety plan. Study limitations include no comparison group, lack of use of standardized measures, no follow-up, non-random convenience sample and individualized treatment for each participant limiting generalisability.

A US based RCT study by Sullivan et al. (2002) evaluated an intensive (average 8.95 hours per week) advocacy intervention which linked up mothers and children with a wide range of community and recreational services, plus a 10 week learning group intervention for children. 80 ethnically diverse mothers and children participated (45 in the intervention), and follow up was done at 4 months. Key findings were that the combined group and family-centred, strengths-based advocacy intervention showed efficacy in reducing mothers' depression and increasing mothers' self-esteem (Significant Condition X Time linear effects found ($p<0.05$): depression (2.13), and self-esteem (2.37) and increasing children's self competence, global self –worth and athletic competence. Significant Condition X Time linear effects found ($p<0.05$): self worth (1.89), physical appearance (2.27), athletic (2.21). The study was randomized, albeit the method of randomization and the intervention received by the comparison group unclear. Rizo et al. (2011) identify this study as rigorous (strengths included a manualized intervention, use of standardized measures and had a high retention rate).

A US based study before and after study [+] by Finkelstein et al. (2005) aimed to understand the benefits for children of providing coordinated services for children and mothers to decrease risk factors and fortify protective buffers to foster children's resiliency and increase resistance to violence, drug/ alcohol use, and other harmful behaviour. Participants in the study were 115 ethnically diverse children aged 5 to 10 years of age in two age groups (5-7; 8-10) whose mothers were in treatment for violence, mental health and substance use concerns. The intervention involved clinical assessment of the child, service coordination and advocacy for mothers and children, and a developmentally matched 10-session skills-building group for children (based on Peled and Davis' manual) held separately from other interventions with mothers in treatment. There was no control group and high attrition due to a barriers such as transportation issues, mother being unable to continue, trust issues, other family members not wanting the child in the study, and change of residence. Seventy-seven percent (75%) of mothers

reported noticing positive behaviour and attitude changes in their children (31%); and increased knowledge and skills related to safety, coping, addiction, and recovery (20%).

A US based RCT [+] study by Noether et al. (2007) evaluated the same intervention as Finkelstein et al. (2005), but reported on 6 and 12 month outcomes for 253 children aged 5-10 77.1% of mothers completed both the 6 month and 12 month follow-ups (82.6% at 6 months, 85.8% at 12 months); involvement in the intervention lead to significant improvements in the domains of positive interpersonal relationships and positive self identity as well as increases in safety knowledge. Younger children showed a greater improvement than older children. Not all children involved in the study had witnessed family violence (even though that was a key aim of the study) but the children who had, were more likely to show positive changes in self identity and interpersonal relationships at 6 and 12 months than those who had not.

Applicability

All studies covered were US-based. However, there is no particular reason to think that there may be barrier to applicability of the non-UK findings.

Evidence Statement 29- Multi-component parenting and therapy interventions

Rizo et al. (2011) [+] reported on 8 studies which evaluated multi - component interventions focused on therapy and parenting (Carter, et al., 2003; Dodd, 2009; Graham-Bermann, et al., 2007; E. N. Jouriles, et al., 2009; E.N. Jouriles, et al., 2001; MacMillan & Harpur, 2003; McDonald, et al., 2006; M. Sullivan, et al., 2004). Two additional studies evaluating a multi-component intervention including parenting and therapy components were identified (Puccia et al., 2012, before and after [+]; Sharp et al, 2011, qualitative [+])

From Rizo et al., 2011, systematic review [+]:

- Carter et al. 2003 (before and after, USA, n=192 children, 64 parents, end of programme)
- Dodd, 2009 (before and after, England, n=NR, end of programme)
- Graham-Berman, et al., 2007 (cluster RCT, USA, n=221 mothers and children, end of programme)
- Jouriles et al., 2001 (RCT, USA, n=36 mothers and children, 5 occasions over 16 months post shelter)
- Jouriles et al., 2009 (RCT, USA, n=66 mothers and children, 6 time points every 4 months 20 months)
- MacMillan & Harper, 2003 (before and after, Canada, n=47 children (from 35 families), end of programme)
- McDonald et al., 2006 (RCT, USA, n=30 families, 24 month)
- Sullivan et al., 2004 (before and after, USA, n=76 children and 46 mothers, end of programme)

Additional Studies:

- Puccia et al., 2012 (before and after [+], USA, n=45 children and their mothers, every 3 months; end of treatment)
- Sharp et al, 2011, (qualitative [+], Scotland, n=27 children; n=25 mothers, end of programme)

There is moderate evidence of effectiveness of multi component interventions focused on therapy and parenting aimed at diverse populations of mothers and children. These interventions showed moderate improvement in children's behaviour and emotions, knowledge about violence and reductions in mothers' stress and ability to manage children.

A US-based before and after study by Carter et al. (2003) evaluated an individual psycho-educational and play therapy group for children and parenting skills group for parents, delivered

over 10-12 weekly 90-minute sessions facilitated by licensed therapists to an ethnically diverse sample of 192 children and 64 parents, with children age 4-18 years. They found significant improvements in children's emotional, behaviour and social problems, and understandings of violence and safety planning. Parents also reported lower stress and fewer behavioural problems with children following treatment. Methodological weaknesses (e.g. lack of comparison group and follow up) limit the formation of strong conclusions regarding effectiveness.

A UK-based before and after study by Dodd (2009) evaluated a community-based group therapy for mothers and their children aimed at improving mother-child relationships and the psychological well-being of mothers and children. Mothers participated in support groups (focused on building confidence, providing emotional support, and teaching parenting skills), children attended therapeutic play groups, and then both participated in "theraplay" groups (focused on improving relationships and attachment). They found that mothers and children were satisfied with the programme and mothers reported improvements in parenting hassles and self-esteem. However, methodological weaknesses (e.g. lack of sample information, limited information on data analysis methods, study design or procedures) limit the formation of strong conclusions regarding effectiveness.

The US based cluster-RCT study by Graham-Bermann et al. (2007) compared a child-only 10-week group therapeutic session (groups addressed knowledge about violence and provided emotional support) for 221 children (111 girls; 110 boys) age 6-12 years, with a child- plus-mother combined 10-week empowerment focused parenting intervention. They found significant improvements in behaviour problems and attitudes about violence in children in the child-plus-mother intervention, which were maintained at follow-up. Both the child-only and child-plus-mother groups showed significant reductions in internalizing and externalizing problems compared to the no-treatment group. This study was identified as being one of the most rigorous (large sample size, follow up, rigorous statistical analyses) papers included in the review by Rizo et al. (2011).

Two US-based RCT studies by Jouriles (2001; 2009) and one US-based RCT study by McDonald et al. (2006) report on the same intervention, a parenting and therapy intervention (focused on child management skills and providing emotional and practical support) delivered in 1-1.5 hour weekly sessions over 8 months to children and caregivers in their home after leaving a shelter. Studies included ethnically diverse samples of varying sizes, and varied in follow-up periods (details noted above). All studies reported improvements in child management and children's behaviour problems in the intervention group. All three studies were identified as rigorous (strengths noted include: experimental design, follow up, use of standardized intervention manual) by Rizo et al. (2011).

A Canadian before and after study by MacMillan and Harpur (2003) evaluated a 10 week 90-minute parenting sessions (focused on improving relationships and positive discipline) for 35 parents, and children's group therapy (psycho-education and relaxation exercises) for 47 children (24 boys and 23 girls; mean age=9.02 years). They found improvements in children's knowledge of DV and improvements in children's externalizing behaviours; parents also demonstrated significant improvements in stress. However, methodological weaknesses (e.g. small sample size, lack of follow up) limit the formation of strong conclusions regarding effectiveness.

A US-based experimental time-interrupted study by Sullivan et al. (2004) evaluated a 9-week group intervention held with 79 children (mean age: 8.51 years) and 46 mothers, with each session beginning with concurrent mother groups (focused on parenting skills and providing support) and child groups (safety planning; trauma and conflict resolution), and ending with a conjoint component (aimed at improving mother-child communication). They found significant improvement in children's mood and trauma symptoms, self blame and behaviour problems, and anger. Mothers reported significant improvements in isolation, life stress and health. However, methodological weaknesses (e.g. small sample size, lack of follow up, limited information on the

intervention and sample or study procedures) limit the formation of strong conclusions regarding effectiveness.

A US-based before and after study (Puccia et al., 2012 [+]) examined a trauma focused cognitive behavioural therapy (TF-CBT) intervention for 45 child clients (n=27 completers) of a community counselling centre and their mothers. The intervention included: conjoint parent-child sessions, psycho-education, relaxation techniques, affective expression and regulation, cognitive coping and processing, parenting skills, trauma narrative, in vivo exposure, and safety skills and safety planning. They found a reduction in symptoms of post-traumatic stress for those who completed the TF-CBT treatment. Limitations of the study include: high attrition, lack of analysis of drop-outs, and limited intervention details.

A Scottish qualitative evaluation study (Sharp, 2011) [+] of group work (as part of the Cedar project) for 27 children age 3-17 and concurrent group work for 25 mothers, with the aims of improving knowledge of violence, safety planning, self-esteem and parent-child interaction. Findings revealed that the programme was broadly positive for raising awareness of abuse, reducing isolation and developing strengths-based responses among children and mothers. They provide limited information on methods of analysis.

Applicability

Two studies were UK-based (Dodd, 2009; Sharp, 2011, qualitative [+]), one study was from Canada (MacMillan and Harpur, 2009) and the remaining studies were US-based. However, there is no particular reason to think that there may be barriers to applicability of the non-UK findings.

7.4. Discussion

7.4.1. Key Findings

This review addressed the nature of the interventions and approaches used in health and social care settings for identifying and responding to children exposed to DV. Our review identified one review article within which 25 articles were in the scope of this review, plus 13 additional articles. While the assessment method used in the review article is not precisely the same as the NICE method, the 25 articles have been quality assessed for strengths and weaknesses and critically appraised by the review authors. However, the quality of these studies is reliant on what is reported by Rizo et al. (2011), and is therefore a limitation of this review.

The Rizo et al. review identified four main approaches to responding to child witnesses of DV. They reported on approaches that are: counselling and therapeutic oriented; crisis and outreach oriented; focused on parenting and the child-parent relationship, and multi-component approaches, involving more than one of the above in addition to approaches such as advocacy, social support and linkages between agencies. We reorganized all the findings, including the Rizo et al. studies, into new categories, reflecting factors such as whether or not the intervention was single or multi-component; therapy or psycho-education focused; aimed at children, or mothers and children; and recognizing the mix of aspects such as advocacy, therapy and parenting. An overview of these findings follows.

There is moderate to strong evidence (from 4 studies covered by the Rizo review plus 2 additional studies) that single component therapeutic interventions aimed at both mother and child are effective with diverse samples in improving child behaviour, mother-child attachment and stress and trauma-related symptoms in mothers and children. All studies included ethnically diverse samples of children and mothers. Intervention approaches varied, including: mother-child psychotherapy, shelter-based parenting intervention combined with play sessions for children, parent-child interaction therapy (including mother-child play, teaching of praise and discipline techniques), and an experiential, activity based and interactive therapy intervention. All studies

reported improvements in the measured outcomes for children and their mothers, though studies varied in quality from moderate to strong.

There is inconsistent evidence (from 2 studies covered by the Rizo review plus 2 additional studies) that single-component psycho-educational interventions aimed at mothers and children are effective in building coping skills, increasing knowledge of DV and improving children's behaviour and mothers' parenting skills. Intervention approaches included: community-based psycho-educational and support groups, home-based group parenting sessions, and 'activity packs' designed to build self-esteem and promote communication between children and mothers living in refuges. While the majority of studies reported improvements on the outcomes measured for children and mothers, in some studies improvements were not sustained at follow-up, while other studies had significant methodological weaknesses (small sample size, weak analysis, lack of information on intervention, etc.), limiting the formation of strong evidence of impact.

There is weak evidence (from 1 study covered by the Rizo review plus 2 additional studies) regarding single component therapeutic interventions. Interventions included: sibling group play therapy and individual play therapy, expressive writing therapy, and equine assisted psychotherapy. Play therapy and equine therapy both demonstrated some improvements with diverse groups of children in behaviour, aggression and self-esteem, but given that there were only 3 studies and these interventions are difficult to compare, it is not possible to note strong evidence of impact.

There is moderate evidence (from 4 studies covered by the Rizo review plus 2 additional studies) that single-component psycho-educational interventions aimed at children are effective in improving children's coping skills, behaviour, emotional regulation, conflict resolution skills and knowledge about violence. Interventions included education on: problem solving and skill building, stress management, coping and relationship skills, understandings of violence, conflict resolution skills, adaptive safety-planning strategies, and education on gender relations. While all studies reported improvements for children, these studies as a whole were moderate in quality (many lacked follow-up, included small sample sizes, etc.) limiting the formation of a strong evidence of impact.

There is moderate evidence (from 4 studies covered by the Rizo review plus 1 additional study) that multi component interventions with a focus on advocacy are effective in reducing the trauma symptoms and stress in both children and families, and in improving child behaviours such as aggression. Interventions included: community-based service planning and care coordination interventions for families, nurse case management and a referral care intervention, and non-parental child care for ethnically diverse low-income families. Overall, these studies reported improvements in psychological and behavioural outcomes for children, with some indicating greater improvement with increased intensity. However, some studies were not very strong (lack of study details, incomplete data, etc.) and therefore only moderate evidence of impact is noted.

There is moderate evidence (from 2 studies covered by the Rizo review plus 2 additional studies) of effectiveness of multi-component interventions including both therapy and advocacy among diverse populations of women and children, some with co-occurring issues of substance use and mental health issues. All studies were conducted with ethnically diverse samples. These interventions increased knowledge and awareness about violence and safety planning, improved self-esteem and self competence and improved interpersonal relationships. Interventions included combinations of: a child advocate with individual therapy and psycho-educational sessions; intensive advocacy for mothers and children and a learning group intervention for children; and coordinated services for children and mothers to address risk for violence and substance use. All studies reported improvements for children (with some noting variations between different age groups of children), but were moderate in quality.

There is moderate evidence (from 8 studies covered by the Rizo review plus 2 additional studies) of effectiveness of multi component interventions focused on therapy and parenting aimed at

diverse populations of mothers and children. These interventions showed moderate improvement in children's behaviour and emotions, knowledge about violence and reductions in mothers' stress and ability to manage children. Interventions typically involved individual or group therapy held concurrently for mothers and children, along with parenting sessions for mothers, and in some cases a conjoint mother-child session to improve communication and implement relational skills. The therapy based components included: psycho-educational therapy, play therapy for children, relaxation exercises, safety skills and planning, and trauma and conflict resolution. Parenting sessions focused on improving skills such as: child management skills, providing emotional and practical support, improving relationships and positive discipline. All studies reported improvements for both children and mothers, and several of the studies reviewed by Rizo were identified as rigorous. However, the majority of studies had significant methodological weaknesses (including lack of sample information, limited information on data analysis methods, study design or procedures) that limit the formation of strong conclusions regarding effectiveness.

7.4.2. Gaps in the Literature

There are limitations in the design of many studies that limit the comparison and generalisability of findings; for example the majority of studies were not randomized trials and did not have follow-up points (were before and after). The diversity of the interventions and the lack of reporting of benefits specific to sub-components of multi-component interventions also make it difficult to compare and discuss the benefits of different modalities. However, in the case of single focus interventions, interventions aimed at mothers and children together (for example groups involving both mothers and children) appear to be more beneficial for improved outcomes for both, than for single focused interventions for children only. In addition, a number of multi-component studies reported improved outcomes for children tied to improved outcomes on the part of their mothers, including two studies that reported on improved outcomes for children when their mother solely received an intervention(s). Multi-component interventions also target both parents and children, often through advocacy as well as therapeutic or parenting focused interventions, confirming the benefits of a continuum oriented approach, with options for parents and children at different levels of risk, and with different preferences for support and treatment.

There was an omission of any gender-based analysis embedded in these studies, despite the gendered nature of DV, and the possibly gendered nature of the effects of child exposure. For example, there was only one study that reported sex differences in the effects on children (McFarlane, et al., 2005b). There was another study with a sample of only girls (Parker, et al., 2006), that did not appear to be a deliberate aspect of the research design, and was not discussed in the analysis of the effects of the intervention. Further, despite the fact that the interventions addressing parenting were primarily designed and used with mothers, the gendered context of women's lives, especially victims of DV was not discussed as part of the analysis of the effects of the interventions. This omission is in stark contrast to the contextual documents on DV in the UK that explicitly address these issues of gender and other intersecting factors.

Finally, the material in this review can be assessed against a broader context. The continuum of key elements identified by Humphreys et al., ranging from identification and assessment to advocacy, offer a wide range of ways as to how interventions for child witnesses of DV might be addressed (Humphreys, et al., 2008). When we examined the rated studies against that continuum, we found that most of our studies fall in the categories of mother-child interventions and child group therapy. While such studies are very important, and offer excellent controlled opportunities for researchers, the other aspects of the continuum are relatively ignored in the literature. Hence, interventions such as general population interventions with children, or flexible, community based educational interventions that may reach more children and may offer broad prevention are less studied, and hence have less evidence surrounding them.

Indeed, in the un-assessed grey literature (that did not meet inclusion criteria), there were some interesting approaches reported, especially in the UK context; for example, a study capturing the preferences of children for interventions such as outreach and support groups (Barron, 2007),

studies underlining the benefits of multisystem, integrated interventions for children and adults (Cleaver, et al., 2006; Templeton, 2010), studies recommending flexible approaches to the delivery of interventions (Crowther & Cowen, 2011; Jeyasingham, 2011), and studies describing brief interventions in the health care and other systems which serve both to identify children needing help and provide supports (Groves, Augustyn, Lee, & Sawires, 2004; Healy & Bell, 2004; National Evaluation of Sure Start Implementation Team, 2007). These are examples of a wider set of options for responding to children exposed to DV.

8. Research Question 5: Effectiveness Review of Partnership Approaches for Assessing and Responding to Domestic Violence

8.1. Background

Multi-agency responses to DV, or coordinated community responses as they are called in the United States, are aimed at improving victim and their children's safety, perpetrator accountability, and developing effective prevention strategies. While the criminal justice system plays an important role in these responses, given that only a fraction of victims report DV to the police, the involvement of a wide range of partner agencies and the community is necessary to effectively respond to DV (Co-ordinated Action Against Domestic Abuse, 2012).

Coordinated community responses to DV in the US emerged from the Duluth Model- a comprehensive community based approach to DV grounded in feminist theory, addressing both perpetrator accountability and victim safety (Garner & Maxwell, 2008). Coordinated community responses in the US have used a variety of approaches to engage the community and coordinate services, including: improving communication among service agencies; the development of shared philosophies or practices for addressing DV; and coordinating responses to families with multiple problems (e.g. DV and child abuse or neglect) (Garner & Maxwell, 2008).

In the UK, multi-agency working to address DV can be traced back to principles of collectivism and mutual support, to improve the local services available for victims (Harvie & Manzi, 2011). DV multi-agencies increased dramatically between the early 1990s to the early 2000s as the partnership approach became a key component of the agenda of the UK government, along with other developed countries. Partnership models were perceived to combine expertise as well as improve cost-sharing, producing greater gains in efficiency. Harvie and Manzi (2011) also describe how in the UK, partnership working has been linked to crime prevention, particularly Crime and Disorder Partnerships (CDRP) which were established to achieve the crime prevention goals identified in The Crime and Disorder Act and Criminal Justice Act of 1998. Statutory agencies worked with local community groups to develop responses to crime, and now multi-agency partnerships are established in all 376 local authorities across England and Wales. They note that this represented a shift in approaches to DV from a focus on small primarily voluntary sector responses to statutory sector responsibility involving formal partnerships.

Multi-Agency Responses in the UK

Integral to the multi-agency approach to DV in the UK are Independent DV Advisors (IDVAs). IDVAs engage with victims at the point of crisis and then mobilize the services of local agencies to support and provide safety to victims and their children (Co-ordinated Action Against Domestic Abuse, 2012). The coordination of public services typically occurs through Multi-Agency Risk Assessment Conferences (MARACs), meetings between statutory and voluntary agencies to share information on high-risk cases and develop safety plans for high-risk victims, where an IDVA represents victims.

MARACs are multi-agency meetings including representation from a diverse range of voluntary and statutory agencies to share information regarding high risk victims of DV and their children, to develop a coordinated action plan to improve safety (Cordis Bright Consulting, 2011). There were approximately 260 MARACs operating in England and Wales in 2011. MARACs typically meet at least monthly, and last an average of 2-4 hours (Cordis Bright Consulting, 2011). MARACs are primarily a Police led process and the majority of case referrals come through the Police (Cordis Bright Consulting, 2011). Best practice guidance (Co-ordinated Action Against Domestic Abuse, 2012) suggests that, as a minimum, six core agencies should consistently attend MARACs,

including: police, probation, IDVAs, housing, children services and health (Steel, Blakeborough, & Nicholas, 2011). Some of the actions commonly reported as outcomes include: making links to safeguarding procedures for children and vulnerable adults, liaising with victims; developing an action plan to reflect the risks and needs of the victim; and identifying opportunities for partner agencies to coordinate actions (Cordis Bright Consulting, 2011).

In the UK, the Co-ordinated Action Against Domestic Abuse (CAADA) is a national charity that supports multi-agency partnerships to address domestic abuse, providing support to professionals and agencies working with high-risk victims (Co-ordinated Action Against Domestic Abuse, 2012). The five-year strategy of CAADA aims to reduce the number of high risk victims experiencing DV in half, from 100,000 to 50,000 and to cut the average time for victims to seek from 5 to 2.5 years. To achieve these goals, they propose: the development of strategies to identify domestic abuse earlier and in particular: increase the access of marginalized women to IDVA services; to provide support and training to improve national service provision; to share and integrate best practice multi–agency responses; and to develop strategies for outcome-driven funding linked to better outcomes for victims. There are 10 principles of effective MARACs developed by CAADA (Cordis Bright Consulting, 2011). These relate to 1) identification, 2) referral, 3) representation, 4) engagement with the victim, 5) research and information sharing, 6) action planning, 7) volume, 8) administration, 9) strategy and governance and 10) equality.

The work of 260 MARACs and approximately 500 IDVAs in 2011 supported over 43,000 adults and 57,000 children (Co-ordinated Action Against Domestic Abuse, 2012). A UK national study examining the effectiveness of IDVA services reported that two-thirds of women receiving IDVA services reported increased linkages with health services and professionals (Howarth, Stimpson, Barran, & Robinson, 2009). Stakeholders from MARACs report that IDVAs are integral in supporting and engaging the victim in the MARAC and achieving successful outcomes for the victim (Cordis Bright Consulting, 2011). However, IDVAs are often overburdened; there are now an estimated 500 IDVAs, although it has been estimated that a minimum of 650 are required to support high-risk victims in the UK (Co-ordinated Action Against Domestic Abuse, 2012).

8.2 Summary of the Literature

A total of 115 full-text study reports were retrieved. An additional 22 reports relevant to Q5 were collected through the grey literature search (a breakdown is provided in the flow-charts in *Appendix G*), including: web-searches and the OpenGrey database. Five papers suggested by a PDG member were also included.

A total of 142 reports were retrieved for full text review. Of these, 109 papers were excluded at the full text screening stage. We were unable to locate two papers and therefore they were excluded (see *Appendix H* for all papers that were unable to be located during the review). No systematic reviews were located. Ten studies received a [-] internal quality rating and are not included in the report of findings, but are listed in *Appendix F*. A total of 21 studies are included and reported on in this review. A summary of the studies included in see *Appendix I.*

8.2.1. Systematic Reviews

No systematic reviews were identified for this question; however, a summary of narrative (non-systematic) reviews is provided in prior to the reporting of findings.

8.2.2. Included Studies

The results of quality assessment are presented in *Appendix K*. Of the studies reviewed, for internal validity, all 21 were of medium quality [+]. For external validity, 8 studies were judged to be of medium quality [+] and 3 of low quality [-], while 10 were qualitative studies and did not receive an external validity rating

Applicability

Ten studies were conducted in the UK, nine in the USA, one in Canada and one in Australia. Potential applicability issues that pertain to specific studies are discussed within the findings of the report and provided in the evidence statements. The majority of studies were qualitative, before and after or cross-sectional studies, limiting generalisability.

8.3. Summary of Non-systematic Reviews

No systematic reviews were identified that examined partnership interventions for addressing domestic violence. Evidence from three non-systematic that were identified during the review process is summarized below.

Partnership Approaches to Domestic Violence

Three narrative reviews discussed integrated or coordinated responses to intimate partner violence (IPV) from different perspectives. Garner and Maxwell (2008) gave an overview of the last 100 years of coordinated community responses to IPV in the United States. The Australian Domestic and Family Violence Clearinghouse (ADFVC) (2010) investigated the meaning of integration, analysed whether there is evidence to support models for integrated services and systems, and looked for direction for future models in New South Wales. Colombini, Mayhew and Watts (2008) reviewed programs and results of health care sector integrated responses to IPV in low- and middle-income countries. Together, these reviews examined the breadth and depth of the challenges, successes and results of integrated response services to IPV.

Criteria selection and Challenges

Two reviews outlined the study selection criteria. The authors at ADFVC (2010) searched for literature that was conceptual and analytic, published from 2005-March 2010 and was included in peer-reviewed, government publications. They indicated that there were difficulties in collecting such data because of limited available evidence for effective models of collaboration in the human service domain (Banks, Dutch et al, 2008; Post, Klevens et al., 2010). There are also inherent challenges in doing research on DV against women; it is often difficult to connect with abused women, and IPV programs suffer from low enrolment and high drop out rates (Robinson & Tregidga, 2007; Zink & Putnam, 2005). In addition, although integrated initiatives almost always include multiple elements, studies are designed to address the impact of the overall intervention, even when participants receive selected services (Visher, Harrell et al., 2008). Finally, a general underreporting of abuse to police gives an imperfect understanding of the extent of violence (Carson, Chung & Day, 2009).

Colombini and colleagues (2008) identified nine studies, either published reviews or grey literature, of programs implemented between 1995-2005 focusing on health-service provision addressing violence against women in low- middle-income countries. Where possible, these reviews included evaluations or measurements. Of these nine studies, five were located in central and Latin America (CONFAD, Brazil; Family counselling centres, Honduras; Profamilia, Dominican Republic; Inppares, Peru; Plafam, Venezuela), three from Asia (One-Stop Crisis Centre (OCSS) Malaysia, Bangladesh, Thailand, Namibia; Prime II, Armenia; Women's Friendly Hospital, Bangladesh), and one from Africa (Gender recovery centre, Kenya). Note that while an overview of findings is provided from these studies, many of these countries are non-OECD countries and are therefore beyond the scope of this review.

Coordinated, or integrated, care: Definitions, models and challenges

All authors agreed that there is no single model for coordinated community responses to IPV. To make sense of the multiple integrated response models, both the ADFVC authors and Colombini et al. (2008) proposed methods of classification.

ADFVC Approach

The authors differentiated between integrated services and integrated systems responses. Integrated services are partly or wholly co-located responses from inter-agency teams. Integrated systems are jurisdiction-wide responses that include different levels of management; require changes to core agency practices; and encompass a range of services, shared protocols and integrated courts and legislative base. Within both models, there is no agreement on which services should be prioritized. For instance, Allan's (2006) study of 41 DV coordinating councils found a focus on criminal justice issues but not on child protection responses. Others emphasized that health services should be an essential part of integration (Bennett & O'Brien, 2007; Welsh, 2008). Still, the authors indicate that a priority for all integrated response systems is the needs of women marginalized by race, income or ability; these women experience disproportionately higher rates of IPV in comparison to the rest of the population. In the New South Wales context, two specific populations must be accounted for: women from culturally and linguistically diverse (CALD) backgrounds and Indigenous communities. Women from CALD backgrounds are less likely to report DV, and have less knowledge about available services; Indigenous women are 35 times more likely to be hospitalized for family violence and 10 times more likely to be killed by their partners than non-Aboriginal women (Al-Yaman, Van Doeland & Wallis, 2006).

The goals for successful agency integration outlined by the authors are: sharing a common vision, setting performance indicators and cross agency agreements and establishing an active form of leadership. Even with these goals taken into account, integrated response programs may face a variety of challenges and limitations including: 1) Lack of monitoring and reliance on formative success measures in many programs may lead to poor evaluations; 2) Increased surveillance of women and children can be a negative outcome of programs that combine child protection agencies and services to women; 3) Power discrepancies may arise between agencies, impeding collaboration; shared decision-making and transparency is recommended; 4) Tensions between agencies may manifest in areas such as information sharing, mandated services for abused women, child witnesses, perpetrator engagement, cultural competence, and the removal of children based on "failure to protect" (Banks et al., 2008); and 5) Lack of additional resources for new programs. Vincent (1999) recommends integrated programs be made central government priorities, have a clear leader advocating on their behalf and receive designated funding.

Colombini, Mayhew and Watts Approach

These authors explained that integrated services might be offered on three levels (provider, facility and system) each with its attendant advantages and challenges. At the provider level, one person offers a range of services to the client during the same consultation. One challenge to this system is entrenched medical hierarchies that might impede service provision. The facility level offers a range of services in one place, but is not necessarily administered by the same individual. Here, there are possibilities for poor management, a shortage of personnel and supplies, lack of equipment and poor physical infrastructure. Finally, the systems level is a multisite operation, where a client disclosing violence can be referred to a different facility. This system might suffer from a lack of coordination between actors and guidelines, underfunding and a weak legislative system.

Structuring these three levels are two models for integration: selective and comprehensive. Selective integration, a feature of the provider and facility levels at both the primary and secondary levels of care is present when a response service offers one or two service components. It is exemplified by a Honduran programme, where regional family-counselling centres are located at mental-health clinics and provide individual and group counselling for abused women, and in a Brazilian pilot project where a counselling programme has been integrated at a medical-school health centre. Comprehensive integration, a feature of the facility or service levels usually at the secondary and tertiary levels of care is present when a wide range of IPV services are provided. At the facility level this model has been appropriated in Malaysia, Bagladesh, Namibia and Thailand by the One-Stop Crisis Centre (OSCC), where health, legal, welfare and counselling services were offered to battered women and then extended to include

rape and sexual victims. Service level integration is exemplified by the International Planned Parenthood Federation (IPPF) in Latin America, which has integrated violence screenings and related support services into sexual and reproductive health services, while affiliate clinics strengthened off-site referral and formed partnerships with NGOs.

Garner and Maxwell Approach

Rather than organizing the different forms of integrated services, these authors uncovered the nearly one hundred-year history of integrated approaches. In 1917, the National Probation Association recommended that family court judges serve long enough terms to ensure the implementation of social service programs. In the 1940s in New York, a specialized magistrate court worked with nonprofits to offer collective assistance to families (Quinn, 2008). Twenty years later, Parnas (1969) suggested criminal courts did not have sufficient resources to help with the underlying problems of violence and recommended more referrals to family agencies to reduce DV recidivism. Although in the 1970s in New York, a lack of research supported rehabilitative programs, leading to a resurgence of punitive responses to IPV, the Duluth Domestic Abuse Intervention Project began a coordinated community response model (Lerman, 1981). By 1994, under the Violence Against Women Act, coordinated community responses for a variety of federal DV intervention and prevention efforts became policy. The implementation and strategies of these models varied; some advocates indicated reductions in subsequent offending from those arrested, imprisoned and treated.

Study Results

ADFVC Results: The authors noted that success measures for programs depend on the purpose of integration. The two most common objectives for integrated strategy are increased safety for women and increased offender accountability (Hague & Bridge, 2008; Hester & Westmarland, 2005; Klevens et al., 2008; National Council of Juvenile and Family Court Judges, 1999; Pence & Shepard, 1999; Robinson, 2006; Rodwell & Smith, 2008; Visher et al., 2009). For the first objective, frequent safety measures are: increased reporting to police (or decreased reporting to police, in longer-term measures), increased protection orders and reduced retractions (Hester & Westmarland, 2005; Robinson & Tregidga, 2007). Increased offender accountability is measured through more arrests, charges and prosecutions, and increased (or reduced) breaches of orders, referrals to and completion of perpetrator programs.

The authors reviewed five robust or promising published evaluations from integrated services: The Greenbook Sites, The U.S. Duluth Domestic Abuse Intervention Project, Cheshire Domestic Abuse Project, The U.K. Northampton Sunflower Centre, and U.S. Centers for Disease Control (CDC) Funded Sites. The type of services offered by each project varied, ranging from case tracking (Duluth), enhanced evidence gathering and “target hardening”(Cheshire) to support and safety planning for women (Duluth; CDC). Evaluation results also varied. For instance, a four-year follow up from the Duluth model indicated that 90% of programme completers had not been violent to their partners in the previous year (Gondolf, 2007); but a separate meta-evaluation found a 40% recidivism rate when all participants (drop outs included) were measured (Dutton, 2007). Greenbook evaluations found increased referrals for DV (Malik et al., 2008) and collaboration between agencies and innovative practice in the child care system, but not in the court or DV systems (Edleson & Malik 2008). Evaluations from the Cheshire and Northampton Sunflower Centre were more positive. Between 2001 and 2004, the Cheshire results showed rises in reported incidents of IPV and charges laid, and reductions in repeat incidents and retractions of reports. The Sunflower Centre showed increased conviction rates and a reduction in the withdrawal of applications for protection orders. Finally, a comparative study between CDC funded sites and a control group found no significant difference in knowledge, beliefs, or attitudes of IPV, knowledge and use of DV services, or risk of exposure to DV after controlling for age, gender, ethnicity, income and education.

Two integrated systems- U.S. Judicial Oversight Demonstration Projects (JODS) and the UK Multi-Agency Risk Assessment Conferences (MARACs) – were also reviewed. With its focus

increasing victim safety, holding offenders accountable and integrating justice system responses, JODS results indicated higher rates of conviction supervision sentences and fewer deferred prosecutions than the control group. Referrals to batterer programs did not have a powerful effect on reducing violence, but other measures did, such as providing women with services beyond court-centred responses (Visher et al, 2008). MARACs represented a compromise between service and system responses by providing a forum to share information across criminal justice, non-government and statutory agencies. Data showed that 40% of women with cases referred to MARACs reported no further violence one year later (Robinson & Tregidga, 2007). Although this form of risk assessment can address specific needs, provide a clear paper trial, target resources, and make the system more aware of dangerous offenders, limitations include lack of cooperation from some victims, underfunding for administrative needs and a high volume of cases (Robinson, 2006).

The authors concluded with a summary of promising Australian practice systems, from the least to the most comprehensive. The South Australian Family Safety Framework reviewed high-risk cases at family safety meetings with a variety of stakeholders. Results indicated that 75% of cases heard did not re-report abuse to the police for a minimum of 3 months post-meeting; 16% demonstrated police reports suggesting moderate DV; 9% showed serious incidents of re-offence. Safe at Home-Tasmania supported the Family Violence Act (2004), giving police the power to immediately issue restraining orders in cases of low or moderate risk, while also coordinating services with the police department. Evaluations showed community and agency support, and recommended an increase in case coordination and greater focus on high-risk cases and child protection. Finally, the Victorian Family Violence System worked to strengthen policy and court systems while providing support for women and their children through legislative reform, along with enhanced counselling and referral services, a 24-hour hotline and a focus on the court system's service. No evaluation had yet been published, but available data showed increases in family violence incidents reports, Intervention Orders applied for by police and in charges laid (Healy, 2009). However, the system tended to focus on women in crisis, leading to a gap in services for those needing long term support (Healey, 2009). Its strengths were that it used one lead agency, offered a range of entry points and services, and provided multiple responses for male perpetrators.

Colombini, Mayhew and Watts Results: These authors identified challenges facing integrated responses by the health care sector in the target countries. The first was in human resources, training and management protocols. One key concern was that health personnel were not adequately trained and sensitive to the needs of the clients. International Planned Parenthood Foundation findings showed that some staff members were initially incredulous and dismissive of women's stories, but this improved as training increased. Second, there were financial, structural and health-system issues. Programs such as the One-Stop Crisis Centre (OSCC), a stand-alone, hospital-based model, faced financial constraints. Other challenges included poor infrastructure, non-existent or poor documentation systems, lack of private examination and counselling rooms. Still, the authors found strong privacy policies: OSCC Malaysia colour coded or stamped registration files to protect confidentiality; Profamilia, Dominican Republic built sound-proofed rooms. Finally, the authors recommended that partnerships with other agencies and organizations expand opportunities for women to access both health and non-health services. OSCC provided a range of services, but only within an ER setting and other hospital units, with limited options for referral to specialist non-health services; the Venezuelan OCSS experienced difficulties following up on externally referred cases. In response, OCSS Malaysia partnered with local women's NGOs; Profamilia Dominican Republic strengthened off-site referrals and established partnerships with local NGOs to refer women to psychological support and shelter.

Garner and Maxwell results: These authors divided their findings between those studies conducted before the year 2000 and those conducted after the year 2000. Although they identified seven pre-2000 studies on coordinated responses, only three compared coordinated to uncoordinated jurisdictions, and there were methodological problems in all. First, Gamache et al. (1988) reported increased arrests, successful prosecutions, and sentences to treatment, but did

not articulate coordination measures or evidence for reduced violence. Steinman (1991) reported a decrease in repeat offenses following the implementation of the coordination policy, but the pre-policy cases were followed for 33.1 months while the post-policy ones were followed only for 14.7 months. While Orchowsky (1999) included a control group, the author did not compare how an arrest increase in the coordinated jurisdiction was associated with reduced offending in that same jurisdiction. Four other studies did not include an uncoordinated intervention as a control group (Babcock & Steiner, 1999; Murphy, Musser & Maton, 1998; Syers & Edleson, 1992; Tolman & Weisz, 1995).

Post- 2000 reports from five major jurisdictions have reported that community coordinated response programs are generally effective in reducing IPV, even though little systematic evidence supports this finding. According to Garner and Maxwell, many of these reports contain methodological flaws. Two reviews describe variation of coordination in demonstration sites, but do not compare coordinated and uncoordinated jurisdictions or show systematic comparisons of repeat offending (Burt et al., 2001; Edleson & Malik, 2008). Therefore only two studies provide a basis for assessing the effectiveness of coordinated responses. Visher et al. (2008) contains evaluations that provide some measures of coordination, report repeats offending, and compare coordinated with non-coordinated jurisdictions. Initial evidence from this study is not positive; it does not indicate a difference in the rates of IPV between coordinated and comparison jurisdictions. Still, Garner and Maxwell cautioned that these early results should not be generalized.

Recommendations

The New South Wales authors summarized their conclusion to the challenges facing integrated responses to IPV in four points. First, there is currently no one model or strategy on how to effectively achieve coordinated responses. Second, it remains a challenge to implement and maintain integrated strategies given the extra time and consensus building required. Third, there are clear advantages to bringing agencies together, especially given the limits of the criminal justice system in helping women and children. Finally, because there is not yet a singular model for an integrated system, those that have succeeded must continue their work.

Colombini and colleagues (2008) wrote that their review is limited because few programs have undergone a systematic evaluation. Nevertheless, available results show that many countries want to respond to IPV, and some key models of integration are being replicated in many settings. Multiple challenges exist at all levels and in all countries – from individual service provider attitudes and lack of knowledge, to managerial and health systems challenges. Complicating things further is that women may present at different entry points with a wide range of problems. It is vital that coherent and effective referrals be established with the health sector and through local partnerships. In addition, external structural and political stresses on IPV policy and laws are necessary. Overall, further research to understand the successes and operational lessons is required to facilitate scaled-up and improved quality of service in different settings.

Garner and Maxwell (2008) cautioned that although the initial evidence from two studies does not show a positive effect for coordinated intervention programs, these findings should be carefully examined for logical and empirical limitations. It is possible no positive effect was found because the programs did not work or the research designs were not rigorous. They concluded that these evaluations only represent the beginning of a 21st-century understanding of community-level interventions and the beginning of a new literature in the area. Now, “battled-hardened, evidence-based, cost-benefit assessments of coordinated responses” are required to move forward.

Summary Statement

Overall, findings from three narrative reviews indicate that there is no single model for multi-agency approaches to IPV. Challenges to integrated approaches include time and consensus building, although these approaches are beneficial in improving the response to women and children. One review (Colombini et al., 2008) included studies from non-OECD countries outside

of the scope of our review, although findings demonstrate global integrated responses to IPV being replicated in a variety of settings. One review (Garner & Maxwell, 2008) did not find a positive effect for coordinated programmes, although the authors note that evidence was limited and studies potentially weak.

8.4. Findings

Allen, 2005

A US-based cross-sectional study by Allen, 2005 [+] examined the elements of DV coordinating council climate and structure associated with perceived effectiveness in attaining objectives, across multiple settings. The study included 43 DV coordinating councils in one US state (out of a total of 44 existing councils). Councils ranged from 8-166 members, and 7 months to 16 years of establishment. Councils involved a range of 5- 17 stakeholder groups, and 3-14 active stakeholder groups. The focus of each DV coordinating council varied (e.g. public education, criminal justice), but overall were aimed at: improving practices and policies for institutional responses to DV, improving communication and cooperation between systems, and enhancing public awareness and responsiveness to DV. A total of 511 members of the 43 councils completed a mailed survey, and a one-hour telephone interview was held with key informants (most often the former/ present chair or leader of the council) from 41 out of the 43 councils.

Four components of council climate were evaluated, including: conflict resolution, presence of a shared mission, shared decision making, and efficient and inclusive leadership. Components of council structure that were assessed included the breadth of official and active (i.e. participating stakeholder groups) council membership, and the presence of formal structures (such as agenda, decision making processes, etc.). The authors hypothesized that councils would be perceived more effectively if they were inclusive, included a broader range of official and active members, and included more formal structures. Effectiveness was defined as participants' perceptions of the success of the councils in meeting intermediate (e.g. strengthening stakeholder relationships) and longer term goals (e.g. changing DV policy and practice). Councils varied in context and goals (e.g. healthcare, public education) and therefore it was not possible to examine single, comparable indicators of effectiveness across councils. Rather the author was interested in participants' views of council effectiveness.

The author, in consultation with two DV professionals, developed the measurement instruments. The survey included the following measures, each using a 6-point Likert style scale: conflict resolution scale, shared mission, power in decision making (including degree of inclusion of all members in decision making process), council leadership (to assess management skills), and council effectiveness (to measure perception of goal achievement). The key informant interview assessed: council membership (both total and active stakeholder group membership), council structure (18 yes/ no questions to assess presence of formal structures and processes), and council goals and accomplishments (including 12 areas associated typically needed to have a coordinated community response to DV).

They found that councils implemented an average of 7.34 of 18 noted formal structures. However, some structures were used by the majority of councils while others were less likely to be used, as follows: regular meetings (100%), meeting by agenda (97%), formal meeting minutes (92%), sub-committees (85%), written mission statement (76%), written goals (63%), formalized decision making protocol (34%), organizational chart (32%), written by-laws (29%), deadline accountability (15%), and member accountability procedures (5%). On average, responses to statements of council effectiveness were rated as "mostly true" for their councils (mean=4.35, SD=0.53). Generally, councils were viewed as less effective at achieving longer term goals (mean=4.27, SD=0.58) compared to intermediate goals (mean=4.50, SD=0.52; t=−4.46, df=40, $p<0.001$). In the final model, leadership ($p<0.003$) and the breadth of active membership ($p<0.001$) were both significant predictors of perceived council effectiveness, and shared power in decision-making

trended towards significance ($p<0.03$). Conflict resolution, breadth of formal membership, and degree to which councils had formal structures in place (e.g. agenda, established decision making processes) were not significantly related to perceived council effectiveness.

These findings reveal that councils were more likely to be rated as effective when they had efficient and inclusive leadership and a diverse breadth of active membership. Limitations of the study include: the potential for response bias (particularly in key informant interviews with council leaders), the potential for different partnership types to have different effectiveness, potential for masking of relationships due to the use of highly inter-related variables, lack of information on setting and context of the various councils, and cross-sectional design (limiting analysis to correlates of council effectiveness). While the study was conducted in the US, there are no specific applicability issues to the UK context.

Allen et al., 2008

A US-based qualitative study by Allen et al., 2008 [+] examined the proximal outcomes and activities of 41 DV coordinating councils within one state, using key informant data from the prior (2005 [+]) study. DV coordinating councils are a community response to DV, aimed at promoting systems change across multiple sectors (including criminal justice, health care, human services and the general public) by facilitating communication across stakeholders and developing joint action to respond to DV. Allen and co-authors were interested in what characterized the activities of councils and the outcomes that councils were established to achieve. They conducted a content analysis of semi-structured 90-minute telephone interviews with a key informant from each of 41 DV coordinating councils. Councils were a mean size of 39 members, and a mean length of existence of 64 months (ranging from 7- 192 months). Local shelter programs typically led councils. Council membership was comprised of: DV programs (100%), law enforcement (100%), prosecuting attorneys office (88%), batterer intervention programs (88%), district court (80%), health care organizations (78%), legal aid (60%), mental health services (59%), social service agencies (58%), child protective services (51%), religious organizations (46%), circuit court (42%), educational institutions (39%), local businesses (15%), and DV survivors (29%). Average yearly funding was $9,447. A total of 12 councils included paid staff. Key informants who participated in interviews were primarily the present or former council chair (56%) or coordinator (27%). Key informants represented the following types of organizations: DV shelter (56%), prosecuting attorney (20%), justice system victim advocates (7%), directors (7%), law enforcement (5%), probation officers (2%), and community organizations (2%). While they aimed to include key informants with a minimum of 1 year experience with the council, two participants did not meet this criteria.

Council demographic and descriptive information (including active and official stakeholder group members) was gathered and key informants were then engaged in an open-ended interview with questions related to: areas of systems change that were targeted by the councils (e.g., mandatory arrest policies, screening for DV), activities engaged in to address goals for change, and any evidence for achievement of outcomes/ goals. Following interviews, transcripts were analysed initially by one author who identified 25 key themes. All authors then engaged in coding themes into 11 categories, and used these categories to code the transcripts. Any coding discrepancies were resolved by group consensus. The final analysis resulted in a total of 6 themes related to primary activities that councils engaged in regularly and 3 themes related to outcomes.

Primary activities engaged in, included: discussing issues (85%), sharing information (51%), identifying weaknesses in the system's response (85%), facilitating training of key stakeholders in the community response (95%), engaging in community education (73%), and lobbying stakeholders who are not members (e.g. meeting with key stakeholder groups who were unwilling to participate directly on the council to provide education on emerging issues or encourage the implementation of a particular policy) (90%). Regarding outcomes, councils appeared to be effective at improving knowledge (81%), relationships (71%) and institutional change (93%). In regards to knowledge promotion, key informants indicated that members had improved

awareness of the roles of other members. For example, one respondent noted: "I feel like it's helped me understand more about their programme and why they're not doing all the things I thought they should do for our clients. I think part of that has been people are just really more aware of what the limitations of other agencies are." In regards to improving relationships, participants spoke about the dismantling of stereotypes and formation of new bonds between members. One key informant noted: "I can really call on elected officials, the police. They're approachable; they're not as defensive." Finally, institutionalized change involved the development of new procedures, protocols and policies. One respondent stated: "The amount of jail sentences, the amount of mandating to the batterers' group, the amount of probation…there is no comparison. We may have had one a year before this. Now every DV case is tried." However, the authors note that while it is difficult to tease out, councils were not always the key venue for these changes, but rather acted as ''backdrops'' for community change (61%). As one participant explained: "The exchanges and cooperation which occur on the council, [create] opportunities [and] have a synergistic effect, with each small improvement creating opportunities for greater [change] in our county."

Findings from this qualitative study suggest that councils were effective in 3 key areas of change: knowledge promotion, relationship building, and institutionalized change. Key limitations of the study include: the reliance on self-report and potential for reporting bias, and the collection of data from only one key informant per council. The authors also note that participants were asked to report on activities and outcomes for the entire 'life' of the council rather than within a specific timeframe, which may have impacted recall and reporting of information. Importantly, they did not investigate the achievement of the particular outcomes for each council, and in fact a prior study by the same lead authors revealed that councils were not uniformly effective in achieving goals (Allen, 2005 [+]). While the study was conducted in the US, there are no specific applicability issues to the UK context.

Banks et al., 2008a

A US-based before and after study by Banks et al., 2008a [+] examined the implementation of the Greenbook recommendations, a 'roadmap' for collaboration between child welfare and DV agencies to address co-occurring child maltreatment and DV, at six demonstration sites.

The Greenbook was developed in 1999 by the National Council of Juvenile and Family Court Judges (NCJFCJ). The US Department of Justice and the U.S. Department Health and Human then provided funding to support the implementation of Greenbook principles in 6 demonstration sites. The Greenbook includes guidelines and principles regarding: collaboration between child welfare systems and child dependency courts (which address child abuse and neglect) and DV service providers (e.g. shelter, family crisis, advocacy service providers); leadership to offer resources and services to support family safety; creating service plans and providing referrals with the goals of safety, stability, and well-being for all victims of family violence; and accountability of DV perpetrators. This study focused on the issue of co-occurring child maltreatment and adult DV and the activities within 6 demonstration sites to train staff, screen and respond to DV, to ensure victim safety and hold perpetrators of violence accountable.

In each site, a national evaluation team worked with local stakeholders and research partners to develop a data collection and sampling strategy, using a participatory framework. Quantitative data was collected; including surveys with service workers (who had ongoing contact with families) and case file reviews. Surveys were conducted at baseline (end of demonstration planning period in 2001) and at follow up (2003). One of the six sites did not complete the follow up survey due to issues with implementation. In four of the five remaining sites, all direct service workers completed surveys; this was not possible in one site due to it being a large urban area and therefore a random sample of service workers completed the survey. At baseline, 81 caseworker surveys were completed; at follow up, 135 caseworker surveys were completed. Case files were collected at baseline (n=616) and at 2- year (n=642) and 4-year (n=562) follow up. Qualitative data, including on-site interviews and implementation activity grids were also collected.

Surveys measured the effect of new policy and practice changes and collaboration on system policy and practice. Case files assessed the co-occurrence of DV with child maltreatment, how DV was identified, what confidentiality measures were taken and frequency of referrals provided to families with co-occurring issues. Data regarding screening and assessment practices were gathered for all files while data on confidentiality and service referrals were collected only for cases with co-occurring DV and child maltreatment. Surveys were developed by the evaluation team and local partners and included single-item indicators (no further details provided). Qualitative interview protocols were also developed collaboratively, and measured: perceptions of system change, and expected and observed outcomes related to the change. Interviews were conducted with 8-12 stakeholders at each site (total number not reported), including: child welfare agency leaders, board members, research partners, and agency staff. 8-12 stakeholders interviewed at each site. Implementation activity grids which included all collaborative activities were created by project directors and the evaluation team.

Survey responses regarding the statement “your agency works closely with DV service providers” increased significantly from baseline (66%) to follow-up (83%) ($p=0.005$). Agreement that agencies trained staff to understand, identify and respond to DV increased significantly between baseline (58%) and follow up (75%) ($p=0.007$). Training in DV for child welfare agency caseworkers was implemented in all sites. While all sites implemented screening tools for DV at intake, stakeholders noted that these were not routinely used. Staff who responded that their agency had written guidelines for reporting of DV to DV service providers increased significantly from baseline (68%) to follow-up (84%) ($p=0.008$). There was also a significant increase in agreement that their agency shares resources with DV service providers from baseline (55%) to follow-up (71%) ($p=0.027$). Stakeholders noted how the Greenbrook principles helped define and increase the value and role of co-located advocates. The response to the statement “your agency includes DV in case conferences” increased, although not significantly from baseline (56%) to follow-up (68%). While three of the sites implemented a multidisciplinary case review team, stakeholders noted constraints in understanding differing institutional policies, particularly in regards to confidentiality issues. In regards to case files, there was a significant increase in referrals for DV from Time 1 to Time 3 (35% to 65%; $\chi2=19.770$, $df=1$, $p=0.000$); the authors note that there was large variability between sites in baseline and follow-up values. There was also a significant increase in batterer referrals from 29% at Time 1 to 45% at Time 2 ($\chi2=7.550$, $df=1$, $p=0.006$) and 53% at Time 3 ($\chi2=13.228$, $df=1$, $p=0.000$).

Overall, findings suggest that the demonstration sites showed changes in a number of practices and policies, including: training of staff to identify, understand and respond to DV; the presence of written guidelines for reporting DV; and sharing resources with DV agencies. However, data also reveals tensions in multidisciplinary case review teams due to differing policies and handling of case information, although the authors note that cross-trainings were implemented to address these issues. Key limitations of the study include: the low response rate to the caseworker survey (overall=37%), variations between sites, and that agencies were at varying stages of implementation during data collection and follow-up. This study evaluates the implementation of a specific set of principles for collaboration between child welfare and DV agencies to address co-occurring child maltreatment and DV in the US, and therefore may not be applicable to other settings.

Banks et al., 2008b

A US-based before and after and qualitative study by Banks et al., 2008b [+] examined collaborative efforts to improve system responses to families who are experiencing child maltreatment and DV. This study reported on the evaluation of the Greenbook initiative that dispersed federal funding to six communities in the USA with the goal of improving collaboration between agencies. The six communities were a diverse group, varying in population, culture, and geography. Some of the sites were racially homogeneous, and others were ethnically and culturally diverse. The organizations ranged in size: 30% 1-20, 16% 21-100, 45% 100+.

The Greenbook initiative was based on the1999 report from the National Council of Juvenile and Family Court Judges entitled Effective Intervention in DV and Child Maltreatment Cases: Guidelines for Policy and Practice, which provided a collaborative roadmap for child welfare systems, dependency courts, and DV service providers (DVSPs) with the principles of promoting safety and well-being for all victims of family violence, holding batterers accountable, and structuring responses to families that are dealing with the co-occurrence of DV and child maltreatment. The Greenbook project emphasized a collaborative foundation led by child protective services agencies, DVSPs, dependency courts, and community members.

The study utilized both qualitative and quantitative methods, with a survey and interviews. A sample of 86 participants stakeholders was surveyed at baseline and 62 at follow-up (10-20 stakeholders completed the survey in each demonstration site at each administration) (8-12 stakeholders from each of the 6 demonstration sites). The qualitative aspect of the study involved interviewing a smaller sample of key informants annually for 6 years (8-12 stakeholders from each of the 6 demonstration sites), and completing a survey. Thematic coding was used, apparently based on pre-established categories. These interviews took place during site visits and emphasized various aspects of the collaborative process: the first site visit focused on engaging partners and establishing the collaborative body; midway through the project the interviews focused on the transition from planning to implementation; and the interviews conducted toward the end focused on the impact of the collaborative work and the shift to sustainability activities. All site visit interviews addressed the facilitators and obstacles critical to the collaborative work. There were several themes investigated in the qualitative interviews each year. The quantitative aspect of the study included ratings of facilitators and obstacles to collaborative work.

The qualitative aspect of the study reported on several themes: institutional empathy involved understanding the context of how other systems operate, and setting realistic expectations for systems change in the various partner organizations. Stakeholders reported that they would have benefited from a better understanding of how each system worked early in the demonstration period. This understanding at the planning stage would have helped them to realistically plan and implement policy and practice change in those systems. Power issues were ongoing obstacles in all the demonstration sites. Effective leadership was another key theme. One stakeholder noted that leaders should also know “who the champions of the initiative are” within each system and should use them effectively." (p. 895). Reaching out to the community was a fourth key theme. One stakeholder remarked that the collaboration sometimes “got ahead of the community” and that the initiative should be “driven by the community, not the other way around.” (p. 895). Finally, needs assessment, particularly logic model and safety audits was helpful. Stakeholders noted that “the logic model process engaged the entire...committee in one direction” and “was huge in helping them to get more focused and move forward.” (p. 896). "Most stakeholders reported during in person interviews that the maintenance of collaborative relationships was the most important part of the work and required the most attention." (p. 894).

Collaborative relationships were useful and effective, particularly for the families with co-occurring DV and child maltreatment or child exposure to DV in that they created benefits such as the minimization of duplication of efforts, effectively identified and provided appropriate services, minimized blaming of non-offending parents, held batterers accountable and advocated for all family members. However, such collaborative approaches are challenging, because of the different historical and organizational characteristics of child and adult victim–serving agencies. The creation of specialized positions such as DV advocates co-located in child welfare agency offices that helped bridge the gap between systems and directly address the relationship between child welfare agencies and DVSPs helped facilitate these differences; however, this aspect of the collaborative work required constant attention over the course of the initiative. The sites also benefited from having a small group of staff responsible for the overall guidance and direction of the initiative to ensure that the collaboration kept on track with its overall goals. Stakeholders reported that needs assessments and analyses, including incorporating the perspective of family

violence victims, were critical to setting priorities for the initiative and keeping goals and objectives prominent throughout the demonstration period. Planning and systems change implementation activities formed the backbone of the initiative collaborative efforts in the Greenbook demonstration sites.

Participants were asked to rate the degree of impact of obstacles and facilitators on their collaboration, using a scaled response (1=not at all, 5=very much). At baseline, the top five obstacles were: “taking longer than expected” (mean=3.476), “existence/ accessibility of data” (mean=3.325), “lack of time by participants” (mean=3.301), “conflicting organizational cultures” (mean=3.274), and “poor understanding of Greenbook Initiative” (mean=3.083). Over time, stakeholders were significantly less likely to agree that existence/ and accessibility of data was an obstacle: (baseline mean=3.325 SD=1.220, follow-up mean=2.871 SD=1.079, t (140)=2.312,p=0.022). Stakeholders were significantly more likely to agree that the following were obstacles at follow-up: lack of resources (t (143)=–3.133 baseline mean=3.012 SD=1.293, follow-up mean=3.654 SD=1.073, p=0.002); burnout of participants (t (143)=–4.258 baseline mean=2.349 SD=1.109, follow-up mean=3.177 SD=1.222, p=0.000); conflicting organizational cultures (t (144)=–2.086 baseline mean=3.274 SD=1.186, follow-up mean=3.677 SD=1.113, p=0.039); lack of leadership buy-in (t (143)=–1.946 baseline mean=2.167 SD=1.051, follow-up mean=2.525 SD=1.149, p=0.054); and lack of accountability (t(116)=–2.505 baseline mean=2.134 SD=1.075, follow-up mean=2.645 SD=1.307, p=0.014).

At baseline, the top five facilitators of collaborative work as rated by survey respondents were (1=not at all, 5=very much): “the partners have the needs of the women and children in mind” (mean=4.167), “involvement of certain key agencies/ groups” (mean=4.155), “having the right people at the table” (mean=4.071), “strong leadership” (mean=4.024), and “commitment of key leaders (mean=3.988). Only one facilitator, “involvement of certain key agencies/ groups”, changed significantly from baseline to follow-up, with respondents becoming significantly less likely to think of it as a facilitator (baseline mean=4.155 SD=0.814, follow-up mean=3.836, SD=0.969, p=0.033).

Findings reveal a number of facilitators to the collaboration, with stakeholders revealing that the partnership required ongoing attention and commitment. The authors also report several obstacles to collaboration at follow up, including: resources, leadership, human resource issues, and conflicting organizational cultures between partners. Weaknesses of this study include: inconsistencies in the timing of data collection, low response to the survey and lack of information on the number of interviews conducted. This study evaluates the implementation of a specific set of principles for collaboration between child welfare and DV agencies to address co-occurring child maltreatment and DV in the US, and therefore may not be applicable to other settings.

Bennett and O'Brien, 2010

A US-based before and after study by Bennett & O’Brien, 2010 [+] examined whether or not different sources of referral to a demonstration project were associated with different outcomes of services. The demonstration project examined integrated and coordinated services for women seeking assistance with IPV or substance use.

The study included a non-random sample of 255 women seeking resources or services for IPV from pilot agencies. Baseline and follow-up assessments were completed by 128 women (50% of the larger sample), which inform the analysis. They refer to the different sources of referral to the demonstration project as different “doors” to services. The number of participants for each door is as follows: IPV door, 32 women (25%); substance abuse door, 53 women (41%), and integrated substance abuse/ IPV door, 43 women (34%). Of the women who participated, 57% were abstinent at baseline, and 52.1% were acute victims of IPV at the time they were seeking services. The mean age was 35.21; the majority of women were European (42%), followed by African American (38%); the mean number of years of education was 11.92; 17% were employed full-time; and the majority were living independently or with someone else (71%).

The demonstration project was established by two state agencies in 2001 to evaluate integrated services for IPV and substance use. These state bodies selected agencies based on geographic location in the state and diversity of clients served. Four agencies were included: an integrated DV/ substance abuse agency serving suburban and urban women; a coordinated set of agencies serving primarily urban and Latina women; an integrated upstate agency serving a mix of urban and rural women; and a downstate coordinated set of agencies serving primarily rural women. In all four settings, the services offered were either substance abuse- oriented (assessment, 12-step groups, outpatient treatment, individual and group counselling, etc.) or DV- oriented (crisis response, shelter, psycho-education, advocacy, case management, counselling, etc). All clients were screened for IPV and substance use at the participating agencies. In the coordinated model the DV and substance use agency collaborated to offer services to a mutual client. Counsellors facilitated screening of women for IPV for women entering substance use treatment, and screening for substance use for women entering IPV programs. Staff members interviewed women at baseline and researchers at 4- and 6- months follow up. Women included in the analysis (n=128) had less fear related to battering, higher levels of DV self-efficacy, and fewer days using substances in the past month than women who were unavailable for follow-up (data not provided).

The following outcome measures were used: type of door to service, substance use days (SUD) in the past month, acuity of violence (in the past 12 months), chronic experiences of battering associated with IPV measured by The Women's Experience of Battering (WEB) scale, self-confidence in managing abuse measured by The DV Self-Efficacy (DVSE) index. Participants also provided information on age, ethnicity, education, employment, living situation, history of psychiatric treatment, arrest history, number of children living with them, probation or parole status, and child protection service status.

Women using the three service doors differed at baseline, ($F(2, 123)=6.89$, $p<0.001$), in experience of battering, but not in WEB measures at follow-up. Similarly, the three groups differed in DVSE at baseline, ($F(2,127)=3.90$, $p<0.05$) but not at follow-up. At baseline, women in the IPV door had significantly lower DVSE (M=25.79, SD=7.11) than women coming through either the SA door (M=29.31, SD=6.90) or the integrated IPV/ SA door (M=29.77, SD=5.94). Past month SUD also differed by service door at baseline ($F(2, 128)=4.80$, $p<0.01$); women entering the IPV door used substances significantly more often at baseline (M=8.94 days, SD=11.23) than women entering either the SA door (M=4.21, SD=8.28) or the SA/ IPV integrated door (M=2.81, SD=7.27). Differences in SUD by door were non-significant at follow-up. With analysis of covariance (ANCOVA), they found no difference in WEB by abstinence at baseline or follow-up, suggesting that the women's experience of battering was independent of abstinence status. Women who had experienced IPV in the past year had higher baseline scores for DVSE (M=27.39, SD=7.7) than women who were abused further in the past (M=30.23, SD=5.87), but there was no significance after controlling for probation or parole status. They found no baseline differences in WEB and SUD by acuity of IPV, and no significant differences at follow up after controlling for baseline values of probation or parole status.

The authors conclude that time since episode of IPV prior to programme admission was not a significant factor for outcomes measured. They also suggest that finding no relationship between acuity of violence and IPV or SA outcomes supports the inclusion of trauma-informed models for working with women in these settings. Limitations of this study include: the lack of comparison group, use of a small sample size, reliance on self-reports and high attrition rate. Finally, because there was a lack of detail provided on the variable services offered within each site, it is difficult to translate these findings to other contexts.

Coll et al., 2010

A US-based before and after study by Coll et al., 2010 [+] examined the effectiveness of a collaborative approach to services for parents involved in the legal system due to DV and child

protection issues. The study included a sample of 53 court-referred families who experienced family violence. This included 92 adult programme participants; however, only 48 or fewer participants completed both pre- and post- test measures. The majority of families were referred to the programme due to concerns of DV and that children were at risk of maltreatment (75%); while fewer (25%) were referred due to substantiated reports of DV and child maltreatment. Participants were primarily: White (90%); high school (30%) or college (32%) educated; employed (62%); earning less than $24, 060 (73%); and had an average of 2 children. The majority of participants had a history of past DV (68%), had a criminal record (77%), had reported DV in their past (90%), and reported substance abuse/ dependence at intake (76%). Some participants had past involvement with child protection (44%), reported mental health problems (35%), and reported being a victim of childhood abuse (33%).

The goal of the intervention was to build collaborative relationships among child protection workers, service providers and courts. A case coordinator works with families to support them throughout the court system process, to coordinate treatment services and provide financial support for court-ordered services. The case coordinator completed client intake, pre- and post-test administration, case management and coordination, monitoring treatment progress and completion, maintaining contact with families, facilitating multidisciplinary team (MDT) meetings with providers and community members, assisting in the development of treatment plans, developing policies and procedures for the programme, developing information sharing agreements, performing research and evaluation functions, and following up with families on evaluation activities. The case coordinator provided treatment and/ or service recommendations to improve family functioning and parent and child safety (e.g. parent education, evaluations for DV and substance use), and based on these recommendations the family court ordered evaluations (DV, substance use, mental health, child at risk, etc.). Participants completed the evaluations, and then case coordinators worked with a treatment planning team (that included the family, family court services, staff from the Department of Health and Welfare, county probation, and advocates involved in the case) to construct a comprehensive treatment plan for the family.

Family functioning was measured using the Intimacy, Conflict, and Parenting—Family Functioning Scale (ICPS-FFS), a 30-item client self-report tool with items measured on a six-point agreement scale. Family functioning and child well-being was also measured using the North Carolina Family Assessment Scale (NCFAS) measured, which includes five domains: environment, social support, family/ caregiver characteristics, family interactions, and child well-being. Spousal assault was measured using the Spousal Assault Risk Assessment (SARA), a 10-item clinical checklist of risk factors which rates risk of partner violence as low, low to moderate, moderate, moderate to high, or high. Finally parental conflict was measured using The Garrity and Baris Parental Conflict Scale (G&B-PCS) which records conflict as minimal, mild, moderate, moderately severe, or severe conflict. These measures were conducted at pre- and post-intervention (approximately 6 months to one year following participation).

Results from the ICPS-FFS indicate that participants noticeably gained in all three areas of family functioning measured (all p's<0.0001): intimacy (mean pre-score=37.5, post=60.8), conflict (mean pre-score=39.7, post=24.9; reduction in score indicates less conflict), and parenting (mean pre-score=25.8, post=38.8). Results from the NCFAS indicate that all areas (environment, parent capabilities, family interactions, family safety, child well-being) as viewed by the clinician improved significantly (all p’s<0.001). For the SARA, both total scores and critical (imminent danger) scores significantly decreased (by an average of 7.3 points and 2.6 points, respectively; p’s<0.0001). G&B-PCS results indicate significant gains for the participant group in moving from severe or moderately severe parental conflict to moderate, mild, or minimal conflict.

Overall finding suggest that having a single case coordinator who collaborated across service providers was effective with court-referred clients and their families for increasing family intimacy and child well-being and decreasing family conflict. Limitations of the study include the lack of a comparison group and high proportion of non-completers (an analysis of pre- test scores

suggested that non-completers may have been at greater risk than completers). These limitations may limit generalisability.

Donovan et al., 2010

A UK based qualitative study [+] provides an evaluation of two multi-agency partnerships for victims of DV: one in an urban location (called the Gateshead Project) and one in a rural location (Cumbria Project). Both projects were aimed at providing holistic, early intervention and specialist services to victims of DV, children and perpetrators, through early intervention at crisis. New services were created in each setting that acted as the core to facilitate multi-agency working with eleven other partner agencies. The service in Gateshead was developed within an existing one, "Safer Families," and police were the only source of referral. The project in Cumbria was piloted with 'Letgo' as the new service, and police were the primary but not only source of referral.

In each site, the eleven partner agencies covered four areas: civil and criminal justice systems, child protection/ welfare, health and housing. These partner agencies agreed to create and implement strategies targeting one or more of the three services provided by Safer Families or Letgo for victims, their children and/ or perpetrators. Foundational strategies that were implemented by partner agencies included: training of agency staff, protocol development for information sharing, development of risk assessment tools, DV awareness raising, and development of DV guidelines. Examples of strategies implemented to support the project included: hiring additional DV staff, provision of housing, development and running of programs for victims, their children or perpetrators, development of additional services or extension of existing services, and systems to flag or monitor DV cases.

Both sites offered tailored, individual support for victims, individual and group work for children and voluntary perpetrator programmes. Independent Domestic Violence Advisors (IDVAs) conducted a risk assessment, provided safety planning and conducted an assessment of need, and if necessary referrals to appropriate partner agencies for which they would act as an advocate. IDVAs also offered emotional and practical support and completed regular reviews of victim risk. Type and frequency of contact varied and was dependent on the particular needs of victims.

For the process evaluation of multi-agency working, interviews were held every six months with senior management and frontline practitioners in partner agencies for the first 3 years of the project (January 2006- December 2008). In addition, minutes from strategic and operational meetings were collected and analysed. Frontline staff members were asked about multi-agency work, working relationships, the impact of the project on multi working multi-agency relationships, hopes and fears for the project, impact of rurality on DV and services, awareness of agency's role in the project, challenges and solutions, and new developments. Senior management were asked about the progress of the project, involvement of senior management of partner agencies, future sustainability, and lessons learned. In Cumbria (Letgo), 55 interviews were held with senior management and 52 with frontline staff. As well, 21 partnership meetings and 5 steering group meetings were observed. In Gateshead (Safer Families), 98 interviews were held with senior management and 72 with frontline staff. In addition, 15 partnership meetings and 16 steering group meetings were observed.

The evaluation revealed that the Cumbria project developed more effective multi-agency working relationships than the Gateshead project. Both developmental factors and operational phase factors were identified. They note that a robust developmental or lead-in phase is crucial to the effectiveness of multi-agency work during the operational phase. The Cumbria project had in place several developmental factors, meaning that when the project started there were fewer operational issues. These developmental factors include: the strength of multi-agency working relationships; strength of DV infrastructure; processes for development, management, and monitoring of the new initiative; and the size and scope of the new initiative. In regards to multi-agency working relationships, the Cumbria project had a history of positive multi-agency working

across the county. Some participants believed that rurality was associated with stronger partnership working due and the presence of a more stable workforce. In addition, in the Cumbria case, Letgo was a new service with entirely new staff and manager. In contrast, Gateshead was located in the pre-existing Safer Families, and there were relationship tensions that presented challenges for the new service, including differences in approaches to DV and the individual styles of key individuals. In terms of infrastructure, Gateshead experienced the loss of its Chair after the bid, then replaced by a Chair who left on long-term leave. The lack of continuity weakened the partnership and structures of accountability. In regards to processes for the development of the project, in Gateshead the bid was led by a small group of partners and based on the existing holistic model of Safer Families, resulting in a lack of shared ownership and engagement, with some partner agencies feeling left out of the process. In contrast, in Cumbria, the bid was submitted by a Strategic Management Board (SMB) including a strong and consistent Chair who facilitated a sense of shared ownership by partner agencies, strong buy in from senior management, and clear communication on the shared impact of targets for partner agencies. In both Cumbria and Gateshead, a housing association became the non-statutory lead agency of each project. Regarding processes for management of the project, in the Cumbria project there was a strong management relationship with the lead housing agency. When (unfounded) concerns were raised that the housing association (which at the time was facing financial difficulties) might use project funding, strong communication, lines of accountability and management within the project resulted in these concerns being quickly addressed. In contrast, in Gateshead, there were tensions between Safer Families and the housing association due to unclear lines of management and accountability between the agencies. Exit interviews for Gateshead also revealed that rather than the recruitment of a large new staff at one time as occurred; incremental recruitment with a lead-in period may have resulted in a stronger team, and allayed some of the issues encountered with developing protocols within the service and between partner agencies. The challenge common to both projects was processes for monitoring the new initiative (to evaluate fulfilment of aims and objectives and gaps in provision) across partner agencies, which continued to be a challenge during the operational phase. In particular, there was inconsistent monitoring (of DV data to support service evaluation) by partner agencies that was not effectively addressed. A final developmental factor reported was taking account of the scope/ size of the new initiative. The Cumbria project was a relatively small pilot project, with fewer cases of reported DV in the area and a small number of practitioners to inform about the project, improving the potential to develop strong working relationships. In contrast, the Gateshead project was in a large urban area with a relatively high level of reported DV, creating challenges in capacity and communication between agencies that were not planned for. Interviews with senior management indicated the need for a longer developmental phase to build relationships and protocols.

In addition to these developmental factors, the evaluation revealed several operational factors associated with the success of partnership work. Issues of power, communication and resources were encountered in each project. The Gateshead project, due partly to size, faced communication issues with partner agencies related to the aims of the project and the role of partner agencies. For example, housing support workers reported a lack of information sharing. Regarding power, practitioners in both sites encountered challenges to credibility in the beginning by police and were viewed as a threat to voluntary sector agencies. Both projects also faced difficulties in securing senior management representatives from health and children's services. Gateshead faced greater power issues including those related to shared ownership, clarity of management and accountability, and inclusive working relationships. Finally, while both projects were well financed they did encounter resource issues related to recruitment and staffing. In particular, staff turnover and absences of key members were identified as concerns. While these operational issues (communication, power, resources) were identified in both sites, the Cumbria project was more apt to deal with these issues due to the stronger developmental factors previously described.

Findings reveal that developmental factors including: the strength of multi-agency working relationships; strength of DV infrastructure; processes for development, management, and

monitoring of the new initiative; and the size and scope of the new initiative, and operational factors including: communication, power and resources impacted the relatively greater strength of multi-agency partnership working in the Cumbria site compared to the Gateshead site. Limitations of the study include limited information on methods, coding and analysis of data. The study was conducted in the UK, and therefore should be directly applicable.

Ernst and Smith, 2012

A US-based before and after study by Ernst & Smith, 2012 [+] examined two different staffing approaches to risk assessment following abuse allegations for seniors 65+ in adult protection services. The study took advantage of a natural experiment in two counties in Maryland, USA. The object was to determine the effect of utilizing a social worker and registered nurse duo (team case management) to do risk assessment of seniors in adult protection compared to a single social worker (standard model). Eighteen months of reported cases were examined using administrative data (n=869) by doing case assessments for physical abuse, neglect and self-neglect, exploitation, and risk in the physical and social environments. The sample was drawn from two counties in Maryland, USA and was comprised of 64.1% women and 35.9% men. The mean age was 80.5 years old. 77.3% were Caucasian and 22.7% African American.

Outcomes were recorded in three categories: none to low risk, medium risk, and high risk. Risk was calculated by subtracting case closing scores from the initial scores at first assessment. Specifically, the approaches were compared as to disposition of cases, risk reduction and recidivism (subsequent reports of maltreatment).

In measures of case disposition, the lone social worker (standard model) was significantly more likely to confirm financial exploitation, physical abuse, and neglect by others. However, the team approach resulted in significantly greater risk reduction in every category but exploitation ($p>0.05$). The team approach significantly reduced physical abuse by mean difference of 0.48 ($t=3.813$, $df=41$,$p <0.001$), neglect by 0.38 ($t=7.177$, $df=818$, $p<0.001$), social environment by 0.19 ($t=2.390$, $df=484$, $p=0.017$), and physical environment by 0.32 ($t=3.908$, $df=721$, $p< 0.001$). There were no significant differences in case recidivism, self-neglect or cost savings.

Findings suggest that the standard model was significantly more likely to confirm financial exploitation, physical abuse, and neglect by others, while team approach resulted in significantly greater risk reduction; however, there were no significant differences in recidivism. However, the results must be interpreted in the context of different socioeconomic levels in the two counties that could affect the results regarding financial exploitation. Secondly, differences in disciplinary training could affect the focus of attention of the nurses compared to the social workers, thereby changing the nature of the identified issues in the team model. Key limitations of this study include: limited information on the experiences of workers, and differences in initial risk scores between counties. They also note that Hispanic cases were excluded from the analysis to enhance the comparability of the jurisdictions. However, this focus on primarily White/ Caucasian and a minority of African American cases may impact the generalisability of findings to diverse populations.

Giacomazzi and Smithey, 2001

A US based qualitative study by Giacomazzi and Smithey, 2001 [+] examines a multi-agency collaboration including a large municipal police department and other service providers in addressing DV against women. The police department received funding to develop the Domestic Violence Prevention Commission to generate an approach to reduce family violence in the community. This was a multi-level collaborative public-private partnership between the police and 88 organizations, including: city, district and county attorney's offices; adult and juvenile probation and parole offices; military; school district; judges; municipal, county, and state legal aid; battered women's shelter; YMCA; transitional living centre; clergy; and volunteer services.

Focus groups and archival research was conducted by study authors to assess interagency work and the extent of the collaboration. Questions addressed: mission, process of collaboration, barriers, and reasons for their agency's involvement in the Commission. The authors reviewed meeting notes and documents for data on meeting content, attendance, and agency participation. Two focus groups were held at the end of the planning phase (Phase 1). A random sample of 19 agencies was originally invited; 14 individuals initially agreed to participate; yet 11 actually participated. Of the 11 participants, 7 were women and 4 men; their roles were as follows: 2 probation officers, 1 policeman, 1 private security officer, 2 non-profit advocates, 2 human services, 1 educator, 1 court administrator, 1 military, and 1 legal aid. An additional two focus groups were held one year following implementation (Phase 2). A total of 18 agencies were randomly selected and all 18 members participated. Of the participants, 15 were women and 3 men; and their roles were as follows: 4 court staff, 4 law enforcement, 4 private social services, 1 educator, 3 public non-profit social services, and 2 private sector.

The planning phase included 22 meetings with an average of 36 attendees. Four community forums were also held to gather resident input on family violence interventions. Commission members ultimately generated final recommendations (marking the end of Phase 1), including: prevention through public awareness, specialized DV response team, enforcement of DV cases, victim's assistance, programs for offenders and funding. Phase 2 involved the prioritization of recommendations and development of 10 subcommittees (e.g. human services, law enforcement, judicial, etc.), and 8 meetings were held with an average attendance of 30 individuals. A Domestic Violence Prevention Coordination unit was developed to help implement recommendations developed by the commission. At the time the article was published, they had begun to investigate the efficacy of police officer family violence training.

Despite the appearance of collaboration, several issues emerged during focus groups, which threatened to disrupt the collaborative inter-agency work. One issue that emerged was self interest as a motivation for participation or 'turfism.' This was reported by focus group participants to be a major issue during phase 2 of the work, and was a significant barrier to collaboration. As one participant stated: "turfness is almost palpable. It is entrenched...the agencies are still only cordial, with all clutching to their territory." Leadership and dominance were also cited as significant barriers to collaboration: some participants described marginalization of non-law enforcement members. Particularly during the planning phase, respondents expressed concerns about the police department as the founders and leaders of the commission, noting a favouring of police responses rather than preventive activities. One participant explained: "no one here is really looking at prevention, just punishment". Other participants noted that a proposed police checklist that was recommended was never implemented due to police resistance. Another barrier was organizational ambiguity leading to unclear expectations. Participants described how there was a waning interest by them and other members in the activities of the Commission during phase 2, along with a lack of organization and unclear expectations of members. One focus group participant explained: "during Phase 1 you knew what was expected and the dates of the meetings...this is not the case in Phase 2." Finally, focus group participants noted an absence of key players in the implementation phase; one participant commented, "Top-level involvement by key agencies seems to be missing from the Commission."

Examination of this Domestic Violence Prevention Commission reveals significant barriers to a meaningful collaborative process, including: territoriality, leadership and dominance by the police department, organizational ambiguity, and inconsistent involvement of key team members. Limitations of this study include: limited information on methods and analysis, and small sample size. Including only focus groups, and not individual interviews, may have biased findings, as the views of some individuals may not be accurately captured (e.g. participants with divergent perspectives may be less likely to express their views). Due to the qualitative nature of the study, findings may not be generalisable, although may be applicable to similar contexts where police agencies are engaging in collaborative DV work.

Laing et al., 2012

An Australian qualitative study by Laing et al., 2012 [+] describe an action research project that was aimed at identifying the factors and benefits associated with enhanced collaboration for women who experience both DV and mental health issues. A working group met monthly for 12 months to generate ideas to improve collaboration between DV and mental health service sectors. The working group included: workers from shelters and community based outreach services (e.g. social workers, psychologists, community workers), and mental health providers from inpatient, crisis and outpatient teams (e.g. nurses, occupational therapist, social workers).

Participants had been invited to join the working group after participating in a previous focus group, which explored barriers to and potential for cross-sector collaboration. The working group included: 9 mental health workers and 7 DV workers at Time 1 (6 months or halfway through the project) and 6 mental health and 5 DV workers at Time 2 (12 months). The working group met monthly and using action research principles engaged in a process of: generation of initiatives, reflecting on and evaluating outcomes, and refining outcomes. Working group participants began by discussing how to address barriers that were identified during the focus groups (held prior to the working group). Priorities identified included: enhancing communication and development of a service agreement. Communication was improved by knowledge and skill sharing through joint training seminars. At monthly meetings, members reviewed joint cases highlighting practices that required attention in order to improve collaboration. Mental health practitioners reported changes in their practice that could benefit women experiencing DV, including: awareness of DV issues and knowledge of DV and the working group developed a formal service agreement between the mental health service and three DV services and lobbied for funding for a DV-MH outreach specialist.

Data collection was conducted over a 12 month period, and included the following data from the monthly working group meetings: reflective memos; records of action research meetings and actions; training programme agendas, attendance; documents developed; and case studies of client impact. Brief telephone interviews were held with 27 participants by research team members who were not conducting the research group. Interviews were coded and analysed for themes.

Several aspects that facilitated collaboration were identified. One was commitment that builds trust and having a shared sense of purpose. One participant reported: "the commitment from management has made it a lot easier... without his commitment it would have been quite hard to work well with the mental health sector," and another reported: "...we’re not the only ones here interested in this, they’re just as interested as we are.’ And then we started to work together a lot better." A second key factor to collaboration was the importance of relationship building. One interviewee explained: "it breaks down that view of seeing the mental health sector as an immovable system that goes against what we are trying to do. It certainly makes joint work a lot more possible." Developing "institutional empathy" was identified as a third key factor for successful collaboration. One respondent explained: "all services have respect for what the other services are trying to do but understanding if they cannot offer help, then we are learning to accept that and not blaming the other service." A final key factor to collaboration was fair leadership and neutrality by the research team. One of the participants reported: "The University [research team leading this action research project] has appeared to take a neutral stand point as to who was doing it wrong or right before the collaboration work, so their input has helped an enormous lot in the project’s success."

Findings provide support for the use of an action research project to facilitate collaboration between mental health and DV service sectors. Several key factors supported this collaboration including: commitment and a shared sense of purpose, relationship building, developing ‘institutional empathy,’ and fair leadership and neutrality by the research team who led the action research project. Limitations of the study include: limited information on participants, and limited information on data collection process and analysis. The study was conducted in an urban centre

(Sydney) in Australia among mental health and DV workers and therefore may be applicable to similar contexts, although the small, qualitative nature of analysis may limit generalisability.

Penhale et al., 2007

A UK-based cross-sectional and qualitative study by Penhale et al., 2007 [+] examined the extent and process of partnership working in adult protection, including the strengths, barriers and disadvantages of using a multi-agency approach. In 2000, the Department of Health issued No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse, and the National Assembly for Wales issued In Safe Hands: Implementing adult protection procedures in Wales (a similar document also focusing on adult protection). Note that “adult protection” encompasses a broad range of victims and types of abuse, focusing on vulnerable adults (e.g. those with disabilities, elders, etc.) and guidance was not specific to DV. Local authority social services departments were responsible for coordinating multi-agency responses to adult protection at the local level, though they did not receive additional funds to support implementation. The main components of this multi-agency approach were: development of an inter-agency framework; a multi-agency management committee (or adult protection committee); a clear definition of the roles and responsibilities of each agency; developing an inter-agency policy with policies and principles; implementation of procedures for receiving and responding to referrals related to adult protection; joint protocols for information sharing; contract monitoring for independent providers; implementation of systems to monitor the effectiveness of adult protection work; adult protection training strategies for relevant staff groups.

This evaluation involved three phases. In the first phase, they sent questionnaires to all 172 Councils with Social Services Responsibilities (CSSRs) in England and Wales, to inquire about the structure and functions of the adult protection arrangements in each CSSR, along with respondents' perceptions of the partnerships. Phase two involved: face-to-face interviews with senior and middle management and operational level social services staff. Focus group discussions were also conducted with members of the multi-agency adult protection committees (APCs), using an adapted version of the partnership assessment tool (PAT), to assess the ‘health’ of multi-organizational partnerships. Interviews were recorded, and transcribed for analysis. Finally, in the third phase semi-structured interviews and focus groups were held with service users, relatives and care-givers, along with representatives from service user groups and support organizations.

While the questionnaire was sent to all 172 CSSRs in phase one, the final analytic sample was 133 CSSRs (60% of surveys were completed by adult protection coordinators, 39% by a manager with adult protection responsibility, and one respondent did not indicate their role). In the second phase, a purposive sample of 26 local authorities was selected, representing a range of geography, local authority type, affluence/ deprivation status, assessed performance and history of adult protection working. From this sample, 32 senior social services managers were interviewed. A purposive sample of social service workers was also chosen to represent a range of practice teams working with adults (older adults, learning disabilities, mental health, physical disabilities, and hospital-based social workers). Finally, a focus group was conducted in each of the 26 sampled local authorities, including 271 participants, all members of the local APC. The authors report that a total of 260 interviews were completed in phase two, though it is not clear what the specific numbers are for the remaining interviewee groups (which included adult protection coordinators, training staff, policy managers, and legal officers). In the third phase, 22 interviews and 19 focus groups were conducted in 16 areas (most of which differed from the areas sampled in phase two) with a snowball sample of service users, care-givers and relatives, and representatives from service user groups and support organizations. This sample was intended to represent a variety of "vulnerable adults" and their supporters. Descriptive statistics were conducted for quantitative questions for the phase one questionnaire, and thematic analysis was conducted for open-ended questions. Interviews and focus groups conducted in phases two and three were qualitatively analysed using Nvivo and a framework analysis approach.

The benefits of partnership working reported included: information sharing; sharing of skills, knowledge, and expertise; shared decision-making, ownership and responsibility amongst agencies, specifically when developing joint procedures and strategies; and co-ordination of responses (reducing the duplication of work) and integration of different agency perspectives. Barriers included: some lack of commitment to partnership working; agencies not providing the needed resources (financial or human resources) and the lack of joint-funding arrangements; lack of clarity regarding the roles and responsibilities of agencies; insufficient information sharing; differences in priorities related to adult protection between agencies; and stalled decision making at both strategic and operational levels, often linked to differing priorities between agencies. Data from the PAT questionnaire revealed a nearly unanimous perception that partnership working approach facilitated the generation of new ideas; encouraged better policy making; improved credibility to policy; and facilitated the implementation of policy and bringing networks together. In contrast, respondents were generally divided on: whether partnership approaches created unrealistic expectations among partners; benefited the providers rather than the consumers of services; could develop an established way of conducting business and bestows status on partners who are not reflective of their constituency. Findings regarding the actual experiences of service users are provided in the previous evidence statement, and findings related to inhibitors to partnership working are reported in the following evidence statement on barriers.

Four major inhibitors to their work were cited by respondents, including: lack of resources (human and financial) for adult protection work; lack of specific legislation to protect vulnerable adults; a concern that some agencies view the 'No Secrets'/ 'In Safe Hands' guidance as optional (as a 'may do' rather than a 'must do' form of guidance); and ambiguous commitment from agencies at local levels to undertake adult protection work and fully participate in partnership working. Findings related to service users experiences of the partnership work and the effectiveness of partnerships for increasing interagency information sharing and policy development are provided in the respective evidence statements and narrative report of findings.

Feedback provided in phase three by service users, families, care-givers and representatives of independent organizations was generally less positive regarding the actual experiences with adult protection. Key issues noted included: difficulties in accessing social services or gaining assistance when required and communication issues and negative experiences with existing adult protection services.

Findings reveal significant strengths, barriers and challenges to partnership working within adult protection. Negative feedback from service users suggest that the current model of working is not effectively meeting the needs of vulnerable adults and their families and care-givers. Limitations of the study include: use of many subjective measures, the bulk of which were from the service provider side rather than the client side (and the client side feedback was noticeably less positive), and limited information on methods (e.g. evaluation instruments used). The scope of the guidance under evaluation was broad (with a focus on adult protection rather than specifically DV) and therefore findings may not be directly transferable to the issue of DV.

Robinson, 2003

A UK-based cross-sectional study by Robinson, 2003 [+] provides an evaluation of the Cardiff Women's Safety Unit (WSU), part of which includes an examination of multi-agency working relationships. The aim of the WSU is to facilitate cooperation between agencies to effectively respond to victims of DV, by providing a central point of access for women and children. Specific goals include: increasing help seeking among victims; increasing arrest, charges and convictions in cases of DV; providing appropriate services to victims; and reducing repeat victimization. The WSU team offers a range of support services including: advocacy, advice, counselling, legal services, housing services, shelter provision, and target hardening. WSU staff includes: one Operational Manager, two Support Workers, one Seconded Police Officer, and one Administrator. The Operational Manager oversees the implementation of policies and practices and service provision, as well as providing DV related training to other agencies. The primary focus of

Support Workers is to provide service and advocacy to women who have experienced DV. The Seconded Police Officer provides criminal justice information and case follow-up. Finally, the Administrator is responsible for budgeting and accounting duties and organizing client survey and contact information.

Three main sources of data formed the evaluation: data from initial interviews/ assessments with a sample of 222 WSU clients (which represents 20% of the 1150 WSU clients from December 2001 to January 2003); police data (DV statistics submitted by the DV Unit of the South Wales Police); surveys completed by 12 prosecutors to examine experiences in prosecuting DV cases and agency relationships, and 77 case files from the Crown Prosecution Service (CPS). Information on referrals (agency that referred the victim to the WSU, as well as the agencies the client was referred to by the WSU) was also collected as a measure of inter-agency working; this information was available for 192 of the 222 WSU clients.

The majority of WSU clients are White females, under 40 years of age, have children, and have typically experienced 6 years of physical abuse from a current partner, and one-quarter have experienced sexual abuse by their current partner. Partners tend to be under 40 years, employed, have previous complaints for DV, and are in a relationship with the WSU client. Prosecutors were an average age of 40 years, primarily White British, had a mean work experience of 11 years, and a mean experience of 7 years in their current position. Half of prosecutors had some prior or current specialization in DV, half had some prior DV education, and the majority (n=9) had experience with 500 or more DV cases.

The evaluation reveals numerous successes of the WSU. In particular, DV protocols have been developed between the WSU and the South Wales Police and the Crown Prosecution Service in Cardiff, improving coordination of services for victims of DV. The WSU has provided DV training for 1,182 community members, including multi-agency training for 240 personnel. New court procedures were implemented, resulting in: the flagging of all DV cases, DV cases being sent to the same court, and cases being reviewed pre-trial on the same day each week. The prioritization and streamlining of DV cases has shorted the DV procedure (from a standard 14 weeks to approximately 7 weeks). In addition, all victims are supported by a WSU member who attends the pre trial review each week to provide advice and DV case information.

Surveys completed by prosecutors from the CPS revealed that the WSU enables them to more effectively handle DV cases; they were most likely to list a WSU member as having the greatest impact on their ability to effectively prosecute DV cases. Relative to other community agencies, prosecutors ranked relationships with the WSU highest in terms of: contact, trust, understanding, cooperation and empathy.

Police data reveals that repeat victimization had decreased by 36% (from 58 pre-WSU to 37 per month post-WSU), that victims refusing to provide a complaint has also decreased by 18% (from 99 to 81 per month), and concern for children reports submitted by officers have increased by 139% (from 22 to 55 per month).

In regards to referrals, the South Wales Police was the agency that made the most referrals to the WSU (n=118 referrals or 62%), followed next by the ‘other’ category (n=29 referrals) and then by Crown Prosecution Service (n=21 referrals). Approximately three-quarters (78%) of WSU clients and 18% of client’s children were provided referrals to other agencies with the average client receiving 2 referrals (although 8 women received 10 or more referrals). The Homesafe agency (for target hardening) received the greatest number of referrals from the WSU (n=83 referrals), followed by counselling (n=53) and police (n=48).

Finally, WSU clients report general satisfaction with police handling of the case with the majority noting that police were respectful, concerned and handled the case seriously. WSU clients reported positive perceptions of the WSU; on a scale rating of 1=not effective to 10=most effective in helping clients achieve safety, the average response was 9.2.

The report highlights several vulnerable sub-populations in Cardiff for whom further work is required to support. These include: women who have experienced sexual abuse by an intimate partner; ethnic minority women and homosexual women and men. They note the need for additional awareness campaigns and/ or funding to support services and initiatives to include these groups.

Overall, the evaluation reveals successes of the WSU, including the development of protocols with the police and Crown Prosecution Service, the improvement of court procedures for DV, the provision of DV training, the development of relationships and provision of support to prosecutors on DV cases, collaboration with the Police and other agencies in receiving and providing referrals, and client satisfaction with WSU services. Further work is required to address specific 'hidden' sub-populations, including: women who experience sexual abuse, ethnic minority women and homosexual women and men. Limitations of the evaluation include: potential for socially desirable responding in the small sample of surveys conducted with prosecutors, lack of information on non-participants/ missing cases, and limited information on inter-agency relationships aside from prosecutors.

Robinson, 2006a

A UK-based cross-sectional and qualitative study by Robinson, 2006a [+] examined the operation and impact of Multi-Agency Risk Assessment Conferences (MARACs) for reducing further victimization among high-risk victims of DV in Cardiff, Wales. A total of 164 cases were discussed in MARACs during the study period, but the final sample reported was 146 (due to involvement in another MARAC (n=10), male victims in couples with a history of violence (n=4), or loss of files (n=2). Victims were all women, an average age of 29 years, and primarily White European (86%), with children in the home (71%), and unemployed (47%). The majority had previous DV complaints on their record (77%). Offenders were an average age of 33 years, and primarily White European (77%), and unemployed (52%). Most were the current partner (39%) or ex-partner (36%) to the victim at the time of offense.

The MARACs were held every 2 weeks (formerly monthly), and offered a space for sharing of information and planning actions to reduce further harm to high risk victims and their children. Meetings included discussion of the circumstances of victims, and development of plans to support their safety. High-risk victims are identified by police risk indictor forms or a case being brought forward by a representative from a participant agency. MARACs tend to include 15 attendees, including representation from: police, probation, social services, the WSU, health, and housing. Much of the work associated with MARACs is administrative in nature and was performed in addition to people's everyday workloads.

Observations were conducted at six MARAC meetings. In addition, key informant interviews were held with representatives from the following agencies: police (n=3), probation (n=1), Women's Safety Unit (WSU) (n=1), social services (n=1), housing and homelessness (n=2), health (n=1), and Women's Aid (n=1). Police incident and police call-out data for the 6-month sample of MARAC victims (n=146 women) were used to assess violence level and risk factors. Semi-structured interviews with 27 women were conducted at 6-months to assess quality of life, safety, and security. The evaluation spanned six months, so follow-up time from the initial DV incident ranged from 1-6 months.

The majority of MARAC victims did not have any new DV complaints on file at the end of the evaluation period (79%) and did not have any police call-outs for DV (70%). However, follow-up interviews with a subsample of victims indicate that there may have been more DV present than would be indicated solely by police records; based on follow-up interviews with MARAC victims, the author found that some incidents were invisible in the police data; therefore, they estimated that 4/10 women were re-victimized during the 6-month study period rather than 3/10, as indicated by police data.

Participants viewed the main output of the MARACs as the sharing of information. This was perceived as key for providing high-risk victims of DV and their children the assistance needed from a range of agencies in order to be safe. Information sharing also provides a more complete picture in the context of the victim's life. For example, one respondent noted: "some agencies may have snippets of info that on their own don't raise any particular concern, it's only when the jigsaw of info is pieced together that the risk factors begin to be understood." An additional benefit cited was the identification of key agency contacts via MARACs. Respondents indicated that the ability to share confidential information was key for effective multi-agency work. Some limitations of MARACs that were noted included: reliance on the cooperation of the victim (e.g. ultimately the decision of the victim if they want to remain with their partner), and administrative responsibility (e.g. generating list of high risk victims, preparing meeting minutes, etc.).

In sum, MARACs appear to help agencies support victims, particularly through improved sharing of information. Limitations of the study include: the lack of a comparison group, limited period of follow-up for re-victimization rates, and inclusion of only high risk victims. The study was conducted in the UK, and therefore will be directly applicable to the UK context, for work with high risk victims.

Robinson, 2006b

A UK based qualitative study by Robinson, 2006b [+] examined the impact of Advice, Support, Safety & Information Services Together (ASSIST), a support service for survivors of domestic abuse in Glasgow whose partners have been brought before the Domestic Abuse Court (DAC). A participatory evaluation was conducted over a two-year period, with interviews and surveys conducted during both the first and second year with key informants in the multi-agency partnership. A total of 13 surveys and 10 interviews were conducted in the first year, and 14 interviews during the second year. Key informants included representatives from the following criminal justice and voluntary sector agencies: ASSIST, Strathclyde Police, the Procurator Fiscals Office, Victim Support Scotland, Social Work, Glasgow City Council, Women's Aid, Women's Support Project, and the Glasgow Violence Against Women Partnership.

ASSIST offers advocacy, information and support to both female and male victims of domestic abuse with a partner or ex-partner involved in the DAC. Victims are referred by the police, and services offered from this time up to the end of court proceedings. Short-term support (up to 12 weeks) is also available following the end of the court process. Support is tailored to the specific needs of victims but generally includes: crisis support, support and advocacy during the court process, support in accessing other needed services (substance use counselling, housing, therapy, etc.), and safety planning. Services typically begin by addressing the immediate concerns of the victim along with completion of intake information, and then they may complete a risk assessment and be offered information, referrals to other agencies, and support throughout the court process.

They found that police respondents perceived ASSIST as improving victim services. One respondent stated: "Service to victims in the pilot area is better across the board – everyone in this area is far more switched on to the difficulties faced by victims because of ASSIST." Police also noted the importance of the collaboration between ASSIST and the criminal justice agencies. As one informant said: "The difference that ASSIST makes is a dual role: 1) individual advocacy for the victim and 2) institutional advocacy for the court." Regular contact between the administrator of ASSIST and the Crown Office and Procurator Fiscal Services administrator was believed to facilitate problem solving and information sharing. Respondents noted strong working relationships and commitment of partners. One participant stated: "To be an effective partner the multi-agency partnership must 'tick a box' in your own organization… if my organization didn't attach importance to this then I wouldn't be an effective partner- I wouldn't get time to come to meetings, etc. The level of commitment is fairly significant- things get done because each agency is committed." However, one participant noted that it was important that all agencies continue to

improve rather than become complacent. Other participants noted that issues related to ownership, responsibility, and emphasis on strategy by partner agencies emerged though these were addressed over time.

Findings suggest that ASSIST was deemed an effective partnership approach, with strong working relationships with the criminal justice system, facilitating improvements in advocacy for victims and the courts. Limitations of the report include: lack of identification of key themes in the evaluation, and lack of comparison of responses made by criminal justice and voluntary staff. The study was conducted in the UK and therefore is directly applicable.

Robinson & Rowlands, 2006

A UK-based qualitative study by Robinson & Rowlands, 2006 [+] examines the Dyn project- a safety planning and advocacy service for gay, bisexual, transgender (GBT) and heterosexual men who have experienced DV in Cardiff and across Wales, delivered in a multi-agency model. They explore the services provided, process of screening referrals, the forms of intervention most helpful to specific client groups, impact on clients and client perceptions.

The evaluation was designed using participatory evaluation. Evaluation data included: 171 case files, 10 case studies, participant observation by one of the authors who was the Dyn Project Coordinator, 4 interviews with Dyn clients, and 7 interviews with practitioners from a range of agencies that have worked with the project. Comments regarding the multi-agency model were primarily drawn from the last data source (interviews with practitioners, 4 of whom were from voluntary sector agencies and 3 of whom were from criminal justice agencies).

Dyn clients were typically referred by the police. Of the case files (n=171), 5% of clients were <20 years old, 29% were age 21-30, 27% were age 31-40, and 21% were age 41-50. The majority (79%) were White European. Where employment status was recorded, men were equally involved in full-time work or unemployed. Approximately 25% of referrals were for gay male victims of domestic abuse. In Cardiff, the men can access either via telephone or face-to-face appointments: advice and information, support, and referrals to other agencies. For men living in other parts of Wales, there is a confidential helpline operating 3hrs per day on Monday, Wednesday and Friday. The Dyn project also provides training to local agencies (including Magistrates, the Crown Prosecution Service, the National Probation Service, health services and community and voluntary groups), and UK-wide agencies (including the: CAADA, the NSPCC and Broken Rainbow). The Dyn project also collaborated with Broken Rainbow to facilitate a UK Lesbian, Gay, Bisexual and Transgender (LGBT) Domestic Abuse Forum for those working on the issues to network and share good practice. A guiding principle of the Dyn Project is that work with men occurs within a multi-agency setting, which must include an information sharing protocol between agencies to protect safety and reduce risk for men, their current or former partners and children.

Based on case file analysis, gay male victims were less likely to understand or report their experiences as abusive but were more willing to use services and support of the Dyn project, compared to heterosexual male victims. Three out of four GBT clients who were interviewed reported that the Dyn Project helped reduce violence and/ or threat of violence, while one reported that violence increased because their partner was upset with them accessing Dyn project support. All 4 participants interviewed reported satisfaction with the project. The researchers recommend the need for linking services for heterosexual male victims to services for women. They note that the Dyn Project was able to link with women's service organization regarding men who attempted to present as victims or provide direct referrals for women who were potential victims of abuse. They suggest that these linkages create an extra 'safety net' for women who have been abused, while providing services for heterosexual men who are victims of abuse.

Interviews with the key informants revealed several strengths of the multi-agency approach. They reported increased information-sharing which meant that better outcomes were possible for the client and some professional suspicion/ anxiety was removed about male victims since the Dyn information helped identify true victims (rather than heterosexual perpetrators presenting to services as victims). Other strengths cited were: providing a more complete picture of the amount of men requiring services and the forms of support required; challenging miss-information and increasing knowledge regarding male victims of domestic abuse; enhancing the awareness and response of other agencies to male victims; and offering a specialist service for GBT victims improving the services available to this community.

Findings suggest that the Dyn project facilitated information sharing between agencies, helping identify victims of abuse and providing support and referrals for victims of abuse. Limitations of the evaluation include: small interview samples and limited information on data analysis. The Dyn Project was aimed at gay, bisexual, transgender (GBT) and heterosexual men in Wales. Findings may therefore be applicable to the UK context, for this sub-population of men.

Robinson & Tregidga, 2007

UK based before and after and qualitative study by Robinson & Tregidga, 2007 [+] examined levels of revictimization one year after being referred to a Multi-Agency Risk Assessment Conference (MARAC) and the victims' perceptions of the intervention. The study included a sample of 22-28% of women referred each month for four months to the Cardiff MARAC. The average age of participants was 29 years, 5% were an ethnic minority, 75% had one or more children in the home and one-third were employed. Seven out of 10 women reported that the perpetrator had alcohol, drug and/ or mental health issues, a criminal record, and was jealous or controlling. Approximately 4 in 10 women reported that the abuse was happening more frequently or becoming worse, or that they had experienced death threats or strangling. A minority of women (between 2 and 3 out of 10) reported that the perpetrator used weapons, threatened suicide, or that they had experienced sexual abuse. On average, victims had more than 3 DV complaints on record.

MARACs offer a forum for information sharing between: statutory agencies, voluntary agencies and the criminal justice system to facilitate the development of action plans to decrease harm to high-risk victims of DV and their children. The Women's Safety Unit (WSU), a community based advocacy service aimed at improving safety for victims of DV, functions as the victim's advocate at MARACs, and provides the victim with information on the action plan. The WSU provides a variety of supports and services for DV victims including: advice, counselling services, housing services, legal services, referrals to shelters, and target hardening.

A total of 102 police DV complaints and records were included in the analysis. Follow up was conducted one year following referral to assess re-victimization. In addition, a sub-sample of 9 women was recruited to participate in interviews. Interviews were structured, 30-45 minutes in length and covered: perceptions of the various agencies, relationships and children, the effect of the abuse on their quality of life, and their opinions as to why they were in their present situation. Interviews were conducted either in the advocate’s office or by telephone. The authors note that interviews with participants often served as a form of counselling, providing women a space to talk about experiences that they may not have discussed before. Coding for themes was based on the interview format.

They found that 74 of the 102 women reported no further violence at 6 months, but at 12 month follow-up 25 of these women had filed complaints. At 12 months, 47% of women reported no violence, 20% had made one report, 11% had made 3 reports and less than 5% had made 4 or more reports. A review of police files revealed that potentially 5 of the women were exposed to violence but did not officially report the incident. With this adjustment, the percentage of women experiencing no violence at 1 year follow up was 42%. Qualitative analysis revealed that women valued the sharing of information. Participants reported perceived benefit in the sharing of

information by agencies so that service providers were aware of their full history and could better assist them. One participant stated: "All the services know about the case history. Everyone seems to be working together. The combination of WSU, Social Services, and welfare has worked." Women also reported feeling support by multiple agencies. One woman expressed: "I can't believe that within a year I've had all this support. I've dealt with my husband for [the] last 10 years and I coped all on my own with it. [But now] people seem to bend over backwards to help you." Another woman said: "to be honest, I have been surprised at the amount of support that has been there for me. It is good that all people in different agencies know what is happening." Continuing challenges were reported including: specific problems with providers, although this was typically directed at a single agency rather than the MARAC, and challenges regarding information related to legal processes, including bail release, and child contact by the perpetrator.

In sum, findings reveal that under half of women did not experience re-victimization 12-months following referral to the MARAC, and women generally viewed MARACs positively for sharing information related to their case and providing support. Limitations of this study include small sample for qualitative interviews, limited information on data collection methods and analysis, and potential conflicts between women's self-report and police reports of violence. The sample included was not ethnically diverse and the majority was unemployed, so may be limited in applicability to similar demographic groups in the UK context.

Sharp and Jones, 2011

A Scottish qualitative study by Sharp & Jones, 2011 [+] evaluated the outcomes of three pilot sites for the Cedar Programme, a group work programme for children/ young people and their mothers (reported in Q4), and assessed the impact of the partnership working model of delivery. Specifically, they examined: referral arrangements, co-facilitation of group-work, the wider impact on inter-agency working and changes in practice relating to domestic abuse.

One of the guiding principles of the Cedar Programme is multi-agency professional learning and practice integration. The aim is to improve partnership working and agency responses to children and young people impacted by domestic abuse and their mothers. The Cedar programme is based on Community Groupwork Treatment Programme, and offers 12 weeks of group-work for both children/ young people and mothers, lead by co-facilitators. Co-facilitators were recruited from a variety of agencies, including: social work, education, nursery or childcare departments, the police, child and adolescent mental health services, Women's Aid, SACRO, Barnardos, and other voluntary sector organisations with a domestic abuse, sexual abuse or single parent focus. Approximately two-thirds of staff attended pre-programme group work training. Each local authority served as a 'host,' and employed two Cedar Coordinators who managed and co-ordinated the group work programme. The Cedar Coordinators acted as the 'single point' for assessments and referrals. Multi-agency Local Advisory Groups (LAGs) were also developed, that met every 6 weeks, in each pilot site and included: Cedar Coordinators, their managers, and staff from key partner agencies. Partner agencies often provided referrals to the group work programme and provided staff to act as co-facilitators.

Data collection included: briefing notes from Local Advisory Group (LAG) and National Partnership meetings, data from 3 Exchange Events, 3 web surveys of all coordinators (n=6) and co-facilitators (n=68), and 5 telephone interviews with a sub-sample of co-facilitators. Of the co-facilitators: 14 were men and 54 women; 5 were affiliated with a local authority, 16 with social work, 6 with education, 1 with the police, 4 with child and adolescent mental health services, 12 with Women's Aid, and 24 with voluntary sector organizations with a domestic abuse, sexual abuse or single parent focus; and most were in non-supervisory or management roles. The Exchange Events were events that brought together the 3 pilot sites to consider the goals of the project, analyse evidence and reflect on practices. Details of participants were not provided for the first Exchange Event; the 2nd event included 40 attendees from pilot sites, National Partnership, and Scottish government; the 3rd event included 60 attendees including: Cedar Graduates, coordinators, co-facilitators, the National Partnership, the Scottish Government and

third sector agencies and local authorities. An evaluation team acted as 'critical friends' to the pilots of the project, making certain that the collection of data was systematic, recording discussions, and reflecting and reporting on emerging findings.

Findings reveal that the pilot provided training for generalist agencies to address domestic abuse recovery, providing new group-work skills and education on theory, language and available resources. They also report that over the course of the pilot, there was an increase in the involvement of non-social work local authority staff. Most co-facilitators reported greater communication and knowledge-sharing between agencies and enhanced awareness of available resources. Co-facilitators reported that they appreciated the opportunity to engage with other agencies, felt supported and valued by Cedar staff and improved their knowledge of the effects of domestic abuse for children. As one respondent noted: "I've changed my own input. I'm more sensitive about the way I put things. I'm more aware of how some young people would take what I say. I'm more confident [in my wider work]. Before I used to think what they needed was a formal service ...professional response - now I'm more child-focused ... think about what would connect with the young people, use their language and ask their opinions."

The authors also highlight several areas of the partnership model that require further attention and development. As the majority of referrals were received from social work agencies, they state the need for further efforts to form relationships with specialist agencies and to educate agencies on the existence of the programme and need to make referrals. Disagreement was reported among some providers regarding the appropriate threshold for intervention for some referrals, as well as ambivalence among some agencies because the programme was not perceived as their primary function. Further attention is required to clarify the expectations of partner agencies that make referrals about their continuing remit for families they refer, and to clarify partnership working practices to avoid either the omission or repetition of efforts. The authors note that there is a need to recruit more male co-facilitators as well as include a more diverse representation from minority groups including: LGBT, disabled, and minority ethnic populations.

Overall, the authors found that the multi-agency model of service delivery for children/ young people and mothers who experience violence was beneficial in improving knowledge, awareness, and communication of staff and partner agencies, while areas for further development focused on the importance of clarifying the role and expectations of partner agencies and the need to include diverse co-facilitators. Limitations of the study include limited information on data collection and analysis, and lack of rich data (limited quotes provided for interview data). Due to the relatively small pilot nature of the study, findings may not be generalisable.

Stanley et al., 2011

A UK cross-sectional and qualitative study by Stanley et al., 2011 [+] examined the collaboration of police and child protection services in cases of DV where a child was present in two local authorities in the UK. Police have been required since 2002 to notify children's social services of all cases of DV where there are children in the home. However, the authors note that the information included in notification forms is determined at the local level.

Data collection included a retrospective analysis of 184 case reports from police and social service records over a 21-month period (original sample was 251, but 22% were omitted from analysis because they were lost, unavailable or possibly not received), as well as 58 individual interviews with police officers (n=8 specialist, n=10 frontline officers), DV advocates (n=6), supervising officers (n=9), children's social workers (n=13), children's social services administrators (n=2), and managers (n=10). Length of experience ranged from 18 months to 30 years (average=10 years). In addition, a short survey was distributed via mail to the Chairs of all Local Safeguarding Children's Boards (LSCBs), and was completed by 57 respondents (a 35% response rate).

Interview participants were asked to discuss processes for recording and transferring information between police and children's social services and to comment on the strengths and weaknesses of the current collaboration. The survey asked respondents to note any innovative practice regarding the management of police notifications of DV in their area. Interview data was analysed for key themes with NVivo, while surveys were reviewed manually. Data from police and children's social services files were inputted into spreadsheets, and then coded and analysed.

During interviews, social workers reported that there was a lack of information on children's experiences of DV in the notifications. Some social workers reported that notifications often involved a verbal incident that did not require a response from their service. For example, participants noted: "we wouldn't accept a notification [or] referral from another agency on that basis" and "I would say the Police need to have a filtering process." Social workers also reported challenges in contacting frontline officers and specialist DV workers outside of formal statutory meetings. Both police officers and social workers reported that inter-professional training, including job shadowing, could improve knowledge of each other's roles and expectations. Police officers reported limited knowledge of the role of social workers and what they did with the information that was provided.

When police records were matched up with social services records, in 40% of the reports, inconsistencies were found between the information in the notification and that included in the original police report; a total of 2 police notifications did not report children's exposure to DV even though it was included in the police report. In addition, only 19% of the police records included a narrative description. Further, only 15% of families notified to child protection services received an assessment or intervention.

Survey respondents identified four innovative approaches for improving collaboration between police and child protective services. These included: increasing the potential for early intervention by directing families away from social services to either voluntary or health organizations; regular interagency meetings to screen notifications; utilizing police risk assessment methods as tools for filtering and directing families to services; and the development of a risk assessment tool that focuses on the child rather than the victim.

In sum, this study reveals challenges in the collaboration of police and child protection services for addressing cases of DV where a child was present. Specifically, issues related to information sharing and knowledge of partner roles and expectations were highlighted. Limitations of the study include the loss of police and social service files (22%) resulting in reduction in analytical sample, and limited information on qualitative analysis. The study was conducted in the UK, and is therefore highly applicable.

Steel et al., 2011

A UK-based cross-sectional and qualitative study by Steel et al., 2011 [+] examined the functions of MARACs, and potential areas for further development. They collected performance monitoring data from 208 MARACs, and quality assurance assessment data from 83 MARACs. They also conducted a national survey of MARAC Chairs, MARAC/ DV coordinators and Independent Domestic Violence Advisers/ specialist domestic abuse support services (a minimum of one response was received from over 90% of known MARACs). Structured interviews were also conducted with 13 members of the National MARAC Steering Group (NMSG), and with 47 representatives from a range of agencies involved in four purposefully selected case study sites. Data was collected from Sep 2010 to Jan 2011. The authors conducted a thematic analysis of qualitative data. Note that data from the various sources were triangulated and reported by theme rather than by data source in the report.

MARACs are multi-agency meetings involving statutory and voluntary agency representatives, who share information about high-risk victims of DV to develop a coordinated action plan to improve victim safety. Examples of agencies that are included on MARACs are: police, probation,

health and housing, IDVAs, children's services. The authors note that at the time of publishing, there were 250 MARACs operating in England and Wales.

Most survey respondents (97%) perceived the MARAC they were involved with to be either "very effective" or "fairly effective" at improving safety among DV victims in their area. Performance monitoring data from MARACs submitted via CAADA suggest that the average repeat victimisation rate (i.e. a repeat episode of DV within 12 months following a case being referred to a MARAC) in the 12 months to Sept 2009 was 22%. However, the authors caution that quality assurance checks have revealed variation in the quality of data collected by MARACs, and therefore note that the quality of these data is a concern.

A review of existing literature on MARAC effectiveness along with analysis of NMSG and case study interviews revealed three integral areas for MARACs' effectiveness, including: improved information sharing; suitable agency representation; and the involvement of the IDVA in representing and including the victim in the process. Generally, there was agreement NMSG and case study interviewees among with best practice guidelines indicating that six core agencies should have regular involvement on MARACs, including: police, probation, IDVAs, housing, children services, and health.

Respondents to the national survey reported that in their opinion, their MARAC was: effective at enhancing information sharing (84%); strengthening links between partner agencies (80%); and improving awareness of domestic abuse among partner agencies (76%). When asked about the CAADA 10 principles of an effective MARAC (see background section for further information), the majority of survey participants (88%) reported being either 'familiar' or 'very familiar' with the principles and the majority (98%) also reported that their MARAC followed all, or most of the ten principles. However, when asked about individual principles, yet there was some variation in reporting of those principles that were completely followed.
Quality assurance data (from a sample of 83 MARACs) measured MARACs performance against each principle using a: 'red' (does not meet key aspects of the standard of practice outlined in the principle), 'amber' (meets most key aspects), and 'green' rating system (meets all key aspects). Findings revealed that administration and research and information sharing were the two CAADA principles most consistently achieved (green or amber). However, QA data revealed that action planning was the principle that MARACs appear to consistently perform less well on (this received the highest number of red ratings).

Possible areas for future development of MARACs included: increasing non-police referrals, enhancing representation of key agencies, improving clarity regarding the links between MARACs and other multi-agency procedures working with victims of domestic abuse, developing links with services aimed at responding to perpetrators, monitoring and evaluation of MARACs, verifying that MARACs are reflective of the community context and providing ongoing local and national training. Specifically, participants noted the need for representation from Black and Minority Ethnic (BME) and Lesbian, Gay, Bisexual and Transgender (LGBT) agencies. Many participants indicated that it may be useful to place MARACs on a statutory footing, suggesting that this may improve agency representation; enhance accountability; and provide better continuity and consistency. However, potential issues with this approach included: greater bureaucracy and responsibility placed on agencies; and the potential that this may compromise victim engagement in the process.

This cross-sectional and qualitative study revealed that MARACs were generally perceived as effective, and a number of key areas of effectiveness, were: information sharing, agency representation and IDVA engagement as victim advocates. Limitations of the study include: that the survey targeted specific MARAC roles (IDVAs, MARAC Chairs and DV/ MARAC co-ordinators) and quality assurance data was only made available for those who opted to collect it. The author also notes that the inclusion of a small sample for qualitative interviews means that findings may not be representative of all MARAC members. These potential sources of bias in data sources may limit the generalisability of findings.

Whetstone, 2001

A US-based before and after (with comparison group) and qualitative study by Whetstone, 2001 [+] examined the efficacy of a pilot project which teamed police officers with victim advocates as first responders to 911 calls for DV cases. The quantitative study analysed data from 4,004 calls within two districts by women and men who were victims of DV (no breakdown provided for treatment vs. comparison). In addition, 45 exit surveys were completed. Based on call data, victims in the two districts were predominantly White and female (80%). The author notes that victim demographics were proportional with the general population within each district though no further details were provided. For the exit survey, 13% were male; 74% were Caucasian and 16% African-American; 51% had a high school diploma/ GED; and 36% had at least one or more years of college.

In addition, a series of interviews were conducted during and after the pilot with personnel, clients and secondary clients (individuals and government agencies that interacted with either personnel or their clients, such as prosecuting attorneys and women's shelters). No further details were provided about the sample of interviewees.

The project involved collaboration between specialized uniformed police officers and victim advocates as first responders/ follow-up investigators to DV cases. This DV coordinated response team (DVU) initially included: three victim advocates including a social service provider, a director, and unit secretary; two patrol officers and one police sergeant; one probation officer, and one correctional officer. Victim advocates responded with assigned uniformed officers to DV 911 calls and participated in any follow-up visits. Advocates and officers were selected and provided training to offer enhanced service in the case of a 911 response to DV. The advocates received training in victim support, counselling and accessing service providers, while police officers were trained in investigative procedures and interview skills related to DV, as well as comprehensive crime scene conduct and follow-up investigations. Probation and corrections officers were included to facilitate enhanced surveillance and supervision of perpetrators. A comparison district was included, which had no analogous DV unit and continued to respond to DV calls as usual. It was chosen based on: volume of calls for service (which were second only to the treatment district), geographic proximity to the treatment district, and similarities in resident housing and income levels.

Data on all DV calls for both the treatment district and the comparison district were collected for the year prior to the intervention and the 18-month duration of the pilot project in one month increments. Data came from: the database of police report records, police radio dispatch records, a computer system in the court offices, and unit records. Quantitative measures from this data included: number of DV calls for service (CFS) (which included DV involving non-intimate-partners as well as mis-classified calls), number of IPV incidents (those within the purview of the DV team in this project), and number of arrested DV perpetrators. Various ratios were calculated from these variables (e.g. number of arrests, number of IPV incidents). Additional data were drawn from exit surveys completed by clients, which included a series of statements using a Likert scale where 1=strongly disagree and 5=strongly agree. Time of follow-up is not clear, though appears to have occurred at the conclusion of the pilot.

Findings from the quantitative portion of the study reveal that the specialized DV unit performed significantly better than the comparison district. Cases initiated by the specialized unit resulted in higher arrest, prosecution and conviction rates. The mean gain in number of arrests/ number of IPV incidents was 11.2% in the treatment district compared to 4% in the comparison district ($p<0.05$). In post-test-only comparisons, the treatment district had significantly higher arrests and prosecutions (mean=33% vs. 28%, $p<0.05$), higher conviction rate as a percentage of intimate DV cases (mean=6% vs. 1%, $p<0.001$), and greater percentages of DV victims receiving medical attention (mean=15% vs. 10%, $p<0.05$). Data from the exit survey demonstrated that victims reported higher satisfaction with the DVU's work (mean=4.73 out of 5, with 5 being the best

score), liked having the victim advocate there to help (mean=4.77) and felt that police should always respond with advocates (mean=4.64).

The qualitative analysis revealed that the vast majority of victims/ clients perceived their experience with the unit positively. The majority of victim respondents were pleased with the level of service and expertise, reported a better understanding of their options, felt their safety had improved, were grateful for support related to court appearances, and reported a modest sense of empowerment. Both prosecutors and judges reported better case preparation by the DVU officers, rather than cases handled only by general assignment police officers. DVU personnel reported strong communication between team members, and prosecutors reported that advocates were integral for maintaining contact with the victims in the first two weeks following the DV incident.

Findings reveal that: the specialized DV unit performed significantly better than the comparison district, demonstrating higher rates of arrests, prosecutions and convictions; victims perceived their experience with the DV unit positively and reported improved safety; and prosecutors, judges and DVU personnel reported that the collaboration between police officers and victim advocates improved their response to victims of DV. Key limitations of the study include: issues with data access which may have resulted in the loss of some cases in the comparison district, and potential contamination in the comparison district by initiatives and a department-wide campaign to improve the DV response. In addition, though it is understood that the author was limited to the available data, it is still a limitation to use arrests, prosecutions, and convictions as the main outcome variable without addressing potential confounders like pre-intervention levels of prosecutions and convictions, or severity of the crime. Findings may not be applicable to areas where victim advocacy services are limited or unavailable.

Woodford, 2010

A Canadian qualitative study by Woodford 2010 [+] examined the factors associated with successful community-government collaborative policy making. A provincial (Newfoundland and Labrador) workgroup was developed to improve income support services for victims of IPV. Leaders in the income support department (referred to as the host department) developed the community-government collaborative workgroup, in response to concerns expressed by advocacy and service organizations that income support system redesign measures were not meeting victims' needs. The host department appointed a total of 12 workgroup members, representing: governmental and non-governmental sectors including advocacy groups and stakeholders from partner government departments and agencies. The workgroup included representation from all regions in the province, and government officials including: policy workers, operational managers and frontline staff.

The workgroup was initially tasked with providing recommendations on how to improve income support services for victims of IPV using transition houses and shelters. Yet, following their initial meeting they requested that the host department broaden the mandate to include the needs of all victims of IPV. The workgroup developed principles for future policies and services including "respect for individual choice" and "responsive and holistic services that are pro-active in the prevention of abuse and violence". The workgroup was held for an eight month period, and involved engagement and consultation with other community and governmental stakeholders. They identified 16 issues and developed 27 recommendations. This collaborative policy group was deemed as successful in integrating input from stakeholders into policy development, and the response of policy makers to act on the input received. All recommendations were implemented, including some that required significant changes in government policy. To support implementation, community agencies collaborated with departmental staff to form operational policies out of the recommendations.

The author conducted all data collection and analysis. Data collection involved: analysis of press releases, the final report of the workgroup, semi-structured interviews with workgroup members from community and government agencies or departments and senior officials in the income

support department. During interviews, participants were asked to retrospectively provide their expectations and concerns of the group, description of the workgroup process, experiences of the group and reflections on impact and policy changes. A follow-up community consultation meeting was also attended which addressed the implementation of recommendations. The author based analysis on the data, conducting multiple reviews of transcripts and documents. Codes were developed until no further themes emerged, and were then reviewed and organized into categories and sub-categories, and relationships between themes identified. Member checking was conducted on preliminary interpretations and memos were kept throughout the process.

Overall, informants described the workgroup extremely positive, all viewing it as a case of successful community participation. Each informant reported being actively involved, viewed themselves as meaningful partners in the policy making process, and believed that the changes made improved services for victims of IPV. Participants reported that all issues raised were discussed and addressed, and no participant recalled an issue being left off of the agenda.

Interrelated design, context and process factors were found to facilitate the success of the workgroup. One key factor was support for the host department's leadership. As one informant noted: "The deputy was amazing. From the outset, it was clear she believed in what we were doing and in community involvement". Another key factor was willingness to be measured risk takers. In Newfoundland, there was a context of support for participatory policy making and violence prevention, yet the community-government collaboration was unique and required significant risk by the host department. Another key factor for success was group size and composition. The group was limited to 12 key stakeholders who were credible, able to commit time to the process and open to teamwork. One informant noted: "[The department] wanted people who could speak to the issues and get the job done". Another key factor was the provision of resources and focus on departmental policy issues. Issues outside the responsibility of the host department were passed on to the appropriate department; as one participant noted, "This meant we could get to work on things that we could actually change—do something about." The workgroup achieved success by engaging other stakeholders. This emerged naturally as the group functioned. Participants also reported the importance of trust, respect, open communication, and equity within the group. This created confidence among members that the workgroup could affect government policy. As one participant noted: "Everyone in the group really believed that improvements [in income support services] were needed, we just were not sure how best to do so." The workgroup used a consensus approach, allowing them to stand behind the recommendations made. Finally, the success of the workgroup stemmed partially from purposeful consideration of responsiveness and feasibility. As one workgroup member reported: "We needed to ask, is this [solution] going to be accepted? Will change happen? Why put something forward if there's no change?"

This case study reports success of a collaborative community-government policy making initiative, connected to a number of design, context and process related factors of the workgroup. Key limitations of the study include the retrospective design and potential for recall bias, and the fact that only one researcher conducted data collection and analysis. The collaboration discussed is a single case study of a specific policy context in Canada and therefore may not be applicable to other contexts.

8.5. Evidence Statements

We have organized the findings using the following categories:

1) Effectiveness of partnerships for increasing referrals and addressing violence
2) Effectiveness of partnerships for increasing interagency information sharing and policy development
3) Enabling factors to partnership working
4) Barriers to partnership working

Evidence Statement 30- Effectiveness of partnerships for increasing referrals and addressing violence

There is moderate evidence from 11 studies that partnerships to address DV were effective at: increasing referrals, reducing further violence, or supporting victims of DV.

Ten quantitative studies and mixed methods studies examining partnerships to address DV, evaluated the impact on referrals, reducing violence or providing victim support. A before and after study (Banks et al., 2008a [+]) examining a collaboration between child welfare and DV agencies reported an increase in referrals for DV and increase in batterer referrals. A before and after study (Bennett & O'Brien, 2010 [+]) revealed that a woman's "door" (source of referral) to service (DV, substance misuse or integrated services) did not significantly effect self confidence in managing abuse, experience of battering, or substance use outcomes at follow up. A before and after study (Coll et al., 2010 [+]) found that having a single case coordinator who collaborated across service providers was effective with court-referred participants and their families for increasing family intimacy and child well-being and decreasing family conflict. A before and after study (Ernst & Smith, 2012 [+]) comparing a team case management and standard single social worker model of risk assessment of seniors in adult protection found that in regards to case disposition, the standard model was significantly more likely to confirm cases of mistreatment, including: financial exploitation, physical abuse, and neglect by others; but for measures of risk reduction, the team approach resulted in significantly reduced risk of physical abuse, neglect, and environmental risks. A cross-sectional and qualitative study (Penhale et al., 2007) of a multi-agency approach to protect vulnerable adults from abuse based on 'No Secrets'/ 'In Safe Hands' found that service users reported: difficulties in accessing social services when needed, communication issues and negative experiences with existing adult protection services. A cross-sectional study (Robinson, 2003 [+]) evaluated the Women's Safety Unit (WSU) which offers a central point for a range of support services for DV victims and their children, found that: the majority of clients were referred by the police to the WSU and received referrals from the WSU to other agencies; repeat victimization and victims refusing to provide a complaint decreased and concern for children reports submitted by officers increased; and WSU clients reported high satisfaction with the WSU. A cross-sectional and qualitative study (Robinson, 2006a [+]) evaluating a sample of MARAC cases revealed that the majority of victims did not have any new DV complaints or police call outs for DV at the end of the evaluation period, although interviews with victims revealed potentially higher rates of re-victimization than police files. A before and after study and qualitative report (Robinson and Tregidga, 2007 [+]) reported that less than half of women reported no violence one year after being referred to a MARAC, and women reported valuing the support from multiple agencies. A cross-sectional and qualitative study (Steel et al., 2011 [+]) found that the majority of respondents perceived the MARAC they were involved with to be either "very effective" or "fairly effective" in improving outcomes for victims of DV; and performance monitoring data suggest that the average repeat victimisation rate in a one year period was 22%, though the authors caution that the quality of these data is a concern. A before and after and qualitative study (Whetstone, 2001 [+]) found that a specialized DV unit including collaboration between police officers and victim advocates performed significantly better than a comparison district, in rates of arrests, prosecutions and convictions of DV; in addition, victims perceived their experience with the DV unit positively and reported improved safety; and prosecutors, judges and DVU personnel reported that the collaboration improved their response to victims of DV.

There is evidence from one qualitative study (Robinson & Rowlands, 2006 [+]) examining the Dyn project, an advocacy service for gay, bisexual, transgender and heterosexual men who have experienced DV. They found that gay male victims were less likely to report their experiences as abusive but more willing to use Dyn services than heterosexual male victims; and three of four men interviewed reported that the Dyn services helped reduce violence and/ or threat of violence, while all reported satisfaction with services received.

Quantitative and mixed-methods studies

Banks et al., 2008a (before and after [+], USA, n=81 caseworker surveys (baseline), n=135 caseworker surveys (follow-up); n=616 case files (baseline), n=642 (2 year), n=562 (4 year); interviews with 8-12 stakeholders at each of 6 sites (total number NR) (interviews included child welfare agency leaders, board members, research partners, and agency staff; other descriptors of participants or agencies NR), baseline, 2 year (surveys and case files), 4 year (case files)) [Examined implementation of the Greenbook principles, a 'roadmap' for collaboration between child welfare and DV agencies to address co-occurring child maltreatment and DV, at six demonstration sites. The Greenbook includes guidelines regarding: collaboration between child welfare systems and child dependency courts (which address child abuse and neglect) and DV providers; leadership to offer resources and services to support family safety; creating service plans and providing referrals with the goals of safety, stability, and well-being for all victims of family violence; and accountability of DV perpetrators] In case file analysis, there was an increase in referrals for DV from Time 1 to Time 3 (35% to 65%; $\chi 2=19.770$, df=1, p=0.000); and a significant increase in batterer referrals from 29% at Time 1 to 45% at Time 2 ($\chi 2=7.550$, df=1, p=0.006) and 53% at Time 3 ($\chi 2=13.228$, df=1, p=0.000).

Bennett & O'Brien, 2010 (before and after [+], USA, n=128 women (completers) seeking resources or services for IPV from pilot agencies (number of participants for each "door" (source of referral to the demonstration project): IPV door, 32 women (25%); substance abuse door, 53 women (41%), and integrated substance abuse/ IPV door, 43 women (34%); 57% abstinent at baseline, and 52.1% were acute victims of IPV at time of seeking services; mean age 35.21, majority European (42%) or African American (38%), mean education of 11.92 years), baseline, 4-months, 6- months [Examined impact of sources of referral to a demonstration project. The demonstration project examined integrated and coordinated services for women seeking assistance with IPV or substance use, including 4 agencies: an integrated DV/ substance abuse agency serving suburban and urban women; a coordinated set of agencies serving primarily urban and Latina women; an integrated agency serving a mix of urban and rural women; and a coordinated set of agencies serving primarily rural women. Services offered were either substance abuse- oriented or DV- oriented] At baseline, women using the three service doors (IPV; substance use (SA); or integrated IPV/ SA) differed in experience of battering ($F(2, 123)=6.89$, $p<0.001$) and self confidence in managing abuse ($F(2,127)=3.90$, $p<0.05$), but not at follow-up.

Coll et al., 2010 (before and after [+], USA, n=53 court referred families who experienced family violence (primarily White, high school or college educated, employed, low income, average of 2 children, previous experience of DV, substance abuse at intake), pre- and post- intervention (6-12 months after completion) [A case coordinator worked with families to support them throughout the court system process, to coordinate treatment services and provide financial support for court-ordered services. The case coordinator provided treatment and/ or service recommendations to improve family functioning and parent and child safety, and based on these recommendations the family court ordered evaluations (DV, substance use, mental health, child at risk, etc.). Participants completed evaluations, and then case coordinators worked with a treatment planning team (including: the family, family court services, Department of Health and Welfare staff, county probation, and advocates) to construct a comprehensive treatment plan for the family] Participants noticeably gained in all three areas of family functioning measured (all p's<0.0001): intimacy (mean pre-score=37.5, post=60.8), conflict (mean pre-score=39.7, post=24.9; reduction in score indicates less conflict), and parenting (mean pre-score=25.8, post=38.8). All areas of family functioning and child well-being (environment, parent capabilities, family interactions, family safety, child well-being) as viewed by the clinician improved significantly (all p's<0.001). Both total scores and critical (imminent danger) scores of spousal assault risk assessment significantly decreased (by an average of 7.3 points and 2.6 points, respectively; p's<0.0001). Outcomes on a parental conflict scale indicate significant gains for the participant group in moving from severe or moderately severe parental conflict to moderate, mild, or minimal conflict.

Ernst & Smith, 2012 (before and after [+], USA, n=869 reported cases of abuse allegations for elders 65+ (64.1% women, 35.9% men; mean age 80.5 year; majority Caucasian) standard case closure (varied) [Compared effect of using a social worker and registered nurse duo (team case management) to do risk assessment of seniors in adult protection, with a single social worker (standard model)] Standard model was significantly more likely to confirm cases of mistreatment including: financial exploitation, physical abuse, and neglect by others; while team approach resulted in significantly greater risk reduction. Team case management significantly improved risk reduction in every category but exploitation ($p>0.05$), significantly reducing physical abuse by a mean difference of 0.48 ($t=3.813$, $df=41$,$p <0.001$), neglect by 0.38 ($t=7.177$, $df=818$, $p<0.001$), social environment by 0.19 ($t=2.390$, $df=484$, $p=0.017$), and physical environment by 0.32 ($t=3.908$, $df=721$, $p< 0.001$). There were no significant differences in case recidivism, self-neglect or cost savings.

Penhale et al., 2007 (cross-sectional and qualitative [+], UK, (Phase 1) final analytic sample n=133 Councils with Social Services Responsibilities (CSSRs) (60% of surveys were completed by adult protection coordinators, 39% by a manager with adult protection responsibility, and one respondent did not indicate their role); (Phase 2) n=32 senior social services managers representing 26 local authorities (range of geography, local authority type, affluence/ deprivation status, assessed performance and history of adult protection working); and interviews with social service workers, adult protection coordinators, training staff, policy managers, and legal officers (numbers NR); and focus groups n=271 participants (in each of the 26 sampled local authorities, all members of the local adult protection committee (APC); (Phase 3): n=22 interviews; 19 focus groups (in 16 areas, most different from Phase 2 sample; including service users, care-givers and relatives, and representatives from service user groups and support organizations), NR [Multi-agency approach to protect vulnerable adults from abuse (No Secrets/ In Safe Hands). The main components of this multi-agency approach were: development of an inter-agency framework; a multi-agency management committee (or adult protection committee); a clear definition of the roles and responsibilities of each agency; developing an inter-agency policy with policies and principles; implementation of procedures for receiving and responding to referrals related to adult protection; joint protocols for information sharing; contract monitoring for independent providers; implementation of systems to monitor the effectiveness of adult protection work; adult protection training strategies for relevant staff groups] Qualitative feedback from service users regarding experiences with adult protection, revealed: difficulties in accessing social services or gaining assistance when required and communication issues and negative experiences with existing adult protection services.

Robinson, 2003 (cross-sectional [+], UK, n=222 WSU client interviews (White females, under 40, with children, average 6 years of physical abuse & one-quarter experienced sexual abuse); [Evaluation of Women's Safety Unit (WSU) in Cardiff which provides a central point of access for women and children who experience DV, offering: advocacy, advice, counselling, legal services, housing services, shelter provision and target hardening] The South Wales Police was the agency that made the most referrals to the WSU (n=118 referrals or 62%). Approximately three-quarters (78%) of WSU clients and 18% of client's children were provided referrals to other agencies with the average client receiving 2 referrals. The Homesafe agency (for target hardening) received the greatest number of referrals from the WSU (n=83 referrals). Police data reveals that repeat victimization decreased by 36% (from 58 to 37 per month pre- to post- WSU), that victims refusing to provide a complaint has also decreased by 18% (from 99 to 81 per month), and concern for children reports submitted by officers increased by 139% (from 22 to 55 per month). WSU clients reported positive perceptions of the WSU; on a scale rating of 1=not effective to 10=most effective in helping clients achieve safety, the average response was 9.2.

Robinson, 2006a (cross-sectional and qualitative [+], UK, n=146 MARAC cases (all women) (analytic sample); Interviews n=subsample of 27 women (all women, average age 29 years, primarily White European, with children in the home, and unemployed, with previous DV complaints. Offenders were an average age of 33 years, primarily White European, unemployed, current or ex partner); Key informant interviews with: police (n=3), probation (n=1), Women's

Safety Unit (WSU) (n=1), social services (n=1), housing and homelessness (n=2), health (n=1), and Women's Aid (n=1)) 1-6 months) [MARACs were held every 2 weeks, and offered a space for sharing of information and planning actions to reduce further harm to high risk victims and their children. Meetings included discussion of the circumstances of victims, and development of plans to support their safety. High risk victims were identified by police risk indictor forms or a case being brought forward by a representative from a participant agency. MARACs tend to include 15 attendees, including representation from: police, probation, social services, the WSU, health, and housing] The majority of MARAC victims did not have any new DV complaints on file at the end of the evaluation period (79%) and did not have any police call-outs for DV (70%). However, based on follow up interviews with a subsample of women, the author estimates that 4/10 women were re-victimized during the 6-month study period rather than 3/10, as indicated by police data.

Robinson & Tregidga, 2007 (before and after and qualitative [+], UK, n=102 police DV complaints and records; interviews n=9 women (mean age 29 years, 5% were an ethnic minority, 75% had one or more children in the home and one-third were employed), 12 months [Examined re-victimization one year after being referred to a MARAC and victims' perceptions of the intervention. MARACs offer a forum for information sharing between: statutory agencies, voluntary agencies and the criminal justice system to facilitate the development of action plans to decrease harm to high-risk victims of DV and their children] At 12 months, 47% of women reported no violence, 20% had made one report, 11% had made 3 reports and less than 5% had made 4 or more reports. After adjustment based on findings from police files, the percentage of women experiencing no violence at 1 year follow up was 42%. Qualitative analysis revealed that women valued the sharing of information by agencies and reported feeling supported by multiple agencies. Challenges were reported including: specific problems with providers (a single agency rather than the MARAC), and challenges regarding information related to legal processes, including bail release, and child contact by the perpetrator.

Steel et al., 2011 (cross-sectional and qualitative [+], UK, n=performance data from 208 MARACs; n=quality assurance assessment data 83 MARACs; national survey (of MARAC Chairs, MARAC/ DV coordinators and IDVAs/ specialist domestic abuse support services from 90% of known MARACs (250 at the time); n=13 interviews with members of the National MARAC Steering Group (NMSG); n=47 interviews with representatives from a range of agencies involved in four purposefully selected case study sites) Sep 2010- Jan 2011) [Multi-agency meetings involving statutory and voluntary agency representatives, who share information about high-risk victims of DV to develop a coordinated action plan to improve victim safety; including following types of agencies: police, probation, health and housing, IDVAs, children's services] Most survey respondents (97%) perceived the MARAC they were involved with to be either "very effective" or "fairly effective" In improving outcomes for victims of DV. Performance monitoring data suggest that the average repeat victimisation rate in the 12 months to Sept 2009 was 22%, though the authors caution that the quality of these data is a concern.

Whetstone, 2001 (before and after with comparison group and qualitative [+], USA, n=4, 004 DV calls (primarily White and female); n=45 exit surveys (primarily White, female, and high school educated), one month increments for one year pre- intervention and during the 18 month project, post-intervention (details not provided) [Treatment district: collaboration between trained uniformed police officers and victim advocates as first responders/ follow-up investigators to DV cases. DV coordinated response team (DVU) included: three victim advocates including a social service provider, a director, and unit secretary; two patrol officers and one police sergeant; one probation officer, and one correctional officer. Victim advocates responded with assigned uniformed officers to DV 911 calls and participated in any follow-up visits. Comparison district: a district with no analogous DVU who continued to respond to DV calls as usual] The mean gain in number of arrests/ number of IPV incidents was 11.2% in the treatment district compared to 4% in the comparison ($p<0.05$). In post-test-only comparisons, the treatment district had significantly higher arrests and prosecutions (mean=33% vs. 28%, $p<0.05$), higher conviction rate (mean=6% vs. 1%, $p<0.001$), and greater percentages of DV victims receiving medical attention (mean=15%

vs. 10%, p<0.05). Data from the exit survey demonstrated that victims reported higher satisfaction with the DVU's work (mean=4.73 out of 5), liked having the victim advocate there to help (mean=4.77) and felt that police should always respond with advocates (mean=4.64). The qualitative analysis revealed that the vast majority of clients perceived their experience with the unit positively; and prosecutors and judges reported being better able to respond to DV victims (better case preparation, and improved maintenance of contact with victims for DVU cases).

Qualitative Studies

Robinson & Rowlands, 2006 (qualitative [+], UK, n=171 case files (referrals over 12 month period); n=10 case studies; n=4 interviews with Dyn clients; n=7 interviews with practitioners from a range of agencies that have worked with the project (Of case files, 5% of clients were <20 years old, 29% were age 21-30, 27% were age 31-40, and 21% were age 41-50; primarily White European; 25% of referrals were for gay male victims of domestic abuse) nr [Dyn project- a safety planning and advocacy service for gay, bisexual, transgender (GBT) and heterosexual men who have experienced DV in Cardiff and across Wales, delivered in a multi-agency model. The police typically referred Dyn clients. In Cardiff, the men can access either via telephone or face-to-face appointments: advice and information, support, and referrals to other agencies. For men living in other parts of Wales, there is a confidential helpline. The Dyn project also provides training to local and UK-wide agencies and co- facilitates a Forum for those working on the issues to network and share good practice] Case file analysis revealed that gay male victims were less likely to understand or report their experiences as abusive but more willing to use services and support of the Dyn project, compared to heterosexual male victims. Three out of four GBT clients who were interviewed reported that the Dyn Project helped reduce violence and/ or threat of violence, while one reported that violence increased because their partner was upset with them accessing Dyn project support. All 4 participants interviewed reported satisfaction with the project. The researchers recommend the need for linking services for heterosexual male victims to services for women to provide extra safety for women.

Applicability

Six studies were conducted in the UK (Penhale et al., 2007 [+]; Robinson, 2003 [+]; Robinson, 2006a [+]; Robinson & Rowlands, 2006 [+]; Robinson & Tregidga, 2007 [+]; Steel et al., 2011 [+]) and five in the USA (Banks et al., 2008a [+]; Bennett & O'Brien, 2010 [+]; Coll et al., 2010 [+]; Ernst & Smith, 2012 [+]; Whetstone, 2001 [+]).Of the US studies, one study evaluates the implementation of a specific set of principles for collaboration between child welfare and DV agencies to address co-occurring child maltreatment and DV in the US, and therefore may not be applicable to other settings (Banks et al., 2008a [+]). The study by Bennett & O'Brien, 2010 [+] provides little detail on the variable services offered within each site, and therefore it is difficult to determine applicability. The study by Coll et al., 2010 [+] did not include a comparison group, and had a high proportion of non-completers, and therefore has limited generalisability. Finally, the study by Ernst & Smith, 2012 [+] specifically examines adult protection services and therefore will be limited in applicability to similar contexts in the UK. Finally, the study by Whetstone, 2001 [+] examined a collaboration between police and advocacy services and therefore will be limited in applicability to contexts where advocacy services are also available.

Evidence Statement 31- Effectiveness of partnerships for increasing interagency information sharing and policy development

There is moderate evidence from nine studies that partnership approaches have been effective in improving relationships, practices and policies of partner agencies to address DV.

Five quantitative and mixed methods studies provide evidence on the effectiveness of partnerships for improving relationships, policies and practices to address DV. A before and after study (Banks et al., 2008a [+]) examining collaboration between child welfare and DV agencies found that stakeholders reported: improved collaboration, staff training, introduction of written guidelines, and sharing of agency resources. A cross-sectional study and qualitative evaluation

(Penhale et al., 2007) of a multi-agency approach to protect vulnerable adults from abuse based on 'No Secrets'/ 'In Safe Hands' found that stakeholders perceived partnership working as effective in developing new ideas and improving policy making and implementation; yet disagreed on the effect of partnerships on: creating unrealistic expectations among partners, benefiting providers over consumers of services, and the status of partner agencies. A cross-sectional study (Robinson, 2003 [+]) evaluating the Women's Safety Unit (WSU) which offers a central point for a range of support services for DV victims and their children, reported the following successes: the development of protocols with the police and Crown Prosecution Service, the improvement of court procedures for DV, the provision of DV training, the development of relationships and provision of support to prosecutors on DV cases, and collaboration with the Police and other agencies in receiving and providing referrals. A cross-sectional and qualitative study (Robinson, 2006a [+]) evaluating a sample of MARAC case outputs found that key informants viewed the main outputs to be information sharing and the identification of key agency contacts. A cross-sectional and qualitative study (Steel et al., 2011 [+]) examining the experiences of a national sample of MARAC members reported that their MARAC was effective, particularly in improving: information sharing, agency representation; and the involvement of the IDVA in representing the victim; and the majority of survey respondents reported that their MARAC was familiar with and followed the CAADA principles for effective MARAC, while quality assurance data revealed that some principles (information sharing and administration) were more consistently followed than others (action planning).

In addition, there is evidence from four qualitative studies. One qualitative study (Allen et al., 2008 [+]) found that coordinating councils were effective at improving knowledge of other partner members and relationships and facilitating institutional change (including the creating of new procedures, protocols and policies). An evaluation of a partnership between voluntary and criminal service sectors to offer support services to victims with a partner attending a domestic abuse court revealed that the partnership was regarded as having strong relationships, partner commitment, and effective advocacy for victims and the court. A study (Robinson & Rowlands, 2006 [+]) evaluating the Dyn project, an advocacy service for gay, bisexual, transgender and heterosexual men who have experienced DV reported improvements in: information-sharing, knowledge of the needs and availability of services for male victims. Finally, one study (Sharp & Jones, 2011 [+]) found that a multi-agency model of service delivery for children/ young people and mothers who experience violence, was beneficial in improving knowledge, awareness, and communication of staff and partner agencies.

Quantitative and Mixed-methods studies

Banks et al., 2008a (before and after [+], USA, n=81 caseworker surveys (baseline), n=135 caseworker surveys (follow-up); n=616 case files (baseline), n=642 (2 year), n=562 (4 year); interviews with 8-12 stakeholders at each of 6 sites (total number NR) (interviews included child welfare agency leaders, board members, research partners, and agency staff; other descriptors of participants or agencies NR), baseline, 2 year (surveys and case files), 4 year (case files)) [Examined implementation of the Greenbook principles, a 'roadmap' for collaboration between child welfare and DV agencies to address co-occurring child maltreatment and DV, at six demonstration sites. The Greenbook includes guidelines regarding: collaboration between child welfare systems and child dependency courts (which address child abuse and neglect) and DV service providers; leadership to offer resources and services to support family safety; creating service plans and providing referrals with the goals of safety, stability, and well-being for all victims of family violence; and accountability of DV perpetrators] On the survey, there was increased agreement regarding: collaboration with DV service providers (66% at baseline to 83% at follow-up, p=0.005); staff training to understand, identify and respond to DV (58% to 75%, p=0.007); existence of written guidelines for reporting DV to DV service providers (68% to 84%, p=0.008); and sharing of agency resources with DV service providers (55% to 71%, p=0.027). Agreement regarding agency inclusion of DV in case conferences also increased, although not significantly from 56% to 68%.

Penhale et al., 2007 (cross-sectional and qualitative [+], UK, (Phase 1) final analytic sample n=133 Councils with Social Services Responsibilities (CSSRs) (60% of surveys were completed by adult protection coordinators, 39% by a manager with adult protection responsibility, and one respondent did not indicate their role); (Phase 2) n=32 senior social services managers representing 26 local authorities (range of geography, local authority type, affluence/ deprivation status, assessed performance and history of adult protection working); and interviews with social service workers, adult protection coordinators, training staff, policy managers, and legal officers (numbers NR); and focus groups n=271 participants (in each of the 26 sampled local authorities, all members of the local adult protection committee (APC); (Phase 3): n=22 interviews; 19 focus groups (in 16 areas, most different from Phase 2 sample; including service users, care-givers and relatives, and representatives from service user groups and support organizations), NR [Multi-agency approach to protect vulnerable adults from abuse (No Secrets/ In Safe Hands). The main components of this multi-agency approach were: development of an inter-agency framework; a multi-agency management committee (or adult protection committee); a clear definition of the roles and responsibilities of each agency; developing an inter-agency policy with policies and principles; implementation of procedures for receiving and responding to referrals related to adult protection; joint protocols for information sharing; contract monitoring for independent providers; implementation of systems to monitor the effectiveness of adult protection work; adult protection training strategies for relevant staff groups] Data from the questionnaire revealed a nearly unanimous perception that partnership working facilitated the generation of new ideas; encouraged better policy making; improved credibility of policy; and facilitated the implementation of policy and bringing networks together. In contrast, respondents were generally divided on: whether partnership approaches created unrealistic expectations among partners; benefited the providers rather than the consumers of services; could develop an established way of conducting business and bestows status on partners who are not reflective of their constituency.

Robinson, 2003 (cross-sectional [+], UK, n=222 WSU client interviews (White females, under 40, with children, average 6 years of physical abuse & one-quarter experienced sexual abuse); n=12 prosecutor surveys (mean of 40 years, White British, mean work experience of 11 years & 7 years in current position); n=77 case files from Crown Prosecution Service) [Evaluation of Women's Safety Unit (WSU) in Cardiff which provides a central point of access for women and children who experience DV, offering: advocacy, advice, counselling, legal services, housing services, shelter provision and target hardening] Successes of the WSU include: developing DV protocols with the South Wales Police and the Crown Prosecution Service in Cardiff, improving coordination of services for victims of DV; providing DV training for 1,182 community members, including multi-agency training for 240 personnel; and facilitating development of new court procedures to prioritize and streamline DV cases. Surveys from prosecutors revealed that the WSU was the member reported as having the greatest impact on their ability to effectively prosecute DV cases, and relative to other community agencies, prosecutors ranked relationships with the WSU highest in terms of: contact, trust, understanding, cooperation and empathy.

Robinson, 2006a (cross-sectional and qualitative [+], UK, n=146 MARAC cases (all women) (analytic sample); Interviews n=subsample of 27 women (all women, average age 29 years, primarily White European, with children in the home, and unemployed, with previous DV complaints. Offenders were an average age of 33 years, primarily White European, unemployed, current or ex partner); Key informant interviews with: police (n=3), probation (n=1), Women's Safety Unit (WSU) (n=1), social services (n=1), housing and homelessness (n=2), health (n=1), and Women's Aid (n=1)) 1-6 months) [MARACs were held every 2 weeks, and offered a space for sharing of information and planning actions to reduce further harm to high risk victims and their children. Meetings included discussion of the circumstances of victims, and development of plans to support their safety. High-risk victims were identified by police risk indictor forms or a case being brought forward by a representative from a participant agency. MARACs tend to include 15 attendees, including representation from: police, probation, social services, the WSU, health, and housing] Key informant participants viewed the main output of the MARACs as the sharing of information including sharing of confidential information and the identification of key agency contacts.

Robinson, 2006b (qualitative [+], UK, n=13 surveys (year 1), n=24 interviews (year 1 and 2)) 2 year evaluation period) [ASSIST offers advocacy, information and support to female and male victims with a partner or ex-partner in the Domestic Abuse Court. ASSIST administrators liaise with victims and with criminal justice personnel to improve the response to victims throughout court proceedings, along with providing crisis support, safety planning and referrals to other services] Surveys and interviews with criminal justice and voluntary service representatives reveal that ASSIST was perceived as an effective partnership approach, with strong working and commitment by members. Services were deemed to improve advocacy for victims and the courts.

Steel et al., 2011 (cross-sectional and qualitative [+], UK, n=performance data from 208 MARACs; n=quality assurance assessment data 83 MARACs; national survey (of MARAC Chairs, MARAC/ DV coordinators and IDVAs/ specialist domestic abuse support services from 90% of known MARACs (250 at the time); n=13 interviews with members of the National MARAC Steering Group (NMSG); n=47 interviews with representatives from a range of agencies involved in four purposefully selected case study sites) Sep 2010- Jan 2011) [Multi-agency meetings involving statutory and voluntary agency representatives, who share information about high-risk victims of DV to develop a coordinated action plan to improve victim safety; including following types of agencies: police, probation, health and housing, IDVAs, children's services] National MARAC Steering Group (NMSG) participants identified three integral areas of MARACs' effectiveness, including: improved information sharing; suitable agency representation; and the involvement of the IDVA in representing the victim. Respondents to the national survey reported that in their opinion, their MARAC was: effective at enhancing information sharing (84%); strengthening links between partner agencies (80%); and improving awareness of domestic abuse among partner agencies (76%). When asked about the CAADA 10 principles of an effective MARAC the majority of survey participants (88%) reported being either 'familiar' or 'very familiar' with the principles and the majority (98%) also reported that their MARAC followed all, or most of the ten principles. Quality assurance data revealed that administration and research and information sharing were the two CAADA principles most consistently achieved, while action planning was the principle that MARACs appear to consistently perform less well on.

Qualitative Studies

Allen et al., 2008 (qualitative [+], USA, n=41 key informants from each of 41 DV coordinating councils (Councils=mean size of 39 members; mean length of existence of 64 months; informants were primarily council chair (56%) or coordinator (27%) and represented: DV shelter (56%), prosecuting attorney (20%), justice system victim advocates (7%), directors (7%), law enforcement (5%), probation officers (2%), and community organizations (2%)) [Primary activities coordinating councils engaged in, included: discussing issues (85%), sharing information (51%), identifying weaknesses in the system's response (85%), facilitating training of key stakeholders in the community response (95%), engaging in community education (73%), and lobbying stakeholders who are not members (90%)] Councils reported to be effective at improving knowledge (81%), particularly the role of other members; relationships (71%), such as dismantling stereotypes and formation of new bonds between members; and institutional change (93%) including development of new procedures, protocols and policies.

Robinson, 2006b (qualitative [+], UK, n=13 surveys (year 1), n=24 interviews (year 1 and 2)) 2 year evaluation period) [ASSIST offers advocacy, information and support to female and male victims with a partner or ex-partner in the Domestic Abuse Court. ASSIST administrators liaise with victims and with criminal justice personnel to improve the response to victims throughout court proceedings, along with providing crisis support, safety planning and referrals to other services] Surveys and interviews with criminal justice and voluntary service representatives reveal that ASSIST was perceived as an effective partnership approach, with strong working and commitment by members. Services were deemed to improve advocacy for victims and the courts.

Robinson & Rowlands, 2006 (qualitative [+], UK, n=171 case files (referrals over 12 month period); n=10 case studies; n=4 interviews with Dyn clients; n=7 interviews with practitioners from a range of agencies that have worked with the project (Of the case files, 5% of clients were <20 years old, 29% were age 21-30, 27% were age 31-40, and 21% were age 41-50; primarily White European; 25% of referrals were for gay male victims of domestic abuse) nr [Dyn project- a safety planning and advocacy service for gay, bisexual, transgender (GBT) and heterosexual men who have experienced DV in Cardiff and across Wales, delivered in a multi-agency model. The police typically referred Dyn clients. In Cardiff, the men can access either via telephone or face-to-face appointments: advice and information, support, and referrals to other agencies. For men living in other parts of Wales, there is a confidential helpline. The Dyn project also provides training to local and UK-wide agencies and facilitates a Forum for those working on the issues to network and share good practice] Strengths of the multi-agency approach included: information-sharing; providing a more complete picture of the amount and needs of men requiring services; increasing knowledge regarding male victims of DV; enhancing the awareness and response of other agencies to male victims; and offering a specialist service for GBT victims.

Sharp and Jones, 2011 (qualitative [+], UK, web survey n=6 coordinators, n=68 co-facilitators (14 men, 54 women; 5 affiliated with a local authority, 16 with social work, 6 with education, 1 with the police, 4 with child and adolescent mental health services, 12 with Women's Aid, 24 with voluntary sector organizations; primarily non-supervisory or management roles); n=5 telephone interviews) [Evaluation of 3 pilot sites for Cedar Programme- a 12 week group-work intervention for children/ young people and their mothers incorporating multi-agency professional learning and practice integration. Specifically, co-facilitators of the programme represent a variety of agencies including: social work, education, nursery or childcare departments, the police, child and adolescent mental health services, and voluntary sector organisations with a domestic abuse, sexual abuse or single parent focus] The pilot programme provided training for generalist agencies to address domestic abuse recovery, providing new group-work skills and education on theory, language and available resources. Over the course of the pilot, there was an increase in the involvement of non-social work local authority staff. Most co-facilitators reported greater communication and knowledge-sharing between agencies and enhanced awareness of available resources.

Applicability

Seven studies were conducted in the UK (Penhale et al., 2007 [+]; Robinson, 2003 [+]; Robinson, 2006a [+]; Robinson, 2006b [+]; Robinson & Rowlands, 2006 [+]; Sharp & Jones, 2011 [+]; Steel et al., 2011 [+]) and two in the USA (Allen et al., 2008 [+]; Banks et al., 2008a [+]).Of the US studies, one study evaluates the implementation of a specific set of principles for collaboration between child welfare and DV agencies to address co-occurring child maltreatment and DV in the US, and therefore may not be applicable to other settings (Banks et al., 2008a [+]).While the study by Allen et al., 2008 [+] was conducted in the US, there are no specific applicability issues to the UK context.

Evidence Statement 32- Enabling factors to partnership working

There is moderate evidence from six studies that various enabling factors, such as leadership and management, active membership, community involvement, strong relationships and communication, training and resources, are associated with effective partnership working.

Three quantitative and mixed methods studies provide information on enabling factors to partnership working. A cross-sectional study (Allen, 2005 [+]) found that DV coordinating councils were more likely to be rated as effective by council members when they had efficient and inclusive leadership and a diverse breadth of active membership; but conflict resolution, breadth of formal membership and presence of formal structures were not significantly related to perceived effectiveness. A before and after and qualitative study (Banks et al., 2008b [+]) found that several themes emerged as important for the success of the Greenbook initiative to address the co-occurrence of DV and child maltreatment, including: institutional empathy, effective

leadership, reaching out to the community, needs assessment, and the maintenance of collaborative relationships. In addition, several factors were rated as important facilitators to collaboration, including (scored in decreasing importance): partners having the needs of women and children in mind, involvement of key agencies/ groups, having the right people at the table, strong leadership, and commitment of key leaders; and at follow-up, stakeholders were significantly less likely to agree that the involvement of key agencies and groups was a facilitator. A cross-sectional and qualitative study (Steel et al., 2011 [+]) examining the experiences of a national sample of MARAC members reported key factors to support effective practices, including: strong partnership links; strong leadership facilitated by the MARAC chair; good coordination from the MARAC coordinator; and the presence of training and induction.

Three qualitative studies also provide evidence on enabling factors for partnerships to address DV. A qualitative report (Donovan et al., 2010 [+]) examining two multi-agency partnerships for addressing DV, revealed that strong developmental factors (including strong multi-agency working relationships; strong DV infrastructure; processes for development, management, and monitoring of the new initiative; and manageable size and scope of the new initiative) contributed to more effective multi-agency working relationships and the capacity to manage issues related to power, communication and resources during the operational phase. A qualitative study (Laing et al., 2012 [+]) examining a working group to improve collaboration between DV and mental health service sectors revealed the following facilitators to collaboration: commitments that build trust and having a shared sense of purpose; relationship building; developing "institutional empathy"; and fair leadership and neutrality by the research team (team leading the project). Finally, a qualitative study (Woodford, 2010 [+]) reported the following factors associated with the success of a community-government collaborative workgroup aimed with improving income support services for victims of IPV: leadership by the host department; willingness to be measured risk takers; small group size and strong group composition; provision of resources and focus on departmental policy issues; trust, respect, open communication, and equity within the group; and purposeful consideration of responsiveness and feasibility.

Quantitative and mixed-methods studies

Allen, 2005 (cross-sectional [+], USA, survey n=511 members; interview n=key informants from 41 DV coordinating councils (councils ranged from 8-166 members; 7 months -16 years of establishment; 5- 17 stakeholder groups and 3-14 active stakeholder groups) [DV Coordinating Councils varied in context and goals (e.g. health-care, public education, criminal justice), but overall aimed at: improving practices and policies for institutional responses to DV, improving communication and cooperation between systems, and enhancing public awareness and responsiveness to DV. Measured participants' views of council effectiveness] On average, responses to statements of council effectiveness were rated as "mostly true" (mean=4.35, SD=0.53). Councils were viewed as less effective at achieving longer term goals (mean=4.27, SD=0.58) compared to intermediate goals (mean=4.50, SD=0.52; $t=-4.46$, df=40, $p<0.001$). Leadership ($p<0.003$) and the breadth of active membership ($p<0.001$) were both predictors of perceived council effectiveness, and shared power in decision-making trended towards significance ($p<0.03$). Conflict resolution, breadth of formal membership, and degree to which councils had formal structures in place (e.g. agenda, established decision making processes) was not significantly related to perceived council effectiveness.

Banks et al., 2008b (before and after and qualitative [+], USA, Survey n=86 (baseline), n=62 follow-up (10-20 stakeholders from each of 6 demonstration sites; Interview n=8-12 stakeholders from each of the 6 demonstration sites; The populations under study were mixed (some racially homogeneous and others ethnically and culturally diverse); Organizations ranged in size: 30% 1-20, 16% 21-100, 45% 100+), baseline, annual 6 year follow-up [Evaluation of Greenbook initiative at 6 demonstration sites, a collaborative roadmap for child welfare systems, dependency courts, and domestic violence service providers (DVSPs) with the principles of promoting safety and well-being for all victims of family violence, holding batterers accountable, and structuring responses to families that are dealing with the co-occurrence of DV and child maltreatment] Qualitative

analysis revealed several themes reported to be important for the success of the initiative, including: institutional empathy, effective leadership, reaching out to the community, needs assessment, and the maintenance of collaborative relationships. At baseline, the top five facilitators of collaborative work as rated by survey respondents were (1=not at all, 5=very much): "the partners have the needs of the women and children in mind" (mean=4.167), "involvement of certain key agencies/ groups" (mean=4.155), "having the right people at the table" (mean=4.071), "strong leadership" (mean=4.024), and "commitment of key leaders (mean=3.988). Only one facilitator, "involvement of certain key agencies/ groups", changed significantly from baseline to follow-up, with respondents becoming significantly less likely to think of it as a facilitator (baseline mean=4.155 SD=0.814, follow-up mean=3.836, SD=0.969, p=0.033).

Steel et al., 2011 (cross-sectional and qualitative [+], UK, n=performance data from 208 MARACs; n=quality assurance assessment data 83 MARACs; national survey (of MARAC Chairs, MARAC/ DV coordinators and IDVAs/ specialist domestic abuse support services from 90% of known MARACs (250 at the time); n=13 interviews with members of the National MARAC Steering Group (NMSG); n=47 interviews with representatives from a range of agencies involved in four purposefully selected case study sites) Sep 2010- Jan 2011) [Multi-agency meetings involving statutory and voluntary agency representatives, who share information about high-risk victims of DV to develop a coordinated action plan to improve victim safety; including following types of agencies: police, probation, health and housing, IDVAs, children's services] A review of existing literature on MARAC effectiveness along with analysis of NMSG and case study interviews revealed the following key factors to support effective practices of MARACs: strong partnership links; strong leadership facilitated by the MARAC chair; good coordination from the MARAC coordinator; and the presence of training and induction. Generally, there was agreement with best practice guidelines indicating that six core agencies should have regular involvement on MARACs, including: police, probation, IDVAs, housing, children services, and health.

Qualitative Studies

Donovan et al., 2010 (qualitative [+], UK, Cumbria, Letgo n=55 senior management interviews, 52 frontline staff interviews, and 21 partnership meetings and 5 steering group meetings were observed; Gateshead, Safer Families n=98 senior management interviews, 72 frontline staff interviews, and15 partnership meetings and 16 steering group meetings were observed (Gateshead: urban setting; Cumbria: rural setting), interviews every 6 months for first 3 years of project) [Evaluation of two multi-agency partnerships aimed at providing holistic, early intervention and specialist services to victims of DV, children and perpetrators, through early intervention at crisis. The service in Gateshead was developed within an existing one, "Safer Families," and police were the only source of referral. The project in Cumbria was piloted with 'Letgo' as the new service, and police were the primary but not only source of referral. Both offered tailored, individual support for victims, individual and group work for children and voluntary perpetrator programmes. IDVAs conducted a risk assessment, provided safety planning and conducted an assessment of need, and if necessary referrals to appropriate partner agencies for which they would act as an advocate and offered emotional and practical support. Type and frequency of contact varied dependent on the particular needs of victims] The Cumbria project developed more effective multi-agency working relationships than the Gateshead project due to stronger developmental factors including: strong multi-agency working relationships; strong DV infrastructure; processes for development, management, and monitoring of the new initiative; and manageable size and scope of the new initiative. Issues of power, communication and resources were encountered in each project although the Cumbria project was better positioned to navigate these challenges due to the presence of stronger developmental factors. However, both projects demonstrated challenges in processes for monitoring the new initiative across partner agencies.

Laing et al., 2012 (qualitative [+], Australia, Time 1 n=9 mental health workers and 7 DV workers; Time 2 n=6 mental health and 5 DV workers (workers from shelters and community based outreach services (e.g. social workers, psychologists, community workers), and mental health providers from inpatient, crisis and outpatient teams (e.g. nurses, occupational therapist, social

workers), 6 months into project (Time 1), 12 months (Time 2) [A working group met monthly for 12 months to develop ideas to improve collaboration between DV and mental health service sectors. Using action research principles, they engaged in a process of: generation of initiatives, reflecting on and evaluating outcomes, and refining outcomes. Priorities identified included: enhancing communication and development of a service agreement. Communication was improved through joint training seminars that improved knowledge and skills related to DV and the development of service agreements between DV and mental health workers. At monthly meetings, members reviewed joint cases highlighting practices that required attention in order to improve collaboration] Mental health practitioners reported several aspects that facilitated collaboration, including: commitments that build trust and having a shared sense of purpose; relationship building; developing "institutional empathy"; and fair leadership and neutrality by the research team (team leading the project).

Woodford, 2010 (qualitative [+], Canada, n=12 workgroup members (representing: governmental and non-governmental sectors including advocacy groups and stakeholders from partner government departments and agencies; representation from all regions in the province, and government officials including: policy workers, operational managers and frontline staff) nr) [Community-government collaborative workgroup tasked with providing recommendations on how to improve income support services for victims of IPV, held for an eight month period, and involved engagement and consultation with other community and governmental stakeholders. They identified 16 issues and developed 27 recommendations, all of which were implemented through processes of collaboration involving community agencies with departmental staff in the formation of operational policies] Overall, informants described the workgroup as extremely positive, all viewing it as a case of successful community participation. Each informant reported being actively involved, viewed themselves as meaningful partners in the policy making process, and believed that the changes made improved services for victims of IPV. Interrelated design, context and process factors were found to facilitate the success of the workgroup, including leadership by the host department; willingness to be measured risk takers; small group size and strong group composition; provision of resources and focus on departmental policy issues; trust, respect, open communication, and equity within the group; and purposeful consideration of responsiveness and feasibility.

Applicability

Two studies were conducted in the UK (Donovan et al., 2010 [+]; Steel et al., 2011 [+]); one in Australia (Laing et al., 2012 [+]), one in Canada (Woodford, 2010 [+]), and two in the USA (Allen, 2005 [+]; Banks et al., 2008b [+]). Two studies were small qualitative studies conducted examining partnership working within a specific context in Australia (Laing et al., 2012 [+]) and Canada (Woodford, 2010 [+]) and therefore may not be generalisable to other settings. One study evaluates the implementation of a specific set of principles for collaboration between child welfare and DV agencies to address co-occurring child maltreatment and DV in the US, and therefore may not be applicable to other settings (Banks et al., 2008b [+]). There is no reason to believe that findings from the other studies would not be applicable to the UK context.

Evidence Statement 33- Barriers to partnership working

There is moderate evidence from nine studies regarding the barriers and challenges to effective partnership working, including: lack of resources (financial and human), differences in the culture of agencies/ organizations, leadership and management issues, lack of commitment, limited monitoring, and addressing diverse populations.

Seven quantitative and mixed methods studies provide evidence on barriers and challenges to partnerships to address DV. A before and after study (Banks et al., 2008a [+]) examining a collaboration between child welfare and DV agencies found that stakeholders reported: inconsistent use of screening tools for DV, along with confidentiality issues among multi-disciplinary case review teams. A before and after and qualitative study (Banks et al., 2008b [+]) examining the Greenbook initiative to address the co-occurrence of DV and child maltreatment,

found that over time respondents were less likely to cite accessibility of data as an obstacle but more likely to agree that lack of resources, burnout of participants, conflicting organizational cultures, lack of leadership buy-in, and lack of accountability were obstacles to success. A cross-sectional and qualitative study (Penhale et al., 2007 [+]) of a multi-agency approach to protect vulnerable adults from abuse based on 'No Secrets'/ 'In Safe Hands' guidance, noted the following challenges: lack of resources, lack of specific legislation to protect vulnerable adults, a concern that some agencies view the guidance as optional, and ambiguous commitment from agencies at local levels. A cross-sectional study (Robinson, 2003 [+]) evaluated the Women's Safety Unit (WSU) which offers a central point for a range of support services for DV victims and their children, note the need for further work to address 'hidden' populations, including: women who have experienced sexual abuse by an intimate partner; ethnic minority women and homosexual women and men. A cross-sectional and qualitative study (Robinson, 2006a) evaluating a sample of MARAC case outputs found that key informants reported concerns over victim cooperation and administrative responsibilities. A cross-sectional and qualitative study (Stanley et al., 2011 [+]) evaluating police notifications of child protection services in cases of DV where a child was present, revealed inconsistencies in police reporting, and limited knowledge of the roles and expectations of the other partner agency; new approaches to improve information sharing are provided. Finally, a cross-sectional and qualitative study (Steel et al., 2011 [+]) examining experiences of a national sample of MARAC members reported the following limitations/ areas for improvement: improving clarity regarding the links between MARACs and other multi-agency procedures working with victims of domestic abuse, developing links with services aimed at responding to perpetrators, monitoring and evaluation of MARACs, verifying that MARACs are reflective of the community context (specifically, the need for representation from Black and Minority Ethnic (BME) and Lesbian, Gay, Bisexual and Transgender (LGBT) agencies), and providing ongoing local and national training.

There is also evidence from 2 qualitative studies regarding barriers to partnership approaches to DV. One qualitative study (Giacomazzi and Smithey, 2001 [+]) found that self interest as a motivation for participation, leadership and dominance of the process by law enforcement, organizational ambiguity, and an absence of key players were challenges to the effectiveness of a multi-level collaborative public-private partnership to address DV. Finally, a qualitative study (Sharp & Jones, 2011 [+]) evaluating a collaborative intervention for children and young people who have experienced violence, reported the need for: clarification of the roles and expectations of partner agencies and the need to include diverse co-facilitators.

Quantitative and mixed methods studies

Banks et al., 2008a (before and after [+], USA, n=81 caseworker surveys (baseline), n=135 caseworker surveys (follow-up); n=616 case files (baseline), n=642 (2 year), n=562 (4year); interviews with 8-12 stakeholders at each of 6 sites (total number NR) (interviews included child welfare agency leaders, board members, research partners, and agency staff; other descriptors of participants or agencies NR), baseline, 2 year (surveys and case files), 4 year (case files)) [Examined implementation of the Greenbook principles, a 'roadmap' for collaboration between child welfare and DV agencies to address co-occurring child maltreatment and DV, at six demonstration sites. The Greenbook includes guidelines regarding: collaboration between child welfare systems and child dependency courts (which address child abuse and neglect) and DV service providers; leadership to offer resources and services to support family safety; creating service plans and providing referrals with the goals of safety, stability, and well-being for all victims of family violence; and accountability of DV perpetrators] While all sites implemented screening tools for DV at intake, stakeholders noted inconsistent use of these tools. Three sites implemented a multidisciplinary case review team, yet stakeholders noted constraints in understanding differing institutional policies, specifically confidentiality issues.

Banks et al., 2008b (before and after and qualitative [+], USA, Survey n=86 (baseline), n=62 follow-up (10-20 stakeholders from each of 6 demonstration sites; Interview n=8-12 stakeholders from each of the 6 demonstration sites; The populations under study were mixed (some racially

homogeneous and others ethnically and culturally diverse); Organizations ranged in size: 30% 1-20, 16% 21-100, 45% 100+), baseline, annual 6 year follow-up [Evaluation of Greenbook initiative at 6 demonstration sites, a collaborative roadmap for child welfare systems, dependency courts, and DV service providers (DVSPs) with the principles of promoting safety and well-being for all victims of family violence, holding batterers accountable, and structuring responses to families that are dealing with the co-occurrence of DV and child maltreatment] At baseline, the top five obstacles were: "taking longer than expected" (mean=3.476), "existence/ accessibility of data" (mean=3.325), "lack of time by participants" (mean=3.301), "conflicting organizational cultures" (mean=3.274), and "poor understanding of Greenbook Initiative" (mean=3.083). Over time, stakeholders were significantly less likely to agree that existence/ and accessibility of data were was an obstacle: (baseline mean=3.325 SD=1.220, follow-up mean=2.871 SD=1.079, t(140)=2.312,p=0.022), but were more likely to agree that the following were obstacles at follow-up: lack of resources (t(143)=–3.133 baseline mean=3.012 SD=1.293, follow-up mean=3.654 SD=1.073, p=0.002); burnout of participants (t(143)=–4.258 baseline mean=2.349 SD=1.109, follow-up mean=3.177 SD=1.222, p=0.000); conflicting organizational cultures (t(144)=–2.086 baseline mean=3.274 SD=1.186, follow-up mean=3.677 SD=1.113, p=0.039); lack of leadership buy-in (t(143)=–1.946 baseline mean=2.167 SD=1.051, follow-up mean=2.525 SD=1.149, p=0.054); and lack of accountability (t(116)=–2.505 baseline mean=2.134 SD=1.075, follow-up mean=2.645 SD=1.307, p=0.014).

Penhale et al., 2007 (cross-sectional and qualitative [+], UK, (Phase 1) final analytic sample n=133 Councils with Social Services Responsibilities (CSSRs) (60% of surveys were completed by adult protection coordinators, 39% by a manager with adult protection responsibility, and one respondent did not indicate their role); (Phase 2) n=32 senior social services managers representing 26 local authorities (range of geography, local authority type, affluence/ deprivation status, assessed performance and history of adult protection working); and interviews with social service workers, adult protection coordinators, training staff, policy managers, and legal officers (numbers NR); and focus groups n=271 participants (in each of the 26 sampled local authorities, all members of the local adult protection committee (APC); (Phase 3): n=22 interviews; 19 focus groups (in 16 areas, most different from Phase 2 sample; including service users, care-givers and relatives, and representatives from service user groups and support organizations), NR [Multi-agency approach to protect vulnerable adults from abuse (No Secrets/ In Safe Hands). The main components of this multi-agency approach were: development of an inter-agency framework; a multi-agency management committee (or adult protection committee); a clear definition of the roles and responsibilities of each agency; developing an inter-agency policy with policies and principles; implementation of procedures for receiving and responding to referrals related to adult protection; joint protocols for information sharing; contract monitoring for independent providers; implementation of systems to monitor the effectiveness of adult protection work; adult protection training strategies for relevant staff groups] The four key inhibitors to partnership reported were: lack of resources; lack of specific legislation to protect vulnerable adults; a concern that some agencies view the 'No Secrets'/ 'In Safe Hands' guidance as optional; and ambiguous commitment from agencies at local levels to fully participate in partnership working.

Robinson, 2003 (cross-sectional [+], UK, n=222 WSU client interviews (White females, under 40, with children, average 6 years of physical abuse & one-quarter experienced sexual abuse); n=12 prosecutor surveys (mean of 40 years, White British, mean work experience of 11 years & 7 years in current position); n=77 case files from Crown Prosecution Service) [Evaluation of Women's Safety Unit (WSU) in Cardiff which provides a central point of access for women and children who experience DV, offering: advocacy, advice, counselling, legal services, housing services, shelter provision and target hardening] Further work is required to address 'hidden' populations, including: women who have experienced sexual abuse by an intimate partner; ethnic minority women and homosexual women and men. They note the need for additional awareness campaigns and/ or funding to support services and initiatives to include these groups.

Robinson, 2006a (cross-sectional and qualitative [+], UK, n=146 MARAC cases (all women) (analytic sample); Interviews n=subsample of 27 women (all women, average age 29 years,

primarily White European, with children in the home, and unemployed, with previous DV complaints. Offenders were an average age of 33 years, primarily White European, unemployed, current or ex partner); Key informant interviews with: police (n=3), probation (n=1), Women's Safety Unit (WSU) (n=1), social services (n=1), housing and homelessness (n=2), health (n=1), and Women's Aid (n=1)) 1-6 months) [MARACs were held every 2 weeks, and offered a space for sharing of information and planning actions to reduce further harm to high risk victims and their children. Meetings included discussion of the circumstances of victims, and development of plans to support their safety. High-risk victims were identified by police risk indictor forms or a case being brought forward by a representative from a participant agency. MARACs tend to include 15 attendees, including representation from: police, probation, social services, the WSU, health, and housing] Key informant participants noted potential issues to partnership effectiveness related to the cooperation of victims (e.g. that victims make the ultimate decision if they want to remain with their partner) and administrative responsibilities (e.g. meeting preparations, developing lists of high risk victims).

Stanley et al., 2011 (cross-sectional and qualitative [+], UK, n=184 case police/ social service case reports (over 21 month period); interview n=58 (police officers, DV advocates, supervising officers, social workers, service administrators, managers; average 10 years experience); survey n=57 Chairs of Local Safeguarding Children's Boards) [Evaluated the (required since 2002) notification of child protection services by police in cases of DV where a child is present, in two local authorities in the UK] Children's social workers reported: a lack of information on children's experiences of DV in the notifications, some notifications that involved a verbal incident that did not require a response from their service, and challenges in contacting frontline officers and specialist DV workers outside of formal statutory meetings. Both police officers and social workers reported a need for inter-professional training could improve knowledge of each other's roles and expectations. When police records were matched up with social services records, inconsistencies were found in 40% of the reports; 2 police notifications did not report children's exposure to DV even though it was included in the police report. In addition, only 19% of the police records included a narrative description and only 15% of families notified to child protection services received an assessment or intervention. Survey respondents identified four approaches for improving collaboration, including: increasing the potential for early intervention by directing families away from social services to either voluntary or health organizations; regular interagency meetings to screen notifications; utilizing police risk assessment methods as tools for filtering and directing families to services; and the development of a risk assessment tool that focuses on the child rather than the victim.

Steel et al., 2011 (cross-sectional and qualitative [+], UK, n=performance data from 208 MARACs; n=quality assurance assessment data 83 MARACs; national survey (of MARAC Chairs, MARAC/ DV coordinators and IDVAs/ specialist domestic abuse support services from 90% of known MARACs (250 at the time); n=13 interviews with members of the National MARAC Steering Group (NMSG); n=47 interviews with representatives from a range of agencies involved in four purposefully selected case study sites) Sep 2010- Jan 2011) [Multi-agency meetings involving statutory and voluntary agency representatives, who share information about high-risk victims of DV to develop a coordinated action plan to improve victim safety; including following types of agencies: police, probation, health and housing, IDVAs, children's services] Possible areas for future development included: improving clarity regarding the links between MARACs and other multi-agency procedures working with victims of domestic abuse, developing links with services aimed at responding to perpetrators, monitoring and evaluation of MARACs, verifying that MARACs are reflective of the community context, and providing ongoing local and national training. Participants noted the need for representation from Black and Minority Ethnic (BME) and Lesbian, Gay, Bisexual and Transgender (LGBT) agencies. Many participants indicated that it may be useful to place MARACs on a statutory footing, suggesting that this may improve agency representation; enhance accountability; and provide better continuity and consistency. However, potential issues with this approach included: greater bureaucracy and responsibility placed on agencies; and the potential that this may compromise victim engagement in the process.

Qualitative Studies

Giacomazzi and Smithey, 2001 (qualitative [+], USA, n=11 participants representing 11 agencies (7 were women and 4 men; 2 probation officers, 1 policeman, 1 private security officer, 2 non-profit advocates, 2 human services, 1 educator, 1 court administrator, 1 military, and 1 legal aid), 2 focus groups at end of planning, 2 at one year following implementation) [Evaluation of multi-level collaborative public-private partnership between the police and 88 organizations, including: city, district and county attorney's offices; adult and juvenile probation and parole offices; military; school district; judges; municipal, county, and state legal aid; battered women's shelter; YMCA; transitional living centre; clergy; and volunteer services] Despite the appearance of collaboration, several issues emerged during focus groups, which threatened to disrupt the collaborative inter-agency work, including: self interest as a motivation for participation or 'turfism'; leadership and dominance of the process by law enforcement; organizational ambiguity leading to unclear expectations; and an absence of key players in the implementation phase.

Sharp and Jones, 2011 (qualitative [+], UK, web survey n=6 coordinators, n=68 co-facilitators (14 men, 54 women; 5 affiliated with a local authority, 16 with social work, 6 with education, 1 with the police, 4 with child and adolescent mental health services, 12 with Women's Aid, 24 with voluntary sector organizations; primarily non-supervisory or management roles); n=5 telephone interviews) [Evaluation of 3 pilot sites for Cedar Programme- a 12 week group-work intervention for children/ young people and their mothers incorporating multi-agency professional learning and practice integration. Specifically, co-facilitators of the programme represent a variety of agencies including: social work, education, nursery or childcare departments, the police, child and adolescent mental health services, and voluntary sector organisations with a domestic abuse, sexual abuse or single parent focus] Challenges were noted among some providers regarding the appropriate threshold for intervention for some referrals, as well as ambivalence among some agencies because the programme was not perceived as their primary function. Further work is required to: form relationships with specialist agencies; to clarify the expectations of partner agencies regarding referrals and working practices to avoid either the omission or repetition of efforts. They also note the need to recruit more male co-facilitators as well as include a more diverse representation from minority groups including: LGBT, disabled, and minority ethnic populations.

Applicability

Six studies were conducted in the UK (Penhale et al., 2007 [+]; Robinson, 2003 [+]; Robinson, 2006a [+]; Sharp & Jones, 2011 [+]; Stanley et al., 2011 [+]; Steel et al., 2011 [+]) and three in the USA (Banks et al., 2008a [+]; Banks et al., 2008b [+]; Giacomazzi & Smithey, 2001 [+]). One is a small qualitative study conducted in the USA, and therefore findings may not be generalisable (Giacomazzi & Smithey, 2001 [+]). Two studies evaluated the implementation of a specific set of principles for collaboration between child welfare and DV agencies to address co-occurring child maltreatment and DV in the US, and therefore may not be applicable to other settings (Banks et al., 2008a [+]; Banks et al., 2008b [+]).

8.6. Discussion

8.6.1. Summary of Findings

Twenty-one studies were included in this review section and organized into four evidence statements: effectiveness for increasing referrals and addressing violence; interagency information sharing and policy development; enabling factors to partnership working; and barriers to partnership working. All studies received a moderate quality rating [+]. These studies included: collaborations among various service providers for handling cases of DV (including: DV agencies, child welfare, police, mental health services), the impact of source of referral on outcomes, MARAC evaluations, evaluations of a community coordinating council, multi-agency approaches to elder abuse, a multi-agency service for gay, bisexual, transgender and heterosexual men who

have experienced DV, a partnership model to address children who witness violence. All studies included partnerships with health, social care, or both health and social care agencies (the details of which are provided in the narratives).

There is moderate evidence from 11 studies that partnerships to address DV were effective at: increasing referrals, reducing further violence, or supporting victims of DV. In general, the majority of studies found that partnership approaches were associated with improvements in various abuse-related measures including: reduced family conflict, a lower risk of mistreatment for elders, reduced re-victimization or threat of violence, improved response to and safety for victims, and increased referrals to support services. In contrast, findings from one study (Penhale et al., 2007 [+]) suggest that a multi-agency approach was not effective in meeting the needs of vulnerable adults; service users reported negative experiences with accessing and using the adult protection services.

There is also moderate evidence from nine studies that partnership approaches have been effective in improving relationships, practices and policies of partner agencies to address DV. Findings from these studies were typically based on stakeholder reports. Overall, findings revealed improvements in: relationships and collaboration between partners, training, knowledge and sharing of information and resources, the development of policies and protocols, involvement of key agencies/ stakeholders.

There is moderate evidence from six studies regarding enabling factors to partnership working. These studies examined member/ stakeholder responses to identify factors associated with the perceived success of the partnership. Overall, studies identified the following enabling factors as key to partnership working: strong leadership, management and coordination, active membership, community involvement, strong relationships and communication, training and resources. Findings from one study (Donovan et al., 2010 [+]) suggest that the presence of strong foundational factors may enable partnerships to more effectively manage potential conflicts (related to communication, resources, etc.).

There is moderate evidence from nine studies regarding the barriers and challenges to effective partnership working. These studies relied on member/ stakeholder responses to identify barriers to partnership working. The following barriers were reported: lack of resources (financial and human), differences in the culture of agencies/ organizations, leadership and management issues, lack of commitment, limited monitoring, and addressing diverse populations. Issues related to the inconsistent following of protocols or guidelines, and confidentiality issues among multi-disciplinary case review teams were commonly cited challenges. The lack of diverse representation in partnerships, and challenges in addressing DV among specific vulnerable groups including LGBT, Black and Minority Ethnic (BME) groups and women who experience sexual abuse was noted in several studies (including Robinson, 2003 [+]; Sharp & Jones, 2011 [+]; Steel et al., 2011 [+]).

8.6.2. Gaps in the Literature

It is difficult to measure the effects of multi-faceted and multi-sectorial approaches to prevention of DV, such as partnerships. There were no high quality studies, and the majority of studies that were included were before or after or qualitative studies providing narrative reports of findings. Some methodological weaknesses of these studies include: scant information on data collection, methods and analysis, or description of sampling; and small sample size (particularly for qualitative studies). However, many studies were conducted in the UK (nine out of twenty), so applicability of the available evidence is relatively high.

Note that within the evidence statement related to advocacy interventions for victims of DV, there is moderate evidence of effectiveness for advocacy interventions that link or refer women who have experienced DV with various support services and resources (including: housing, legal, addictions, mental health, etc.). Some improvements noted within this evidence statement

include: women's access to community resources, reductions in rates of IPV, improvements in safety, decreased depression, reductions in various stressors, and improvements in parenting stress and children's well-being (see chapter four for more details). Together with findings from this section, these findings suggest that victims of DV may benefit from advocacy-related and multi-agency responses, although there is a lack of strong (i.e. [++]) studies in the literature.

There was a lack of research examining partnership working specifically addressing 'honour'-based violence. While no studies were found evaluating the effectiveness of multi-agency approaches for addressing 'honour'-based violence or forced marriage, multi-agency practice guidelines for handling cases of forced marriage do exist in the UK (Stobart, 2009) and MARACs in the UK do cover cases of 'honour'-based violence.

There was also a lack of research that specifically discussed the inclusion or impact of partnership working that is related to agencies serving men who experience violence (one exception was the study by Robinson & Rowlands 2006 [+] which evaluated the Dyn Project) or for diverse sub-groups of women and men experiencing violence. No studies discussed the impact of partnership working for lesbian women who experience violence. One report notes that MARACs in the UK do not currently review a large number of cases of LGBT victims (less than 1% in the year leading up to December 2007) (Co-ordinated Action Against Domestic Abuse, 2012). This may be due to a lack of recording of cases involving LGBT victims, a lack of referral to the MARACs, and/ or a lack of access of domestic abuse or police services by LGBT victims of abuse. They note the need for inclusion of LGBT agencies and community groups on MARACs, and the need for representatives from the LGBT agencies participating in MARACs to encourage referrals and recording of accounts involving LGBT victims. More robust evaluations are required to examine partnership responses for victims, perpetrators, and children who experience violence and to address elder abuse and 'honour' based violence.

A key aspect of improving the response to DV is the involvement of related service systems, such as the alcohol treatment system. Only one study included in the main report assessed integrated DV and substance use services (Bennett & O'Brien, 2010 [+]) and they did not evaluate the effectiveness of the partnership but rather focused on outcomes for women who enter various 'doors' of service.

Several of the facilitators and barriers to effective multi-agency working identified in the evidence statements are echoed in the contextual literature. For example, the literature review included in the report by Robinson and Tregidga (2005) reveals key components of MARACs for addressing DV as: ongoing communication, conducting risk assessment, providing advocacy to victims, translating policy into action, and holding perpetrators accountable. In addition, criticism has been made that if ineffectively structured, multi-agency partnerships risk becoming "talking shops" (Robinson, 2005). Another criticism made of multi-agency approaches is the limited involvement of victims and witnesses in the monitoring and intervention process, leading to potential issues regarding agency accountability to victims (Cordis Bright Consulting, 2011).

Finally, there are several examples of multi-agency approaches to respond to DV in the UK that were not captured in the main findings of the report (i.e. did not meet inclusion criteria). Two examples include Manchester's Multi-agency Domestic Abuse Strategy and London's DV Strategies (2001; 2005). Manchester's Second Multi-agency Domestic Abuse Strategy is aimed at addressing communication, prevention, provision and protection related to DV (Manchester Partnership, 2010). Some of the strategies include embedding DV into multi-agency priorities; promoting standardized training for DV and forced marriage by safeguarding boards; developing and implementing referral processes for all statutory and voluntary sector services to domestic and sexual violence services; and evaluating and building upon various forms of multi-agency work including: the multi-agency criminal justice work of the Integrated Domestic Abuse Programme (IDAP), Multi-agency Risk Assessment Case Conference (MARAC), Multi-agency Public Protection Arrangements (MAPPA) and the Specialist Domestic Violence Courts.

In 2001, the mayor of London released a London Domestic Violence Strategy which provided a vision for addressing DV (Mayor of London, 2001). This included a focus on the coordination of DV services and the development of a London-wide Domestic Violence Forum to facilitate joint planning and service provision. The report highlights the various components of a successful inter-agency DV forum including: involvement of statutory agencies with senior management support; involvement of Women's Aid, independent refuge projects and advocacy services; participation of community and women's organizations; involvement of the voluntary sector; consistent and committed attendance and involvement of members (ideally as part of job fulfillment); commitment from member agencies; adoption of guiding principles; clear aims and objectives and terms of reference; clear and accountable working structure, avoiding unnecessary bureaucracy; resources for activities and co-ordination of the Forum; employment of a co-ordinator with administrative support; focusing all activities on the needs of abused women and children and the reduction of violence; development of concrete initiatives and activities which are; integration of equalities issues; involvement of, and informal accountability to, women survivors of DV and their children; and evaluation and monitoring of forum effectiveness.

The second London DV Strategy, released in 2005, provides a review of the achievements of the first strategy along with recommendations for moving forward (Mayor of London, 2005). While they note successes in improving networking and information sharing opportunities, they note several challenges, including: lack of engagement by some key agencies; wide variation in the expectations of the Forum by members; interest by a larger number of agencies than is manageable; and duplication with other DV fora. The key priority of the second strategy is for the development of IDVA services in every borough in London, noting that independence is integral to ensuring that victim safety is the priority of multi-agency involvement.

Appendix A. Search Strategies and Results

Database searches

MEDLINE (OvidSP)
Date of search: May 11, 2012
Number of records: 5334

1. Domestic Violence/
2. Spouse Abuse/
3. Battered Women/
4. Elder Abuse/
5. (domestic adj (violen* or abus* or attack* or cruel*)).tw.
6. (spous* adj3 (violen* or abus* or attack* or cruel*)).tw.
7. (intimate partner adj3 (violen* or abus* or attack* or cruel*)).tw.
8. (relationship adj3 (violen* or abus* or attack* or cruel*)).tw.
9. (batter* adj3 (wom#n or man or men or wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling*)).tw.
10. (assault* adj3 (wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling* or family)).tw.
11. (gender based adj (violen* or abus* or attack* or cruel*)).tw.
12. ((same sex or same gender) adj3 (violen* or abus* or attack* or cruel*)).tw.
13. (hono?r adj3 (killing or violen* or abus* or attack* or cruel*)).tw.
14. (force* adj2 marriage*).tw.
15. ((elder* or aged) adj3 (violen* or abus* or attack* or cruel*)).tw.
16. (child* adj parent adj3 (violen* or abus* or attack* or cruel*)).tw.
17. (parental adj (violen* or abus* or attack* or cruel*)).tw.
18. ((famil* or interpersonal) adj (violen* or abus* or attack* or cruel*)).tw.
19. (sibling* adj3 (violen* or abus* or attack* or cruel*)).tw.
20. or/1-19
21. evaluation studies as topic/ or feasibility studies/ or pilot projects/ or programme evaluation/
22. evaluation studies/ or validation studies/
23. exp treatment outcome/
24. intervention*.tw.
25. screening.tw.
26. exp Counselling/
27. counsel?ing.tw.
28. support*.tw.
29. (advice or advise).tw.
30. refuge*.tw.
31. Emergency Shelter/
32. emergency housing.tw.
33. therap*.tw.
34. prevent*.tw.
35. (collaborat* adj3 partner*).tw.
36. Information Dissemination/
37. mediat*.tw.
38. outreach.tw.
39. victim service*.tw.
40. (hotline* or helpline*).tw.
41. advoca*.tw.
42. protocol*.tw.
43. Guideline/
44. safety plan.tw.
45. communit*.tw.
46. Education/
47. Technology/
48. computer assisted.tw.
49. Health Promotion/
50. Harm Reduction/

51. recover*.tw.
52. school based.tw.
53. (conflict* adj3 resol*).tw.
54. (early adj3 identif*).tw.
55. (perpetrat* adj3 treat*).tw.
56. "Referral and Consultation"/
57. multi-agency.tw.
58. or/21-57
59. 20 and 58
60. limit 59 to (english language and yr="2000 -Current")

EMBASE (OvidSP)
Date of search: May 11, 2012
Number of records: 7086

1. Domestic Violence/
2. Family Violence/
3. Partner Violence/
4. Battered Woman/
5. Elder Abuse/
6. (domestic adj (violen* or abus* or attack* or cruel*)).tw.
7. (spous* adj3 (violen* or abus* or attack* or cruel*)).tw.
8. (intimate partner adj3 (violen* or abus* or attack* or cruel*)).tw.
9. (relationship adj3 (violen* or abus* or attack* or cruel*)).tw.
10. (batter* adj3 (wom#n or man or men or wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling*)).tw.
11. (assault* adj3 (wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling* or family)).tw.
12. (gender based adj (violen* or abus* or attack* or cruel*)).tw.
13. ((same sex or same gender) adj3 (violen* or abus* or attack* or cruel*)).tw.
14. (hono?r adj3 (killing or violen* or abus* or attack* or cruel*)).tw.
15. (force* adj2 marriage*).tw.
16. ((elder* or aged) adj3 (violen* or abus* or attack* or cruel*)).tw.
17. (child* adj parent adj3 (violen* or abus* or attack* or cruel*)).tw.
18. (parental adj (violen* or abus* or attack* or cruel*)).tw.
19. ((famil* or interpersonal) adj (violen* or abus* or attack* or cruel*)).tw.
20. (sibling* adj3 (violen* or abus* or attack* or cruel*)).tw.
21. or/1-20
22. evaluation/
23. qualitative research/
24. exp treatment outcome/
25. intervention*.tw.
26. screening.tw.
27. exp Counselling/
28. counsel?ing.tw.
29. support*.tw.
30. (advice or advise).tw.
31. refuge*.tw.
32. Emergency Shelter/
33. emergency housing.tw.
34. therap*.tw.
35. prevent*.tw.
36. (collaborat* adj3 partner*).tw.
37. Information Dissemination/
38. mediat*.tw.
39. outreach.tw.
40. victim service*.tw.
41. (hotline* or helpline*).tw.
42. advoca*.tw.
43. protocol*.tw.
44. Practice guidelines/
45. safety plan.tw.

46. communit*.tw.
47. Education/
48. Technology/
49. computer assisted.tw.
50. Health Promotion/
51. Harm Reduction/
52. recover*.tw.
53. school based.tw.
54. (conflict* adj3 resol*).tw.
55. (early adj3 identif*).tw.
56. (perpetrat* adj3 treat*).tw.
57. Patient referral/
58. multi-agency.tw.
59. or/22-58
60. 21 and 59
61. limit 60 to (english language and yr="2000 -Current")

Cochrane Database of Systematic Reviews (OvidSP)
Number of records: 75
Cochrane Central Register of Controlled Trials (OvidSP)
Number of records: 292
Database of Abstracts of Reviews of Effectiveness (OvidSP)
Number of records: 37
Date of searches: May 11, 2012

1. Domestic Violence/
2. Spouse Abuse/
3. Battered Women/
4. Elder Abuse/
5. (domestic adj (violen* or abus* or attack* or cruel*)).tw.
6. (spous* adj3 (violen* or abus* or attack* or cruel*)).tw.
7. (intimate partner adj3 (violen* or abus* or attack* or cruel*)).tw.
8. (relationship adj3 (violen* or abus* or attack* or cruel*)).tw.
9. (batter* adj3 (wom#n or man or men or wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling*)).tw.
10. (assault* adj3 (wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling* or family)).tw.
11. (gender based adj (violen* or abus* or attack* or cruel*)).tw.
12. ((same sex or same gender) adj3 (violen* or abus* or attack* or cruel*)).tw.
13. (hono?r adj3 (killing or violen* or abus* or attack* or cruel*)).tw.
14. (force* adj2 marriage*).tw.
15. ((elder* or aged) adj3 (violen* or abus* or attack* or cruel*)).tw.
16. (child* adj parent adj3 (violen* or abus* or attack* or cruel*)).tw.
17. (parental adj (violen* or abus* or attack* or cruel*)).tw.
18. ((famil* or interpersonal) adj (violen* or abus* or attack* or cruel*)).tw.
19. (sibling* adj3 (violen* or abus* or attack* or cruel*)).tw.
20. or/1-19
21. evaluation studies as topic/ or feasibility studies/ or pilot projects/ or programme evaluation/
22. evaluation studies/ or validation studies/
23. exp treatment outcome/
24. intervention*.tw.
25. screening.tw.
26. exp Counselling/
27. counsel?ing.tw.
28. support*.tw.
29. (advice or advise).tw.
30. refuge*.tw.
31. Emergency Shelter/
32. emergency housing.tw.
33. therap*.tw.
34. prevent*.tw.
35. (collaborat* adj3 partner*).tw.

36. Information Dissemination/
37. mediat*.tw.
38. outreach.tw.
39. victim service*.tw.
40. (hotline* or helpline*).tw.
41. advoca*.tw.
42. protocol*.tw.
43. Guideline/
44. safety plan.tw.
45. communit*.tw.
46. Education/
47. Technology/
48. computer assisted.tw.
49. Health Promotion/
50. Harm Reduction/
51. recover*.tw.
52. school based.tw.
53. (conflict* adj3 resol*).tw.
54. (early adj3 identif*).tw.
55. (perpetrat* adj3 treat*).tw.
56. "Referral and Consultation"/
57. multi-agency.tw.
58. or/21-57
59. 20 and 58
60. limit 59 to yr="2000 -Current"

AMED (via NICE)
Date of search: May 15, 2012
Number of records: 201

1. (domestic AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
2. (spous* AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
3. (intimate AND partner AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
4. (relationship AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
5. (batter* AND (wom#n OR man OR men OR wife OR wives OR husband* OR spous* OR partner* OR boyfriend* OR girlfriend* OR mother* OR father* OR parent* OR sibling*)).ti,ab
6. (assault* AND (wife OR wives OR husband* OR spous* OR partner* OR boyfriend* OR girlfriend* OR mother* OR father* OR parent* OR sibling* OR family)).ti,ab
7. ("gender based" AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
8. ((("same sex" OR "same gender") AND (violen* OR abus* OR attack* OR cruel*))).ti,ab
9. (hono?r AND (killing OR violen* OR abus* OR attack* OR cruel*)).ti,ab
10. (force* AND marriage*).ti,ab
11. (((elder* OR aged) AND (violenc* OR abus* OR attack* OR cruel*))).ti,ab
12. ((child* AND parent) AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
13. (parental AND (violenc* OR abus* OR attack* OR cruel*)).ti,ab
14. (((famil* OR interpersonal) AND (violenc* OR abus* OR attack* OR cruel*))).ti,ab
15. (sibling* AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
16. DOMESTIC VIOLENCE/ OR ELDER ABUSE/
17. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16
18. ((intervention* OR screening OR counsel?ing OR support* OR advice OR advise OR refuge* OR "emergency shelter" OR "emergency housing" OR therap* OR prevent* OR (collaborat* AND partner*) OR "information dissemination" OR mediat* OR outreach OR victim AND service* OR hotline* OR helpline* OR advoca* OR protocol* OR guideline* OR "safety plan" OR communit* OR "computer assisted" OR "harm reduction" OR recover* OR "school based" OR (conflict* AND resol*) OR (early AND identif*) OR (perpetrat* AND treat*) OR refer* OR multi-agency)).ti,ab
19. PROGRAMME EVALUATION/ OR TREATMENT OUTCOME/
20. COUNSELLING/
21. REFERRAL AND CONSULTATION/
22. HEALTH PROMOTION/
23. 18 OR 19 OR 20 OR 21 OR 22
24. 17 AND 23
25. 17 and 23 [Limit to: Publication Year 2000-Current and (Languages English)]

British Nursing Index (via NICE)
Date of search: May 15, 2012
Number of records: 290

1. ELDERLY ABUSE/ OR DOMESTIC VIOLENCE/
2. (domestic AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
3. (spous* AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
4. (intimate AND partner AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
5. (relationship AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
6. (batter* AND (wom#n OR man OR men OR wife OR wives OR husband* OR spous* OR partner* OR boyfriend* OR girlfriend* OR mother* OR father* OR parent* OR sibling*)).ti,ab
7. (assault* AND (wife OR wives OR husband* OR spous* OR partner* OR boyfriend* OR girlfriend* OR mother* OR father* OR parent* OR sibling* OR family)).ti,ab
8. ("gender based" AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
9. ((("same sex" OR "same gender") AND (violen* OR abus* OR attack* OR cruel*))).ti,ab
10. (hono?r AND (killing OR violen* OR abus* OR attack* OR cruel*)).ti,ab
11. (force* AND marriage*).ti,ab
12. (((elder* OR aged) AND (violenc* OR abus* OR attack* OR cruel*))).ti,ab
13. ((child* AND parent) AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
14. (parental AND (violenc* OR abus* OR attack* OR cruel*)).ti,ab

15. (((famil* OR interpersonal) AND (violenc* OR abus* OR attack* OR cruel*))).ti,ab
16. (sibling* AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
17. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16
18. CRISIS INTERVENTION/ OR HEALTH PROMOTION/ OR COUNSELLING/
19. SCREENING/
20. (intervention* OR screening OR counsel?ing OR support* OR advice OR advise OR refuge* OR "emergency shelter" OR "emergency housing" OR therap* OR prevent* OR (collaborat* AND partner*) OR "information dissemination" OR mediat* OR outreach OR victim AND service* OR hotline* OR helpline* OR advoca* OR protocol* OR guideline* OR "safety plan" OR communit* OR "computer assisted" OR "harm reduction" OR recover* OR "school based" OR (conflict* AND resol*) OR (early AND identif*) OR (perpetrat* AND treat*) OR refer* OR multi-agency).ti,ab
21. 18 OR 19 OR 20
22. 17 AND 21
23. 17 and 21 [Limit to: Publication Year 2000-Current]

Health Management Information Consortium [HMIC] (via NICE)
Date of search: May 15, 2012
Number of records: 775

1. (domestic AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
2. (spous* AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
3. (intimate AND partner AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
4. (relationship AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
5. (batter* AND (wom#n OR man OR men OR wife OR wives OR husband* OR spous* OR partner* OR boyfriend* OR girlfriend* OR mother* OR father* OR parent* OR sibling*)).ti,ab
6. (assault* AND (wife OR wives OR husband* OR spous* OR partner* OR boyfriend* OR girlfriend* OR mother* OR father* OR parent* OR sibling* OR family)).ti,ab
7. ("gender based" AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
8. ((("same sex" OR "same gender") AND (violen* OR abus* OR attack* OR cruel*))).ti,ab
9. (hono?r AND (killing OR violen* OR abus* OR attack* OR cruel*)).ti,ab
10. (force* AND marriage*).ti,ab
11. (((elder* OR aged) AND (violenc* OR abus* OR attack* OR cruel*))).ti,ab
12. ((child* AND parent) AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
13. (parental AND (violenc* OR abus* OR attack* OR cruel*)).ti,ab
14. (((famil* OR interpersonal) AND (violenc* OR abus* OR attack* OR cruel*))).ti,ab
15. (sibling* AND (violen* OR abus* OR attack* OR cruel*)).ti,ab
16. DOMESTIC VIOLENCE/ OR ELDER ABUSE/
17. PARTNER ABUSE/
18. 1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17

19. ((intervention* OR screening OR counsel?ing OR support* OR advice OR advise OR refuge* OR "emergency shelter" OR "emergency housing" OR therap* OR prevent* OR (collaborat* AND partner*) OR "information dissemination" OR mediat* OR outreach OR victim AND service* OR hotline* OR helpline* OR advoca* OR protocol* OR guideline* OR "safety plan" OR communit* OR "computer assisted" OR "harm reduction" OR recover* OR "school based" OR (conflict* AND resol*) OR (early AND identif*) OR (perpetrat* AND treat*) OR refer* OR multi-agency)).ti,ab
20. HEALTH PROMOTION/
21. exp EVALUATION/ OR exp ASSESSMENT/
22. exp REFERRAL/
23. PILOT PROJECTS/
24. exp COUNSELLING/
25. DISSEMINATION OF INFORMATION/
26. exp GUIDELINES/
27. HARM REDUCTION/
28. exp EDUCATION/
29. TECHNOLOGY/
30. 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29
31. 18 AND 30
32. 18 and 30 [Limit to: Publication Year 2000-Current and (Language Type English)]

CINAHL (EBSCOhost)
Date of search: May 16, 2012
Number of records: 6317

S1. (MH "Domestic Violence")
S2. (MH "Intimate Partner Violence")
S3. (MH "Dating Violence")
S4. (MH "Battered Women")
S5. (MH "Battered Men")
S6. (MH "Elder Abuse")
S7. (domestic N1 (violen* or abus* or attack* or cruel*))
S8. spous* N3 (violen* or abus* or attack* or cruel*)
S9. intimate partner N3 (violen* or abus* or attack* or cruel*)
S10. relationship N3 (violen* or abus* or attack* or cruel*)
S11. batter* N3 (wom?n or man or men or wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling*)
S12. assault* N3 (wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling* or family)
S13. gender based N1 (violen* or abus* or attack* or cruel*)
S14. ((same sex or same gender) N3 (violen* or abus* or attack* or cruel*))
S15. hono#r N3 (killing or violen* or abus* or attack* or cruel*)
S16. force* N2 marriage*
S17. ((elder* or aged) N3 (violenc* or abus* or attack* or cruel*))
S18. (child* N1 parent N3 (violen* or abus* or attack* or cruel*))
S19. parental N1 (violenc* or abus* or attack* or cruel*)
S20. ((famil* or interpersonal) N1 (violenc* or abus* or attack* or cruel*))
S21. sibling* N3 (violen* or abus* or attack* or cruel*)
S22. S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13 or S14 or S15 or S16 or S17 or S18 or S19 or S20 or S21
S23. (MH "Evaluation Research+")
S24. (MH "Pilot Studies")
S25. (MH "Programme Evaluation")
S26. (MH "Validation Studies")
S27. (MH "Treatment Outcomes+")
S28. intervention*
S29. screening
S30. (MH "Counselling+")
S31. counsel#ing
S32. support*
S33. advice or advise
S34. refuge*
S35. emergency N1 (shelter* or housing)

S36. therap*
S37. prevent*
S38. collaborat* N3 partner*
S39. information N3 disseminat*
S40. mediat*
S41. outreach
S42. victim service*
S43. hotline* or helpline*
S44. advoca*
S45. protocol*
S46. (MH "Practice Guidelines")
S47. safety plan
S48. communit*
S49. (MH "Education")
S50. (MH "Technology")
S51. computer assisted
S52. (MH "Health Promotion")
S53. (MH "Harm Reduction")
S54. recover*
S55. school based
S56. conflict* N3 resol*
S57. early N3 identif*
S58. perpetrat* N3 treat*
S59. (MH "Referral and Consultation")
S60. multi-agency
S61. S23 or S24 or S25 or S26 or S27 or S28 or S29 or S30 or S31 or S32 or S33 or S34 or S35 or S36 or S37 or S38 or S39 or S40 or S41 or S42 or S43 or S44 or S45 or S46 or S47 or S48 or S49 or S50 or S51 or S52 or S53 or S54 or S55 or S56 or S57 or S58 or S59 or S60
S62. S22 and S61
Limited to Published Date 2000-2012; English Language

PsycINFO (EBSCOhost)
Date searched: May 31, 2012
Number of records: 8439

S1. (DE "Domestic Violence")
S2. (DE "Intimate Partner Violence")
S3. (DE "Partner Abuse")
S4. (DE "Battered Females")
S5. (DE "Abuse Reporting")
S6. (DE "Elder Abuse")
S7. (domestic N1 (violen* or abus* or attack* or cruel*))
S8. spous* N3 (violen* or abus* or attack* or cruel*)
S9. intimate partner N3 (violen* or abus* or attack* or cruel*)
S10. relationship N3 (violen* or abus* or attack* or cruel*)
S11. batter* N3 (wom?n or man or men or wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling*)
S12. assault* N3 (wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling* or family)
S13. gender based N1 (violen* or abus* or attack* or cruel*)
S14. ((same sex or same gender) N3 (violen* or abus* or attack* or cruel*))
S15. hono#r N3 (killing or violen* or abus* or attack* or cruel*)
S16. force* N2 marriage*
S17. ((elder* or aged) N3 (violenc* or abus* or attack* or cruel*))
S18. (child* N1 parent N3 (violen* or abus* or attack* or cruel*))
S19. parental N1 (violenc* or abus* or attack* or cruel*)
S20. ((famil* or interpersonal) N1 (violenc* or abus* or attack* or cruel*))
S21. sibling* N3 (violen* or abus* or attack* or cruel*)
S22. S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13 or S14 or S15 or S16 or S17 or S18 or S19 or S20 or S21
S23. (DE "Programme Evaluation")
S24. (DE "Treatment Effectiveness Evaluation")

S25. (DE "Treatment Outcomes")
S26. intervention*
S27. screening
S28. (DE "Counselling")
S29. counsel#ing
S30. support*
S31. advice or advise
S32. refuge*
S33. (DE "Shelters") OR (emergency N1 (shelter* or housing))
S34. therap*
S35. prevent*
S36. collaborat* N3 partner*
S37. (DE "Information Dissemination")
S38. mediat*
S39. outreach
S40. victim service*
S41. hotline* or helpline*
S42. advoca*
S43. protocol*
S44. guideline*
S45. safety plan
S46. communit*
S47. (DE "Education")
S48. (DE "Technology")
S49. computer assisted
S50. (DE "Health Promotion")
S51. (DE "Harm Reduction")
S52. recover*
S53. school based
S54. conflict* N3 resol*
S55. early N3 identif*
S56. perpetrat* N3 treat*
S57. (DE "Professional Referral")
S58. multi-agency
S59. (S23 or S24 or S25 or S26 or S27 or S28 or S29 or S30 or S31 or S32 or S33 or S34 or S35 or S36 or S37 or S38 or S39 or S40 or S41 or S42 or S43 or S44 or S45 or S46 or S49 or S50 or S51 or S52 or S53 or S54 or S55 or S56 or S57 or S58)
S60. S22 and S59
Limited to Scholarly (Peer Reviewed) Journals; Publication Year from: 2000-2012; English

LGBT Life (EBSCOhost)
Date of search: May 29, 2012
Number of records: 301

S1. DE "FAMILY violence" OR DE "LGBT family violence"
S2. DE "SAME-sex partner abuse" OR DE "LESBIAN partner abuse"
S3. (domestic N1 (violen* or abus* or attack* or cruel*))
S4. spous* N3 (violen* or abus* or attack* or cruel*)
S5. intimate partner N3 (violen* or abus* or attack* or cruel*)
S6. relationship N3 (violen* or abus* or attack* or cruel*)
S7. batter* N3 (wom?n or man or men or wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling*)
S8. assault* N3 (wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling* or family)
S9. gender based N1 (violen* or abus* or attack* or cruel*)
S10. ((same sex or same gender) N3 (violen* or abus* or attack* or cruel*))
S11. hono#r N3 (killing or violen* or abus* or attack* or cruel*)
S12. force* N2 marriage*
S13. ((elder* or aged) N3 (violenc* or abus* or attack* or cruel*))
S14. (child* N1 parent N3 (violen* or abus* or attack* or cruel*))
S15. parental N1 (violenc* or abus* or attack* or cruel*)
S16. ((famil* or interpersonal) N1 (violenc* or abus* or attack* or cruel*))

S17. sibling* N3 (violen* or abus* or attack* or cruel*)
S18. intervention*
S19. screening
S20. counsel#ing
S21. support*
S22. advice or advise
S23. refuge*
S24. emergency N1 (shelter* or housing)
S25. therap*
S26. prevent*
S27. collaborat* N3 partner*
S28. information N3 disseminat*
S29. mediat*
S30. outreach
S31. victim service*
S32. hotline* or helpline*
S33. advoca*
S34. protocol*
S35. safety plan
S36. communit*
S37. computer assisted
S38. recover*
S39. school based
S40. conflict* N3 resol*
S41. early N3 identif*
S42. perpetrat* N3 treat*
S43. multi-agency
S44. (S18 or S19 or S20 or S21 or S22 or S23 or S24 or S25 or S26 or S27 or S28 or S29 or S30 or S31 or S32 or S33 or S34 or S35 or S36 or S37 or S38 or S39 or S40 or S41 or S42 or S43)
S45. S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13 or S14 or S15 or S16 or S17
S46. DE "WOMEN'S shelters"
S47. S44 or S46
S48. S45 and S47
Limited to Peer Reviewed

Social Work Abstracts (EBSCOhost)
Date of search: May 30, 2012
Number of records: 646

S1. (domestic N1 (violen* or abus* or attack* or cruel*))
S2. spous* N3 (violen* or abus* or attack* or cruel*)
S3. intimate partner N3 (violen* or abus* or attack* or cruel*)
S4. relationship N3 (violen* or abus* or attack* or cruel*)
S5. batter* N3 (wom?n or man or men or wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling*)
S6. assault* N3 (wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling* or family)
S7. gender based N1 (violen* or abus* or attack* or cruel*)
S8. ((same sex or same gender) N3 (violen* or abus* or attack* or cruel*))
S9. hono#r N3 (killing or violen* or abus* or attack* or cruel*)
S10. force* N2 marriage*
S11. ((elder* or aged) N3 (violenc* or abus* or attack* or cruel*))
S12. (child* N1 parent N3 (violen* or abus* or attack* or cruel*))
S13. parental N1 (violenc* or abus* or attack* or cruel*)
S14. ((famil* or interpersonal) N1 (violenc* or abus* or attack* or cruel*))
S15. sibling* N3 (violen* or abus* or attack* or cruel*)
S16. intervention*
S17. screening
S18. counsel#ing
S19. support*
S20. advice or advise

S21. refuge*
S22. emergency N1 (shelter* or housing)
S23. therap*
S24. prevent*
S25. collaborat* N3 partner*
S26. information N3 disseminat*
S27. mediat*
S28. outreach
S29. victim service*
S30. hotline* or helpline*
S31. advoca*
S32. protocol*
S33. safety plan
S34. communit*
S35. computer assisted
S36. recover*
S37. school based
S38. conflict* N3 resol*
S39. early N3 identif*
S40. perpetrat* N3 treat*
S41. multi-agency
S42. (S16 or S17 or S18 or S19 or S20 or S21 or S22 or S23 or S24 or S25 or S26 or S27 or S28 or S29 or S30 or S31 or S32 or S33 or S34 or S35 or S36 or S37 or S38 or S39 or S40 or S41)
S43. S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13 or S14 or S15
S44. S42 and S43
Limit to Published Date 2000-2012

ERIC (EBSCOhost)
Date of search: May 30, 2012
Number of records: 1681

S1. DE "FAMILY violence"
S2. DE "ELDER abuse"
S3. (domestic N1 (violen* or abus* or attack* or cruel*))
S4. spous* N3 (violen* or abus* or attack* or cruel*)
S5. intimate partner N3 (violen* or abus* or attack* or cruel*)
S6. relationship N3 (violen* or abus* or attack* or cruel*)
S7. batter* N3 (wom?n or man or men or wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling*)
S8. assault* N3 (wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling* or family)
S9. gender based N1 (violen* or abus* or attack* or cruel*)
S10. ((same sex or same gender) N3 (violen* or abus* or attack* or cruel*))
S11. hono#r N3 (killing or violen* or abus* or attack* or cruel*)
S12. force* N2 marriage*
S13. ((elder* or aged) N3 (violenc* or abus* or attack* or cruel*))
S14. (child* N1 parent N3 (violen* or abus* or attack* or cruel*))
S15. parental N1 (violenc* or abus* or attack* or cruel*)
S16. ((famil* or interpersonal) N1 (violenc* or abus* or attack* or cruel*))
S17. sibling* N3 (violen* or abus* or attack* or cruel*)
S18. intervention*
S19. screening
S20. counsel#ing
S21. support*
S22. advice or advise
S23. refuge*
S24. emergency N1 (shelter* or housing)
S25. therap*
S26. prevent*
S27. collaborat* N3 partner*
S28. information N3 disseminat*
S29. mediat*

S30. outreach
S31. victim service*
S32. hotline* or helpline*
S33. advoca*
S34. protocol*
S35. safety plan
S36. communit*
S37. computer assisted
S38. recover*
S39. school based
S40. conflict* N3 resol*
S41. early N3 identif*
S42. perpetrat* N3 treat*
S43. multi-agency
S44. (S18 or S19 or S20 or S21 or S22 or S23 or S24 or S25 or S26 or S27 or S28 or S29 or S30 or S31 or S32 or S33 or S34 or S35 or S36 or S37 or S38 or S39 or S40 or S41 or S42 or S43)
S45. S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13 or S14 or S15 or S16 or S17
S46. DE "emergency shelters"
S47. S44 or S46
S48. S45 and S47
Limited to Published Date 2000-2012

Social Policy & Practice (OvidSP)
Date of search: June 13, 2012
Number of records: 3583

1. (domestic adj (violen* or abus* or attack* or cruel*)).mp
2. (spous* adj3 (violen* or abus* or attack* or cruel*)).mp
3. (intimate partner adj3 (violen* or abus* or attack* or cruel*)).mp.
4. (relationship adj3 (violen* or abus* or attack* or cruel*)).mp.
5. (batter* adj3 (wom#n or man or men or wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling*)).mp.
6. (assault* adj3 (wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling* or family)).mp
7. (gender based adj (violen* or abus* or attack* or cruel*)).mp.
8. ((same sex or same gender) adj3 (violen* or abus* or attack* or cruel*)).mp
9. (hono?r adj3 (killing or violen* or abus* or attack* or cruel*)).mp.
10. (force* adj2 marriage*).mp.
11. ((elder* or aged) adj3 (violen* or abus* or attack* or cruel*)).mp.
12. (child* adj2 parent adj3 (violen* or abus* or attack* or cruel*)).mp
13. (parental adj (violen* or abus* or attack* or cruel*)).mp
14. ((famil* or interpersonal) adj (violen* or abus* or attack* or cruel*)).mp.
15. (sibling* adj3 (violen* or abus* or attack* or cruel*)).mp.
16. or/1-15
17. intervention*.mp.
18. screening.mp.
19. counsel?ing.mp.
20. support*.mp.
21. (advice or advise).mp.
22. refuge*.mp.
23. (emergency adj (housing or shelter)).mp.
24. therap*.mp.
25. prevent*.mp.
26. (collaborat* adj3 partner*).mp.
27. (information adj3 disseminat*).mp.
28. mediat*.mp.
29. outreach.mp.
30. victim service*.mp.
31. (hotline* or helpline*).mp.
32. advoca*.mp.
33. protocol*.mp.

34. guideline*.mp.
35. safety plan*.mp.
36. communit*.mp.
37. computer assisted.mp.
38. education.mp.
39. technology.mp.
40. health promotion.mp.
41. harm reduction.mp.
42. recover*.mp.
43. school based.mp.
44. (conflict* adj3 resol*).mp.
45. (early adj3 identif*).mp.
46. (perpetrat* adj3 treat*).mp.
47. referral.mp.
48. multi-agency.mp.
49. or/17-48
50. 16 and 49
51. limit 50 to yr="2000 -Current"

Women's Studies International (EBSCOhost)
Date of search: June 13, 2012
Number of records: 2513

S1. (MH "Domestic Violence")
S2. (MH "Intimate Partner Violence")
S3. (MH "Dating Violence")
S4. (MH "Family Violence")
S5. (MH "Abused Women")
S6. (MH "Older people - Abuse of")
S7. (domestic N1 (violen* or abus* or attack* or cruel*))
S8. spous* N3 (violen* or abus* or attack* or cruel*)
S9. intimate partner N3 (violen* or abus* or attack* or cruel*)
S10. relationship N3 (violen* or abus* or attack* or cruel*)
S11. batter* N3 (wom?n or man or men or wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling*)
S12. assault* N3 (wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling* or family)
S13. gender based N1 (violen* or abus* or attack* or cruel*)
S14. ((same sex or same gender) N3 (violen* or abus* or attack* or cruel*))
S15. hono#r N3 (killing or violen* or abus* or attack* or cruel*)
S16. force* N2 marriage*
S17. ((elder* or aged) N3 (violenc* or abus* or attack* or cruel*))
S18. (child* N1 parent N3 (violen* or abus* or attack* or cruel*))
S19. parental N1 (violenc* or abus* or attack* or cruel*)
S20. ((famil* or interpersonal) N1 (violenc* or abus* or attack* or cruel*))
S21. sibling* N3 (violen* or abus* or attack* or cruel*)
S22. S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13 or S14 or S15 or S16 or S17 or S18 or S19 or S20 or S21
S23. intervention*
S24. screening
S25. counsel#ing
S26. support*
S27. advice or advise
S28. refuge*
S29. emergency N1 (shelter* or housing)
S30. therap*
S31. prevent*
S32. collaborat* N3 partner*
S33. information N3 disseminat*
S34. mediat*
S35. outreach
S36. victim service*

S37. hotline* or helpline*
S38. advoca*
S39. protocol*
S40. safety plan
S41. communit*
S42. computer assisted
S43. recover*
S44. school based
S45. conflict* N3 resol*
S46. early N3 identif*
S47. perpetrat* N3 treat*
S48. multi-agency
S49. (S23 or S24 or S25 or S26 or S27 or S28 or S29 or S30 or S31 or S32 or S33 or S34 or S35 or S36 or S37 or S38 or S39 or S40 or S41 or S42 or S43 or S44 or S45 or S46 or S47 or S48)
S50. S22 and S49
Limited to Scholarly (Peer Reviewed) Journals; Published Date 2000-2012

Family & Society Studies Worldwide (EBSCOhost)
Date of Search: June 18, 2012
Number of records: 5455

S1. (domestic N1 (violen* or abus* or attack* or cruel*))
S2. spous* N3 (violen* or abus* or attack* or cruel*)
S3. intimate partner N3 (violen* or abus* or attack* or cruel*)
S4. relationship N3 (violen* or abus* or attack* or cruel*)
S5. batter* N3 (wom?n or man or men or wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling*)
S6. assault* N3 (wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling* or family)
S7. gender based N1 (violen* or abus* or attack* or cruel*)
S8. ((same sex or same gender) N3 (violen* or abus* or attack* or cruel*))
S9. hono#r N3 (killing or violen* or abus* or attack* or cruel*)
S10. force* N2 marriage*
S11. ((elder* or aged) N3 (violenc* or abus* or attack* or cruel*))
S12. (child* N1 parent N3 (violen* or abus* or attack* or cruel*))
S13. parental N1 (violenc* or abus* or attack* or cruel*)
S14. ((famil* or interpersonal) N1 (violenc* or abus* or attack* or cruel*))
S15. sibling* N3 (violen* or abus* or attack* or cruel*)
S16. intervention*
S17. screening
S18. counsel#ing
S19. support*
S20. advice or advise
S21. refuge*
S22. emergency N1 (shelter* or housing)
S23. therap*
S24. prevent*
S25. collaborat* N3 partner*
S26. information N3 disseminat*
S27. mediat*
S28. outreach
S29. victim service*
S30. hotline* or helpline*
S31. advoca*
S32. protocol*
S33. safety plan
S34. communit*
S35. computer assisted
S36. recover*
S37. school based
S38. conflict* N3 resol*
S39. early N3 identif*

S40. perpetrat* N3 treat*
S41. multi-agency
S42. (S16 or S17 or S18 or S19 or S20 or S21 or S22 or S23 or S24 or S25 or S26 or S27 or S28 or S29 or S30 or S31 or S32 or S33 or S34 or S35 or S36 or S37 or S38 or S39 or S40 or S41)
S43. S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13 or S14 or S15
S44. S42 and S43
Limited to Scholarly (Peer Reviewed) Journals; Published Date 2000-2012

Violence & Abuse Abstracts (EBSCOhost)
Date of search: June 20, 2012
Number of records: 3551

S1. (domestic N1 (violen* or abus* or attack* or cruel*))
S2. spous* N3 (violen* or abus* or attack* or cruel*)
S3. intimate partner N3 (violen* or abus* or attack* or cruel*)
S4. relationship N3 (violen* or abus* or attack* or cruel*)
S5. batter* N3 (wom?n or man or men or wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling*)
S6. assault* N3 (wife or wives or husband* or spous* or partner* or boyfriend* or girlfriend* or mother* or father* or parent* or sibling* or family)
S7. gender based N1 (violen* or abus* or attack* or cruel*)
S8. ((same sex or same gender) N3 (violen* or abus* or attack* or cruel*))
S9. hono#r N3 (killing or violen* or abus* or attack* or cruel*)
S10. force* N2 marriage*
S11. ((elder* or aged) N3 (violenc* or abus* or attack* or cruel*))
S12. (child* N1 parent N3 (violen* or abus* or attack* or cruel*))
S13. parental N1 (violenc* or abus* or attack* or cruel*)
S14. ((famil* or interpersonal) N1 (violenc* or abus* or attack* or cruel*))
S15. sibling* N3 (violen* or abus* or attack* or cruel*)
S16. intervention*
S17. screening
S18. counsel#ing
S19. support*
S20. advice or advise
S21. refuge*
S22. emergency N1 (shelter* or housing)
S23. therap*
S24. prevent*
S25. collaborat* N3 partner*
S26. information N3 disseminat*
S27. mediat*
S28. outreach
S29. victim service*
S30. hotline* or helpline*
S31. advoca*
S32. protocol*
S33. safety plan
S34. communit*
S35. computer assisted
S36. recover*
S37. school based
S38. conflict* N3 resol*
S39. early N3 identif*
S40. perpetrat* N3 treat*
S41. multi-agency
S42. (S16 or S17 or S18 or S19 or S20 or S21 or S22 or S23 or S24 or S25 or S26 or S27 or S28 or S29 or S30 or S31 or S32 or S33 or S34 or S35 or S36 or S37 or S38 or S39 or S40 or S41)
S43. S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13 or S14 or S15
S44. S42 and S43
Limited to Publication Date: 2000-2012; Document Type: Article

Appendix B. UK Grey Literature Excluded From The Review

The following tables report the UK Grey Literature that was reviewed, but not included in the report. Note that not all studies reported in the tables are also reported in *Appendix D* and *Appendix F*, as some suggestions from the PDG were excluded prior to entering the review process (but are included in these tables).

Table 1. Research Question 1 (Prevention) Excluded UK Grey Literature

Citation	Location of work	Abstract	Reason for exclusion
Brunner, R. (2010). *A baseline study of domestic abuse prevention activities in seven local authorities in Scotland.* Edinburgh, UK: National Children and Young People's Prevention Network.	Scotland	Provides examples 7 district's approach to prevention work provided by local authority 'leads.' 'Spotlight examples' highlight prevention work in individual local authorities, and 'ranges of practice' create a picture of the delivery of prevention activities. The data includes information on strategies, networks and 'next steps'.	Does not evaluate the outcome of an intervention
Craig, Y. J. (2000). Mediation and empowering older people to resolve interpersonal conflicts leading to elder abuse and contribute to its prevention An exploratory study. London, UK: London Guidhall University.	England	This thesis examines the social convergence about the demographic rise in elder abuse and the increasing use of mediation processes for resolving social problems with participant observation of several mediation projects, finding elder empowerment, but unclear on the ability of mediation to stop future violence or challenge structural abuse.	Does not evaluate the outcome of an intervention
CRG Research Ltd. (2009). *An independent evaluation of the TRUST education project.* Cardiff, UK: CRG Research.	Wales	No abstract	Unable to locate
Ellis, J. (2004). *Preventing violence against women and girls. A study of educational programmes for children and young people.* London, UK: Womankind Worldwide.	England	No abstract	Book
End Violence Against Women (2007). *Making the Grade, The third annual independent analysis of UK Government initiatives on violence against women.* London, UK: End Violence Against Women Coalition.	England, Wales and Scotland	Making the Grade is an assessment by members of the independent violence against women sector of how UK Government Departments tackle violence against women. It is based on the responses that Secretaries of State give to 12 questions that are calculated on a 10 point scale.	Does not evaluate the outcome of an intervention
End Violence Against Women Coalition. (2011). *A different world is possible: Promising practices to prevent violence against women and girls.* London: Author.	Scotland	Highlights examples of promising practices to prevent violence against women and girls and share important insights from practitioners on the ground at a grass-roots level.	Does not evaluate the outcome of an intervention
Fox, C., Gladd, D., & Coor, M. (2010). *Boys to Men: First Report Findings from the Pilot Evaluation of Relationships without Fear.* Keele, UK: University of Keele.	England	To develop an evaluation of the effectiveness of *Relationships without Fear*, a school-based domestic abuse prevention programme, and to create a 12 item measurement tool for the evaluation, Attitudes towards Domestic Violence Questionnaire.	Intervention setting outside of health and social services (School)
Great Britain Home Office (2008). *National domestic violence delivery plan: annual progress report 2007/08.* London, UK: Home Office.	England	Outlines key objectives and activities for 2008/09	Does not evaluate the outcome of an

			intervention
Great Britain Home Office (2009). *National domestic violence delivery plan: annual progress report 2008-09.* London, UK: Home Office.	England	This report sets out four objectives:increasing early identification and intervention with victims of domestic violence by front-line professionals; building capacity; improving the criminal justice response; and supporting victims through the criminal justice system and managing perpetrators to reduce risk.	Does not evaluate the outcome of an intervention
Hester, M. & Westmarland, N. (2005). *Tackling domestic violence: Effective interventions and approaches* (Research Study 290). London, UK: Home Office.	England	No abstract	Non-systematic review
Kalaga, H., & Kingston, P. (2007). *A review of literature on effective interventions that prevent and respond to harm against adults.* Edinburgh, UK: Scottish Government Social Research.	Scotland	No abstract	Non-systematic review
Kelly, L., & Humphreys, C. (2000). *Reducing Domestic Violence ... What Works? Outreach and Advocacy Approaches*. London, UK: Home Office, Policing and Reducing Crime Unit.	England	No abstract	Book
Louise Brown Research (2004). *Evaluation of the Scottish domestic abuse helpline.* Edinburgh,UK: Scottish Executive, Social Research.	Scotland	The Helpline offers emotional and practical support to victims of domestic abuse and provides information on relevant issues and local sources of specialist help. Calls are free and are not recorded on telephone bills.	Does not evaluate the outcome of an intervention
Maguire, R., Lerpiniere, J., & Wilson, A. (2010). *The evaluation of the 'Why create a drama?' Project.* Edinburgh, UK: National Children and Young People's Prevention Network.	Scotland	'Why Create a Drama?' is a school based prevention initiatives taking account of practitioners' experience and children and young people's views. Nine schools, four primary and five secondary, from six local authorities participated in the Project. Using material generated by children and young people during a series of five participatory workshops in each school, Baldy Bane devised two age appropriate performances to raise awareness of domestic abuse issues for primary and secondary schools.	Intervention setting outside of health and social services (School)
Maxwell, C., Chase, E., Warwick, I., & Aggleton, P., with Wharf, H. (2009). *Freedom to achieve. Preventing violence, promoting equality: A whole school approach.*London, UK: Womankind Worldwide.	England	Between 2004 and 2010, WOMANKIND pioneered the development of a national strategic framework to embed violence against women and girls' education work in schools. The programme had three key elements: supporting schools, research, and policy change.	Intervention setting outside of health and social services (School)
Scottish Executive (2003). *Preventing domestic abuse: a national strategy.* Edinburgh,UK: Scottish Executive.	Scotland	Outlines prevention strategies and the responsibilities of various government entities.	Does not evaluate the outcome of an intervention
Scottish Government (2010). *Implementation report: National Domestic Abuse Delivery Plan for Children and Young People - Autumn 2009.* Edinburgh,UK: Scottish Government.	Scotland	Reports programme developments, and sets out a framework for monitoring and guiding future work.	Does not evaluate the outcome of an intervention
Stanley, N., Fell, B., Miller, P., Thomson, G. & Watson, J.P. (2009). *Men's Talk: Research to inform Hull's social marketing initiative on domestic violence.* Preston, UK: University of Central Lancashire and Hull PCT.	Hull, England	This research project is seeking to understand the views of men in general, and perpetrators in particular, and how this can inform the content and marketing of a new service established in Hull in April 2009.	Does not evaluate the outcome of an intervention

Table 2. Research Question 2 (Screening) Excluded UK Grey Literature

Citation	Location of work	Abstract	Reason for exclusion
Debbonaire, T. (2008). *The pilot of the Respect/Relate/CAFCASS domestic violence risk identification tool: Evaluation Report.* London, UK: Respect	Cardiff, Wales	Practitioners made various suggestions for improving or developing the screening tool.	Does not evaluate the outcome of an intervention.
Standing Together Against Domestic Violence (2004). *Health and domestic violence: Improving safety through screening.* London, UK: Standing Together Against Domestic Violence	Hammersmith and Fulham, England	The aim of the health project was to create institutional change with regard to the health service's response to domestic violence.	Does not evaluate the outcome of an intervention.

Table 3. Research Question 3 (Victim Interventions) Excluded UK Grey Literature

Citation	Location of work	Abstract	Reason for exclusion
Association of London Government. (2006). *Sanctuary projects.* London, UK: Association of London Government.	London, England	An enviromental scan of sanctuary schemes.	Does not evaluate the outcome of an intervention
Department of Health. (2009). *Report on the consultation: The review of No Secrets guidance.* London, UK: Department of Health.	UK	The aim of the consultation was to learn about the views and experiences of adult safeguarding. The main question was whether and how the No Secrets guidance needed to change and whether new legislation was necessary.	Does not evaluate the outcome of an intervention
Kazimirski, A., Keogh, P., Kumari, V., Smith, R., Gowland, S., Purdon, S., & Khanum, N. (2009). *Forced marriage: Prevalence and service response.* London, UK: National Centre for Social Research.	UK	To determine the prevalence for forced marraiges, identify and critically describe front-line responses to forced marraiges, prevention, models of good or poor practice, and good practice impediments and facilitators.	Does not evaluate the outcome of an intervention

Table 4. Research Question 3 (Perpetrator Interventions) Excluded UK Grey Literature

Citation	Location of work	Abstract	Reason for exclusion
Against Domestic Violence and Abuse In Devon. (2009). *"REPAIR" Resolve to End the Perpetration of Abuse in Relationships.* Exeter, UK: Devon County Council.	Devon, England	N/A	Unable to locate
Bullock, K., Sarre, S., Tarling, R., & Wilkinson, M. (2010). *The delivery of domestic abuse programmes: An implementation study of domestic abuse programmes in probation areas and Her Majesty's Prison Service.* London, UK:	England and Wales	This research examined the implementation of domestic violence perpetrator programmes in the Probation Service and the Prison Service.	Intervention setting outside of health and social services (Justice system)

Ministry of Justice.			
Hester, M., Westmarland, N., Gangoli, G., Wilkinson, M., O'Kelly, C., Kent, A., & Diamond, A. (2006). *Domestic Violence Perpetrators: identifying needs to inform early intervention*. Bristol, UK: University of Bristol, Northern Rock Foundation and Home Office.	England	The purpose of this reseach was to develop a detailed picture of domestic violence perpetrators entering the criminal justice system, identify agencies and services involved in interventions with such perpetrators, and highlight help-seeking pathways and potential opportunities for early intervention and prevention.	Does not evaluate the outcome of an intervention
Kelly, E. (2002). *Working with men as part of a multi-agency approach to tackling domestic abuse: Final report.* Edinburgh, UK: City of Edinburgh Council.	Scotland	N/A	Unable to locate
Respect UK (2010). *Respect Briefing Paper: Evidence of Effects of Domestic Violence Perpetrator Programmes on Women's Safety.* London, UK: Respect.	England	No abstract	Non-systematic review.
Respect UK (2010). *Respect briefing paper on unsafe domestic violence perpetrator interventions.* London, UK: Respect.	England	Outlines the consequences of operating without an integrated support service, and references standards.	Does not evaluate the outcome of an intervention
Respect UK (2010). *Respect position statement: gender and domestic violence.* London, UK: Respect.	England	Respect believes that practice experience and analysis of rigorous research demonstrates that a thorough understanding of the complex dynamics of gender is vital to responding effectively to domestic violence.	Does not evaluate the outcome of an intervention
Respect UK (2010). *Respect practice guideline: Values, purposes and methods of identifying who is doing what to whom in intimate partner violence.* London, UK: Respect	England	An evidence based statement of Respect's position on the ways that adults may use violence and abusive behaviour in intimate relationships, and the impact of context. Discusses assessment practice tools and guidelines.	Does not evaluate the outcome of an intervention
Stanley, N., Borthwick, R., Graham-Kevan, N., & Chamberlain, R. (2011). *Strenght to change: Find the strength to stop domestic violence.* Hull, UK: National Health Service.	Hull, Scotland	The report did not collect data on any hard outcomes for either men or their partners. It provides an in-depth account of the work of the project from service users, staff and other stakeholders.	[-] internal quality rating
Westmarland, N., & Hester, M. (2007). *Time for change: An assessment of services for domestic abuse perpetrators in Bristol.* Bristol, UK: University of Bristol.	Bristol, England	The remit of this research was to: provide a review of relevant literature; develop profiles of domestic violence perpetrators in Bristol; map current work with perpetrators in Bristol; estimate the scale of the problem; provide a needs assessment and; discover potential referral routes and suggest relevant programme 'advertising'.	Does not evaluate the outcome of an intervention
Westmarland, N., Kelly, L., & Chalder-Mills, J. (2010). *Domestic violence perpetrator programs: What counts as success?* London: Respect.	England	Participant, funder, and practitioner interviews on their definitions of what constitutes programme success.	Does not evaluate the outcome of an intervention

Table 5. Research Question 3 (Elder Interventions) Excluded UK Grey Literature

Citation	Location of work	Abstract	Reason for exclusion

Association of Directors of Social Services. (2004). *Young people & vulnerable adults facing forced marriage: Practice guidance for social workers.* London, UK: Foreign & Commonwealth Office.	England	These are guidelines for social service workers for protecting young British nationals and vulnerable adults from the crimes and abuses of human rights associated with forced marriage.	Does not evaluate the outcome of an intervention
Bell, J. & Stanley, N. (2005). *Tackling domestic violence at a local level: An evaluation.* Hull, UK: University of Hull	England	No abstract	Book
Coy, M., Thiara, R., Kelly, L., & Phillips, R. (2011). *Into the foreground: An evaluation of the Jacana Parenting Programme.* London, UK: Child and Abuse Studies Unit.	Hackney, England	The Jacana Parenting Service was a pilot programme in partnership between the nia project and Domestic Violence Intervention Project to support parents affected by current and historic domestic violence. The programme offered separate interventions for men as perpetrators and support to women as victim-survivors, using individual and group work, and was funded by the Parenting Fund.	[-] internal quality rating
Jones, A., Bretherton, J., Bowles, R. & Croucher, K. (2010). *The effectiveness of schemes to enable households at risk of domestic violence to stay in their own homes.* London, UK: Department for Communities and Local Government.	UK	A review of evidence on sancutary schemes through interviews with national stakeholders, a review of case studies and other literature, and inverviews with service providers and households.	Does not evaluate the outcome of an intervention
Lloyd, C., Wollny, I., White, C., Gowland, S., & Purdon, S. (2011). *Monitoring and evaluation of family intervention services and projects between February 2007 and March 2011.* London, UK: Department of Education.	UK	A report based on the families referred to family interventions in 159 local authorities. The outcomes analysis is based on a smaller number of LAs (120) where families had actually exited a family intervention.	[-] internal quality rating
McInnes, K., & Newman, T. (2006). *Domestic abuse in North Somerset: A scoping exercise.* Ilford, UK: Barnardo's Policy and Research Team.	North Somerset, England	An environmental scan describing the range and content of services in North Somerset for families affected by domestic abuse, with a survey of practitioners and survivors, a best practices literature review, and the impact of the scoping review.	Does not evaluate the outcome of an intervention
Regan, L. (2004). *Final report of the Portsmouth Domestic Violence Early Intervention Project (EIP) evaluation.* London, UK: Child and Woman Abuse Studies Unit.	Portsmouth, England	Provides a background to the evaluation and ithe design of a screening tool, and summarises some of the problems encountered during implementation.	Does not evaluate the outcome of an intervention
Taket, A., Beringer, A., Irvine, A., & Garfield, S. (2004). *Tackling domestic violence: Exploring the heath service contribution.* London, UK: Home *Office.*	Brimingham, North Devon, Torridge, Salford, and Wakeford, England	The 4 programs involved training, screening, GP practice, and resource packs and handbooks. Evaluation is on the implementation phase of the projects.	Does not evaluate the outcome of an intervention

Table 6. Research Question 4 (Children Exposed to DV) Excluded UK Grey Literature

Citation	Location of work	Abstract	Reason for exclusion
Audit Commission. (2000). Seeing the light: innovation in local public services: London	UK	Descriptions of various local projects.	Does not evaluate the outcome of an

Borough of Sutton: helping children who have witnessed domestic violence. London, UK: Local Government.			intervention
Barraclough, S. (2005). *Assessment and intervention for pre-school children exposed to domestic violence.* London, UK: Refuge.	UK	Looks in depth at pre-school (under 5 years old) children's responses to domestic violence within a refuge setting through interviews with 38 mothers and 33 children.	Does not evaluate the outcome of an intervention
Crowther, K., & Cowen, G. (2011). *Effective Relationships with Vulnerable Parents to Improve Outcomes for Children and Young People: Final Study Report.* Leeds, UK: York Consulting.	UK	The report examined how Action for Children professionals develop effective relationships with vulnerable parents. The focus of the research was to develop a skills framework that would define the key aspects of effective professional relationships and the competencies required to achieve them.	Does not evaluate the outcome of an intervention
Institute of Public Care. (2007). *What works in promoting good outcomes for children in need who experence domestic violence?* Eninburgh, UK: Social Services Improvment Agency.	Scotland	A best practices literature review and environmental scan of national and local programs looking at how to promote good outcomes for children in need where there is domestic violence, parental substance misuse, and / or poor parenting in particular.	Non-systematic review
Jeyasingham, D. (2011). *Evaluation of Trafford Children and Young People Service Targeted Mental Health in Schools Project.* Telford, UK: Telford and Wrekin Council.	Trafford, England	The evaluation of Trafford's Targeted Mental Health in Schools project is based on data from interviews with professionals working in schools and other agencies involved with TaMHS and a small number of observations of the project's work. Children and families who used the service were asked whether they wanted to take part in the evaluation but no service users chose to do so.	Does not have outcomes relevant to research question
Mullender, A. (2004). *Tackling domestic violence: Providing support for children who have witnessed domestic violence.* London, UK: Home Office.	UK	Good practice recommendations and suggestions for a range of practitioners and professionals who have a role in commissioning, developing or delivering initiatives to support children who have in the past or are currently witnessing domestic violence.	Does not evaluate the outcome of an intervention
Smith, C., Grimes, M., Morrison, F., Houghton, C., & Stafford, A. (2008). *Consultation with children and young people with experience of domestic abuse on Scottish Government National Domestic Abuse Delivery Group draft proposals.* Edinburgh, UK: University of Edinburgh.	Scotland	Reports on three consultations made with 33 children from the ages of 8-16 to provide a voice to young people in the shaping of policy proposals.	Does not evaluate the outcome of an intervention
West Sussex Daphne Research Project Team. (2004). *Does witnessing domestic violence determine a child or young persons pattern of offending and are available interventions effective in reducing these patterns?* Littlehampton, UK: West Sussex Youth Offending Team.	England	No abstract	Book

Table 7. Research Question 5 (Partnerships) Excluded UK Grey Literature

Citation	Location of work	Abstract	Reason for exclusion
Cleaver, H., Nicholson, D., Tarr, S., & Cleaver, D. (2006). *The response of child protection practices and procedures to children exposed to domestic*	London, England	This study explored how children's social care responds to family problems that require both adult and children's services, identify factors for successful inter-agency working, and explore the perceptions of children and parents on the	Does not evaluate a formal partnerhip

violence or parental substance misuse. London, UK: Department for Education and Skills.		intervention.	
Cordis Bright Consulting. (2011). Research into multi-agency assessment conferences (MARACs). London, UK: Great Britain Home Office.	England and Wales	A wider review of Multi-Agency Risk Assessment Conferences (MARACs) to improve understanding of how MARACs are working and potential areas of development from a national online survey which explored the characteristics of the MARAC; the multi-agency contributions of MARAC partners; the involvement of IDVAs and victims; agency attendance; the MARAC operating model; referrals and caseload levels; working practices; barriers and levers; links to other local public protection arrangements; impacts of future funding; and whether MARACs should be on a statutory footing.	Does not evaluate the outcome of an intervention
Great Britain Department for Children Schools and Families. (2010). Think family pathfinders: research update. England, UK: Department for Children Schools and Families.	Nottingham, England	An update from the *Think Family Pathfinders Evaluation* with background information on the programme; an overview of participating families and their needs and levels of risk; the models of delivery and common approaches; examples of the new ways of working with families at risk of poor outcomes; and emerging evidence of impact. Practical examples of how local authorities are restructuring service provision and developing new working practices. No formal evaluation in this report.	Does not evaluate the outcome of an intervention
Hirst, A. (2009). *Multiple and Complex Needs Initiative: Programme evaluation report.* Edinburgh, UK: Scottish Government Social Research.	Scotland	The *Multiple and Complex Needs Initiative* describes 14 pilot projects: African Health Project, Improving Primary Health Care Services for People with MCN, Inequalities Sensitive Practice Initiative, LGBT young people with MCN, Male Carers Initiative, Partnerships for Access to Health Project, Plan2Change, Positively Sorted, Project Empower, RCA Trust project (formerly Renfrew Council on Alcohol); Routes out of Prison, Securing Care for Ethnic Elders in Scotland, Supporting BME Families of Deaf Children, Tayside Domestic Abuse and Substance Misuse.	Does not evaluate a partnership
Home Office (2000). Multi-Agency Guidance for Addressing Domestic Violence. London, UK: Home Office, Marketing and Communications Group.	England and Wales	The report's purpose is to raise awareness with all agencies falling within the policy remit of the Departments concerned. It sets out some of the general issues and some ways in which together and individually they might address domestic violence effectively. It seeks to give a background and framework for carrying out this work, rather than giving detailed operational guidance.	Does not have outcomes relevant to research question
Local Government Improvement and Development. (2009). *Bolsover's supporting women suffering from domestic violence.* London, UK: Local Government Association.	Derbyshire, England	Bolsover District Council is supporting a coordinated approach to provide specialist support services for women suffering from domestic violence. This brief report is a reply to the Equities and Human Rights Commission *Map the Gaps 2* to contest their rating and enemerate their services for domestic violence.	Non-systematic review.
Manchester Partnership. (2010). *Multi Agency Domestic Abuse Strategy 2010-2014*. Manchester, UK: Manchester City Council.	Manchester, England	Describes the Manchester Model for the commissioning of domestic abuse services: duty to inform, consult, and involve; assess needs; plan services; secure outcomes; monitor and review; and improve.	Does not have outcomes relevant to research question
Nolan, J. (2011). *An evaluation of the Dyn Project's Advocacy and Support Services: Final evaluation report.* Pontypridd, UK: University of Glamorgan and the Welsh Centre for Crime and Justice.	Wales	An evaluation of the provision of advocacy services by the Dyn Project to men experiencing domestic abuse in Cardiff. Therefore, some of the key concerns were whether it meets the needs of individuals referred to the service, whether it provides value for money for the Community Safety Partnership, and whether there is sufficient demand for the service for it to continue.	[-] internal quality rating
Parmar, A., Sampson, A., & Diamond, A. (2005).	England	This report draws upon the independent evaluations of a number of multi-agency	Does not evaluate

Tackling domestic violence: Providing advocacy and support to survivors of domenstic violence. London: Home Office.		projects which aimed to support female victims of domestic violence, and which were unded under the remit of the Crime Reduction Programme (CRP) Violence Against Women Initiative (VAWI).	the outcome of an intervention
Robinson, A. L. (2009). *Independent Domestic Violence Advisors: A process evaluation.* Cardiff: UK: Cardiff University.	Cardiff, Wales	To assess how Independent Domestic Violence Advisor (IDVA) services have been implemented in various settings and the perceived impact they have had with regard to providing support to victims of domestic violence.	Does not evaluate the outcome of an intervention
Robinson, A.L. (2009). *Independent Sexual Violence Advisors: A process evaluation.* Cardiff, UK: Cardiff University.	Cardiff, Wales	The overall aim of the work is to assess how Independent Sexual Violence Advisor (ISVA) services have been implemented in various settings and the perceived impact they have had with regard to providing support to victims of sexual violence.	Does not have outcomes relevant to research question
Robinson, A.L., Hudson, K., & Brookman, F. (2009). *A process evaluation of YNYS staff, the Sexual Assault Referral Centre in Cardiff: Final evaluation report.* Cardiff, UK: Cardiff University.	Cardiff, Wales	A process evaluation of the Sexual Assault Referral Centre serving Ynys Saff describes both a pre-operational development period and a post-implementation operational period. The aims of the research were to describe the SARC and how it is similar or different to other existing SARCs, to describe the initial throughput of victims, and to describe the multi-agency approach used to develop and implement the SARC, and the levers available and barriers facing those involved.	Does not have outcomes relevant to research question
Scottish Government. (2009). *A partnership approach to tackling violence against women in Scotland: Guidance for multi-agency partnerships.* Edinburgh, UK: Scottish Government.	Scotland	Offers guidance on developing an agreed definition of violence against women, terms of reference for the partnership and partners, clear remits for partners singly and jointly, shared understanding and vision, agreed action plans, sharing information and consistent policies. Includes examples of how multi-agency partnerships across the country are tackling these issues.	Does not evaluate the outcome of an intervention
Stobart, E. (2009). *Multi-agency practice guidelines: Handling cases of forced marriage.* London, UK: Foreign and Commonwealth Office, Forced Marriage Unit.	England	Practice guidelines *The Right to Choose* issued under s.63 Q(1) Forced Marriage (Civil Protection) Act 2007 to provide supplementary guidance and advice to frontline practitioners. Specific guidelines also provided for health professionals; schools, colleges and universities; police officers; children's social care; adult social care; and local housing authorities.	Does not evaluate the outcome of an intervention
Taskforce on the Health Aspects of Violence Against Women and Children. (2010). *Responding to violence against women and children: The role of the NHS.* London, UK: Department of Health.	England	The report examines the role of the NHS in meeting the challenge of violence and abuse against women and children, including the treatment and support of victims of violence - in partnership with other agencies - in preventing violence and abuse. It describes the key issues identified by women and children themselves, and by NHS staff as well as by experts from a wide range of interested bodies. It sets out a number of recommendations to address these issues.	Does not evaluate the outcome of an intervention
Templeton, L. (2009). *Getting the foundations right – Improving the response of alcohol services with clients and families where there is also domestic violence/abuse. Year 1 external evaluation report for the Embrace Project.* London, UK: Alcohol Concern.	London, England	The Embrace Team is developing an outcomes grid to facilitate measurement of what is achieved by the pilot sites over the duration of the project.	Preliminary data for Templeton 2011
Templeton, L. & Galvani, S. (2011). *Think family safety: Enhancing the response of alcohol services to domestic abuse and families.* London, UK: Alcohol Concern.	England	The external evaluation offers a broad, independent evaluation of work of the Embrace Team, the work at the nine pilot sites, and the extent to which the Embrace project achieved a wider dissemination of the Embrace model.	[-] internal quality rating

Appendix C. Screening Checklists

Table 8. Abstract screening checklist

1.	Does the study include?: · adults/ young people in current or former intimate relationships who are experiencing or have experienced domestic violence · Elders/ other adults abused by family members · Victims or perpetrators of honour based violence or killings, or adults/ children at risk of experiencing forced marriage · Victims or perpetrators of violence by children/young people to their parents · Perpetrators of domestic violence · Children exposed to domestic violence · The general population (ie. domestic violence prevention approaches aimed at general public)	YES/UNCLEAR – go to Q2	NO – exclude
2.	Does the study relate to domestic violence among intimate partners or family members?	YES/UNCLEAR – go to Q3	NO – exclude
3.	Was the study conducted in one of the identified OECD countries? [1]	YES/UNCLEAR – go to Q4	NO – exclude
4.	Was the study published in 2000 or later?	YES/UNCLEAR – go to Q5	NO – exclude
5.	Does the study present an approach/ intervention for preventing domestic violence from happening in the first place?	YES/UNCLEAR – include in section/ question #1 and go to Q6	NO – go to Q6
6.	Does the study present information on an approach or intervention to help those working in health and social care to identify, and where appropriate, intervene to prevent domestic violence?	YES/UNCLEAR – include in section/ question #2 and go to Q7	NO – go to Q7
7.	Does the study present information on an approach or intervention to help those working in health and social care to respond to domestic violence?	YES/UNCLEAR – include in section/ question #3 and go to Q8	NO – go to Q8
8.	Does the study present information on an approach or intervention to identify and respond to children who are exposed to domestic violence?	YES/UNCLEAR – include in section/ question #4 and go to Q9	NO – go to Q9
9.	Does the study present information on types of partnership or partnership approaches for assessing and	YES/UNCLEAR – include in section/ question #5 and go to Q10	NO – go to Q10

[1] Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Netherlands, New Zealand, Norway, Portugal, Spain,Sweden, Switzerland, United Kingdom, United States.

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	responding to domestic violence?		
10.	The article does **not** describe an intervention/ approach, but does provide background/ contextual material relevant to the research topic (e.g. theoretical paper, commentary, etc)	YES– retain for background/ contextual literature	NO – go to Q11
11.	Is the study a cost-benefit or cost-effectiveness analysis, or any other type of economic evaluation, or a systematic review including such studies?	YES/UNCLEAR – provide to NICE for cost-effectiveness review	NO – exclude

Table 9. Full text screening checklist

1.	Does the study include?: - adults/ young people in current or former intimate relationships who are experiencing or have experienced domestic violence - Elders/ other adults abused by family members - Victims or perpetrators of honour based violence or killings, or adults/ children at risk of experiencing forced marriage - Victims or perpetrators of violence by children/young people to their parents - Perpetrators of domestic violence - Children exposed to domestic violence The general population (ie. domestic violence prevention approaches aimed at general public)	YES– go to Q2	NO/UNCLEAR – exclude
2.	Does the study relate to domestic violence among intimate partners or family members?	YES– go to Q3	NO/UNCLEAR – exclude
3.	Was the study conducted in one of the identified OECD countries? [2]	YES/UNCLEAR – go to Q4	NO – exclude
4.	Was the study published in 2000 or later?	YES/UNCLEAR – go to Q5	NO – exclude
5.	Does the study present an approach/ intervention for preventing domestic violence from happening in the first place?	YES/UNCLEAR – include in section/ question #1 and go to Q6	NO – go to Q6
6.	Does the study present information on an approach or intervention to help those working in health and social care to identify, and where appropriate, intervene to prevent domestic violence?	YES/UNCLEAR – include in section/ question #2 and go to Q7	NO – go to Q7
7.	Does the study present information on an approach or intervention to help those working in health and social care	YES/UNCLEAR – include in section/ question #3 and go to	NO – go to Q8

[2] Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Luxembourg, Netherlands, New Zealand, Norway, Portugal, Spain,Sweden, Switzerland, United Kingdom, United States?

	to respond to domestic violence?	Q8	
8.	Does the study present information on an approach or intervention to identify and respond to children who are exposed to domestic violence?	YES/UNCLEAR – include in section/ question #4 and go to Q9	NO – go to Q9
9.	Does the study present information on types of partnership or partnership approaches for assessing and responding to domestic violence?	YES/UNCLEAR – include in section/ question #5 and go to Q10	NO – go to Q10
10.	The article does **not** describe an intervention/ approach, but does provide background/ contextual material relevant to the research topic (e.g. theoretical paper, commentary, etc.)	YES– retain for background/ contextual literature	NO – go to Q11
11.	Is the study a cost-benefit or cost-effectiveness analysis, or any other type of economic evaluation, or a systematic review including such studies?	YES/UNCLEAR – provide to NICE for cost-effectiveness review	NO – go to Q12
12.	Is the study a primary study (RCT, case-control, cohort study, observational study, qualitative study, etc.)or a systematic review including such studies?	YES, PRIMARY STUDY – include in review and go to Q13 YES, SYSTEMATIC REVIEW – retain for review/ reference scanning	NO – go to Q13
13.	Is the source not a primary study or systematic review study, but from the grey literature (website, report, thesis, conference proceeding, etc.) and addresses one or more research question/s (one or more of items #5-9)?	YES/UNCLEAR – include	NO- exclude

Appendix D. Studies Excluded During Full Text Screening

The following tables include the abstracts and the reason for exclusion for all studies that were excluded on full text. This table does not include studies that were excluded for negative quality ratings (see *Appendix F*).

Table 10. Research Question 1 (Prevention) Studies Excluded on Full Text

Study Details	Abstract	Reason for Exclusion
Agnew, T. (2006). Beating abuse. *Nursing Older People, 18(1)*, 10-12.	The article focuses on an awareness-raising campaign on elder abuse launched by the non-profit organization Help the Aged, in partnership with the charitable foundation Action on Elder Abuse. An information booklet has been produced by the new campaign to give the general public, including older people who are being abused and health and care workers, the clues they need to recognize abuse and information about sources of help. The campaign aims to put pressure on the government of Great Britain to make elder abuse the responsibility of several departments.	Does not evaluate the outcome of an intervention
Alizadeh, V., Hylander, I., Kocturk, T., & Tornkvist, L. (2010). Counselling Young Immigrant Women Worried About Problems Related to the Protection of 'Family Honour'- from the Perspective of Midwives and Counsellors at Youth Health Clinics. *Scandinavian Journal of Caring Sciences, 24(1),* 32-40.	Background: Annually, thousands of women are exposed to violence and murder by male relatives in the name of family honour. In Sweden young women with immigrant backgrounds consult primary healthcare services for problems related to the protection of 'family honour' (PFH). However, there is little knowledge about how to manage this specific type of family violence in the primary healthcare systems of industrialized countries. Aim: To generate a theoretical model to promote knowledge about how youth clinic (YC) personnel in Swedish primary care perceive and manage problems related to the PFH. Methods: Seven midwives and five counsellors at four YCs in Stockholm suburbs participated in four group interviews. Data were analysed according to the grounded theory method. Results: The YC staff's main concern is to avoid making the young womens' situation worse with their constant anxiety about having breeched the 'honour rules'. Three consecutive steps have been discerned in the worry analysis process to help the girls struggling with problems related to PFH: (i) creation of a refuge where their secret can be safely disclosed, (ii) risk assessment consisting of assessing the degree of the young women's anxiety, the risk of disclosure of the secret and the risk of repercussions if the secret is disclosed and (iii) worry-reducing measures, which may take the form of four different strategies: empowerment, keeping the secret, mediation and secondary prevention. Conclusion: Youth clinics have a key role in preventing repercussions caused by problems related to PFH. The study provides a theoretical model that can be used as a tool in preventive work with young women anxious about honour-related family violence. The findings were presented to a group of midwives and counsellors for validation.	Does not evaluate the outcome of an intervention
Antle, B. F., Karam, E., Christensen, D.N., Barbee, A.P., & Sar, B.K. (2011). An Evaluation of Healthy Relationship Education to Reduce Intimate Partner Violence. *Journal of Family Social Work, 14(5)*, 387-406.	This research evaluated the impact of the Within My Reach healthy relationship education programme on intimate partner violence for 419 high-risk adults in an urban area. Key outcomes such as relationship knowledge, communication/conflict resolution skills, relationship quality, and physical and emotional abuse were evaluated through survey research immediately post- and 6-months postprogram participation. Results suggest that participation in the Within My Reach programme is associated with a statistically significant decrease in physical and emotional abuse, as well as isolation behaviours. Differences by participant demographics and the role of communication skills and relationship quality as mediators of these outcomes are also discussed.	Does not evaluate the outcome of an intervention
Artichoker, K., Gullickson, V., & South Dakota Coalition Against Domestic Violence and Sexual Assault (2003). *Raising Public*	No abstract	Does not evaluate the outcome of an intervention

Awareness on Domestic Violence in Indian Country. Washington, DC: National Resource Centre on Domestic Violence.		
Ball, B., Kerig, P. K., & Rosenbluth, B. (2009). Like a Family but Better Because You Can Actually Trust Each Other: The Expect Respect Dating Violence Prevention Programme for at-Risk Youth. *Health Promotion Practice, 10(Suppl 1),* 45S-58S.	Expect Respect, a teen dating violence prevention programme, was among four programs selected by the Centers for Disease Control and Prevention to participate in an empowerment evaluation project. As one aspect of this project, a qualitative study was designed to investigate the effects of Expect Respect support groups for at-risk youth. The goal was to understand the "how and why" of the programme's impact on participants. Group interviews were conducted with five boys' and five girls' support groups after completion of the programme. Settings included public middle and high schools and alternative schools in juvenile detention. Participants were asked to describe significant learning experiences in support groups as well as changes in their relationships resulting from programme participation. Youths across all groups reported learning new skills including improved communication, anger control, and alternatives to violence. They reported increased knowledge about healthy relationships and warning signs of dating violence and expanded awareness of their own and others' abusive behaviours. Changed relationship norms were uniquely expressed by a boys' group in juvenile detention. Findings indicate that the experience of emotional safety in groups and positive relationships among group members were instrumental in the learning process.	Intervention setting outside of health and social services (School)
Bandyopadhyay, A., Deokar, A., & Omar, H.A. (2010). Adolescent dating violence: A comprehensive review. *International Journal of Child and Adolescent Health, 3(3)*, 305-320.	Adolescent dating violence is a health and social problem, worldwide. The objective of this review was to identify the risk factors and consequences of dating violence, assess the prevention measures taken to increase awareness regarding it and provide an overview of the screening and interventional tools used to support the teens involved in dating violence. Methods: A review of the literature, published in the last 29 years, was conducted and the content was critically analysed. Conclusions: There is an increasing trend of dating violence in a younger population. Consistent definitions, comprehensive assessment tools and focused screening are required to assess the actual prevalence of dating violence. Dating history, context of the date, peer influence, prior history of abuse, alcohol and drugs have been identified as significant risk factors for dating violence. Dating violence has acute as well as long term effects on the body and mind. Since, victims may not report it or even may not identify dating violence as a hazard, the responsibility of screening for it lies heavily on health care providers. Interventional measures should be implemented in a non-judgmental manner, giving due importance to the safety of the adolescents. Primary prevention programs are the key feature to reduce dating violence and require the co-operative participation of several components of the community including school personnel, health care providers, parents and the youth.	Non-systematic review
Banyard, V. L., Eckstein, R.P., & Moynihan, M.M. (2010). Sexual violence prevention: the role of stages of change. *Journal of Interpersonal Violence, 25(1),* 111-135.	Increasing numbers of empirical studies and theoretical frameworks for preventing sexual violence are appearing in the research- and practice-based literatures. The consensus of this work is that although important lessons have been learned, the field is still in the early stages of developing and fully researching effective models, particularly for the primary prevention of this problem in communities. The purpose of this article is to discuss the utility of applying the transtheoretical model of readiness for change to sexual violence prevention and evaluation. A review of this model and its application in one promising new primary prevention programme is provided, along with exploratory data about what is learned about programme design and effectiveness when the model is used. The study also represents one of the first attempts to operationalize and create specific measures to quantify readiness for change in the context of sexual violence prevention and evaluation. Implications for programme development and evaluation research are discussed.	Does not evaluate the outcome of an intervention
Barkin, S. (2003). Preventing youth violence: an office-based approach. *Pediatric Case Reviews, 3(1),* 30-39.	No abstract	Does not evaluate the outcome of an intervention
Berkowitz, A.D. (2004). *Working*	No abstract	Non-systematic review

with men to prevent violence against women: An overview (Part One). Harrisburg, PA: National Resource Centre on Domestic Violence.		
Berkowitz, A.D. (2004). *Working with Men to Prevent Violence Against Women: Programme Modalities and Formats (Part Two).* Harrisburg, PA: National Resource Centre on Domestic Violence.	No abstract	Non-systematic review
Bilukha, O., Hahn, R.A., Crosby, A., Fullilove, M.T., Liberman, A., Moscicki, E., Snyder, S., Tuma, F., Corso, P., Schofield, A., & Briss, P.A. (2005). The effectiveness of early childhood home visitation in preventing violence: A systematic review. *American Journal of Preventive Medicine, 28(2),* 11-39.	No abstract	Systematic review with outcome of child maltreatment
Boba, R., & Lilley, D. (2009). Violence Against Women Act (VAWA) Funding: a nationwide assessment of effects on rape and assault. *Violence Against Women, 15(2),* 168-185.	Although evaluations of process and implementation suggest that the Violence Against Women Act (VAWA) funding programme has resulted in positive outcomes, no study has evaluated its impact on violent crime. This study examines panel data from 1996 to 2002 (10,371 jurisdictions) throughout the United States. Findings indicate that VAWA grants were associated with reductions in rape and assault. These relationships persisted after controlling for general downward crime trends and effects of other justice grants. The results provide support for continued existence of this funding stream and for additional evaluation to determine exactly which programs funded are effective in reducing crime.	Intervention setting outside of health and social services (Justice system)
Brackley, M., Davila, Y., Thornton, J., Leal, C., Mudd, G., Shafer, J., Castillo, P., & Spears, W. (2003). Community readiness to prevent intimate partner violence in Bexar County, Texas. *Journal of Transcultural Nursing, 14(3),* 227-236.	The purpose of this article is to describe the Community Readiness Model implemented by the San Antonio Safe Family Coalition in Bexar County, Texas, a coordinated community response to prevent intimate partner violence. The project used a participatory action process to (a) determine the city's and county's stage of readiness to prevent intimate partner violence; (b) identify differences in the city and county by dividing the area into sectors for the assessment; (c) engage the community in determining the accuracy and usefulness of the results of the assessment; (d) develop targeted strategies to move the city and county to a higher stage of readiness for prevention of intimate partner violence; and (e) evaluate the results of the project.	Does not evaluate the outcome of an intervention
Bradford, M., & Nancarrow, H. (2005). *Koora the Kangaroo: Prevention at Woorabinda State School- Evaluation Report*. Queensland, AU: Queensland Centre for Domestic and Family Violence Research.	Context for the project: Nature and prevalence of Indigenous violence in Australia. Disturbing levels of family violence and the associated impacts on families, children and community life are not unique to Woorabinda. Data from numerous quantitative ;and qualitative studies show that the incidence and prevalence of Indigenous family violence is widespread and disproportionately high when compared to non-Indigenous violence in Australian society (Memmott, 2001). The homicide rate among Indigenous Australians, for example, is approximately ten times that of the national average, as illustrated in findings from an Australian Institute of Criminology study of homicide data for the eleven-year period of 1989-2000. The study revealed that Indigenous people represented 15.1% of victims, and 15.7% of offenders in homicide incidents recorded in Australia, although they constitute only about two per cent of the Australian population (Mouzos 2001). Further, a comparative analysis of recorded	Intervention setting outside of health and social services (School)

	Indigenous and non-Indigenous homicides in Australia during 1989-2000 indicated that 33% of non-Indigenous homicides occurred between family members, compared with 61% of Indigenous homicides occurring between family members.	
Brown, G.W., & Brown, C.V. (2009). Family violence. Prevention doesn't have to be an impossible dream. *Alaska Medicine, 51,* 10-13.	No abstract	Non-systematic review
Campbell, J.C., & Manganello, J. (2006). Changing public attitudes as a prevention strategy to reduce intimate partner violence. *Journal of Aggression, Maltreatment and Trauma, 13(3-4),* 13-39.	Although violence by intimate partners has decreased in the past decade, it is still a problem affecting many women. For instance, IPV accounted for 22% of violent crimes against women between 1993 and 1998 (NCVS). The paucity of research evaluating the effectiveness of primary prevention strategies to reduce IPV has been recognized in various reports on intimate partner violence. Experts have suggested that public awareness campaigns would be helpful both to inform abused women about strategies for getting help, and to potentially change public attitudes and norms about IPV. This article reviews published research available on public education campaigns regarding intimate partner violence, as well as education campaigns conducted for other issues, in order to better understand the potential for success and the limitations of this type of intervention.	Non-systematic review
Casey, E.A., & Ohler, K. (2012). Being a positive bystander: male antiviolence allies' experiences of "stepping up". *Journal of Interpersonal Violence, 27(1),* 62-83.	As bystander approaches become increasingly prevalent elements of sexual and domestic violence prevention efforts, it is necessary to better understand the factors that support or impede individuals in taking positive action in the face of aggressive or disrespectful behaviour from others. This study presents descriptive findings about the bystander experiences of 27 men who recently became involved in antiviolence against women work. More specifically, we describe the consistency with which respondents actively intervene in the speech or behaviour of others, the strategies they use, and the factors they weigh as they deliberate taking action. Respondents report a complex and interrelated set of individual and contextual influences on their choices within bystander opportunities, which hold implications for both violence-specific models of bystander behaviour and for prevention intervention development.	Does not evaluate the outcome of an intervention
Chamberlain, L. (2008). *A prevention primer for domestic violence.* Harrisburg, PA: National Resource Centre on Domestic Violence.	No abstract	Non-systematic review
Choi, N.G., & Mayer, J. (2000). Elder abuse, neglect, and exploitation: risk factors and prevention strategies. *Journal of Gerontological Social Work, 33(2)*, 5-25.	Along with health care providers, social workers are the professionals most likely to be responsible for detecting signs of elder maltreatment and providing interventions and preventive services. In this study, using data from a county adult protective services unit, we discuss the complex nature of domestic elder maltreatment, identify risk factors for different types of maltreatment, and recommend prevention strategies. Specifically, we compare self-neglecting elders and those abused and/or neglected by others. Of the latter, we further compare risk factors for physical and emotional/psychological abuse and/or neglect with risk factors for financial exploitation only. The risk factors analysed include elders' gender, age, living arrangement, acute or chronic health conditions, mental health status, cognitive deficits, size of social support, and alcohol abuse. As preventive strategies, we discuss case-management services, caregiver support services, and alcohol/substance abuse screening and treatment.	Does not evaluate the outcome of an intervention
Clarke, C. (2002). NHS systems that work to prevent abuse of vulnerable adults. *Journal of Adult Protection, 4(1),* 34-41.	The Government's stated aims to modernise health services has seen the establishment of agencies and safeguards designed to ensure quality and protect patients. This paper considers how those agencies and safeguards may serve to prevent the abuse of vulnerable adults..	Does not evaluate the outcome of an intervention
Close, S.M. (2005). Dating violence prevention in middle school and high school youth.	TOPIC: Dating violence and interpersonal abuse among middle school and high school students. PURPOSE: To review the current literature and evaluate the need of conducting further study in order to create early interventions for the prevention of relationship abuse. SOURCES USED: Case report and review of the literature.	Non-systematic review

Journal of Child & Adolescent Psychiatric Nursing, 18(1), 2-9.	CONCLUSIONS: Dating violence among middle school and high school youth must be addressed by screening risk and offering anticipatory guidance during each health maintenance visit in order to prevent victimization of youth in dating and attraction relationships.	
Cohen, L., Davis, R., & Graffunder, C. (2005). *Before it occurs: Primary prevention of intimate partner violence and abuse*. Oakland, CA: Prevention Institute.	No abstract	Non-systematic review
Collins, M., & Walford, M. (2008).Helping vulnerable adults to keep safe. J*ournal of Adult Protection, 10(1),* 7-12.	Adult protection is about prevention and, failing that, investigation and aftercare. This article describes innovative work in Powys, mid Wales, where trainers are working with vulnerable adults to help them to reduce the risk that they will be abused, or if the worst happens, where to turn for help. College staff have developed a course that runs on one afternoon a week for the academic year for people with learning disabilities. For people with mental health problems the approach had been workshop based, with a programme of six or eight workshops run by skilled trainers. For older people a third approach has been developed because there are so many older people who need to hear about Keeping Safe. After piloting one-off workshops and presentations, the trainer has worked with staff and volunteers from a variety of agencies who already work with older people to train them as trainers working in pairs. Those who have received the training will be delivering sessions in luncheon clubs, day services, care homes etc.	Does not evaluate the outcome of an intervention
Commission of the European Communities (2004). *Final report from the Commission to the European Parliament and the Council on the Daphne Programme (2000 - 2003).*	No abstract	Does not evaluate the outcome of an intervention
Conway, P., Cresswell, J., Harmon, D., Pospishil, C., Smith, K., Wages, J., & Weisz, L. (2010). Using empowerment evaluation to facilitate the development of intimate partner and sexual violence prevention programs. *Journal of Family Social Work, 13(4),* 343-361.	This article addresses the question, "What factors contributed to successful completion of a needs and resource assessment in local communities, using the empowerment evaluation approach?" Case studies of three successful projects allow the exploration of organizational, community, state, and national factors that contributed to a strong needs and resource assessment, including original data collection, to guide the development of a plan to prevent intimate partner and sexual violence. The overall project was guided by empowerment evaluation principles. Each local community used additional conceptual frameworks, including grounded theory, Kolberg's theory of moral development, gender-role attitudes as operationalized by the rape myth acceptance and Olweis' systemic approach to bullying. Local programs focused on specific populations and collected original data through a variety of methods. For instance, one local agency utilized already existing surveys to assess bullying within their public school setting. Another community assessed the attitudes of male sex offenders and other male community members regarding gender-role attitudes, violence, and risk and protective factors for perpetration. A third community administered a random phone survey, examining attitudes toward rape, other violence against women, and gender roles. Each community integrated the results of their original data collection into their needs and resource assessment. Preliminary information regarding the communities' experience with the completion of needs and resource assessments, using the empowerment evaluation framework, indicate that successful projects used specific theories or frameworks to guide data collection. Positive collaboration with evaluators and community prevention coalitions characterized each community's experience.	Does not evaluate the outcome of an intervention
Cornelius, T.L., & Resseguie, N. (2007). Primary and secondary prevention programs for dating violence: A review of the	Recent research has consistently demonstrated that a significant proportion of dating relationships are characterized by violent interactions. Aggression that occurs in the context of dating relationships is associated with a variety of deleterious effects in the context of the current relationship, and provides a potential trajectory to more severe forms of violence in later relationships. These data have led researchers and practitioners to	Non-systematic review

literature. *Aggression and Violent Behaviour, 12(3),* 364-375.	develop and implement programs designed to prevent such violent dating behaviours. This comprehensive review examines the literature on primary and secondary prevention programs for dating violence, with emphases on methodological and theoretical issues. Ubiquitous limitations of the current research are identified, as well as future directions and implications for researchers and practitioners in the field.	
Cox, P. J., Ortega, S., Cook-Craig, P. G., & Conway, P. (2010). Strengthening systems for the primary prevention of intimate partner violence and sexual violence: CDC's DELTA and EMPOWER programs. *Journal of Family Social Work, 13(4),* 287-296.	No abstract	Does not evaluate the outcome of an intervention
Craig, Y. J. (2000). *Mediation and empowering older people to resolve interpersonal conflicts leading to elder abuse and contribute to its prevention An exploratory study.* London, UK: London Guidhall University.	No abstract	Does not evaluate the outcome of an intervention
Crooks, C.V., Goodall, G.R., Baker, L.L., & Hughes, R. (2006). Preventing Violence Against Women: Engaging the Fathers of Today and Tomorrow. C*ognitive and Behavioural Practice, 13(1),* 82-93.	Although fathers play a key role in helping their children develop ideas about gender relations and close relationships, they have been largely overlooked as a resource to help prevent violence against women. This paper explores some of the reasons why fathers have not been successfully engaged in violence prevention. Engaging fathers to promote wider definitions of masculinity for themselves and their children is presented as a major mechanism by which fathers could help prevent violence against women. The information-motivation-behaviour model of change, developed for preventing high-risk sexual behaviour, is applied to the area to provide structure for understanding previous and current attempts to engage fathers. Examples of innovative programs are used to highlight the application of this model. 2006 Association for Behavioural and Cognitive Therapies.	Does not evaluate the outcome of an intervention
Crooks, C.V., Goodall, G.R., Hughes, R., Jaffe, P.G., & Baker, L.L. (2007). Engaging men and boys in preventing violence against women: applying a cognitive-behavioural model. *Violence Against Women, 13(3),* 217-239.	Although historically the prevention of relationship violence has been seen as a women's issue, more recently recognition has emerged regarding the need to engage men as partners in these initiatives. Early attempts have been mainly driven by grassroots efforts and have not been consistent with a particular theory of behaviour and attitude change. This article investigates the application of cognitive-behavioural strategies to engaging men and boys in violence prevention, within a profeminist framework. Three fundamental components of a cognitive-behavioural therapy approach--goal setting, core beliefs, and strategies for change--are discussed and examples of promising initiatives are used to highlight these ideas.	Non-systematic review
Delta Prep. (2012). *Intimate partner violence is preventable: We can stop this violence before it starts.* Montgomery, AL: Alabama Coalition Against Domestic Violence.	No abstract	Does not evaluate the outcome of an intervention
Denkeler, K. (2005). Preventative Care. *Violence Prevention Tips, 5(2)*, 74-87.	No abstract	Does not evaluate the outcome of an intervention

Donovan, R.J., Francas, M., Paterson, D., & Zappelli, R. (2000). Formative research for mass media-based campaigns: Western Australia's Freedom From Fear campaign targeting male perpetrators of intimate partner violence. *Health Promotion Journal of Australia, 10(2),* 78-83.	ISSUES ADDRESSED: Violence against women by their partners is recognised as a major public health problem in both developed and developing countries. Traditional domestic violence campaigns focus on legal threats and sanctions in an attempt to stop men from being violent. The Western Australian "Freedom from Fear" campaign is aimed at motivating violent men to voluntarily call a Men's Domestic Violence Helpline and hence be referred on to counselling programs. In its first phase, the campaign relies totally on mass media advertising to create awareness of the Helpline and to motivate calls. Formative research was crucial to ensure that target men would respond to the advertising messages. In particular, the advertising could not be seen by violent men to be condemning their violence, while at the same time it could not be seen to condone men's violence towards women. METHODS: A series of focus group discussions was held with men from the general population and with violent men. The early groups attempted to identify what message strategy would be most effective in motivating target men to call the Helpline. Later groups were used to evaluate and refine concept executions developed as a result of the early group findings. The most effective concept executions identified were then presented to various key stakeholders to identify any unintended undesired effects. Animatics of three advertisements were then quantitatively tested with 18-40 year-old men to assess understanding and believability of the advertisements. The advertisements were also tested against victims and the children of victims to ensure there were no unintended undesired effects. RESULTS: Group discussions with violent men indicated that the most effective message strategy centred on the impact of domestic violence on children, regardless of whether the men had children of their own. After testing a number of message strategies and concept executions, three concepts were developed to the animatics stage. Quantitative testing of these with 302 men showed that all respondents showed some correct understanding of the advertisements' messages, and 89% rated the advertisements as very or fairly believable. As evidence for the success of the formative research, in the first 7 months of the campaign 1385 target men called the Helpline, including 867 who identified themselves as perpetrators of physical abuse. Of these, 411 men agreed to referral to a service provider. CONCLUSION: Formative research with violent men ensured that the mass media advertising would be effective in encouraging violent and potentially violent men to voluntarily call a Men's Domestic Violence Helpline, by focusing on an appropriate message strategy without being judgemental or indicating retribution. Similarly, the research ensured that undesirable unintended messages of condoning violence were not communicated, and that the advertisements did not unduly upset victims. SO WHAT? The campaign results endorse the efficacy of promoting a telephone helpline as a way of encouraging perpetrators to voluntarily enter counselling programs, and hence as an effective strategy for the prevention of domestic violence.	Does not evaluate the outcome of an intervention
Douglas, U., Bathrick, D., & Perry, P.A. (2008). Deconstructing male violence against women: the men stopping violence community-accountability model. *Violence Against Women, 14(2),* 247-261.	Men Stopping Violence (MSV), a 24-year-old metro Atlanta-based organization that works to end male violence against women, uses an ecological, community-based accountability model as the foundation of its analysis of the problem of male violence against women and of its work with individuals and in communities. The MSV community-accountability model of male violence against women offers a view of the cultural and historical mechanisms that support violence against women. The model, and the strategies and programs that have grown out of it, demonstrate the potential for disrupting traditions of abuse and dominance at the individual, familial, local, national, and global levels.	Does not evaluate the outcome of an intervention
Dugan, L., Rosenfeld, R., Nagin, D.S. (2003). Exposure reduction or retaliation? The effects of domestic violence resources on intimate-partner homicide. *Law & Society Review, 37,* 169-198.	Rates of homicide involving intimate partners have declined substantially over the past 25 years in the United States, while public awareness of and policy responses to domestic violence have grown. To what extent has the social response to domestic violence contributed to the decline in intimate-partner homicide? We evaluate the relationship between intimate-partner homicide and domestic violence prevention resources in 48 large cities between 1976 and 1996. Controlling for other influences, several types of prevention resources are linked to lower levels of intimate-partner homicide, which we interpret in terms of their capacity to effectively reduce victims' exposure to abusive or violent partners. Other resources, however, are related to higher levels of homicide, suggesting a retaliation effect when interventions stimulate increased aggression without adequately reducing exposure. In light of other research on deficiencies in accessing and implementing prevention	Does not evaluate the outcome of an intervention

	resources, our results suggest that too little exposure reduction in severely violent relationships may be worse than none at all.	
End Violence Against Women (2007). *Making the Grade, The third annual independent analysis of UK Government initiatives on violence against women.* London, UK: End Violence Against Women Coalition.	No abstract	Does not evaluate the outcome of an intervention
Farrell, H.M. (2011). Batterers: a review of violence and risk assessment tools. *Journal of the American Academy of Psychiatry & the Law, 39(4*), 562-574.	Batterers are often identified in the criminal justice system after they have inflicted significant abuse on their victims. The increasing public health initiatives surrounding intimate partner violence focus on identification of victims and their protection. Little emphasis is placed, however, on the batterers themselves. Forensic specialists become involved in risk assessment for violence only after a perpetrator has inflicted significant damage on his victim and entered the criminal justice system. This article serves to bring awareness of the many factors, including neurobiology and neuropsychology, that contribute to the development of a batterer. Two instruments useful in identifying violence risk will be highlighted, along with a proposal for future research that could broaden risk assessment applications to other noncriminal settings, allowing for early detection and prevention of violent acts.	Does not evaluate the outcome of an intervention
Faulkner, A. (2012). Prevention of abuse; a brief review of the literature. *Journal of Adult Protection, 14(1)*, 35-38.	Reviews the literature on prevention in adult safeguarding and identifies the themes that emerge, with particular reference to personalisation and the views of service users. Explains how the review was carried out, covering literature on psychological abuse, sexual abuse, physical abuse and domestic violence, mostly concerning older adults or people with learning difficulties. Discusses various adult safeguarding themes identified in the literature including: identifying people at risk of abuse; raising public awareness; providing information, advice and advocacy; providing training and education; organisational practices and procedures; community links and community support; regulation and legislation; inter-agency collaboration; and empowerment and choice. Finds evidence of a range of factors that may contribute to preventing abuse in the context of adult safeguarding. Highlights the difficulty in demonstrating that abuse has been or is being prevented. Recommends that local authorities consider risk enablement for service users as a parallel process to adult safeguarding.	Non-systematic review
Feder, L., Holditch Niolon, P., Campbell, J., Wallinder, J., & Nelson, R., Larrouy, H. (2011). The Need for Experimental Methodology in Intimate Partner Violence: Finding Programs That Effectively Prevent IPV. *Violence Against Women, 17(3),* 340-358.	The lack of rigorous evaluations of intimate partner violence (IPV) programs has severely limited our knowledge about what works. However, IPV programs can be rigorously evaluated through randomized controlled trials (RCTs) conducted ethically and safely. This article provides an example of how a RCT to test an IPV preventive intervention—the Enhanced Nurse Family Partnership Study (ENFPS)—was successfully implemented by a partnership of researchers and practitioners. The article concludes with some recommendations, arrived at by the researchers and practitioners on the ENFPS team, for achieving a successful collaboration thought to be essential in executing a field experiment.	Does not evaluate the outcome of an intervention
Foshee, V.A., Bauman, K.E., Ennett, S.T., Suchindran, C., Benefield, T., & Linder, G.F. (2005). Assessing the effects of the dating violence prevention programme "safe dates" using random coefficient regression modeling. *Prevention Science, 6(3),* 245-258.	The Safe Dates Project is a randomized trial for evaluating a school-based adolescent dating violence prevention programme. Five waves of data were used to examine the effects of Safe Dates over time including primary and secondary prevention effects, moderators, and mediators of programme effects. Using random coefficients models, with multiple imputation of missing data, significant programme effects were found at all four follow-up periods on psychological, moderate physical, and sexual dating violence perpetration and moderate physical dating violence victimization. Marginal effects were found on sexual victimization. Effects on severe physical perpetration at all four follow-up periods were moderated by prior involvement in that type of violence. Primary and secondary prevention effects were found and the programme was equally effective for males and females and for whites and non-whites. Programme effects were mediated by changes in dating violence norms, gender-role norms, and awareness of community services.	Intervention setting outside of health and social services (School)

Fox, C., Gladd, D., & Coor, M. (2010). *Boys to Men: First Report Findings from the Pilot Evaluation of Relationships without Fear.* Keele, UK: University of Keele.	A number of school-based domestic abuse prevention programmes have been developed in the UK but evidence as to the effectiveness of such programmes is limited (Hilton, 2000; Mullender, 2004; Worrall et al, 2008). The main aim of the research reported here was to develop an evaluation of the effectiveness of one such programme - Relationships without Fear (RwF) delivered by Arch North Staffs.	Intervention setting outside of health and social services (School)
Gardner, S.P., & Boellaard, R. (2007). Does Youth Relationship Education Continue to Work after a High School Class? A Longitudinal Study. *Family Relations, 56(5),* 490-500.	Connections: Relationships and Marriage ("Connections") is a high school marriage education curriculum designed to teach students how to develop healthy relationships and marriages. This study evaluated the effectiveness of this curriculum over 4-years postintervention with a matched set of 72 high school students who were in either the "Connections" group or a control group. Findings suggest that although most of the immediate impacts of the curriculum fade within 4 years after the curriculum, the "Connections" group shows an increase in self-esteem, a decrease in dating and relationship violence, and an increase in family cohesion over 4 years. Implications for further development of such curricula are discussed as well as implications for practitioners.	Intervention setting outside of health and social services (School)
Gewirtz, A., & August, G. (2008). Incorporating Multifaceted Mental Health Prevention Services in Community Sectors-of-Care. *Clinical Child & Family Psychology Review, 11(1),* 1-11.	This article proposes a framework for embedding prevention services into community sectors-of-care. Community sectors-of-care include both formal and grassroot organizations distributed throughout a community that provide various resources and services to at-risk children and their families. Though the child population served by these organizations is often at elevated risk for mental health problems by virtue of children exposure to difficult life circumstances (poverty, maltreatment, homelessness, domestic violence, etc.) these children face many barriers to accessing evidence-based prevention or treatment services. We review evidence and propose a framework for integrating prevention services into community sectors-of-care that serve high-risk children and families.	Does not evaluate the outcome of an intervention
Gillen, S. (2010). Saying no to mate crime. *Learning Disability Today, 10(8).*	Exploitation and abuse of people with learning disabilities by those closest to them, including friends and partners. Initiatives to raise awareness of 'mate crime' are discussed, including the 'Safety Net' project, which provides training for people with learning disabilities regarding making friends and developing relationships. Community nurse-run sessions to support women are described.	Does not evaluate the outcome of an intervention
Godenzi, A., & De Puy, J. (2001). Overcoming boundaries: A cross-cultural inventory of primary prevention programs against wife abuse and child abuse. *Journal of Primary Prevention, 21(4), 455-*475.	This paper reviews existing primary prevention programs against wife and child abuse in the USA, Canada and France. There are a large variety of primary prevention approaches to wife and child abuse, but no systematic overview of these programs exists. In addition, knowledge of intervention programs has been limited by language barriers. This paper looks beyond language differences to provide a fuller view of the spectrum of recent intervention programs. We present a qualitative overview of existing programs and discuss the similarities and differences among different intervention strategies.	Non-systematic review
Gould, B., Coulter, M., & Perry-Casler, S. (2000). Distance Learning: A Useful Tool for the Prevention and Treatment of Domestic Violence. *Journal of Instruction Delivery Systems, 14(1),* 11-16.	Reviews a major videoconferencing project concerning domestic violence as a practical means of: (1) examining the underlying assumptions used concerning project development and delivery; (2) sharing information on critical lessons learned; and (3) offering recommendations to future users who are planning to conduct similar distance learning activities.	Does not evaluate the outcome of an intervention
Great Britain Home Office (2008). *National domestic violence delivery plan: annual progress report 2007/08.* London, UK: Home Office.	Government work on domestic violence is brought together in the cross-government National Domestic Violence Delivery Plan. In 2005 the Home Office published its first National Report on Domestic Violence, containing the framework of the National Delivery Plan which identified 5 key objectives for 2005/06 to address all aspects of domestic violence, from prevention through to victim care and the response of the criminal justice system. This, the fourth national report provides an update on work during 2007/08 and outlines key objectives and activity for 2008/09.	Does not evaluate the outcome of an intervention
Great Britain Home Office (2009). *National domestic violence*	This report sets out four objectives:[undefined]increasing early identification of and intervention with victims of domestic violence by using all points of contact with front-line professionals; building capacity within the sector to	Does not evaluate the outcome of an

delivery plan: annual progress report 2008-09. London, UK: Home Office.	provide effective advice and support victims; improve the criminal justice response; and support victims through the criminal justice system and manage perpetrators to reduce risk.	intervention
Hahn, R.A., Bilukha, O.O., Crosby, A., Fullilove, M.T., Liberman, A., Moscicki, E.K., Snyder, S., Tuma, F., Schofield, A., Corso, P.S., Briss, P., & Task Force on Community Preventive, Services (2003). First reports evaluating the effectiveness of strategies for preventing violence: early childhood home visitation. Findings from the Task Force on Community Preventive Services. *Morbidity & Mortality Weekly Report. Recommendations & Reports, 52(RR-14),* 1-9.	Early childhood home visitation programs are those in which parents and children are visited in their home during the child's first 2 years of life by trained personnel who provide some combination of the following: information, support, or training regarding child health, development, and care. Home visitation has been used for a wide range of objectives, including improvement of the home environment, family development, and prevention of child behaviour problems. The Task Force on Community Preventive Services (the Task Force) conducted a systematic review of scientific evidence concerning the effectiveness of early childhood home visitation for preventing several forms of violence: violence by the visited child against self or others; violence against the child (i.e., maltreatment [abuse or neglect]); other violence by the visited parent; and intimate partner violence. On the basis of strong evidence of effectiveness, the Task Force recommends early childhood home visitation for the prevention of child abuse and neglect. The Task Force found insufficient evidence to determine the effectiveness of early childhood home visitation in preventing violence by visited children, violence by visited parents (other than child abuse and neglect), or intimate partner violence in visited families. (Note that insufficient evidence to determine effectiveness should not be interpreted as evidence of ineffectiveness.) No studies of home visitation evaluated suicide as an outcome. This report provides additional information regarding the findings, briefly describes how the reviews were conducted, and provides information that can help in applying the recommended intervention locally.	Non-systematic review
Hamby, S., Nix, K., De Puy, J., & Monnier, S. (2012). Adapting dating violence prevention to francophone Switzerland: a story of intra-western cultural differences. *Violence & Victims, 27(1)*, 33-42.	Dating violence prevention programs, which originated in the United States, are beginning to be implemented elsewhere. This article presents the first adaptation of a violence prevention programme for a European culture, Francophone Switzerland. A U.S. dating violence prevention programme, Safe Dates (Foshee & Langwick, 1994), was reviewed in 19 youth and 4 professional focus groups. The most fundamental programme concepts--"dating" and "violence"--are not the same in Switzerland and the United States. Swiss youth were not very focused on establishing monogamous romantic relationships, and there is no ready translation for "dating." Violence has not become the focus of a social movement in Switzerland to the same extent that it has in the United States, and distinctions among terms such as "dating violence" and "domestic violence" are not well known. Psychoeducational approaches are also less common in the Swiss context. As the movement to prevent violence extends worldwide, these issues need greater consideration.	Does not evaluate the outcome of an intervention
Hammond, W.R., Whitaker, D.J., Lutzker, J.R., Mercy, J., & Chin, P.A. (2006). Setting a violence prevention agenda at the Centers for Disease Control and Prevention. *Aggression and Violent Behaviour, 11,* 112-119.	Historically, public health has affected quality of life through the application of scientific methods to solve health problems and broad implementation of the answers to those problems. The public health approach is multidisciplinary and scientific, and is explicitly directed toward identifying effective approaches to prevention. This article provides an overview of the public health approach in the areas of violence prevention. In particular, we describe the unique role of the Centers for Disease Control and Prevention (CDC) in violence prevention and control, and CDC efforts in terms of our current mission, organizational structure, research, and programs. We also describe the application of the public health approach to specific areas of violence prevention. Examples include CDC activities in priority areas including family and intimate partner violence, sexual violence, child maltreatment, youth violence, and suicide prevention. Emerging research priorities and trends in those areas are also discussed. Issues related to the implementation and dissemination of effective programs and policies are addressed, as well as prospects and challenges to the full realization of public health objectives. Published by Elsevier Ltd.	Does not evaluate the outcome of an intervention
Henry, D.B. (2012). Mediators of effects of a selective family-focused violence prevention approach for middle school students. *Prevention Science,*	This study examined how parenting and family characteristics targeted in a selective prevention programme mediated effects on key youth proximal outcomes related to violence perpetration. The selective intervention was evaluated within the context of a multi-site trial involving random assignment of 37 schools to four conditions: a universal intervention composed of a student social-cognitive curriculum and teacher training, a selective family-focused intervention with a subset of high-risk students, a condition combining these two interventions, and a no-	Intervention setting outside of health and social services (School)

13(1), 1-14.	intervention control condition. Two cohorts of sixth-grade students (total N=1,062) exhibiting high levels of aggression and social influence were the sample for this study. Analyses of pre-post change compared to controls using intent-to-treat analyses found no significant effects. However, estimates incorporating participation of those assigned to the intervention and predicted participation among those not assigned revealed significant positive effects on student aggression, use of aggressive strategies for conflict management, and parental estimation of student‚Äôs valuing of achievement. Findings also indicated intervention effects on two targeted family processes: discipline practices and family cohesion. Mediation analyses found evidence that change in these processes mediated effects on some outcomes, notably aggressive behaviour and valuing of school achievement. Results support the notion that changing parenting practices and the quality of family relationships can prevent the escalation in aggression and maintain positive school engagement for high-risk youth.	
Hickman, L.J., Jaycox, L.H., & Aronoff, J. (2004). *Dating Violence Among Adolescents: Prevalence, Gender Distribution, and Prevention Programme Effectiveness.* Santa Monica, CA: RAND Corporation.	Relative to violence among adult intimate partners, violence among adolescent dating partners remains an understudied phenomenon. In this review, we assess the state of the research literature on teen dating violence. Our review reveals that the broad range of estimates produced by major national data sources and single studies make conclusions about the prevalence of teen dating violence premature. Similarly, our review of what is known about risk factors reveals inconsistency among studies. We assess published evaluations of adolescent dating violence prevention programs and discuss their findings and limitations. Finally, we discuss challenges to researchers in this area and suggest that additional investment in high-quality basic research is needed to inform the development of sound theory and effective prevention and intervention programs.	Non-systematic review
Hockenhull, J., Whittington, R., Leitner, M., Barr, W., McGuire, J., Cherry, MG, Flentje, R., Quinn, B., Dundar, Y., & Dickson, R. (2012). A systematic review of prevention and intervention strategies for populations at high risk of engaging in violent behaviour: update 2002–8. *Health Technology Assessment, 16(3),* 1366-5278.	No abstract	Non-systematic review
Huefner, J.C., Ringle, J.L., Chmelka, M.B., & Ingram, S.D. (2007). Breaking the cycle of intergenerational abuse: The long-term impact of a residential care programme. *Child Abuse & Neglect, 31,*187-199	Objective: The number of youth in residential care programs who have been abused is high. The relationship between childhood abuse victimization and adult intimate partner violence (IPV) is well documented. This study compared the rates of IPV 16 years after individuals had participated in a long-term residential care programme with individuals accepted to the programme who did not participate. The IPV rates for these two groups were also compared to national normative data. Method: Information on adult functional outcomes was obtained from former residential care and comparison youth via a confidential survey that was administered either by telephone or by mail. Analysis was limited to respondents who were currently married or involved in a marriage-like relationship (n=13 1; 92% male). Results: The IPV rates for the sample were 9.3% for those who stayed in the residential programme less than 18 months and 6.5% for those who stayed more than 18 months, neither of which were significantly different from the national norm of 8.4%. The IPV rate for the comparison group was 26.1%, which was significantly higher than the national norm. Regardless of length of programme stay, respondents who were maltreated in childhood had a 14.5% IPV rate, which was significantly lower than the estimated 36-42% rate projected for individuals with similar backgrounds. Conclusion: We conclude that time spent in a treatment-oriented residential care programme was associated with lower adult IPV rates. Specifically, the skills taught in a long-term, treatment-based residential programme (e.g., healthy interpersonal relationships, self-government) may have a long-term beneficial impact for adolescents at high risk of adult IPV.	Does not evaluate the outcome of an intervention
Hyman, I., Guruge, S., Stewart,	The best mechanisms to prevent violence against women were reviewed in a critical appraisal conducted by the	Non-systematic review

D.E., & Ahmad, F. (2000). Primary prevention of violence against women. *Women's Health Issues, 10(6),* 288-293.	University Health Network Women's Health Programme. Several promising primary interventions were identified. These included: educational and policy-related interventions to change social norms, early identification of abuse by health and other professionals, programs and strategies to empower women, safety and supportive resources for victims of abuse, and improved laws and access to the criminal justice system. The policy recommendations emerging from this analysis are presented.	
Jannone, L. (2011). Community services for victims of interpersonal violence. *Nursing Clinics of North America, 46(4),* 471-476.	Interpersonal violence can be categorized into youth violence, childhood maltreatment, intimate partner violence, elder abuse, or sexual violence. Just as there are several different victims of interpersonal violence, there are various different community services and prevention programs for each particular type of interpersonal violence. This article reviews the literature on community services and prevention available for all victims of interpersonal violence, and examines the literature on whether these programs are effective. .	Non-systematic review
Jayawardena, K.M., & Liao, S. (2006). Elder abuse at end of life. *Journal of Palliative Medicine, 9(1),* 127-136.	CONTEXT: Advances in health care and changing demographics have led to an aging population whose care at the end of life has become complex. Patients at the end of life, by the nature of their clinical and social circumstances, are at high risk for elder abuse. Underreporting of elder abuse is a growing concern. The clinical presentation of abuse may overlap with the natural dying process, further compounding the problem. EVIDENCE ACQUISITION: Articles were obtained through a PubMed search using the terms "elder abuse" and "elder mistreatment" and from the University of California, Irvine's Elder Abuse Forensic Centre library. Additional references were followed through these first set of articles and also from colleagues expert in this field. EVIDENCE SYNTHESIS: Multidisciplinary teams have been shown to be the most effective intervention for the assessment and prevention of abuse. Most abuse occurs at home by family members; the hospice team may be the only outside professionals coming into the home. Caregiver stress and victim dependency increase the risk for abuse. Although physical abuse is the most commonly envisioned, neglect is the most common form of abuse. Financial abuse is often the underlying motivation for other forms of abuse. CONCLUSIONS: Health professionals have an ethical and legal responsibility to both report and work to prevent suspected abuse. The interdisciplinary team can make a significant impact on elder abuse, a major detriment on quality of life.	Non-systematic review
Jaycox, L.H., McCaffrey, D. Eiseman, B. Aronoff, J., Shelley, G., Collins, R., & Marshall,G. (2006). Impact of a School-Based Dating Violence Prevention Programme among Latino Teens: Randomized Controlled Effectiveness Trial. *Journal of Adolescent Health, 39(5),* 694-704.	Purpose: Given the high rate of dating violence between teens and associated deleterious outcomes, the need for effective prevention and early intervention programs is clear. Break the Cycle's Ending Violence curriculum, a three-class-session prevention programme focused on legal issues, is evaluated here for its impact on Latino/a youth. Methods: Tracks within large urban high schools that had at least 80% Latino/a students were randomized to immediate or delayed curriculum. Classrooms were randomly selected within tracks and individual student outcomes were assessed pre- and post-intervention and six months later. Results: Students in intervention classrooms showed improved knowledge, less acceptance of female-on-male aggression, and enhanced perception of the helpfulness and likelihood of seeking assistance from a number of sources immediately after the programme. Improved knowledge and perceived helpfulness of an attorney were maintained six months later. There were no differences in recent abusive/fearful dating experiences or violence victimization or perpetration. Conclusions: The Ending Violence curriculum has an impact on teen norms, knowledge, and help-seeking proclivities that may aid in early intervention for dating violence among Latino/a students.	Intervention setting outside of health and social services (School)
Jaycox, L., McCaffrey, D., Weidmer, D., Ocampo, B., Grant, M., Hickman, C., Quigley, L., & Rand, D. (2006). *Curbing Teen Dating Violence: Evidence from a School Prevention Programme.* Santa Monica, CA: RAND Corporation.	This research brief summarizes a survey about the effectiveness of programs from Break the Cycle, a nonprofit organization dedicated to developing and fielding dating-violence prevention programs. The study evaluated "Ending Violence," a three-class-session prevention programme. Developed by a Los Angeles-based nonprofit group called Break the Cycle, the programme focuses on the law, highlighting legal rights of victims of domestic violence and legal responsibilities of perpetrators. The teachers are bilingual, bicultural attorneys. This programme has three distinctive features: it is brief (three class sessions), it is compatible with existing health curricula, and it focuses on the legal dimension of dating violence. This perspective is usually new to teens--especially Latino teens in families that have recently immigrated--who may be unfamiliar with their rights under U.S. law or how to exercise them. The programme also informs students about its legal services programme, in which attorneys are available to teens at no cost to help them with dating violence issues. Key findings include:	Intervention setting outside of health and social services (School)

	(1) Break the Cycle's dating-violence prevention programme improved Latino teens' knowledge of dating abuse and legal recourse, reduced their acceptance of female-on-male dating violence (but not male-on-female dating violence, whose acceptance was already low), and enhanced teens' perceptions about seeking help if they experience dating violence; (2) Latino teens experiencing problems with dating violence who seek help are most likely to turn to informal sources of support (family and peers); and (3) Intervention programs can educate teens about the importance of intervening when they witness an incident of violence or abuse among their friends.	
Jenson, J.M., & Howard, M.O. (2000). Causes and Prevention of Youth Violence. *Denver University Law Review, 77(4),* 629-660.	The empirical evidence of risk factors for youth violence is reviewed and effective approaches to preventing violence in family, school, and community settings are identified. Because knowledge of the unique individual and social conditions that cause young people to engage in violence is limited, acts of violence are difficult to understand, making the prediction and prevention of violent behaviour difficult. Despite such limitations, there have been important advances in our knowledge of the causes of youth violence over the past several decades. Longitudinal studies assessing the effects of broad-based and targeted prevention programs have also identified promising strategies to prevent childhood aggression and youth violence. The discussion focuses on two areas: 1) the causes of youth violence; and 2) risk factors for youth violence. In the discussion of risk factors for youth violence, the population indicators of youth violence are given in tabular form.	Non-systematic review
Jewkes, R. (2002). Violence against women III: intimate partner violence: causes and prevention. *Lancet, 359(9315),* 1423-1429.	Unlike many health problems, there are few social and demographic characteristics that define risk groups for intimate partner violence. Poverty is the exception and increases risk through effects on conflict, women's power, and male identity. Violence is used as a strategy in conflict. Relationships full of conflict, and especially those in which conflicts occur about finances, jealousy, and women's gender role transgressions are more violent than peaceful relationships. Heavy alcohol consumption also increases risk of violence. Women who are more empowered educationally, economically, and socially are most protected, but below this high level the relation between empowerment and risk of violence is nonlinear. Violence is frequently used to resolve a crisis of male identity, at times caused by poverty or an inability to control women. Risk of violence is greatest in societies where the use of violence in many situations is a socially-accepted norm. Primary preventive interventions should focus on improving the status of women and reducing norms of violence, poverty, and alcohol consumption.	Does not evaluate the outcome of an intervention
Jouriles, E.N., Platt, C., & McDonald, R. (2009). Violence in Adolescent Dating Relationships. *Prevention Researcher, 16(1),* 3-7.	Beginning with a definition of dating and dating violence among adolescents, this article explores the factors which impact such violence. It concludes with a review of two school-based prevention/intervention programs (Safe Dates and The Youth Relationships Project).	Does not evaluate the outcome of an intervention
Kalaga, H., & Kingston, P. (2007). A review of literature on effective interventions that prevent and respond to harm against adults. Edinburgh,UK: Scottish Government, Social Research.	No abstract	Systematic review with primary outcome not DV
Katz, J., Heisterkamp, H.A., & Fleming, W.M. (2011). The social justice roots of the Mentors in Violence Prevention model and its application in a high school setting. *Violence Against Women, 17(6),* 684-702.	The social justice roots and theory of the Mentors in Violence Prevention (MVP) model is presented, followed by an empirical study examining the influence of MVP in high school settings. Findings reveal students exposed to the MVP model are more likely to see forms of violence as being wrong and are more likely to take actions to intervene than students not exposed to the programme. Findings support the premises on which MVP is founded.	Intervention setting outside of health and social services (School)
Kelly, L., & Humphreys, C. (2000). *Reducing Domestic Violence ... What Works? Outreach and*	No abstract	Book

Advocacy Approaches. London, UK: Home Office, Policing and Reducing Crime Unit.		
Kelly, P.J., Lesser, J., Peralez-Dieckmann, E., & Castilla, M. (2007). Community-based violence awareness. *Issues in Mental Health Nursing, 28(3),* 241-253.	Violence against women is a major influence on women's mental health. We used popular education techniques to train 14 Spanish-speaking women as promotoras (community health workers) to increase awareness about violence against women in low income Texas communities. These women then conducted over 80 presentations in Spanish in local community settings. The impact of the programme on the promotoras and on women attending the presentations was evaluated using qualitative methods. This research lends support to the idea that nurses working in community mental health settings must use innovative primary prevention strategies and evaluation mechanisms to change awareness about violence against women.	Does not evaluate the outcome of an intervention
Keygnaert, I., Anastasiou, A., Camilleri, K., Degomme, O., Devile, W., Dias, S., Field, C. A., Kovats, A., Vettenburg, N., & Temmerman, M. (2011). *Senperforto: Determinants for effective prevention and response actions of SGBV perpetration and victimization in the European asylum reception system.* Tropical Medicine and International Health Conference: 7th European Congress on Tropical Medicine and International Health Barcelona Spain.	Sexual and gender-based violence (SGBV) is a global public health issue and a violation of human rights. Although asylum seekers are considered as particularly vulnerable, so far no cross-national studies assessed the patterns between SGBV experience and prevention knowledge, attitudes, practices and needs within the European reception system. Hence, this study explores which determinants in SGBV perpetration and victimization within the EU reception system are decisive for 'desirable prevention'. Applying community-based participatory research from a socioecological perspective; 599 interviews were conducted with professionals working and residents staying at reception facilities in Belgium, Greece, Hungary, Ireland, Malta, the Netherlands, Portugal and Spain. They reported 660 violence cases in the year prior to the interview. SPSS and R were used for analysis of quantitative data. Our results indicate that both professionals and residents are vulnerable to victimization and/or perpetration of psychological (n=362) as well as sexual violence (n=68) regardless of age, sex or residence status. Undocumented migrants are more likely to be victimized physically compared to others (OR 2.23; P30: OR 3.8; P< 0.001), to group aggression (OR: 2.55; P< 0.001) and to be committed by national citizens (OR: 14; P< 0.001). Thus, in order to be effective, it is paramount for SGBV prevention and response actions within the European reception sector, to mainstream for sexual and psychological violence. However, as for physical and socio-economical violence it is a prerequisite to differentiate according to age, residence status and social network. In support of this, the Senperforto project group developed a Frame of Reference on SGBV prevention and response for the European asylum and reception sector.	Conference abstract
Kingsley, B. (2002). Community empowerment: Promoting the safety and minimising the abuse of older people. *Australian Journal of Primary Health, 8(2),* 98-101.	Elder abuse is a taboo topic that older people talk about in hushed whispers and community workers are hesitant to raise. Nevertheless the abuse of older people is a social issue and a tragedy of an ageing population. To promote the safety of older citizens health professionals cannot stand by and allow clients to be abused where they experience harm at the hands of someone they know and from whom they should be able to expect safe care. The harmful and damaging nature of elder abuse compels practitioners to work with the community to address and resolve this social problem. Evolving from focus group discussions with older people in Perth, Western Australia, a series of community education and empowerment forums were held under the auspice of The Council on the Ageing (WA) Inc. The forums used an innovative drama format to illustrate the issues of elder abuse and demonstrate potential solutions. Forum evaluation indicated that this format was successful in raising awareness of elder abuse, what it is, why it happens and what resources are available to deal with it. From the forums caregivers and older people learned new strategies on how to minimise their risk of abusing or to resist becoming a victim of abuse.	Does not evaluate the outcome of an intervention
Leander, K. (2002). Preventing men's violence against women. *Acta Psychiatrica Scandinavica Supplementum (412),* 15-19.	OBJECTIVE: The treatment and prevention of men's violence against women has increasingly been recognized as an issue not only for the criminal justice but also for the health and public health sectors. It is necessary to determine how health care can avoid accelerating women's 'entrapment' in a violent situation and to contribute to empowering them to take proactive steps. METHOD: Research and experience reveal how the nature of domestic violence can lead to health care playing a preventive role. The responsible body for health care in Stockholm, the Stockholm County Council, is one of several public authorities involved in a county-wide initiative	Non-systematic review

	called Operation Kvinnofrid, which has focused on internal training programmes as well as public poster campaigns. RESULTS: Public awareness campaigns in combination with internal training programmes do have an impact, especially where political and management will is clear. CONCLUSION: Heightened awareness among the public, enhanced skills among health workers, and multiagency coordination of the response to men's violence against women are essential elements of the long-term prevention of this violence.	
Local Government: Improvement and Development (2008). *Making Sense of Domestic Violence.* London, UK: Local Government	This case study looks at the approaches to the issue of domestic violence that are proven to work, including: - The Coordinated Community Response model - Prevention and early intervention - Key role for health services - The WORTH (Ways of Responding through Health) Project, West Sussex - Local and national publicity campaigns - Education in schools and colleges for young people It also looks at the support available to victims and outlines why these approaches work.	Does not evaluate the outcome of an intervention
Louise Brown Research (2004). *Evaluation of the Scottish domestic abuse helpline.* Edinburgh,UK: Scottish Executive, Social Research.	The Scottish Executive, as part of its commitment to implement the National Strategy on Domestic Abuse, established a National Domestic Abuse Helpline in June 2000. The Helpline offers emotional and practical support to victims of domestic abuse and provides information on relevant issues and local sources of specialist help. Calls are free and are not recorded on telephone bills.	Does not evaluate the outcome of an intervention
Macy, R.J. (2010). Violence against women in North Carolina. *North Carolina Medical Journal, 71(6),* 556-560.	Research shows that partner violence and sexual assault against women are significant statewide problems in North Carolina. This commentary provides an overview of the research on evidence-based interventions designed to prevent such violence, highlights current prevention efforts in North Carolina, and offers future directions.	Does not evaluate the outcome of an intervention
Meraviglia, M.G., Becker, H., Rosenbluth, B., Sanchez, E., & Robertson, T. (2003). The Expect Respect Project: Creating a Positive Elementary School Climate. *Journal of Interpersonal Violence, 18(11),* 1347-1360.	The Expect Respect Project, a violence prevention programme, was developed to reduce the incidence of bullying and sexual harassment by creating a positive school climate in which inappropriate behaviours are not tolerated and staff members respond consistently to incidents. The project implemented an educational intervention for students, parents, and staff members on expecting respect in student relationships and strategies for responding to inappropriate student behaviours. This article describes the educational intervention and evaluation of the project. Findings from the project showed a significant increase in awareness of bullying following the educational intervention. Bullying was reported to have occurred in areas with less adult supervision such as the playground, cafeteria, hallway, and buses. Students thought staff would respond to inappropriate behaviours by telling students to ignore verbal bullying or sexual harassment. In contrast, staff at the elementary schools thought adults would respond to inappropriate behaviours by telling the bully to stop, calling his or her parents, or giving a specific punishment.	Intervention setting outside of health and social services (School)
Mitchell-Clark, K., & Autry, A. (2004). *Preventing family violence: Lessons from the community engagement initiative.* San Francisco, CA: Futures Without Violence.	This handbook distills learnings about organizing at the community level and provides advice culled from the experiences of site leaders and other seasoned organizers. It is intended for anyone who wants to initiate or expand family violence prevention work, including agencies addressing family and community health, community development groups, and grassroots leaders. It includes information on getting started, strategies for effective engagement, advice on funding a project, and information on measuring a project's effectiveness.	Does not evaluate the outcome of an intervention
Mitchell, K.S., & Freitag, J.L. (2011). Forum Theatre for Bystanders: A New Model for Gender Violence Prevention. *Violence Against Women, 17(8),* 990-1013.	This article introduces the "Forum Theatre for Bystanders" (FTB) approach to gender violence prevention as practiced by social change groups at several midwestern universities in the United States. Largely informed by Augusto Boal's Theatre of the Oppressed and contemporary research on bystander theory, the Forum Theatre for Bystanders model offers a community-based approach that increases bystander responsibility and reduces victim blaming. The authors describe this model in detail and offer examples from their work to demonstrate its usefulness and efficacy.	Does not evaluate the outcome of an intervention
Mouden, L.D. (2000). Dentistry's role in family violence prevention. *Texas Dental Journal, 117(10),* 62-66.	No abstract	Does not evaluate the outcome of an intervention

Moynihan, M.M., Banyard, V.L., Arnold, J.S., Eckstein, R.P., & Stapleton, J.G. (2010). Engaging intercollegiate athletes in preventing and intervening in sexual and intimate partner violence. *Journal of American College Health, 59(3),* 197-204.	Objective: the object of this exploratory evaluation was to evaluate the "Bringing in the Bystander" sexual and intimate partner violence prevention programme with a new sample of intercollegiate athletes. PARTICIPANTS AND METHODS: fifty-three male and female athletes participated in the programme (experimental group), and 86 were in the control group. All completed pretest, posttest, and 2-month follow-up surveys, including assessment of rape myth acceptance, intent to engage in bystander behaviours, bystander confidence, and bystander behaviours. RESULTS: the programme worked overall and for both women and men, improved bystander confidence and intent to engage in bystander behaviours, and did not create significant backlash effects (ie, worsening of attitudes as a result of programme). CONCLUSIONS: the programme fits with the intent of the National Collegiate Athletic Association CHAMPS/Life Skills programme regarding its focus on the overall development of student-athletes and demonstrates the promising bystander approach compatible with the 2007 American College Health Association toolkit, Shifting the Paradigm: Primary Prevention of Sexual Violence.	Intervention setting outside of health and social services (School)
Moynihan, M.M., Banyard, V.L., Arnold, J.S., Eckstein, R.P., & Stapleton, J.G. (2011). Sisterhood may be powerful for reducing sexual and intimate partner violence: an evaluation of the Bringing in the Bystander in-person programme with sorority members. *Violence Against Women, 17(6),* 703-719.	Sorority members may be at greater risk than other college women for sexual violence and intimate partner violence (IPV). We evaluated the Bringing in the Bystander in-person programme with sorority members who participated in the programme (n=30) compared with those who did not (n=18). Results indicate that programme participants showed increased bystander efficacy, likelihood to help, and responsibility for ending violence without unintended "backlash" effects. Implications include a call for future programming with more diverse sorority members over longer time. In addition, we discuss what the findings might mean for formal campus policies and practices for preventing sexual violence and IPV.	Intervention setting outside of health and social services (School)
No Author (2008). Elder Abuse: Prevalence and Prevention Research. *Community Care, 1715,* 30-31.	No abstract	Does not evaluate the outcome of an intervention
Noonan, R.K., & Charles, D. (2009). Developing teen dating violence prevention strategies: formative research with middle school youth. *Violence Against Women, 15(9),* 1087-1105.	Intimate partner violence (IPV) peaks in youth and young adulthood and is associated with multiple adolescent risk behaviours and negative health outcomes. Targeting youth with prevention messages before they start dating may avert teen dating violence and subsequent adult IPV. This article discusses findings from focus groups with middle school youth to determine behaviours and beliefs regarding dating violence. To develop effective prevention messages, participants were asked questions about characteristics of middle school dating relationships, healthy relationships, relationship norms, unhealthy relationships, emotional abuse, physical abuse, sexual abuse, intervening in violent situations, and trusted sources for information about dating violence. The recommendations for prevention efforts include an emphasis on skill building, tailoring efforts for particular subgroups, and identifying innovative ways of reaching youth.	Does not evaluate the outcome of an intervention
Nurse, J., Habibula, S., & Sethi, D. (2009). *Interventions for the prevention of relationship and dating violence in adolescents and young people.* Cochrane Database of Systematic Reviews, 4.	This is the protocol for a review and there is no abstract. The objectives are as follows: To assess the evidence for the efficacy of interventions designed to prevent relationship and dating violence in adolescents and young people.	Protocol for systematic review (full review not published)
O'Dwyer, C., & O'Neill, D. (2008). Developing strategies for the prevention, detection and management of elder abuse. *Journal of Elder Abuse and*	It is only within the past two decades that elder abuse has received governmental attention in Ireland. Prior to this, there had been little awareness and no structures in place to tackle the problem. Media highlighting of particular cases, and an exploratory study undertaken in 1998, prompted the setting up of a governmental working group on elder abuse. Unique to this group was the trialling of a proposed system in two pilot sites. This allowed for recommendations based on actual practice, and has lead to the adoption of a network of elder abuse	Does not evaluate the outcome of an intervention

Neglect, 20(2), 169-180.	caseworkers, amongst other recommendations..	
O'Leary, K.D., Woodin, E.M., & Timmons Fritz, P.A. (2006). Can we prevent the hitting? Recommendations for preventing intimate partner violence between young adults. *Journal of Aggression, Maltreatment and Trauma, 13(3-4),* 121-178.	All empirically-evaluated partner violence prevention programs were reviewed. Most changed knowledge and attitudes regarding dating and sexual aggression, but few demonstrated behavioural change. Peer violence and substance use programs directed toward at-risk individuals demonstrate much larger effects than those directed at all individuals. Research is needed to (a) identify risk-factors for violence persistence, (b) examine the cost-benefit of universal and targeted programs, and (c) explore the ability of programs, such as parenting, stress management, and substance abuse programs, to reduce partner aggression. We recommend that institutions implement hierarchical systems of prevention, with brief interventions for all; more extensive programme for moderate levels of aggression; and intensive psychosocial and legal interventions for serious offenders.	Non-systematic review
Oliver, W. (2000). Preventing domestic violence in the African American community. The rationale for populate culture interventions. *Violence Against Women, 6(5),* 533.	This article explores how aspects of black popular culture can be effectively used to enhance awareness of domestic violence among African-Americans and access to domestic violence treatment interventions for this population. Black popular culture can be used to enhance the cultural sensitivity and competence of intervention efforts designed to prevent and reduce domestic violence among African-Americans.	Does not evaluate the outcome of an intervention
Oschwald, M., Renker, P., Hughes, R.B., Arthur, A., Powers, L.E., & Curry, M.A. (2009). Development of an accessible Audio Computer-Assisted Self-Interview (A-CASI) to screen for abuse and provide safety strategies for women with disabilities. *Journal of Interpersonal Violence, 24(5),* 795-818.	To increase safety and minimize the risk of interpersonal violence, it is critical that women with disabilities and Deaf women have an opportunity to identify whether or not abuse is happening in their lives. Awareness and knowledge of what constitutes abusive behaviours is an essential first step in addressing interpersonal violence. This article includes a description of the development and evaluation of the Safer and Stronger Programme (SSP), an audio computer-assisted self-interview programme, which was created for women with disabilities and Deaf women for the purposes of increasing awareness of abuse, encouraging safety-planning behaviours, and providing information about community resources.	Does not evaluate the outcome of an intervention
Pomeroy, E., Cowlagi, G.P., Danielle E., Cook, P., Bost, J., & Stepura, K. (2011). Educating students about interpersonal violence: Comparing two methods. *Journal of Social Work Education, 47(3),* 525-544.	This pilot study (N=63) used a mixed methods design to compare the impact of peer theater education, traditional peer education, and a comparison group on the in-depth attitudes and knowledge concerning interpersonal violence (IPV) among social work students in an introductory social work course. Six focus groups were conducted with students to assess their attitudes and thoughts about IPV prior to the intervention and 2 months after the intervention. The results indicate greater knowledge and healthier attitudes toward IPV for both the peer education and peer theater groups, with little change in the comparison group. Participants in the peer theater group, however, communicated a better ability to integrate their knowledge with real-life situations and practically apply this knowledge.	Intervention setting outside of health and social services (School)
Potter, S.J. (2012). Using a Multimedia Social Marketing Campaign to Increase Active Bystanders on the College Campus. *Journal of American College Health, 60,* 282-295.	Recent research found that training men and women to understand the role of bystanders in situations where violence against women (VAW) is occurring may reduce the incidence of VAW (Moynihan & Banyard, 2004). Therefore a public awareness campaign to increase understanding of the prosocial role of bystanders in reducing VAW was developed and implemented. The current article discusses the role of media campaigns in addressing public health issues and describes the initial development, implementation, and evaluation of a media campaign focused on the bystander role in reducing the incidence of VAW. Conclusions and future directions of this exploratory project are discussed.	Based on same data as Potter (2012)
Potter, S.J., Moynihan, M.M., & Stapleton, J.G. (2011). Using social self-identification in social marketing materials aimed at reducing violence against women	The Know Your PowerTM social marketing campaign images model active bystander behaviours that target audience members can use in situations where sexual and relationship violence and stalking are occurring, have occurred, or have the potential to occur. In this practitioner note, we describe strategies that we have used to engage target audience members in the development of the social marketing campaign that we hope can be used by practitioners. We give examples from the development and evaluation of the Know Your Power(TM)	Does not evaluate the outcome of an intervention

on campus. *Journal of Interpersonal Violence, 26(5)* 971-990.	social marketing campaign that used focus group and other types of feedback from the target audience to inform the direction of the campaign.	
Potter, S.J., Moynihan, M.M., Stapleton, J.G., & Banyard, V.L. (2009). Empowering bystanders to prevent campus violence against women: a preliminary evaluation of a poster campaign. *Violence Against Women, 15(1),* 106-121.	Bystander-focused in person sexual violence prevention programs provide an opportunity for skill development among bystanders and for widening the safety net for survivors. A social marketing campaign was designed modeling prosocial bystander behaviour and using content familiar to target audience members by staging and casting scenes to look similar to the people and situations that the target audience regularly encounters. We refer to this sense of familiarity as social self-identification. In this exploratory study, we attempt to understand how seeing oneself and one's peer group (e.g., social self-identification) in poster images affects target audience members' (e.g., college students) willingness to intervene as a prosocial bystander. The posters in the social marketing campaign were displayed throughout a midsize northeastern public university campus and neighboring local businesses frequented by students. During the last week of the 4-week poster display, the university's homepage portal featured an advertisement displaying a current model of an iPod offering undergraduate students an opportunity to win the device if they completed a community survey. We found that among students who had seen the posters, those who indicated that the scenes portrayed in the posters looked like situations that were familiar to them were significantly more likely to contemplate taking action in preventing a situation where sexual violence had the potential to occur. Furthermore, students who indicated familiarity with the poster content were more likely to indicate that they had acted in a manner similar to those portrayed in the poster. Future directions based on findings from this exploratory study are discussed.	Intervention setting outside of health and social services (School)
Potter, S.J., & Stapleton, J.G. (2011). Bringing in the target audience in bystander social marketing materials for communities: suggestions for practitioners. *Violence Against Women, 17(6),* 797-812.	Researchers at a midsized public northeastern university evaluated the efficacy of a poster campaign to determine if students increase their knowledge of prosocial bystander behaviours and willingness to intervene in instances of sexual violence after viewing a series of campaign posters where student actors model appropriate bystander behaviours. During the last week of the campaign, undergraduates were invited to participate in a Web survey. The results of this preliminary evaluation indicate promising variation in the awareness of students who reported seeing the campaign compared to those who did not.	Intervention setting outside of health and social services (School)
Potter, S.J., Stapleton, J.G., & Moynihan, M.M. (2008). Designing, implementing, and evaluating a media campaign illustrating the bystander role. *Journal of Prevention & Intervention in the Community, 36(1-2),* 39-55.	Objective: To evaluate the campus-wide administration of the Know Your Power bystander-oriented social marketing campaign. Participants: Undergraduate students at a public college were invited to participate in a public awareness survey before and after the 6-week campaign administration in February and March 2009. Methods: Pretest and posttests were administered (N=353) to examine if exposure to the campaign changed students' stage of scale scores. Results: Exposure to the social marketing campaign increased participants' awareness of their role in reducing sexual and relationship violence and stalking, increased their expressed willingness to get involved in reducing the incidence these types of violence, and resulted in participants being more likely to report having taken action to reduce these types of violence. Conclusions: As college students explore their role as community members, it is an opportunity for college educators to design and administer prevention messages highlighting behavioural norms to be explored and adopted.	Intervention setting outside of health and social services (School)
Rhoades, G.K., & Stanley, S.M. (2011). Using individual-oriented relationship education to prevent family violence. *Journal of Couple & Relationship Therapy, 10(2),* 185-200.	Relationship aggression has negative effects on adults, children, and society. In this article, we outline the potential benefits of using relationship education programs that are designed for and delivered to individuals (rather than couples) for preventing relationship aggression. Next, we briefly review one such programme, Within My Reach, and related research on its effectiveness in preventing relationship aggression. Implications of this research for future research, clinical practice, and policy are also discussed.	Does not evaluate the outcome of an intervention
Rosenbluth, B. (2002). Expect Respect: A School-Based Programme Promoting Safe and Healthy Relationships for Youth.	No abstract	Intervention setting outside of health and social services

Harrisburg, PA: National Resource Centre of Domestic Violence.		(School)
Runyan, C. W., Gunther-Mohr, C., Orton, S., Umble, K., Martin, S.L., & Coyne-Beasley, T. (2005). PREVENT: a programme of the National Training Initiative on Injury and Violence Prevention. *American Journal of Preventive Medicine, 29*, 252-258.	Training practitioners to use evidence-based approaches to the primary prevention of violence is challenging as a result of the dearth of well-evaluated intervention programs and the lack of familiarity of some practitioners in drawing critically on existing literature. An element of the National Training Initiative in Injury and Violence Prevention, the PREVENT (Preventing Violence Through Education, Networking, and Technical Assistance) programme began in late 2003 to train practitioners to address multiple types of violence by encouraging more widespread use of evidence-based approaches to primary prevention. It is intended to reach practitioners involved in addressing violence against women, sexual violence, child maltreatment, youth violence, and suicide in varied community settings. The programme uses a combination of varied types of face-to-face training and distance learning coupled with opportunities for networking and technical assistance. Ultimately the programme intends to stimulate and facilitate changes in individual, organizational, and cultural awareness and practices fostering primary prevention of violence. The project employs formative, process, and impact evaluation techniques aimed at improving delivery of the training as well as tracking changes in individual and organizations.	Does not evaluate the outcome of an intervention
Ryan, G. (2005). Preventing violence and trauma in the next generation. *Journal of Interpersonal Violence, 20(1),* 132-141.	Research in recent times has clearly demonstrated that violence is predictable and preventable; however, the primary prevention of abusive and violent behaviour will not occur without personal, interpersonal, and social change. This article reviews the empirical research supporting hypotheses for primary prevention of many risks associated with children becoming abusive.	Non-systematic review
Schecter, M., & Dougherty, D. (2009). Combating elder abuse through a lawyer/social worker collaborative team approach: JASA Legal/Social Work Elder Abuse Prevention Programme (LEAP). *Care Management Journals, 10(2),* 71-76.	No abstract	Does not evaluate the outcome of an intervention
Schwartz, J.P., Magee, M.M., Griffin, L.D., & Dupuis, C.W. (2004). Effects of a Group Preventive Intervention on Risk and Protective Factors Related to Dating Violence. *Group Dynamics, 8(3),* 221-231.	Research on interpersonal violence has focused primarily on the areas of child abuse and domestic violence. The study of interpersonal violence in other social interactions has, until recently, been largely ignored, owing to the perception that its occurrence is extremely rare. Over the past 15 years, empirical evidence supporting the phenomenon of dating or courtship violence has emerged and research has found abusive behaviour to be common in college dating relationships. In addition, it has been suggested that an even greater percentage of dating partners are psychologically abused than are physically abused and that psychological abuse may precede physical abuse. Traditionally, intervention efforts have been directed toward both individuals who have committed abuse and individuals identified as victims of abuse, whereas areas of primary prevention and early intervention have been neglected. Certain macrosocietal factors and intra-personal and interpersonal variables have been recognized as contributing to the occurrence of dating violence. In particular, fostering the skills for the development of strong and healthy relationships between individuals has been identified as a key target for dating violence prevention	Intervention setting outside of health and social services (School)
Scottish Executive (2003). *Preventing domestic abuse: a national strategy.* Edinburgh,UK: Scottish Executive.	No abstract	Does not evaluate the outcome of an intervention
Scottish Government (2010).	Presents an account of programme developments since its launch in 2008. Sets out a framework for monitoring	Does not evaluate the

Implementation report: National Domestic Abuse Delivery Plan for Children and Young People - Autumn 2009. Edinburgh,UK: Scottish Government.	and guiding the future work of all those sharing in the commitment to reduce the prevalence of domestic abuse and its impact on children, families and communities in Scotland.	outcome of an intervention
Semple, R.J. (2001). Psychological abuse in intimate relationships: A New Zealand perspective. *New Zealand Journal of Psychology, 30(2),* 60-71.	Reviews literature on psychological abuse in intimate relationships in New Zealand, noting that there are indications that psychological abuse committed by men against their female partners is more prevalent than physical or sexual abuse and may result in greater negative effects. The review focuses on how psychological abuse is characterized when it is attendant to and independent of physical or sexual abuse. Some of the characteristics and determinants of men who abuse their partners are described. Psychometric assessments of psychological abuse are reviewed and relevant portions of the Domestic Violence Act (1995) are discussed. Prevention programs and psychosocial perspectives on treatment for both perpetrators and victims are critically examined. The author offers recommendations for future research.	Does not evaluate the outcome of an intervention
Shepherd, J. (2007). Preventing alcohol-related violence: A public health approach. *Criminal Behaviour and Mental Health, 17(4),* 250-264.	Background: Studies of the relationship between alcohol and violent injury confirm that while there is some evidence of a direct pharmacological association, many other factors are relevant to the frequency and severity of both violent perpetration and being a victim of violence. It is now widely recognized that official police statistics are a poor indicator of the nature and extent of public violence. Aims: Accident and emergency departments and trauma surgeons are not only in a position to provide more accurate information on the nature and extent of clinically significant injury, but they can contribute substantially to violence prevention. This can be achieved through individually targeted interventions in conjunction with other clinicians on the one hand, and on the other through public health and community initiatives, in conjunction with other community agencies, including the police and local authorities. This article describes some of those initiatives and the evidence underpinning them.	Non-systematic review
Shepherd, S. (2009). Home is where the hatred is. *Health Service Journal, 119(6151),* 22-24.	One in four women in the UK experiences domestic violence at some time. The health secretary strongly supports a multi-agency approach to the problems. A preventive approach in Hull is attracting interest from around the NHS.	Does not evaluate the outcome of an intervention
Sheppard, M., & Zelli, D. (2008). *Mobilizing Communities to Prevent Domestic Violence*. Harrisburg, PA: National Resource Centre on Domestic Violence.	No abstract	Does not evaluate the outcome of an intervention
Shilling, D. (2009) Abuse Prevention: Two Approaches. *Victimization of the Elderly & Disabled, 11(6),* 81.	No abstract	Does not evaluate the outcome of an intervention
Shorey, R. C., Zucosky, H., Brasfield, Hope, F., Jeniimarie, C., Tara L., Sage, C., & Stuart, G.L. (2012). Dating violence prevention programming: Directions for future interventions. *Aggression & Violent Behaviour, 17(4),* 289-296.	Abstract: Dating violence among college students is a widespread and destructive problem. The field of dating violence has seen a substantial rise in research over the past several years, which has improved our understanding of factors that increase risk for perpetration. Unfortunately, there has been less attention paid to dating violence prevention programming, and existing programs have been marred with methodological weaknesses and a lack of demonstrated effectiveness in reducing aggression. In hopes of sparking new research on dating violence prevention programs, the current review examines possible new avenues for dating violence prevention programming among college students. We discuss clinical interventions that have shown to be effective in reducing a number of problematic behaviours, including motivational interventions, dialectical behaviour therapy, mindfulness, and bystander interventions, and how they could be applied to dating violence prevention. We also discuss methodological issues to consider when implementing dating violence prevention	Non-systematic review

	programs. [Copyright &y& Elsevier]; Copyright of Aggression & Violent Behaviour is the property of Pergamon Press - An Imprint of Elsevier Science and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use. This abstract may be abridged. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material for the full abstract.	
Simbandumwe, L., Bailey, K., Denerro, S., Migliardi, P., Bacon, B., & Nighswander, M. (2008). Family violence prevention programs in immigrant communities: Perspectives of immigrant men. *Journal of Community Psychology,* 36, 899-914.	The Strengthening families in Canada Family Violence Prevention Project was aimed at engaging immigrant and refugee communities in family violence prevention. The project, which received support from the Community Mobilization Programme, National Crime Prevention Strategy, involved a partnership of four community health and education organizations. The project had three streams: women's, youth, and men's. The women's and youth streams were composed of educational sessions on violence prevention. The third stream consisted of a qualitative research project examining immigrant and refugee man's views of family violence and their suggestions for prevention education. The authors present findings from this research and offer suggestions for future implementation of prevention programming for immigrant and refugee families.	Does not evaluate the outcome of an intervention
Sise, M. J., & Sise, C.B. (2005). An internet-based violence prevention resource guide for trauma care professionals. *Journal of Trauma, Injury, Infection and Critical Care, 58(1),* 30-34.	No abstract	Does not evaluate the outcome of an intervention
Slater, P. (2001). Preventing the abuse of vulnerable adults. *Journal of Social Policy, 30,* 673-684.	UK policy on adult protection has been accompanied by a reaffirmation of the importance of prevention in relation to children and families. However, the "No secrets" documentation from the Department of Health (DH, 2000) and its accompanying circular do not offer any guidance on the meaning of "prevention". In residential and nursing care, prevention is explicitly promoted via a combination of transparent standards and rigorous regulation. This paper explores policies which, while diverse in their explicit aims, could claim to pursue an implicitly preventive objective in relation to the protection of vulnerable adults from abuse (POVA). These include community care, and self-help and social inclusion initiatives..	Does not evaluate the outcome of an intervention
Slep, A.M., & Heyman, R.E. (2008). Public health approaches to family maltreatment prevention: resetting family psychology's sights from the home to the community. *Journal of Family Psychology, 22(4),* 518-528.	The authors review recent trends within the family maltreatment research field toward a public health approach, discuss the rationale for community-level interventions for family maltreatment, and sketch the history and development of community-level prevention approaches. Next, to illustrate the both the logistic and the scientific challenges of such work, the authors discuss the development and testing of an empirically guided, research-community partnership for the prevention of family maltreatment, the United States Air Force's NORTH STAR initiative (New Orientation to Reduce Threats to Health From Secretive Problems That Affect Readiness). Finally, recommendations are made for effective and disseminable family maltreatment prevention interventions.	Intervention setting outside of health and social services (Military)
Smith, M. (2011). *A different world is possible: Promising practices to prevent violence against women and girls.* London, UK, End Violence Against Women Coalition.	No abstract	Does not evaluate the outcome of an intervention
Smith, P. (2000). Peer education: Does focusing on male responsibility change sexual assault attitudes? *Violence Against Women, 6(11),* 1255-	A peer education programme emphasizing male responsibility in decreasing sexual assault led to a decrease in rape tolerant attitudes among high school students immediately following a 45-minute presentation. Trained high school students presented information on sexual assault risk reduction, rape culture, sexual assault law, how to help a friend who has been assaulted, and male responsibility in preventing sexual assault. Whereas the scores of female students showed less acceptance of rape myths and victim-blaming attitudes than males at both	Intervention setting outside of health and social services (School)

1268.	pretest and posttest, the attitudes of male students showed more improvement following the presentation than those of the females.	
Stephens, K. A., & George, W.H. (2009). Rape prevention with college men: Evaluating risk status. *Journal of Interpersonal Violence, 24(6),* 996-1013.	This study evaluates the effectiveness of a theoretically based rape prevention intervention with college men who were at high or low risk to perpetrate sexually coercive behaviour. Participants (N=146) are randomly assigned to the intervention or control group. Outcomes include rape myth acceptance, victim empathy, attraction to sexual aggression, sex-related alcohol expectancies, and behavioural indicators, measured across three time points. Positive effects are found for rape myth acceptance, victim empathy, attraction to sexual aggression, and behavioural intentions to rape. Only rape myth acceptance and victim empathy effects sustain at the 5-week follow-up. High-risk men are generally unaffected by the intervention although low-risk men produced larger effects than the entire sample. Results suggest rape prevention studies must assess risk status moderation effects to maximize prevention for high-risk men. More research is needed to develop effective rape prevention with men who are at high risk to rape.	Intervention setting outside of health and social services (School)
Temple, J.R., Stuart, G.L., & O'Farrell, T.J. (2009). Prevention of intimate partner violence in substance-using populations. *Substance Use & Misuse, 44(9-10), 1*318-1328.	Although the prevention of intimate partner violence is a major public health priority for the United States, little is known about how to prevent this form of violence. The strong cross-sectional and longitudinal association between substance misuse and partner violence suggests that substance-misusing populations may be an ideal audience for implementing partner violence prevention programs. This approach is reviewed from the perspective of universal, selective, and indicated prevention programs.	Does not evaluate the outcome of an intervention
Tharp, A. T., Burton, T., Freire, K., Hall, D., Harrier, S., Latzman, N., Luo, F., Niolon, P., Holditch, R., Mia, V., & Kevin J. (2011). Dating Matters: Strategies to promote healthy teen relationships. *Journal of Women's Health, 20(12),* 1761-1765.	Teen dating violence (TDV) is a preventable public health problem that has negative consequences for youth. Despite evidence that youth in urban communities with high crime and economic disadvantage may be at particularly high risk for TDV, little work has specifically addressed TDV in these communities. The Centers for Disease Control and Prevention (CDC) has developed a comprehensive approach to prevent TDV-Dating Matters: Strategies to Promote Healthy Teen Relationships-that addresses gaps in research and practice. This Report from CDC describes the programmatic activities, implementation support, evaluation, and surveillance of the Dating Matters initiative, which will be implemented in four urban communities.act.	Intervention setting outside of health and social services (School)
The National Resource Centre on Domestic Violence (2000). *Making the Peace: An Approach to Preventing Relationship Violence Among Youth.* Harrisburg, PA: The National Resource Centre on Domestic Violence.	No abstract	Intervention setting outside of health and social services (School)
Townsend, S.M. (2010). *National Sexual Violence Resource Centre Prevention Assessment: Year 1 Report: National Strengths and Needs Assessment.* Enola, PA: National Sexual Violence Resource Centre.	No abstract	Does not evaluate the outcome of an intervention
Wai Wan, M., & Bateman, W. (2007). Adolescents and intimate partner violence: Evaluating a brief school-based education programme. *International Journal of Health Promotion and*	Intimate partner violence (IPV) is a significant public health concern that may begin in adolescent dating relationships. Little is known about the effectiveness of education in British schools to prevent dating violence. The aims of this pilot study were: (1) to examine the baseline attitudes towards, knowledge of, and self-reported IPV among 204 British adolescents, and (2) to measure whether knowledge and attitudes changed among adolescents who participated in an educational intervention, compared to a non-participating comparison group. Anonymous questionnaires were completed before and following participation in a three-session school-based	Intervention setting outside of health and social services (School)

Education, 45(1), 17-23	programme taught by trained teachers who utilised existing teaching resources. At baseline, 36% mostly or totally agreed that violence is bound to occur in a relationship and a third of boys reported that it is acceptable to hit a female partner in certain situations. Eleven per cent of girls who had a partner reported that they had been physically victimised. Following intervention, adolescents in the intervention group had better knowledge of partner violence but little attitude change was found. The findings suggest a need to develop and implement evidence-based programmes at a younger age which target attitudes and behaviours.	
Washington, S., & Katz, J. (2002). Preventing physical, psychological, and sexual aggression in college dating relationships. *The Journal of Primary Prevention, 22(4)*, 361-374	The present experiment evaluated the effectiveness of a brief programme to prevent physical, psychological, and sexual aggression in dating relationships. The programme consisted of an educational video followed by a discussion led by either a female presenter or male/female co-presenters. 123 undergraduates (45 males, 78 females) were randomly assigned to either an intervention condition or the control condition. Participants in both intervention conditions endorsed more prosocial attitudes about dating aggression immediately following the intervention and compared to control participants. The programme was well-received by both male and female participants regardless of the sex of the presenters. However, some attitude changes were not maintained at a delayed follow-up. Recommendations for future prevention studies are discussed.	Intervention setting outside of health and social services (School)
Wathen, C.N., & MacMillan, H.L. (2003). Interventions for violence against women: scientific review. *Journal of American Medical Association, 289(5),* 589-600.	CONTEXT: Intimate partner violence is prevalent and is associated with significant impairment, yet it remains unclear which interventions, if any, reduce rates of abuse and reabuse. OBJECTIVE: To systematically review, from the perspective of primary health care, the available evidence on interventions aimed at preventing abuse or reabuse of women. DATA SOURCES: MEDLINE, PsycINFO, CINAHL, HealthStar, and Sociological Abstracts were searched from the database start dates to March 2001 using database-specific key words such as domestic violence, spouse abuse, partner abuse, shelters, and battered women. References of key articles were hand searched. The search was updated in December 2002. STUDY SELECTION: Both authors reviewed all titles and abstracts using established inclusion/exclusion criteria. Twenty-two articles met the inclusion criteria for critical appraisal. DATA EXTRACTION: Following the evidence-based methods of the Canadian Task Force on Preventive Health Care, both authors independently reviewed the 22 included studies using an established hierarchy of study designs and criteria for rating internal validity. Quality ratings of individual studies--good, fair, or poor--were determined based on a set of operational parameters specific to each design category developed with the US Preventive Services Task Force. DATA SYNTHESIS: Screening instruments exist that can identify women who are experiencing intimate partner violence. No study has examined, in a comparative design, the effectiveness of screening when the end point is improved outcomes for women (as opposed to identification of abuse). No high-quality evidence exists to evaluate the effectiveness of shelter stays to reduce violence. Among women who have spent at least 1 night in a shelter, there is fair evidence that those who received a specific programme of advocacy and counselling services reported a decreased rate of reabuse and an improved quality of life. The benefits of several other intervention strategies in treating both women and men are unclear, primarily because of a lack of suitably designed research measuring appropriate outcomes. In most cases, the potential harms of interventions are not assessed within the studies reviewed. CONCLUSIONS: Much has been learned in recent years about the epidemiology of violence against women, yet information about evidence-based approaches in the primary care setting for preventing intimate partner violence is seriously lacking. The evaluation of interventions to improve the health and well-being of abused women remains a key research priority.	Systematic review that does not include any interventions meeting inclusion criteria (All references prior to 2000 except one that was excluded previously for being US Navy sample)
Weiland Bowling, S., Schindler Zimmerman, T., & Carlson Daniels, K. (2000). Empower:' A feminist consciousness-raising curriculum for adolescent women. *Journal of Child & Adolescent Group Therapy, 10(1),* 3-28.	According to the authors, female adolescents often come to therapy with symptoms of growing up female in a patriarchal culture. Several authors have suggested a need for feminist intervention to help adolescent females become aware of societal messages and to empower them to reject unhealthy messages. This paper presents a feminist curriculum created for use with female adolescents that includes the following topics: self-knowledge, self-esteem, assertive communication, relationship violence, body image, sexual decision-making, career exploration, and self-care. A pilot curriculum was implemented with positive outcomes for participants.	Does not evaluate the outcome of an intervention

Wolfe, D.A., Crooks, C., Jaffe, P., Chiodo, D., Hughes, R., Ellis, W., Stitt, L., Donner, A. (2009). A school-based programme to prevent adolescent dating violence: a cluster randomized trial. *Archives of Pediatrics & Adolescent Medicine, 163(8),* 692-699.	OBJECTIVE: To determine whether an interactive curriculum that integrates dating violence prevention with lessons on healthy relationships, sexual health, and substance use reduces physical dating violence (PDV). DESIGN: Cluster randomized trial with 2.5-year follow-up; prespecified subgroup analyses by sex. SETTING: Grade 9 health classes. PARTICIPANTS: A total of 1722 students aged 14-15 from 20 public schools (52.8% girls). Intervention A 21-lesson curriculum delivered during 28 hours by teachers with additional training in the dynamics of dating violence and healthy relationships. Dating violence prevention was integrated with core lessons about healthy relationships, sexual health, and substance use prevention using interactive exercises. Relationship skills to promote safer decision making with peers and dating partners were emphasized. Control schools targeted similar objectives without training or materials. MAIN OUTCOME MEASURES: The primary outcome at 2.5 years was self-reported PDV during the previous year. Secondary outcomes were physical peer violence, substance use, and condom use. Analysis was by intention-to-treat. RESULTS: The PDV was greater in control vs intervention students (9.8% vs 7.4%; adjusted odds ratio, 2.42; 95% confidence interval, 1.00-6.02; P=0.05). A significant group x sex interaction effect indicated that the intervention effect was greater in boys (PDV: 7.1% in controls vs 2.7% in intervention students) than in girls (12.1% vs 11.9%). Main effects for secondary outcomes were not statistically significant; however, sex x group analyses showed a significant difference in condom use in sexually active boys who received the intervention (114 of 168; 67.9%) vs controls (65 of 111 [58.6%]) (P<0.01). The cost of training and materials averaged CA$16 per student. CONCLUSION: The teaching of youths about healthy relationships as part of their required health curriculum reduced PDV and increased condom use 2.5 years later at a low per-student cost.	Intervention setting outside of health and social services (School)
Wolfe, D. A., Crooks, Claire V., Chiodo, D., Hughes, R., & Ellis, W. (2012). Observations of adolescent peer resistance skills following a classroom-based healthy relationship programme: A post-intervention comparison. *Prevention Science, 13(2),* 196-205.	This study examines peer resistance skills following a 21-lesson classroom-based intervention to build healthy relationships and decrease abusive and health-risk behaviours among adolescents. The Fourth R instructs students in positive relationship skills, such as negotiation and delay, for navigating challenging peer and dating scenarios. Observational data from 196 grade 9 students participating in a larger cluster randomized controlled trial were used to evaluate post-intervention acquisition of peer resistance skills. Pairs of students engaged in a role play paradigm with older student actors, where they were subjected to increasing pressure to comply with peer requests related to drugs and alcohol, bullying, and sexual behaviour. Specific and global measures of change in peer resistance responses were obtained from two independent sets of observers, blinded to condition. Specific peer resistance responses (negotiation, delay, yielding to pressure, refusal, and compliance) were coded by research assistants; global peer resistance responses were rated by teachers from other schools (thinking / inquiry, application, communication, and perceived efficacy). Students who received the intervention were more likely to demonstrate negotiation skills and less likely to yield to negative pressure relative to controls. Intervention students were also more likely to use delay than controls; control girls were more likely to use refusal responses; the number of times students complied with peer requests did not differ. Teacher ratings demonstrated significant main effects favoring intervention youth on all measures. Programme and research implications are highlighted.	Non systematic review
Wolfe, D.A., & Jaffe, P.G. (2003). Prevention of domestic violence and sexual assault. Harrisburg, PA: National Resource Centre on Domestic Violence.	No abstract	Intervention setting outside of health and social services (School)
World Health Organization (2010). *Violence prevention: The evidence*. Geneva: World Health Organization.	No abstract	Does not evaluate the outcome of an intervention
World Health Organization, & London School of Hygiene and	No abstract	Non-systematic review

Tropical Medicine, (2010). *Preventing intimate partner and sexual violence against women: Taking action and generating evidence.* Geneva: World Health Organization.		
Wyatt, G.E., Hamilton, A.B., Myers, H.F., Ullman, J.B., Chin, D., Sumner, L.A., Loeb, T.B., Carmona, J.V., Zhang, M.Y., & Liu, H.H. (2011). Violence prevention among HIV-positive women with histories of violence: Healing women in their communities. *Women's Health Issues, 21,* S255-S260.	Experiences of past and current gender-based violence are common among HIV-positive women in the United States, who are predominantly from ethnic minority groups. However, culturally congruent, feasible interventions for HIV-positive women who have experienced past and/or current violence are not widely available. The Office on Women's Health Gender Forum has made several recommendations for responding to the National HIV/AIDS Strategy Implementation Plan, including recommendations to incorporate gender-based violence prevention into a comprehensive, gender-responsive national strategy. This paper draws on an example of a community-based project for HIV-positive women, the Healing Our Women Project, to illustrate how violence prevention can be achieved within peer-led and community-based programming. Strong community partnerships, responsiveness to community needs and local cultural norms, a trained workforce, and culturally competent care are programmatic cornerstones of gender-responsive services. HIV-positive women with histories of gender-based violence and risk factors for current and future violence deserve the highest quality gender-responsive services to ensure that they can address their health needs within contexts of safety and respect.	Does not evaluate the outcome of an intervention
Yeater, E A., Naugle, A.E., O'Donohue, W., & Bradley, A.R. (2004). Sexual assault prevention with college-aged women: a bibliotherapy approach. *Violence and victims, 19(5),* 593-612.	The present research evaluated the efficacy of a skills-based bibliotherapy approach to sexual assault prevention for college-aged women. One hundred and ten participants were followed prospectively for 16 weeks. A self-help book, written by the authors, was compared to a wait-list control on several self-report measures. Results revealed significant differences between groups, with bibliotherapy participants reporting decreased participation in risky dating behaviours and improvement in sexual communication strategies across a variety of dating situations. However, results suggested that the self-help book was no more effective than the wait-list control in reducing rates of sexual victimization. Limitations of the study and directions for future sexual assault prevention research with women are discussed.	Intervention setting outside of health and social services (School)

Table 11. Research Question 2 (Screening) Studies Excluded on Full Text

Study Details	Abstract	Reason for Exclusion
Agar, K., Read, J., & Bush, J. (2002). Identification of abuse histories in a community mental health centre: The need for policies and training. *Journal of Mental Health, 11(5),* 533-543.	In the context of studies finding low levels of enquiry about abuse by clinicians in the U.S.A. and the U.K., the medical records of 200 consecutive adult clients of a New Zealand Community Mental Health Centre were reviewed. All information regarding clients' abuse histories contained within the files was noted. The results suggest that enquiry about abuse is not routinely taking place. Assessments conducted using a form with an abuse section identified significantly greater prevalence rates of abuse than assessments conducted without the form. When notes in the current chart from previous contacts with mental health services were included, a prevalence rate of 46% for childhood and/or adulthood abuse was calculated. Only approximately half of this abuse, however, was identified in the notes of the current admission. Recommendations are proposed regarding the need for unit policies ensuring routine enquiry about abuse in standardised admission procedures, and for providing clinicians with training in how and when to enquire about abuse, and how to respond.	Does not evaluate the outcome of an intervention
Alaggia, R., Regehr, C. & Jenney, A. (2012). Risky business: An ecological analysis of intimate partner violence disclosure. *Research on Social Work Practice,*	Objective: A multistage, mixed-methods study using grounded theory with descriptive data was conducted to examine factors in disclosure of intimate partner violence (IPV). Method: In-depth interviews with individuals and focus groups were undertaken to collect data from 98 IPV survivors and service providers to identify influential factors. Quantitative data were also collected on adult trauma levels and child concerns from20women. Results: An ecological analysis revealed that IPV disclosure occurs within a complex interplay	Describes factors associated with women's disclosure of violence

22(3), 301-312.	of distinct individual and environmental considerations. Specific system level factors of the ecological framework— ontogenic, micro, exo, and macro—emerged as influencing disclosure and ultimately shaped women's disclosure processes. Conclusion: IPV disclosure remains a ''risky business'' with perceived negative outcomes outweighing benefits. Results reinforce that social work interventions need to occur at all levels of the human ecology in order to provide effective responses.	
Allen, N.E., Lehrner, A., Marrison, E., Miles, T., & Russell, A. (2007). Promoting systems change in the health care response to domestic violence. *Journal of Community Psychology, 35(1),* 103-120.	Community psychologists have a long-standing interest in promoting systems change to improve the lives of individuals and communities. To more fully illuminate a multilevel model of those factors involved in the promotion of systems change, the current study examined individual- and organizational level characteristics related to health care providers' implementation of a desired reform in the community response to intimate partner violence, namely, universal screening practices. Efforts to reform the health care system's response to domestic violence prove to be difficult. The current study surveyed 209 providers across 12 health care settings to examine those factors related to reform implementation. Findings indicate that individual characteristics (perceived capacity to screen and positive beliefs about screening) and the presence of an organizational climate for implementation (e.g., consequences for implementation or failure to implement, resources to support implementation, policies and procedures consistent with desired practices) affect the extent to which health care providers engage in routine screening practices. The implications of these findings for promoting systems change, in general, and the health care system's response to domestic violence, in particular, are discussed.	Does not evaluate the outcome of an intervention
Alt, K.L., Nguyen, A.L., & Meurer, L.N. (2011). The Effectiveness of Educational Programs to Improve Recognition and Reporting of Elder Abuse and Neglect: A Systematic Review of the Literature. *Journal of Elder Abuse & Neglect, 23(3*), 213-233.	Health professionals often lack adequate protocols or knowledge to detect, manage, and prevent elder maltreatment. This systematic review describes and evaluates existing literature on the effectiveness of educational interventions to improve health professionals' recognition and reporting of elder abuse and neglect. Fourteen articles described 22 programs ranging from brief didactics to experiential learning and targeted a variety of health and social service audiences. Most evaluations were limited to satisfaction measures. These programs may result in increased awareness, collaboration, and improved case finding. However, using the published literature to guide new programme planning is constrained by lack of details and limited evaluations.	Non-systematic review
Anderson, B., Marshak, H. & Hebbeler, D.L. (2002). Identifying intimate partner violence at entry to prenatal care: Clustering routine clinical information. *Journal of Midwifery & Women's Health, 47(5).*	Research on use of a screening tool to identify risk from routine data.	Does not evaluate the outcome of an intervention
Anetzberger, G. J. (2001). Elder abuse identification and referral: The importance of screening tools and referral protocols. *Journal of Elder Abuse & Neglect, 13(2),* 3-22.	Barriers exist with regard to elder abuse identification and reporting nationwide and in individual states like Ohio. Screening tools and referral protocols have been shown to be helpful in overcoming some of these barriers. However, existing instruments typically lack three qualities: (1) distinction as to types, signs, and risk factors of elder abuse; (2) inclusion of domestic violence in late life as a specific aspect of elder abuse; and (3) delineation of appropriate state laws and community services for effective intervention. This article discusses a project to develop, test, and disseminate screening tools and a referral protocol for improving the identification and reporting of elder abuse and domestic violence in late life by Ohio service providers. The impetus, goal, and organization of this 18 month initiative are described.	Does not evaluate the outcome of an intervention
Anetzberger, G.J., Palmisano, B.R., Sanders, M., Bass, D., Dayton, C., Eckert, S., & Schimer, M.R. (2000). A model intervention for elder abuse and dementia. *Gerontologist, 40(4),* 492-497.	This article describes a 2-year collaborative project in Cleveland, OH, that improved the reporting and management of potential and suspected elder abuse situations involving persons with dementia. Educational curricula for cross-training, screening tools, and referral protocols were developed and tested for staff and volunteers in adult protective services and dementia care. A handbook for caregivers of persons with dementia was produced that enables caregivers to self-identify elder abuse risk and seek appropriate interventions to prevent abuse. Project organization, implementation, and evaluation are discussed along with strategies for	Does not evaluate the outcome of an intervention

	replication in other communities.	
Anglin, D. & Sachs, C. (2003). Preventive care in the emergency department, screening for domestic violence in the emergency department. *Academic Emergency Medicine, 10(10),* 1118-1127.	OBJECTIVE: The most effective methods for identification and management of domestic violence (DV) victims in health care settings are unknown. The objective of this study was to systematically review screening for DV in the emergency department (ED) to identify victims and decrease morbidity and mortality from DV. METHODS: Using the terms "domestic violence" or "partner violence," and "identification" or "screening," and "emergency," the authors searched MEDLINE, the Cochrane Database, and Emergency Medical Abstracts from 1980-2002. They selected articles studying screening tools, interventions, or determining the incidence or prevalence of DV among ED patients. The studies were analysed using evidence-based methodology. RESULTS: Three hundred thirty-nine articles resulted from the literature search. Based on selection criteria, 45 were reviewed in detail and 17 pertained to the ED. From references of these 17 articles, three additional articles were added. Screening can be conducted using a brief verbal screen and existing ED personnel. A randomized, controlled trial did not demonstrate a difference in screening rates between experimental and control hospitals. No studies assessed the effect of ED screening for DV on morbidity or mortality of domestic violence. An ED-based advocacy programme resulted in increased use of shelters and counselling. CONCLUSIONS: Because of the paucity of outcomes research evaluating ED screening and interventions, there is insufficient evidence for or against DV screening in the ED. However, because of the high burden of suffering caused by DV, health care providers should strongly consider routinely inquiring about DV as part of the history, at a minimum for all female adolescent and adult patients.	Non-systematic review
Anthony E.K., Lehning, A.J., Austin, M.J., & Peck, M.D. (2009). Assessing elder mistreatment: instrument development and implications for adult protective services. *Journal of Gerontological Social Work, 52(8)*, 815-836.	Assessment of elder mistreatment is hindered by a myriad of factors, including inconsistent definitions, divergent and untested theories of causation, and limited research attention to the problem. In addition to these difficulties, professionals encounter complex situations requiring considerable clinical assessment skills and decision-making capacity. Adult Protective Services (APS) workers, as well as mandated reporters such as healthcare providers and social workers, need an assessment tool that can reliably and accurately assess for elder mistreatment. Based on a structured review of screening and assessment instruments, this article discusses the psychometric properties of 15 instruments and the relevance to APS. Implications of the findings for future research, practice, and policy are discussed.	Non-systematic review
Aylett, J. (2008). Learning the lessons in training from abuse inquiries: Findings and recommendations. *Journal of Adult Protection, 10(4).*	Summary of the recommendations and common themes featured in inquiry reports relating to the abuse of vulnerable adults. The need for a coherent strategy for disseminating inquiry findings is discussed with reference to relevant literature, and ways by which the findings and recommendations from serious case reviews have been embedded in training delivered by Kent County Council are outlined.	Does not evaluate the outcome of an intervention
Babcock Irvin, C., Wyer, P.C., & Gerson, L.W. (2000). Preventive care in the emergency department, Part II: Clinical preventive services - An emergency medicine evidence-based review. *Academic Emergency Medicine, 7(9),* 1042-1054.	Emergency departments (EDs) provide an opportunity to initiate preventive services for millions of Americans who have no other source for these services. OBJECTIVES: To identify primary and secondary preventive interventions appropriate for inclusion in routine emergency care and, secondarily, to recommend areas in which research into the efficacy and cost-effectiveness of interventions is needed. METHODS: Systematic reviews were performed on 17 candidate preventive interventions with potential applicability in the ED. All but one was selected from those reviewed by the U.S. Preventive Services Task Force (USPSTF). Each two-person review team followed a template that provided a uniform approach to search strategy, selection criteria, methodology appraisal, and analysis of the results of primary studies bearing on ED cost-effectiveness. Assigned proctors provided methodological guidance to the review teams throughout the review process. A grading scheme was developed that took into account the evidence and recommendations of the USPSTF supporting primary efficacy of the intervention and the level of evidence supporting ED application identified by the Society for Academic Emergency Medicine Public Health and Education Task Force (PHTF) review teams. RESULTS: Seventeen reviews were completed. The following interventions received an alpha rating, indicating that evidence is sufficient to support offering these services in the ED setting, assuming sufficient resources are available: alcohol screening and intervention, HIV screening and referral (in high-risk, high-prevalence	Non-systematic review

	populations), hypertension screening and referral, adult pneumococcal immunizations (age >/=65 years), referral of children without primary care physicians to a continuing source of care, and smoking cessation counselling. Interventions receiving a beta or gamma rating, indicating that existing research is not sufficient to recommend for or against instituting them routinely in the ED, include: identification and counselling of geriatric patients at risk of falls, Pap tests in women having a pelvic exam in the ED, counselling for smoke detector use, routine social service screening, depression screening, domestic violence screening, safe firearm storage counselling, motorcycle helmet use counselling, and youth violence counselling programs in the ED. Interventions not recommended for ED implementation (omega rating) include Pap test screening for women not having a routine pelvic exam, diabetes screening, and pediatric immunizations. CONCLUSIONS: A set of recommendations for prevention, screening, and counselling activities in the ED based on systematic reviews of selected interventions is presented. The applicability of these primary and secondary preventive services will vary with the different clinical environments and resources available in EDs. The PHTF recommendations should not be used as the basis of curtailing currently available services. This review makes clear the need for further research in this important area.	
Bacchus, L., Mezey, G. & Bewley, S. (2002). Women's perceptions and experiences of routine enquiry for domestic violence in a maternity service. *British Journal of Obstetrics and Gynaecology, 109(1)*, 9-16.	Objective: A qualitative study examining women's perceptions and experiences of routine enquiry for domestic violence in a maternity service. Design: Purposive sampling was used to select a sub-sample from a larger group of women who participated in a domestic violence in pregnancy screening study undertaken at Guy's and St Thomas' Hospitals in London. Setting: Interviews were conducted in women's homes and general practitioner's surgeries. Sample: Ten women who experienced domestic violence in the last 12 months (including pregnancy), six women who experienced domestic violence in the last 12 months, but not in pregnancy, and 16 women with no history of domestic violence. Methods: Semi-structured interviews conducted during the postpartum period (up to 14 months). Main outcome measures: Women's views on the acceptability and relevance of routine enquiry for domestic violence. Results: Routine enquiry for domestic violence in maternity settings is acceptable to women if conducted in a safe, confidential environment by a trained health professional who is empathic and non-judgmental. The effectiveness of routine enquiry to elicit a history of domestic violence is influenced by factors such as lack of time, confidential consulting time, continuity of care, training and availability of resources. Conclusions: Further research is needed to determine whether the use of on-site specialist domestic violence workers will increase midwives' ability to routinely enquire about domestic violence.	Describes client's preferences or acceptability of screening
Bacchus, L.J., Bewley, S., Vitolas, C.T., Aston, G., Jordan, P., & Murray, S.F. (2010). Evaluation of a domestic violence intervention in the maternity and sexual health services of a UK hospital. *Reproductive Health Matters, 18(36),* 147-157.	This paper reports on an evaluation of a domestic violence intervention in the maternity and sexual health services of a UK hospital. The intervention encompassed guidelines, staff training, inclusion of routine enquiry for domestic violence with all patients, and referral of women disclosing violence to an on-site advocacy service. An "assumption querying" approach was applied to evaluate the intervention. Programmatic assumptions were identified and tested using interviews with service providers and patients, review of patient records, and pre- and post-training questionnaires. Domestic violence training resulted in changes in health professionals' knowledge and practice in the short-term, but universal routine enquiry was not achieved even in a context of organisational support, guidelines, training and advocacy. Potential and actual harm occurred, including breaches of confidentiality and failure to document evidence, limiting women's ability to access civil and legal remedies. Advocacy support led to positive outcomes for many women, as long as support to maintain positive changes, whether women stayed with or left the violent partner, continued to be given. Maternity and sexual health services were found to be opportune points of intervention for domestic violence services that combine routine enquiry by clinicians, support after disclosure and attention to harm reduction.	Does not evaluate the outcome of an intervention
Bair Merritt, M.H., Feudtner, C., Mollen, C.J., Winters, S., Blackstone, M., & Fein, J.A. (2006). Screening for intimate partner	OBJECTIVE: To compare women's acceptability ratings of 2 different intimate partner violence screening methods, an audiotape questionnaire and a written questionnaire, in a pediatric emergency department. DESIGN: Randomized clinical trial. SETTING: An urban, pediatric, tertiary care centre emergency department. PARTICIPANTS: Female caregivers of children. MAIN EXPOSURE: Intimate partner violence screening by	Describes client's preferences or acceptability of

violence using an audiotape questionnaire: A randomized clinical trial in a pediatric emergency department. *Archives of Pediatrics & Adolescent Medicine, 160(3)*, 311-316	either an audiotape or written questionnaire method. MAIN OUTCOME MEASURES: Perceptions of each screening method's safety, acceptability, and ease of use. RESULTS: Fifty (10%) of 497 participants reported intimate partner violence, 30 (11%) of 266 in the audiotape group and 20 (9%) of 231 in the written questionnaire group (P=0.30). Women in the audiotape group were significantly more likely to report that the audiotape method did not put them at risk and was private. Women in both groups were satisfied with their screening method and were willing to use it again. Women in both groups preferred their given method over the idea of direct emergency department provider screening. CONCLUSIONS: Screening for intimate partner violence with an audiotape method appears to have several advantages compared with screening by a written questionnaire, and the audiotape method may be associated with slightly higher rates of disclosing intimate partner violence.	screening
Bair-Merritt, M.H., Mollen, C.J., Yau, P.L., & Fein, J.A. (2006). Impact of domestic violence posters on female caregivers' opinions about domestic violence screening and disclosure in a pediatric emergency department. *Pediatric Emergency Care, 22(11),* 689-693.	OBJECTIVES: The objectives of this study were to examine female caregivers' attitudes about the display of domestic violence (DV) resources in a pediatric emergency department (ED) and to explore whether these resources engendered positive feelings about DV screening and encouraged disclosure. METHODS: We conducted a cross-sectional survey in a pediatric ED during 2 distinct periods, comparing responses of female caregivers before (pre) and after (post) displaying DV posters and cards. Women were surveyed about (1) personal experience with DV, (2) the appropriateness of DV posters and screening in a pediatric ED, and (3) willingness to divulge DV, if abused. RESULTS: The 2 groups (pre, n=133; post, n=136) did not significantly differ with respect to age, race, education, or personal DV history. The majority endorsed that "it is appropriate to have DV posters," with the post group responding in this manner more often than the pre group (pre, 85%; post, 95%; odds ratio [OR], 3.3; 95% confidence interval [CI], 1.3-8.5). The post group was less likely to prefer pediatric ED DV screening (pre, 76%; post, 63%; OR, 0.5; 95% CI, 0.3-0.9) and tended to be less likely to say that they would divulge (pre, 85%; post, 75%; OR, 0.6; 95% CI, 0.3-1.1). In both groups, women with a DV history were less likely than women without this history to say that they would disclose DV to their pediatric ED provider (P<0.001). CONCLUSIONS: These results suggest the need for further exploration of how to most effectively help and provide resources for abused women in this setting.	Describes client's preferences or acceptability of screening
Baird, K., Salmon, D., & Price, S. (2005). Learning from the bristol pregnancy and domestic violence programme. *British Journal of Midwifery, 13(11),* 692-696.	This paper reports on an evaluation of the Bristol Pregnancy and Domestic Violence Programme, introduced to support the launch of routine antenatal enquiry for domestic violence. In particular, it focuses on data from a national survey of Higher Education Institutions (HEIs) (n=23) and interviews with educationalists (n=10) that assessed the potential impact on education of the introduction of routine antenatal enquiry. Findings suggest that a more systematic approach to domestic violence teaching is needed, focusing on the development of skill acquisition in 'asking the question'. While HEIs were enthusiastic about their role, professionally developed competencies for pre-registration students are also required to sustain routine enquiry in the longer term. Similarly, existing staff require access to validated programmes within trusts, in association with child protection training to enable existing practitioners to role-model good practice. Where possible, education should be delivered interprofessionally to enable practitioners to establish their role alongside other professionals and agencies, particularly the voluntary sector	Describes practitioners perspectives on screening
Ballard, R.H., Holtzworth-Munroe, A., & Amy, G. (2011). Detecting intimate partner violence in family and divorce mediation: A randomized trial of intimate partner violence screening. *Psychology, Public Policy, and Law, 17(2),* 241-263.	Handling mediation cases with a history of intimate partner violence (IPV) is one of the most controversial issues in the field of divorce mediation. Before deciding whether and how to mediate cases with IPV, mediators must first detect violence. Using random assignment of cases to an enhanced screening condition (n=30) and to a standard screening control condition (n=31), we compared information gathered from a brief, behaviorally specific IPV screening questionnaire to mediators' independent determination of the presence or absence of violence using standard mediation clinic screening procedures. Mediators did not label as violent about half of the cases reporting IPV on the screening questionnaire. Mediators were more likely to report IPV when fathers were reported (by mothers) to have engaged in a greater number of differing violent behaviours, but a score reflecting severity and frequency of party reported violence did not predict mediator detection of violence. In cases with two mediators, mediators did not always agree on whether or not the case involved IPV. Possible	Intervention setting outside of health and social services (Justice system)

	reasons for the differences in mediator and party reports of IPV are considered, and we emphasize the potential importance of using systematic methods to screen for violence in divorce mediation.	
Bass, D.M., Anetzberger, G.J., Ejaz, F.K., & Nagpaul, K. (2001). Screening tools and referral protocol for stopping abuse against older Ohioans: A guide for service providers. *Journal of Elder Abuse & Neglect, 13(2),* 23-38.	Screening Tools and Referral Protocol for Stopping Abuse Against Older Ohioans: a guide for service providers (STRP) represents the product of an 18 month project aimed at improving the identification and reporting of elder abuse and domestic violence in late life. This article presents each component of STRP, describing it in detail and suggesting when and how it can be used. Recommendations also are offered for the replication of STRP in other locales as well as for its further evaluation.	Does not evaluate the outcome of an intervention
Belfiglio, G. (2001). Should primary care providers screen for domestic violence? *Preventive Medicine in Managed Care, 2(3),* 147-150.	No abstract	Does not evaluate the outcome of an intervention
Berger, R.P., Bogen, D., Dulani, T., & Broussard, E. (2002). Implementation of a programme to teach pediatric residents and faculty about domestic violence. *Archives of Pediatrics & Adolescent Medicine, 156(8),* 804-810.	OBJECTIVES: To obtain information about pediatric resident and staff knowledge, attitudes, and screening practices related to domestic violence (DV), to implement a domestic violence education programme, and to evaluate whether the programme resulted in changes in these 3 domains. DESIGN: Interventional with before and after survey evaluation. SETTING: A hospital-based, pediatric residency continuity clinic that serves families in Pittsburgh, Pa. PARTICIPANTS: Pediatric residents (n=51), medicine-pediatric residents (n=6), continuity clinic faculty (n=22), and certified-registered nurse practitioners (n=5). RESULTS: Prior to implementation of the DV education programme, respondents correctly answered questions about the prevalence of DV (74 participants [90%]), the racial distribution of DV victims (66 participants [80%]), and the significant overlap between child abuse and DV (75 participants [91%]). Seventy-nine participants (96%) believed that screening for the presence of DV was part of their role as pediatric health care providers. At baseline, 17 (21%) of the 82 participants reported that they were routinely screening for signs of DV during well-child care visits compared with 39 (46%) after attending the education programme (P=0.005). Among participants who attended both educational session 25% (9/36) were routinely screening for the presence of DV prior to the intervention, compared with 46% (16/35) after the intervention (P=0.008). At baseline, 33 (40%) of the 82 participants had identified at least 1 case of DV in the prior 6 months compared with 45 (53%) after training. Prior to training, 18 participants (22%) were aware of resources for DV victims compared with 45 (53%) after training (P<0.001). CONCLUSIONS: To our knowledge, this is one of the first pediatric studies to demonstrate that using a short, multifaceted educational module, it is possible to change DV screening practices and to increase identification of DV victims among pediatric residents, continuity clinic faculty, and certified-registered nurse practitioners at a pediatric teaching hospital.	Describes practitioners perspectives on screening
Boyle, A., & Jones, P.B. (2006). The acceptability of routine inquiry about domestic violence towards women: A survey in three healthcare settings. *British Journal of General Practice, 56(525).*	Domestic violence is frequently only disclosed when healthcare staff directly inquire. Healthcare staff worry that inquiry may offend. The aim was to identify the characteristics of women who find inquiry about domestic violence by health care staff unacceptable. The setting was three general practice surgeries, one antenatal clinic and one emergency department in Cambridge, England, with a total of 2,306 women attending for health care. The method was a cross-sectional survey. The conclusions were inquiry about domestic violence by healthcare staff is acceptable to most women. Acceptability is highest in women who have not been abused in the last year and who are attending the antenatal clinic. Women who attend the antenatal clinic have lower rates of abuse within one year.	Describes client's preferences or acceptability of screening
Buck, L., & Collins, S. (2007). Why don't midwives ask about domestic abuse? *British Journal of Midwifery, 15(12),* 753-758.	Routine screening for domestic abuse in pregnancy is recommended and midwives are in an ideal position for this role. However due to an apparent reluctance to enquire about domestic abuse it often remains a hidden problem with detrimental consequences for women and their unborn children. The aim of this systematic review was to identify the most commonly reported factors that prevent healthcare professionals from routinely screening women for domestic abuse. Six electronic databases were searched for all articles published in the	Non-systematic review

	English language up to January 2006. Data, including all the reported reasons for not screening for domestic abuse, were extracted from all the studies which met the inclusion criteria. A simple 'vote-counting' analysis was performed with graphical representation and calculation of weighted means. Thirteen papers met the inclusion criteria. The perceived barriers to screening appeared similar across a range of specialities and clinical settings. The most commonly cited factors were: lack of time, lack of training, and inadequate resources. Domestic abuse remains a serious public health issue and is frequently exacerbated by pregnancy. Our results suggest that raising awareness of the issue should help midwives understand the need to prioritise screening and find the time required to do so. Encouragingly it also suggests that improving basic education and increasing access to simple resources, such as leaflets giving details of where to get support, may provide practitioners with the confidence required to ask women about domestic abuse.	
Burke, C. (2008). Use of brief screening tool may reveal partner violence. *Contemporary Pediatrics, 25(3),* 88-91.	The article focuses on a study which evaluated a new tool for screening parents for intimate partner violence (IPV). A comparison of the validity of the Parent Screening Questionnaire (PSQ) with the much longer "gold standard" Revised Conflict Tactics Scale (CTS2) is conducted. The PSQ includes 20 questions including three IPV screening questions, while the CTS2 is comprised of 78 statements that assess how intimate partners resolve conflict. The study noted a total of 12% of mothers answered "yes" to at least one of the three PSQ screening questions for IPV. And responses on the CTS2 ranged from 9% reporting a physical injury in the past year to 76% reporting psychological aggression.	Does not evaluate the outcome of an intervention
Cairns, K., & Hoffart, I. (2009). *Keeping women alive - assessing the danger.* Edmonton, AB: Alberta Council of Women's Shelters.	No abstract	Does not evaluate the outcome of an intervention
Catallo, C. (2006). Review: meta-analysis of qualitative studies generated recommendations for healthcare professionals meeting with women who had experienced intimate partner violence. *Evidence Based Nursing, 9(4)*, 125-125.	No abstract	Review of article
Chang, J.C., Decker, M.R., Moracco, K.E., Martin, S.L., Petersen, R., & Frasier, P.Y. (2005). Asking about intimate partner violence: Advice from female survivors to health care providers. *Patient Education & Counselling, 59(2),* 141-147.	Understanding the perspectives of women who have experienced IPV will allow us to identify specific techniques of addressing IPV that increase patient comfort and willingness to disclose and/or seek help. Our study objective was to identify what advice women who had experienced IPV would give health providers regarding how to ask about and discuss the issue of IPV. The women in our study advised that providers (1) give a reason for why they are asking about IPV to reduce women's suspicions and minimize stigma, (2) create an atmosphere of safety and support, (3) provide information, support and access to resources regardless of whether the woman discloses IPV. They emphasized that a provider's asking about IPV is an opportunity to raise patient awareness of IPV, communicate compassion and provide information and not merely a screening test to diagnose a pathologic condition.	Describes client's preferences or acceptability of screening
Choo, E.K., Nicolaidis, C., Newgard, C.D., Hall, M.K., Lowe, R.A., McConnell, M.K., & McConnell, K.J. (2012). Association between emergency department resources and diagnosis of intimate partner violence. *European Journal of Emergency Medicine, 19(2),* 83-88.	OBJECTIVE: There is little information about which intimate partner violence (IPV) policies and services assist in the identification of IPV in the emergency department (ED). The objective of this study was to examine the association between a variety of resources and documented IPV diagnoses. METHODS: Using billing data assembled from 21 Oregon EDs from 2001 to 2005, we identified patients who were assigned a discharge diagnosis of IPV. We then surveyed ED directors and nurse managers to gain information about IPV-related policies and services offered by participating hospitals. We combined billing data, survey results, and hospital-level variables. Multivariate analysis assessed the likelihood of receiving a diagnosis of IPV depending on the policies and services available. RESULTS: In 754 597 adult female ED visits, IPV was diagnosed 1929 times. Mandatory IPV screening and victim advocates were the most commonly available IPV resources. The	Correlational study design

	diagnosis of IPV was independently associated with the use of a standardized intervention checklist (odds ratio: 1.71; 95% confidence interval: 1.04-2.82). Public displays regarding IPV were negatively associated with IPV diagnosis (odds ratio 0.56; 95% confidence interval: 0.35-0.88). CONCLUSION: IPV remains a rare documented diagnosis. Most common hospital-level resources did not demonstrate an association with IPV diagnoses; however, a standardized intervention checklist may play a role in clinician's likelihood of diagnosing IPV.	
Chuang, C., & Liebschutz, J.M. (2002). Screening for intimate partner violence in the primary care setting: a critical review. *Journal of Clinical Outcomes Management, 9(10),* 565-571.	No abstract	Non-systematic review
Cohen, M. (2011). Screening tools for the identification of elder abuse. *Journal of Clinical Outcomes Management, 18(6),* 261-270.	Objective: To review existing tools for screening for elder abuse. Methods: Search of international databases and a review of validated tools for identifying abuse and screening for abuse. Results: Elder abuse prevalence rates are underestimated in the literature, and many abuse victims fail to receive the professional help that could improve their quality of life. A number of structured and validated tools can be used to identify abuse victims. Three types of tools are discussed: direct questioning, inspecting for signs of abuse, and evaluating for risk factors for abuse. An integrative model that encompasses the 3 screening modes is described. Considerations regarding special populations and cultural aspects should be incorporated into the screening process. Conclusion: Brief screening tools have many advantages, but they also have weaknesses. Further research is needed to assess their validity, applicability, and accuracy for use in different settings and by different professionals.	Non-systematic review
Cohen, M., Levin, S.H., Gagin, R., & Friedman, G. (2007). Elder abuse: Disparities between older people's disclosure of abuse, evident signs of abuse, and high risk of abuse. *Journal of the American Geriatrics Society, 55,*1224-1230.	Objectives: To assess and compare three types of assessment tools for identifying elder abuse: direct questions to elicit disclosure of abuse if it exists, identification of evident signs of abuse, and assessment of high risk for abuse. Design: Cross-sectional. Setting: Rambam and Hadassah medical centers, Israel. Participants: Seven hundred thirty persons aged 70 and older hospitalized in general hospitals in 2004/05 and their principal caregivers. Measurements: Expanded indicator of abuse (E-IOA) tool, questionnaires looking for evident signs of abuse, and direct experience of abusive behaviour. Results: Although 5.9% of respondents disclosed experiencing abusive behaviours, 21.4% were identified with evident signs of abuse, and 32.6% were classified as being at high risk for abuse. More than 70% of those who disclosed abuse were identified with evident signs and were at high risk for abuse. Those who disclosed being abused suffered particularly from physical and sexual abuse. According to logistic regression, higher caregiver subjective burden was a predictor of disclosure (odds ratio (OR)=1.81, 95% confidence interval (CI)=1.19-2.74), evident signs of abuse (OR=1.86, 95% CI:1.45-2.35), and high risk of abuse (OR=1.55, 95% CI:1.27-1.88); heavier objective caregiver load was a predictor of evident signs of abuse (OR=1.14, 95% CI:1.05-1.24) and of high risk (OR=1.18, 95% CI:1.06-1.38) only; and respondent functional status was a predictor of evident signs of abuse (OR=1.88, 95% CI:1.70-2.37). Conclusion: The use of the three assessment tools is needed for optimal identification of abuse, whereas assessment for high risk proved an efficient method in the absence of respondent disclosure or professional detection of signs of abuse. Hospitalization provides an excellent opportunity for identifying elderly persons at risk of abuse.	Study conducted in Israel
Cooper, C., Maxmin, K., Selwood, A., Blanchard, M., & Livingston, G. (2009). The sensitivity and specificity of the Modified Conflict Tactics Scale for detecting clinically significant elder abuse. *International*	Background: A third of family carers of people with dementia describe acting abusively in research studies, but far fewer cases of abuse are currently detected in clinical situations. This discrepancy may be explained by inadequate detection by health professionals, or disagreement regarding what constitutes elder abuse. This study was undertaken to determine the sensitivity and specificity of the revised Modified Conflict Tactics Scale (MCTS) for detecting clinically significant abuse. Methods: We interviewed 220 family carers of people consecutively referred to psychiatric services with dementia in Essex and London (U.K.), using the MCTS to	Does not compare more than one screening test

Psychogeriatrics, 21(4), 774-778.	measure abuse. We defined abuse cases using (1) the MCTS conventional scoring system; (2) the Pillemer criteria; and (3) clinical judgement of an expert panel. Results: Our panel judged that 15 (6.8%) of carers reported potentially clinical concerning abusive behaviour; but 47 (21%) were cases according to the Pillemer criteria and 74 (34%) using the MCTS conventional scoring system. We developed a weighted MCTS scoring system, with high sensitivity and specificity fo rdetecting clinically concerning abuse. Conclusions: The MCTS could be used routinely in clinical practice with carers of people with dementia to detect clinically concerning cases of abuse, many of which are currently being missed.	
Cornelia, H., & Charlotte, S. (2011). The Breaking the Taboo projects - raising awareness of, and training staff in, community health and care services on violence against older women within families. *The Journal of Adult Protection, 13(1),* 323-335.	Breaking the Taboo and Breaking the Taboo Two are 2 projects funded by the European Commission which focused on violence against older women and families and involved research and training activities. This article describes the projects and their results. Breaking the Taboo aimed to raise awareness about violence against older women within familial settings, and involved partners from Austria, Belgium, Finland, France, Germany, Italy, Poland and Portugal. It included a survey on provision for dealing with cases of abuse against older women, and production of a brochure and workshop for community health and social services staff members on how to recognise and react in such cases. Breaking the Taboo Two involved partners from Austria, Belgium, Bulgaria, Germany, Portugal and Slovenia, and developed a two-day training course for community health and social services staff who work in older people's own homes to recognise and act in cases of violence against older women, and a trainer handbook. The article discusses staff and managers' perceptions of violence against older women, types of abuse against older women reported, recognising abuse and barriers to recognition, strategies to deal with abuse against older women within the family, training courses for health and social services staff on violence against women, and results of trial training workshops.	Does not evaluate the outcome of an intervention
Daly, J. M., & Jogerst, G. J. (2005). Readability and content of elder abuse instruments. *Journal of Elder Abuse & Neglect, 17(4),* 31-52.	Since elder abuse was first acknowledged as a health care and social problem, incidence and prevalence of mistreatment has been assessed sparingly in the United States and other countries around the world. Standardized instruments for determining the prevalence of elder abuse have not been developed and other instruments measuring a person's function and spousal violence have been adapted for the measurement of elder abuse prevalence. The purposes of this paper are to (1) ascertain the reading grade level of the most frequently used elder abuse prevalence instrument's text and (2) determine the content validity of the instruments with respect to the types of elder abuse included in them. A review of the instruments used to measure elder abuse prevalence was completed and a questionnaire was developed to measure the reading grade level and type of elder abuse content in four instruments. The Fry Readability, Flesch Reading Ease, and McLaughlin Grading formulas were used to determine reading grade level. A questionnaire regarding content validity was sent to 69 faculty and staff in one university department and a 59% return was achieved. The Conflict Tactics Scale and the Hwalek-Sengstock Elder Abuse-Screening Test had the lowest mean score at the 6th grade reading level. Results of content analysis for types of elder abuse demonstrated none of the instruments are comprehensive. Instruments to measure the prevalence are needed which balance readability and content validity.	Does not evaluate the outcome of an intervention
Debbonaire, T. (2008). *The pilot of the Respect/Relate/CAFCASS domestic violence risk identification tool: Evaluation Report.* London, UK: Respect.	No abstract	Does not evaluate the outcome of an intervention
Dienemann, J., Glass, N., Hyman, R. (2005). Survivor preferences for response to IPV disclosure. *Clinical Nursing Research, 14(3),* 215-233	Intimate partner violence (IPV) is a major cause of health conditions among women presenting for health care. Many physicians and nurses miss potential opportunities to increase battered women's safety. The purpose of this study is to increase health care providers' understanding of abused women's preferences concerning provider response when they do disclose IPV in order to increase effectiveness of interventions. A total of 26 abused women from a larger study participated in five focus groups at three agencies on "how a hospital or doctor's office can be most helpful to a woman who is experiencing domestic violence." Women identified	Describes client's preferences or acceptability of screening

	seven preferences for responses: (a) treat me with respect and concern, (b) protect me, (c) documentation, (d) give me control, (e) immediate response, (f) give me options, and (g) be there for me later. These findings indicate that women prefer an active role by health care providers when responding to disclosure.	
Dodge, A.C., McLoughlin, E., Saltzman, L.E., Nah, G., Skaj, P., Campbell, J.C., & Lee, D. (2002). Improving intimate partner violence protocols for emergency departments: An assessment tool and findings. *Violence Against Women, 8(3),* 320-338.	A Protocol Assessment Tool (PAT) was developed to assess emergency departments' (Eds') protocols regarding treatment of patients sustaining partner violence. Using this tool, project staff members evaluated the content of written protocols submitted by ED nurse managers in California and in a national sample in 1992-1993 and in 1996-1997. The number of protocols and their overall content improved significantly in California between 1992-1993 and 1996-1997, and there was a suggestion of improvement in the national sample. Advocacy efforts influenced Joint Commission on Accreditation of Healthcare Organizations guidelines and California laws, which in turn may have stimulated increases in the quantity and quality of protocols. The PAT permits readers to evaluate their local facility's protocols.	Does not evaluate the outcome of an intervention
Dowd, M.D., Kennedy, C., Knapp, J.F., & Stallbaumer-Rouyer, J. (2002). Mothers' and health care providers' perspectives on screening for intimate partner violence in a pediatric emergency department. *Archives of Pediatrics & Adolescent Medicine, 156(8)*, 794-799.	OBJECTIVE: To determine the attitudes, feelings, and beliefs of mothers and pediatric emergency department health care providers toward routine intimate partner violence screening. METHODS: This qualitative project employed focus groups of mothers who brought their children to a children's hospital emergency department for care, and physicians and nurses who staffed the same department. We held 6 ethnically homogeneous mother focus groups (2 white, 2 African American, and 2 Latina) and 4 provider focus groups (2 predominately female nurse focus groups and 2 physician groups: 1 male and 1 female). Professional moderators conducted the sessions using a semistructured discussion guide. All groups were audiotaped and videotaped, and tapes were reviewed for recurring themes. RESULTS: A total of 59 mothers, 21 nurses, and 17 physicians participated. Mothers identified intimate partner violence as a common problem in their communities, and most remarked that routine screening for adult intimate partner violence is an appropriate activity for a pediatric emergency department. However, many expressed concern that willingness to disclose might be affected by a fear of being reported to child protective services. They stressed the importance of addressing the child's health problem first, that screening be done in an empathetic way, and that immediate assistance be available if needed. Themes identified in the provider groups included concerns about time constraints, fear of offending, and concerns that unless immediate intervention was available, the victim could be placed in jeopardy. Many said they would feel obligated to notify child protective services on disclosure of intimate partner violence. CONCLUSIONS: Intimate partner violence screening protocols in the pediatric emergency department should take into consideration the beliefs and attitudes of both those doing the screening and those being screened. Those developing screening protocols for a pediatric emergency department should consider the following: (1) that those assigned to screen must demonstrate empathy, warmth, and a helping attitude; (2) the importance of addressing the child's medical needs first, and a screening process that is minimally disruptive to the emergency department; (3) a defined, organized approach to assessing danger to the child, and how and when it is appropriate to notify child protective services when a caregiver screens positive for intimate partner violence; and (4) that resources must be available immediately to a victim who requests them.	Describes client's preferences or acceptability of screening
Ejaz, F. K., Bass, D.M., Anetzberger, G., & Nagpaul, K., (2001). Evaluating the Ohio elder abuse and domestic violence in late life screening tools and referral protocol. *Journal of Elder Abuse & Neglect, 13(2),* 39-58.	This article describes the evaluation processes employed in the Ohio project to develop and test screening tools and referral protocols on elder abuse and domestic violence. Three focus groups and a Roundtable of experts were utilized to develop the materials in the first year. In the second year, a formal quantitative evaluation that involved 160 practitioners in Ohio was implemented to review the materials and to use them with clients. Findings from the quantitative evaluation were incorporated to make changes that led to a final document that was much simpler, less lengthy and more relevant to novice practitioners.	Does not evaluate the outcome of an intervention
Erlingsson, C.L., Carlson, S.L., & Saveman, B-I. (2003). Elder abuse risk indicators and screening questions: results from a literature	In order to examine and compare expert opinions from elder abuse literature on risk indicators and screening questions to perspectives of experts from both developed and developing countries, a literature search was combined with a modified Delphi process involving 17 panel members. Each method resulted in a consensus on 48 risk indicators. These shared only 35% content. Each method also resulted in a consensus on screening	Non-systematic review

search and a panel of experts from developed and developing countries. *Journal of Elder Abuse & Neglect, 15(3),* 185-203.	questions: Thirteen questions for the literature search and nine for the Delphi panel. There were divergences between Delphi panel participants' responses from developed and developing countries indicating that more research is needed in developing countries.	
Ernst, A., Weiss, S., Goldstein, L., Hall, J., & Clark, R. (2007). Computer versus paper format for intimate partner violence (IPV) screening. *Academic Emergency Medicine, 14(5),* S44-S44.	SUMMARY. Background: The incidence of acute cases of intimate partner violence (IPV) in the Emergency Department (ED) patients is between 2 and 7.2%. Ongoing IPV may be an immediate cause of presentation for medical care, or it may not be readily apparent. Over the last two decades efforts to improve identification of IPV in the ED have been successful. Methods: A medline literature search from 1981-2001 was performed. A review of intimate partner violence from the emergency department provider perspective is performed. A discussion of the screening/detection of intimate partner violence and the barriers to improving detection rates is provided. Results: The review of the current literature shows that IPV is a frequent cause of illness or injury in patients presenting in the ED. Screening programs for intimate partner violence have shown to increase the identification of patients experiencing acute episodes of abuse and seeking treatment. The difficulty has been in sustaining the programs and improving the screening of patients. Patient, provider and systems barriers prevent adequate recognition and management of the problem. Conclusion: Detection of IPV in patients presenting to the ED can be improved by providing educational programs and screening tools to health care providers. Sustaining the screening programs is more difficult and requires a health care system-wide effort.	Describes client's preferences or acceptability of screening
Ernst, A.A., & Weiss, S.J. (2002). Intimate partner violence from the emergency medicine perspective. *Women & Health, 35(2-1),* 71-81.	BACKGROUND: The incidence of acute cases of intimate partner violence (IPV) in the Emergency Department (ED) patients is between 2 and 7.2%. Ongoing IPV may be an immediate cause of presentation for medical care, or it may not be readily apparent. Over the last two decades efforts to improve identification of IPV in the ED have been successful. METHODS: A medline literature search from 1981-2001 was performed. A review of intimate partner violence from the emergency department provider perspective is performed. A discussion of the screening/detection of intimate partner violence and the barriers to improving detection rates is provided. RESULTS: The review of the current literature shows that IPV is a frequent cause of illness or injury in patients presenting in the ED. Screening programs for intimate partner violence have shown to increase the identification of patients experiencing acute episodes of abuse and seeking treatment. The difficulty has been in sustaining the programs and improving the screening of patients. Patient, provider and systems barriers prevent adequate recognition and management of the problem. CONCLUSION: Detection of IPV in patients presenting to the ED can be improved by providing educational programs and screening tools to health care providers. Sustaining the screening programs is more difficult and requires a health care system-wide effort.	Non-systematic review
Falsetti, S.A. (2007). Screening and responding to family and intimate partner violence in the primary care setting. *Primary Care, 34(3),* 641-657.	It is now widely recognized that family violence and intimate partner violence (IPV) is prevalent, affecting 1 to 4 million women a year in the United States alone. Children and men are also victims of IPV. The consequences can be devastating and can affect both mental and physical health. The aims of this article are to review prevalence data, review mental and physical health consequences, and discuss screening and interventions appropriate to primary health care settings.	Non-systematic review
Fogarty, C.T., Burge, S., & McCord, E.C. (2002). Communicating with patients about intimate partner violence: screening and interviewing approaches. *Family Medicine, 34(5),* 369-375.	Intimate partner violence is a major public health concern; it contributes to poor physical and mental health in affected individuals, primarily women. Due to documented poor detection rates of intimate partner violence by physicians, the medical community has focused increasing attention on the successful identification of victims in all medical contexts. Family medicine educators need to be aware of the current status of knowledge about intimate partner violence and convey this to students and residents. In this article, we review the literature on screening tools to identify victims of partner violence, discuss the pitfalls of relying on screening tools, review barriers to identification of partner violence from clinician and patient perspectives, and recommend a patient-centered method for conversing with patients about intimate partner violence.	Non-systematic review
Fraga, S., Costa, D., Dias, S., & Barros, H. (2012). Does interview setting influence disclosure of	Background: violence is a very sensitive research topic and interview's setting might influence the participation rate and response accuracy. We aimed to evaluate such effect when assessing the prevalence of different types of violence in a sample of urban elderly by comparing those interviewed at home with those assessed at	Does not evaluate the outcome of an

violence? A study in elderly. *Age and Ageing 41,* 70-75.	the research office. Methods: study subjects were members of a cohort of urban dwellers previously assembled using random digit dialling. The initial 450 individuals aged 60-84 years old were invited to participate in the present study, after being randomly allocated into two groups: 150 for being scheduled to research office interview and 300 to home interview. Both groups allocated were similar regarding gender, age, education, marital status and behavioural characteristics such as smoking and drinking alcohol. Information was obtained by face-to-face standardised interviews. Results: we obtained a participation rate of 67.0% in the group allocated to home interview and 70.7% in the other group (P=0.431). No statistically significant differences were found when prevalence of violence during the previous year was compared according to the interview setting (physical 2.5 versus 1.0%, psychological 19.7 versus 19.0%, financial mistreatment 8.6 versus 9.5%, sexual 1.0 versus 1.0% and neglect 5.1 versus 3.8% in home and research office, respectively). Conclusion: our results indicate that the interview setting has no influence both in participation rate and in the prevalence estimates of different types of violence in the elderly.	intervention
Froerer, A.S., Lucasb, B.M. & Brown, T.C. (2012). Current Practices of Intimate Partner Violence Assessment Among Marriage and Family Therapy Trainees at a University Clinic. *Journal of Couple & Relationship Therapy, 11(1),* 16-32.	Research shows that the majority of couples presenting for couple therapy have experienced or are currently experiencing intimate partner violence (IPV) within their relationships. It is also known that few couples present for therapy with IPV as their main concern and seldom do couples spontaneously report IPV. A review of the literature that provides a rationale for the utilization of a universal screening process for IPV is provided. After which, the authors look at the current IPV assessment and screening practices of marriage and family therapists in a marriage and family therapy training facility. A logistic regression procedure was used to determine if an IPV assessment could be predicted based on risk factors of IPV from self-report intake information completed by participants. Unfortunately, only if clients actually indicated that physical violence within their relationship was a current issue were they assessed.	Non-systematic review
Fulmer, T., Guadagno, L., Bitondo Dyer, C., & Connolly, M.T. (2004). Progress in elder abuse screening and assessment instruments. *Journal of the American Geriatrics Society, 52(2)*, 297-304.	The responsibility of identifying elder mistreatment (EM) often falls on the healthcare professional. Many different screening and assessment instruments have been developed to aid healthcare professionals in making determinations about EM. The purpose of this article is to review existing EM screening and assessment instruments to examine progress in this field. The value and limitations of these instruments with regard to their use in different clinical and healthcare settings are discussed. The settings in which EM screening and assessment are conducted are also considered. The authors conclude that there is much to be done in terms of achieving consensus on what constitutes an appropriate screen or assessment instrument for detecting EM. Effort must be focused on instruments that can be used for brief, rapid screenings and those that can be used for more-detailed diagnostic assessments.	Non-systematic review
Glowa, P.T., Frazier, P.Y., Wang, L., Eaker, K., & Osterling, W.L.(2003). What happens after we identify intimate partner violence? The family physician's perspective. *Family Medicine, 35(10),* 730-736.	Background and Objectives: Despite increased emphasis on asking about intimate partner violence (IPV), little data exists on patient outcomes. We surveyed family physicians in New Hampshire and North Carolina to determine rates of asking about IPV, patient outcomes after disclosure, and changes in the doctor-patient relationship as a result of patient disclosure. Methods: Active members of the New Hampshire and North Carolina Academies of Family Physicians were surveyed. Data were analysed using SAS PC. Results: Data are similar between the two states. Physicians who regularly ask about IPV more often identify victims. Further, physicians in general ask more often about IPV now than 5 years ago. On average, physicians report 4.95 interventions for patients disclosing abuse, most often treating the physical and emotional complaints and documenting abuse. Physicians reported positive patient outcomes (e.g., improved mental health, seeking counselling or services) more often than negative outcomes (e.g., disruption of finances or housing and fear of worsened violence). Physicians believed that many outcomes resulted from disclosure to the physician. They also believed that IPV disclosure led to more work for the physician but an improved doctor-patient relationship. Conclusions: This is the first study of physician views of patient outcomes and the first study reporting an increase in the proportion of physicians asking about IPV Our findings suggest that more physicians may be asking about IPV and more frequently. Additional studies are needed to compare physician and patient perceptions of outcomes resulting from disclosure.	Does not evaluate the outcome of an intervention

Griffin, M.G., Uhlmansiek, M.H., Resick, P.A., & Mechanic, M.B. (2004). Comparison of the posttraumatic stress disorder scale versus the clinician-administered posttraumatic stress disorder scale in domestic violence survivors. *Journal of Traumatic Stress, 17(6)*, 497-503.	The posttraumatic diagnostic scale (PDS) is a self-report instrument for PTSD that is simple to administer and has demonstrated good psychometric properties. We compared the PDS with the gold standard clinician administered PTSD scale (CAPS) diagnostic interview for PTSD. We assessed 138 women who were victims of domestic violence using both the PDS and the CAPS. Findings confirmed that PTSD develops at a high base rate in this sample. The PDS generally performed well in relation to the CAPS although with a tendency to overdiagnose PTSD. The findings lend further support to the use of the PDS as a diagnostic tool for PTSD but indicate that it is better at identifying survivors with PTSD than those without the disorder.	Does not evaluate the outcome of an intervention
Haggblom, A., Hallberg, L.R., & Möller, A.R. (2005). Nurses' attitudes and practices towards abused women. *Nursing & Health Sciences, 7(4),* 235-242.	Research with nurses in the Aland Islands, a Swedish-speaking area of Finland, to investigate their knowledge, practices and training related to violence against women. Questions included knowledge of work-based guidelines for domestic violence issues, assessment and education of abused women, and documentation of incidence. The effect of in-service training on knowledge and practice was measured.	Does not evaluate the outcome of an intervention
Haggerty, L.A., Hawkins, J.W., Fontenot, H., & Lewis-O'Connor, A. (2011). Tools for screening for interpersonal violence: state of the science. *Violence & Victims, 26(6)*, 725-737.	In recent decades, the prevalence of abuse against women, older persons, and persons with disabilities has become a major public health problem. Health professionals, urged by their professional associations to universally screen these groups, have employed various tools in an effort to identify individuals in need of help. Yet many of the tools used widely in clinical settings have limitations in terms of empirical soundness. This article presents tools used to screen women, older persons, and persons with disabilities as well as data on the reliability and validity of these instruments. These properties and the resources needed to reduce harm are important factors to consider before implementing screening. The article concludes with a summary of the risk-benefit issues related to the use of these tools and universal screening in general.	Non-systematic review
Hanson, R.F., & Self-Brown, S. (2010). Screening and assessment of crime victimization and its effects. *Journal of Traumatic Stress, 23(2),* 207-214.	The authors provide a review of tools used to screen and assess history and mental health consequences of adult crime victimization. These measures can be utilized across a broad range of settings that may serve crime victims, including venues for first response (e.g., law enforcement offices or emergency departments), primary medical care, or mental health treatment facilities, regardless of whether or not the crime was reported. The authors conclude with a discussion on limitations in the field and directions for future research.	Does not evaluate the outcome of an intervention
Heyman, R E., & Smith Slep, A.M. (2009). Reliability of family maltreatment diagnostic criteria: 41 site dissemination field trial. *Journal of Family Psychology, 23(6),* 905-910.	R. E. Heyman and A. M. S. Slep (see record 2006-10939-007) developed and conducted an effectiveness trial of a diagnostic system for child and partner maltreatment. The current investigation tested the widespread dissemination of the diagnostic system at 41 child and partner maltreatment services sites (n=549 partner maltreatment cases and n=342 child maltreatment cases). Agreement between field and master reviewers' decisions was good for partner physical and emotional abuse (κ=0.83–0.84). Agreement was also good for child physical, emotional, and sexual abuse (κ=0.73–0.89) but lagged slightly for child neglect (κ=0.66). Thus, multifaceted and content valid family maltreatment diagnostic criteria can be disseminated reliably. Replication studies of interrater agreement of the diagnostic system in typical clinical and agency settings are necessary; however, the high levels of agreement in myriad field sites imply that consistency of maltreatment determinations is achievable in widespread use.	Intervention setting outside of health and social services (Military)
Higgins, L.P., & Hawkins, J.W. (2005). Screening for abuse during pregnancy: implementing a multisite programme. *American Journal of Maternal Child Nursing, 30(2),* 109-114.	Screening for abuse at every healthcare visit is a standard of practice promulgated by many healthcare professional organizations. The need for such screening is underscored by reports of homicide as a leading cause of maternal mortality during pregnancy and the first year of the baby's life in Massachusetts and Maryland, and by the calculation of the costs of intimate partner violence in the United States. This article discusses how we addressed problems that arose in implementing screening for abuse in 13 different sites as a part of a clinical nursing research project. Engaging in clinical nursing research necessitates close relationships with clinical agencies and their staff members. This often means establishing and maintaining relationships with all nurses caring for patients in each clinical unit serving as a study site. For research on abuse during pregnancy, our study team members were engaged in interactions with prenatal care providers at	Does not evaluate the outcome of an intervention

	13 different study sites. Central to the study was implementing use of a standardized abuse screening tool, the Abuse Assessment Screen, at each study site. This article also describes the lessons we learned in attempting to implement such a large scale change in clinical practice.	
Holtrop, T.G., Fischer, H., Gray, S.M., Barry, K., Bryant, T., & Du, W. (2004). Screening for domestic violence in a general paediatric clinic: Be prepared! *Pediatrics, 114(5),* 1253-1257.	OBJECTIVES: Exposure to violence, particularly domestic violence (DV), negatively affects children's physical, emotional, and cognitive well-being. The American Academy of Pediatrics recommends routine DV screening of female caretakers of paediatric patients. Few reports of screening in paediatric practices exist, and none have reported outcomes from a resident-run urban academic centre. We set out to determine whether the use of the Partner Violence Screen (PVS) increases detection of DV and to test the mechanics of implementing large-scale DV screening in a busy, paediatric residency training clinic. METHODS: Using the PVS, we screened a sample of consecutive female caretakers/guardians of children seen for paediatric care in the general paediatric clinic of Children's Hospital of Michigan from March 1, 2002, through February 28, 2003. Positive screens obtained during the study period were compared with the number of DV referrals received by the clinic social workers from January 1, 2001, through December 31, 2001, before PVS screening began. To test the mechanics of screening, we also analysed the number of forms returned blank or marked "no opportunity to screen" in the last 8 months of the study period. RESULTS: In the 12 months before use of the PVS, our social work department received 9 referrals because of DV from the general paediatric clinic, among a total of 5446 caretakers/guardians bringing 6380 children for a total of 13,576 patient care visits. In contrast, the social work department received 164 referrals because of positive screening results among 5445 caretakers/guardians bringing 7429 children for 17,346 patient care visits in the 12-month study period after introduction of the PVS. Fourteen of 164 positive PVSs were found to involve nondomestic violence perpetrated by nonpartners or violence with the patient as the victim, not the mother or female caretaker. A total of 150 PVSs involved true DV. The difference in identification of DV with the PVS, compared with the rate before its introduction, was highly significant. The positive predictive value for the PVS was 91.5%, and the identified prevalence rate was 3.7%. In the last 8 months of the study period, 6301 of 8055 PVS forms (78%) were completed; 1754 of 8055 PVS forms (22%) were left blank, but it was not possible to determine whether these represented duplicate screening forms for instances in which the mother or female caretaker had brought >1 child for care. CONCLUSIONS: Formal screening for DV with the PVS in this study setting of a busy, urban, academic, general paediatric clinic appeared to be very successful, in terms of increasing referrals and documentation of previously unrecognized DV situations. This increase signals the need for resources (time and/or social work services) to provide appropriate referral services. The PVS identifies nonpartner violence occasionally.	Does not evaluate the outcome of an intervention
Horiuchi, S., Yaju, Y., Kataoka, Y., Grace Eto, H., & Matsumoto, N. (2009). Development of an evidence-based domestic violence guideline: supporting perinatal women-centred care in. *Japan Midwifery, 25(1),* 72-78.	OBJECTIVE: to develop an evidenced-based, women-centred care clinical guideline designed to assist midwives and other health-care providers in Japanese hospitals, clinics and midwifery offices, in identifying and supporting potential or actual perinatal victims of domestic violence. DESIGN: systematic review and critical appraisal of extant research; structured assessment of clinical guideline development. METHOD: systematic and comprehensive literature search. Appraisal of Guidelines for Research and Evaluation (AGREE) was used to assess the guideline development for purposes of assuring methodological quality. FINDINGS: electronic searches of medical and nursing databases between February and December 2003 retrieved 2392 articles. Selected as evidence were 157 articles yielding 28 recommendations aligned to clinical assessment questions. KEY CONCLUSIONS: using expert consensus and external reviews, recommendations were generated that provided the at-risk perinatal group with the best possible practice available to prevent further harm. IMPLICATIONS FOR PRACTICE: the evidenced-based clinical guideline fosters a supportive environment for educating health-care providers on domestic violence, and to improve clinic access for at-risk perinatal women. Information on domestic violence and a negotiated midwife-client safety plan can be initiated for potential or actual victims of domestic violence, and is achieved through understanding the risks of the woman and her foetus or baby, while respecting the woman's intention.	Non-systematic review

Howard, J. (2008). Domestic violence screening: Findings of a pilot project conducted by allied health staff in community health. *Australian Journal of Primary Health, 14(1),* 43-51.	This article examines a pilot project that introduces screening for domestic violence into an allied health team at a community health service. The screening was delivered over a three-month period from May 2005, with 44 clients screened. It explores the context in which the project was initiated, the experience of allied health staff in undertaking the screening, and project findings. It concludes that although the screening did not result in significant numbers of women disclosing domestic violence, it enhanced the capacity of allied health staff to respond to women who have experienced domestic violence, and strengthened the linkages between allied health and counselling staff.	Describes practitioners perspectives on screening
Kataoka, Y., Yaju, Y., Eto, H., Matsumoto, N., & Horiuchi, S. (2004). Screening of domestic violence against women in the perinatal setting: a systematic review Japan. *Journal of Nursing Science, 1(2)*, 77-86.	Aim: To review published studies focusing on the screening of domestic violence (DV) against women, in particular, the instruments, the screening methods and the interventions used to help abused women after screening. Based on the results of the review, the suitability of introducing routine screening for DV in the perinatal setting in Japan would be assessed. Methods: National Guideline Clearinghouse database, HSTAT, PubMed, CINAHL, the Cochrane Library and the Ichushi-Web were all used to searched from when records were first held until February 2003 for eligible primary studies and systematic reviews for this literature review. Each selected article was independently read and appraised by two reviewers who finally selected 12 primary studies and three systematic reviews that fulfilled the criteria for inclusion. Results: Three studies evaluated screening instruments for DV (i.e. Abuse Assessment Screen, Partner Violence Screen and Violence Against Women Screen) and of these, the Violence Against Women Screen was the most valid, reliable and suitable for use in the clinical setting in Japan. The three studies that examined the screening method had differing results, but the one conducted in Japan showed a significantly higher rate of identification in the self-administered questionnaire group compared with the interview group. The six studies that tested the effectiveness of interventions for abused women showed that counselling sessions after screening and the advocacy programme for postsheltered women were effective in reducing DV. Conclusion: Routine screening of all pregnant women in Japan for DV should be introduced, considering the high burden of suffering that women expose to DV experience, and the existence of both acceptable screening instruments and effective interventions.	Non-systematic review
Kim, J., Dubowitz, H., Hudson-Martin, E., & Lane, W. (2008). Comparison of 3 data collection methods for gathering sensitive and less sensitive information. *Ambulatory Pediatrics, 8(4)*, 255-260.	OBJECTIVE: When gathering sensitive information about personal experiences such as child abuse, drug and alcohol use, and intimate partner violence (IPV), it is especially important for both research and clinical purposes to use optimal methods to limit socially desirable responses. The purpose of this paper is to determine which of the following 3 methods is optimal for gathering data: 1) face-to-face interviews, 2) self-administered paper and pencil questionnaires, or 3) audio computer-assisted self-interviews (ACASI). METHODS: The sample consisted of 514 parents bringing their preschoolers (0-5 years) to a paediatric primary care clinic for a checkup. The parent screening questionnaire (PSQ) addressing psychosocial problems was completed by participants themselves. Participants completed the PSQ in 1 of 3 ways: paper and pencil, face-to-face interview, or directly onto a computer (ACASI). RESULTS: In general, ACASI yielded the highest rates for sensitive problems such as social isolation and parental stress, with face-to-face interviews occupying an intermediate position. The differences between ACASI and self-administered paper and pencil questionnaires were significant for many items. The differences between ACASI and face-to-face interviews, however, were modest. There were no significant group differences among the 3 methods in the prevalence rates of the neutral, less sensitive items. CONCLUSION: ACASI resulted in greater disclosure of sensitive information than did a paper and pencil approach. No significant differences were observed between the computer-assisted interview and the face-to-face interview, both done in a research setting. The 3 methods appeared similar when gathering less sensitive data.	Does not evaluate the outcome of an intervention
Kimberg, L. (2001). Addressing intimate partner violence in primary care practice. *Medscape Womens Health, 6(1).*	No abstract	Non-systematic review

Klingbeil, C.G., Johnson, N.L., Totka, J.P., & Doyle, L. (2009). How to select the correct education strategy: When not to go online. *Journal for Nurses in Staff Development, 25(6),* 287-291.	Screening for intimate partner violence is an important injury prevention strategy. Nurses who develop staff education, to promote screening, need to select a method that is sensitive to learners. Online learning, although convenient, is not well suited to sensitive topics such as screening for intimate partner violence. The purpose of this article is to describe a curriculum for intimate partner violence screening based on self-efficacy theory, which includes a hospital-produced video, a role play, and a discussion.	Does not evaluate the outcome of an intervention
Korenstein, D., Thomas, D.C., Foldes, C., Ross, J., Halm, E., & McGinn, T. (2003). An evidence-based domestic violence education programme for internal medicine residents. *Teaching & Learning in Medicine, 15(4),* 262-266.	BACKGROUND: Domestic violence (DV) is prevalent but often unrecognized, and it is a challenge to teach. This article presents an evidence-based DV education programme for medical residents and incorporates it into a women's medicine curriculum. DESCRIPTION: An initial 3 hour seminar included video and case discussion, literature review, and role play. Participants then actively screened patients for 2 weeks and returned for a follow-up discussion session. The programme was well received. EVALUATION: Six to 12 months after the intervention, key features questions were utilized to measure ability to correctly suspect DV in patient situations. Residents who had not attended the programme served as controls. Three of the 8 questions were suspicious for abuse. Fifty-four percent of respondents in the intervention group correctly suspected DV in at least 2 out of 3 questions compared with 20% of controls (p=0.02). CONCLUSIONS: An evidence-based DV education programme was well received and helped correctly suspect DV.	Does not evaluate the outcome of an intervention
Koziol-McLain, J., Giddings, L., Rameka, M., & Fyfe, E. (2008). Intimate partner violence screening and brief intervention: Experiences of women in two New Zealand Health Care Settings. *Journal of Midwifery & Women's Health, 53(6),* 504-510.	The identification of intimate partner violence (IPV) against women as a public health problem has led to routine health care site-based screening and brief intervention policies. However, there is a lack of evidence supporting the usefulness and safety of such policies. Our objective was to ascertain the acceptability, usefulness, and harm of a brief health care site-based screening intervention. In this qualitative study, semi structured interviews were conducted with 36 women several weeks after a standardized screening intervention in either an emergency department (adult and paediatric) or primary health care setting. The majority of women (97%) welcomed the IPV screening intervention and perceived it as nonthreatening and safe. The women reported no increased risk of harm because of the screening. The responses showed that the intervention had a therapeutic and educational quality, and the attitude and approach of the person asking the intervention questions was critical to a positive outcome. Women without a history of violence cautioned that IPV screening may be offensive to those who are abused, whereas those who reported abuse thought IPV screening was essential "to stop it [from] happening." Our findings challenge concerns that IPV screening is offensive to women and increases their potential for danger. Participants were appreciative of the opportunity to tell their abuse stories in a safe and supportive context, and challenged the health care system to implement IPV screening, asking "What took you so long?"	Describes client's preferences or acceptability of screening
Krasnoff, M., & Moscati, R. (2002). Domestic violence screening and referral can be effective. *Annals of Emergency Medicine, 40(5),* 485-492.	STUDY OBJECTIVE: We provide a targeted intervention in the emergency department for intimate partner violence (IPV) victims and to facilitate follow-up care from a professional case manager. METHODS: This observational case study was conducted in an urban ED from July 1, 1997, through December 31, 1999. The targeted population consisted of all English-speaking women between the ages of 18 and 65 years presenting 24 hours a day, 7 days a week. There were 3 components to the study. The first consisted of an effort to improve the screening for IPV of female patients seen in the ED. The primary outcome for this component was the correlation of increased screening rates with increased violence detection. Universal screening of all women for IPV regardless of their chief complaint was encouraged through an IPV script and a new reporting area on the nursing note. The second component was an on-site IPV advocacy intervention. Once IPV was identified by means of screening or self-disclosure, the nurse notified a volunteer advocate from a local human service agency, who came to the ED within 30 minutes, conducted a crisis intervention, and encouraged the patient to follow-up with the case manager. The outcomes were patient cooperation with the ED intervention and subsequent follow-up with the community-based agency. The third phase was telephone-based counselling by an IPV case manager to help the client reduce her exposure to additional violence. The outcome was the client's self-report of a life free of violence. RESULTS: Of the 528 women identified as IPV	Does not evaluate the outcome of an intervention

	victims, 475 (84%) agreed to speak to the advocate, and 258 (54% of those seen by the advocate) accepted case management follow-up. After the case management process, lasting 3 to 6 weeks, 127 women reported that they no longer believed they were at risk for violence from their abuser. CONCLUSION: Through a coordinated effort by the medical staff and the volunteer advocates, 258 of 528 IPV victims seen in the ED received ongoing community-based services to address their experience of IPV.	
Kropp, P.R. (2008). Intimate partner violence risk assessment and management. Violence & Victims, 23(2), 202-220.	While risk assessment is important in the management of intimate partner violence perpetrators, the science and practice of risk assessment in this field are still in early development. This article reviews the literature on intimate partner violence risk assessment. The original intent was to direct discussion to assist the Military Family Advocacy Programme (FAP), U.S. Department of Defense, to develop guidelines for the treatment of domestic violence offenders. The article is divided into sections as follows: (a) Defining Risk; (b) The Risk Factors; (c) Models of Risk Assessment; (d) Existing Risk Instruments; (e) The Role of the Victim in Risk Assessment; (f) Qualifications to Conduct Assessments; (g) Communicating Risk; and (h) Managing Risk. Relevant issues and controversies are raised throughout the article.	Non-systematic review
Lachs, M.S., & Pillemer, K. (2004). Elder abuse. Lancet, 364(9441), 1263-1272.	Elder abuse has received increasing attention over the past decade as a common problem with serious consequences for the health and wellbeing of old people. Our aim is to assist clinicians by summarising recent international research and clinical findings about elder abuse, and to assess their quality, relevance, and feasibility for health-care providers in clinical practice. This seminar includes issues of definition and frequency of elder abuse and a summary of major known risk factors. The advantages and disadvantages of screening for elder abuse are discussed. We review clinical manifestations and diagnosis of elder abuse, and propose a protocol for medical assessment of a patient with confirmed or suspected abuse. Suggestions for treatment are offered on the basis that elder abuse is multifactorial and needs individual medical and social intervention strategies, preferably in the context of a multidisciplinary team.	Non-systematic review
Liebschutz, J., Liebschutz, J., Battaglia, T., Finley, E., & Averbuch, T. (2008). Disclosing intimate partner violence to health care clinicians - what a difference the setting makes: A qualitative study. *BMC Public Health, 8,* 229.	BACKGROUND: Despite endorsement by national organizations, the impact of screening for intimate partner violence (IPV) is understudied, particularly as it occurs in different clinical settings. We analysed interviews of IPV survivors to understand the risks and benefits of disclosing IPV to clinicians across specialties. METHODS: Participants were English-speaking female IPV survivors recruited through IPV programs in Massachusetts. In-depth interviews describing medical encounters related to abuse were analysed for common themes using Grounded Theory qualitative research methods. Encounters with health care clinicians were categorized by outcome (IPV disclosure by patient, discovery evidenced by discussion of IPV by clinician without patient disclosure, or non-disclosure), attribute (beneficial, unhelpful, harmful), and specialty (emergency department (ED), primary care (PC), obstetrics/gynaecology (OB/GYN)). RESULTS: Of 27 participants aged 18-56, 5 were white, 10 Latina, and 12 black. Of 59 relevant health care encounters, 23 were in ED, 17 in OB/GYN, and 19 in PC. Seven of 9 ED disclosures were characterized as unhelpful; the majority of disclosures in PC and OB/GYN were characterized as beneficial. There were no harmful disclosures in any setting. Unhelpful disclosures resulted in emotional distress and alienation from health care. Regardless of whether disclosure occurred, beneficial encounters were characterized by familiarity with the clinician, acknowledgement of the abuse, respect and relevant referrals. CONCLUSION: While no harms resulted from IPV disclosure, survivor satisfaction with disclosure is shaped by the setting of the encounter. Clinicians should aim to build a therapeutic relationship with IPV survivors that empowers and educates patients and does not demand disclosure.	Describes client's preferences or acceptability of screening
Lincoln, H.S., & Lincoln, M.J. (2010). Role of the odontologist in the investigation of domestic violence, neglect of the vulnerable, and institutional violence and torture. *Forensic Science*	Dentists have a significant role to identify and intervene in domestic abuse, violence, and neglect of the vulnerable. Over 75% of abuse victims have injuries to the head, face, mouth, and neck and so dentists are often first responders. However, under recognition and under reporting of domestic abuse and violence is a particular problem among health care providers, including dentists. Forensic odontologists are well suited to lead the training of their clinical colleagues in the various cultural determinants to abuse, including aetiology, symptoms, physical signs of abuse, as well as appropriate reporting. In addition to leading their colleagues,	Non-systematic review

International, 201(1-3), 68-73.	forensic odontologists play an essential role as part of multidisciplinary teams that investigate conflict situations, serious crimes, exploitation of disadvantaged populations, and other serious violence and abuse. Whether in conflict zones or within private families, early detection and intervention is important to prevent establishment of abusive social and family patterns that perpetuate a "cycle of violence". This is especially true in young children, the most vulnerable population of all. To support this theory of early and effective intervention, this paper comprehensively reviews the most recent evidence concerning the aetiology, detection, and prevention of violence and abuse.	
Lo Fo Wong, S., Wester, F., Mol, S., Römkens, R., Hezemans, D., & Lagro-Janssen, T. (2008). Talking matters: Abused women's views on disclosure of partner abuse to the family doctor and its role in handling the abuse situation. *Patient Education and Counselling, 70(3),* 386-394.	Objective: We aimed to explore what women valued most in disclosing partner abuse to their doctor and whether disclosure played a role in handling their abuse situation. Methods: A qualitative method was used to understand abused women's views and experiences with disclosure to their family doctor. Thirty-six women were interviewed within 4 weeks after disclosure to their family doctor. Results: Most women went to see the doctor for some medical complaint, and only three women planned to disclose the abuse. Twenty-five women valued most their doctor's communicative approach with empathy or empowering and nine women valued most the instrumental approach. Eight women of the latter group wanted this combined with a communicative approach. After disclosure to the family doctor, a group of women (n=20) perceived a real change in their possibilities to handle their situation. They appeared to be in a position we named: 'in transition', a state in which they started or continued a process of change. Another group of women (n=13) appeared to be in a 'locked-up' position, a state without any prospect on change, feeling out of control and fearing the abuser. Three women reacted reserved towards change. Conclusion: A communicative approach, providing empathy and empowerment, is important to women in disclosing partner abuse. More than half of the women perceived possibilities for a change. Practice implications: Talking about abuse is an important step in a woman's process of change. Doctors should acknowledge the advantage of their position as a professional confidant and ask women about abuse.	Describes client's preferences or acceptability of screening
MacMillan, H.L., Wathen, C.N., Jamieson, E., Boyle, M., McNutt, L.A., Worster, A., Lent, B., Webb, M, & McMaster Violence Against Women Research Group.(2006). Approaches to screening for intimate partner violence in health care settings: A randomized trial. *The Journal of the American Medical Association 296(5),* 530-536.	CONTEXT: Screening for intimate partner violence (IPV) in health care settings has been recommended by some professional organizations, although there is limited information regarding the accuracy, acceptability, and completeness of different screening methods and instruments. OBJECTIVE: To determine the optimal method for IPV screening in health care settings. DESIGN AND SETTING: Cluster randomized trial conducted from May 2004 to January 2005 at 2 each of emergency departments, family practices, and women's health clinics in Ontario, Canada. PARTICIPANTS: English-speaking women aged 18 to 64 years who were well enough to participate and could be seen individually were eligible. Of 2602 eligible women, 141 (5%) refused participation. INTERVENTION: Participants were randomized by clinic day or shift to 1 of 3 screening approaches: a face-to-face interview with a health care provider (physician or nurse), written self-completed questionnaire, and computer-based self-completed questionnaire. Two screening instruments-the Partner Violence Screen (PVS) and the Woman Abuse Screening Tool (WAST)-were administered and compared with the Composite Abuse Scale (CAS) as the criterion standard. MAIN OUTCOME MEASURES: The approaches were evaluated on prevalence, extent of missing data, and participant preference. Agreement between the screening instruments and the CAS was examined. RESULTS: The 12-month prevalence of IPV ranged from 4.1% to 17.7%, depending on screening method, instrument, and health care setting. Although no statistically significant main effects on prevalence were found for method or screening instrument, a significant interaction between method and instrument was found: prevalence was lower on the written WAST vs other combinations. The face-to-face approach was least preferred by participants. The WAST and the written format yielded significantly less missing data than the PVS and other methods. The PVS and WAST had similar sensitivities (49.2% and 47.0%, respectively) and specificities (93.7% and 95.6%, respectively). CONCLUSIONS: In screening for IPV, women preferred self-completed approaches over face-to-face questioning; computer-based screening did not increase prevalence; and written screens had fewest missing data. These are important considerations for both clinical and research efforts in IPV screening.	Describes client's preferences or acceptability of screening

Mahoney, B.C. (2006). Reducing barriers against routine screening for intimate partner violence. *American Journal for Nurse Practitioners, 10(10),* 45-48.	No abstract	Non-systematic review
Mayer, B.W. (2001). *Clinical evaluation of emergency department screening guidelines for domestic violence: identification of nurse and female victim variables.* Tampa, FL; University of South Florida.	No abstract	Book
McCord-Duncan, E.C., Floyd, M., Kemp, E.C., Bailey, B., & Lang, F. (2006). Detecting potential intimate partner violence: which approach do women want? *Family Medicine, 38(6),* 416-422.	INTRODUCTION: Screening for or detection of intimate partner violence (IPV) in women is recommended, but no published studies compare respondent preferences for how screening should occur. This study sought to determine women's preferences for IPV detection. METHODS: Using a video stimulus method, 97 women viewed a short videotape portraying an encounter between a female physician and an established female patient. Participants evaluated three methods the physician used to detect IPV: the Partner Violence Screen (PVS), items from the Woman Abuse Screening Tool (WAST), and a patient-centered (PC) approach. Women also identified responses to avoid and suggested what the physician should say to explore IPV. RESULTS: Thirty-eight of 97 participants (39%) reported having experienced IPV. The most preferred screening method was the PC approach, followed closely by questions from the WAST. The PVS was the least preferred method of IPV detection compared to the others, and more than half of the participants recommended avoiding it, regardless of their IPV status. Two thirds of the participants' written suggestions of their preferred approach to exploring IPV were for the PC approach. Preferences were not associated with demographics. DISCUSSION: Of the IPV assessment types tested, primary care patients most preferred the PC approach, followed by the questions from the WAST. The PVS questions should be avoided. Preferences for certain approaches were not affected by any demographic variable, nor a history of IPV.	Describes client's preferences or acceptability of screening
McNutt, L.A., van Ryn, M., Clark, C., & Fraiser, I. (2000). Partner violence and medical encounters - African-American women's perspectives. *American Journal of Preventive Medicine, 19(4),* 264-269.	Objective: To examine the relationship between intimate partner violence (IPV) victimization and patient satisfaction with medical encounters among an African-American population. Design: Cross-sectional, self-administered, anonymous survey. Setting: Community-based, primary care centre. Patients: Consecutive African-American women recruited from an urban health centre. A total of 102 women provided sufficient information to reveal whether they were currently experiencing IPV and to allow us to assess their experiences in their most recent primary care encounter. Measurements: Patients' perceptions of their most recent encounter using questions adopted from the Medical Interview Satisfaction Scale and Consultation Satisfaction Questionnaire. We used the Conflicts Tactics Scale, supplemented with questions measuring sexual violence and emotional abuse, to assess IPV "in the past year." Results: Women who reported current IPV rated several aspects of the encounter more negatively than did women who did. not report current abuse. The IPV victims were less likely to report that they felt respected and accepted during the encounter, and they provided lower ratings of the quality of communication with their providers. Conclusions: It is unclear why victims of partner violence experience medical encounters as less satisfactory. Researchers need to expand studies of medical encounters as experienced by abused women to determine whether IPV status adversely affects general medical care.	Describes client's preferences or acceptability of screening
National Indian Council on Aging (2004). *Elder abuse in Indian Country: A review of the literature.* Washington, DC: National Centre	In 2002, the National Centre on Elder Abuse awarded a grant to the National Indian Council on Aging (NICOA) to explore the nature and extent of elder abuse in Indian country, describe what is currently being done about it, and identify promising approaches and practices for addressing the problem. The project was carried out in two phases. During the first phase, a review of the literature on elder abuse in Indian country was conducted.	Non-systematic review

on Elder Abuse.	This included a review of published research articles as well as reports and monographs that emerged from public policy hearings, summits or meetings. This document presents the findings of the literature review. It further describes the roles of key agencies and organizations in abuse prevention and consolidates the recommendations that appear in the literature.	
No author (2004). Clinical guidelines. Screening for family and intimate partner violence: recommendation statement. *Annals of Internal Medicine, 140(5),* 382.	No abstract	Non-systematic review
No author (2010). Literature review: pediatric care. Intimate partner abuse should be identified in the pediatric setting. *Nurse Practitioner, 35(9).*	No abstract	Non-systematic review
O'Connor-Lewis, A. (2007). *When Push Comes to Shove: Screening Mothers for Intimate Partner Violence During a Pediatric Visit.* Boston College, Boston MA.	The American Academy of Pediatrics (1998) recommended that all pediatric providers incorporate IPV screening as a routine assessment, yet no systematic research has been conducted to examine best practice guidelines or preferred methods by which to screen. While screening women for IPV in adult setting has parallel challenges to screening in pediatric settings, there are unique issues to screening in pediatric settings. For example, the mother is not the patient, there are safety issues around screening in front of children, no screening tools have been tested in paediatrics, issues of mandatory reporting of child abuse and child witness to violence arise, and there are challenges around documentation. In the context of feminist theory, for this study I used a mixed methods approach to compare conditions of screening mothers for IPV (computer, paper and pencil, and face to face screening) in a pediatric health care setting; examine the opinions that have about the use of abuse assessment screen (AAS) and the GET SSAFEER tool; and explore the mothers overall satisfaction with screening.	Describes client's preferences or acceptability of screening
Ogle, R.L., & Baer, J.S. (2003). Addressing the service linkage problem. Increasing substance abuse treatment engagement using personalized feedback interventions in heavy-using female domestic violence shelter residents. *Journal of Interpersonal Violence, 18(11),* 1311-1324.	Two personalized substance abuse assessment and feedback interventions were tested for effectiveness in engaging female domestic violence shelter residents in substance abuse treatment. One hundred forty-seven residents were assessed for quantity and frequency of substance use, negative consequences due to use, motivation to change substance use behaviour, and psychopathological symptoms related to substance abuse. Assessment identified (33) 22% of participants as heavy substance users. Twenty of the 33 heavy-using residents received one of two personalized substance use feedback interventions: face-to-face feedback or written feedback placed in shelter mailboxes. Treatment engagement was defined as attending at least one substance abuse treatment session within 30 days after the intervention. Results showed a significant difference in treatment engagement rates in favour of the face-to-face feedback group (60% vs. 0%). The results provide preliminary data suggesting that substance abuse assessment can be effectively accomplished in the shelter environment and that the face-to-face feedback procedure may be an effective intervention to bridge the service linkage problem between domestic violence services and substance abuse treatment.	Does not evaluate the outcome of a screening intervention
Onifade, R., Von Rege, I., Mumford, S., & Bewley, S. (2010). Achieving continuous improvement in routine questioning about domestic violence with an embedded advocacy service. *Journal of Obstetrics & Gynaecology, 30(6),* 550-552.	Domestic violence (DV) is a common but underreported cause of morbidity in pregnant women. A retrospective review of maternity notes of 103 women who delivered October-November 2007, followed by prospective review of records after feedback intervention of 168 pregnant women who had a nuchal scan in February 2008 was undertaken. The aim was to determine: (1) the proportion of women who were asked abuse questions at any time during pregnancy and postnatally; (2) the prevalence of disclosed domestic violence; (3) the sociodemographic predictors of a pregnant woman being asked about DV; (4) if feedback is associated with improved routine questioning. Routine enquiry about DV in pregnancy significantly increased from 53% in 2007 to 66% in 2008 ($p<0.05$). Current DV was disclosed by 3.6% of women in both surveys. Domestic violence is common in pregnancy. After implementation of training and an embedded DV advocacy service, routine	Describes client's preferences or acceptability of screening

	enquiry demonstrated significant increase over time.	
Oregon Evidence-Based Practice Centre (2012). *Screening women for intimate partner violence and elderly and vulnerable adults for abuse: Systematic review to update the 2004 U.S. preventive services task force recommendation.* Portland, OR: Agency for Healthcare Reserach and Quality.	BACKGROUND: Intimate partner violence (IPV) and abuse of elders and vulnerable persons is common in the United States and often undetected. Screening individuals without obvious signs of abuse in health care settings could identify those at risk and lead to interventions that reduce exposure to violence and abuse and improve health outcomes PURPOSE: To update the previous 2004 evidence report on screening for IPV and abuse of elders and vulnerable persons for the U.S. Preventive Services Task Force (USPSTF). DATA SOURCES: We reviewed the Cochrane Central Register of Controlled Trials and Cochrane Database of Systematic Reviews through the fourth quarter of 2011, and MEDLINE and PsycINFO from 2002 to January 9, 2012, for relevant English-language studies, systematic reviews, and meta-analyses. Reference lists of papers and citations of key studies were reviewed manually and by using Scopus.STUDY SELECTION: The screening population included adults who have no obvious signs or symptoms of abuse who interact with health care providers in a number of health care settings. Studies were selected based on pre-established selection criteria using randomized, controlled trials to determine the effectiveness of screening and interventions to reduce abuse and improve health outcomes; studies of diagnostic accuracy to evaluate the ability of screening instruments to identify abused individuals; and studies of any design to determine harms of screening and interventions. DATA EXTRACTION: For studies of screening and interventions, information about the patient populations, study designs, screening methods, types of interventions, followup, methods of analysis, and results were abstracted. For studies of screening instruments, details about the study designs, instruments, reference standards, populations, methods of administration, and results were abstracted. Predefined criteria developed by the USPSTF were used to rate the quality of studies as good, fair, or poor. DATA SYNTHESIS: For IPV, a randomized, controlled trial comparing IPV screening versus no screening in Canadian health care settings indicated that both groups had reductions in IPV recurrence, post-traumatic stress disorder symptoms, and alcohol problems, as well as improvements in scores for quality of life, depression, and mental health after 18 months of followup; however, differences between groups were not statistically significant for these outcomes. Six instruments with 1 to 8 items demonstrated sensitivity and specificity >80 percent in clinical populations of asymptomatic women; results varied between studies and across instruments. A trial of pregnant women reported decreased violence and improved birth outcomes with counselling versus usual care. Two trials of home visitation versus no visitation for young mothers resulted in improved outcomes with visitation. Counselling resulted in decreased pregnancy coercion and resolution of unsafe relationships versus usual care in one trial. Two trials of counselling showed improved outcomes in intervention and control groups without differences between them (counselling vs. referral cards, nurse management vs. usual care in pregnancy). For abuse of elder and vulnerable adults, few studies met inclusion criteria. A descriptive study of elderly abused veterans who were identified in primary care clinics and referred to case management found that 5 percent were reported to Adult Protective Services and 6 percent required nursing home placement or conservatorship arrangements. A single instrument, the Elder Abuse Suspicion Index, was evaluated for diagnostic accuracy and had sensitivity and specificity of 9 to 47 percent and 75 to 97 percent, respectively, depending on the number of positive responses to specific questions. LIMITATIONS: Studies of IPV were limited by heterogeneity, lack of true control groups, high and/or differential loss to followup, self-reported measures, inadequate power, recall bias, missing data, Hawthorne effect among control participants, and reference standards that were not credible or replicable in diagnostic accuracy studies. Studies of elder and vulnerable adult abuse were lacking. CONCLUSIONS: A trial of screening showed reductions in IPV recurrence and improvement in related outcomes for both screening and comparison groups, but interpretations are limited by high attrition and the Hawthorne effect. Trials of IPV interventions for pregnant women and young mothers showed improved outcomes for the intervention versus usual care groups. Several instruments have been developed for IPV screening; six instruments with 1 to 8 items demonstrated sensitivity and specificity >80 percent in clinical populations of asymptomatic women, although results varied between	Does not evaluate the outcome of an intervention

	studies and across instruments. Studies were lacking to address screening elderly and vulnerable adults for abuse.	
Owen-Smith, A., Hathaway, J., Roche, M., Gioiella, M.E., Whall-Strojwas, D., & Silverman, J. (2008). Screening for domestic violence in an oncology clinic: Barriers and potential solutions. *Oncology Nursing Forum, 35(4).*	Research in the USA on the effectiveness of the implementation of a domestic violence screening protocol by cancer nurses in a gynaecologic oncology clinic. The examination of barriers to domestic violence screening and its documentation is described and the identification of possible solutions is discussed.	Describes the process of implementing a new screening tool (no before measures)
Paluzzi, P., Gaffikin, L., Nanda, J. (2000). The American College of Nurse-Midwives' Domestic Violence Education Project: Evaluation and results. *Journal of Midwifery & Women's Health, 45(5),* 384-391.	From October 1994 through September 1998, the American College of Nurse Midwives conducted a nationwide Domestic Violence Education Project. The project aimed to encourage universal screening for domestic violence among all women being seen for care. A four-pronged set of objectives was used, including policy, basic education, continuing education, and advocacy/activism. A description of the project and the results of the project evaluation, including replicable features, are presented. Process and outcome evaluations were performed using both quantitative and qualitative data. Surveys, interviews, and site visits formed the basis for the evaluation of the policy reform, education programme, and advocacy components. Pretests and posttests of training participants formed the basis of the evaluation of the continuing education component. All project objectives were met. Policy reform occurred as expected. Changes were noted in education programs in both didactic content and clinical exposure. Changes in clinical behaviour as assessed by the pretests and posttests look promising, although numbers of respondents at 12 and 24 months after training are small. Participants reported an increase in advocacy and activism. The Domestic Violence Education Project seems to be a successful and somewhat replicable model for changing attitudes about a health topic (among providers) with possible implications for clinical practice.	Does not evaluate the outcome of an intervention
Perciaccante, V.J., Carey, J.W., Susarla, S.M., & Dodson, T.B. (2010). Markers for intimate partner violence in the emergency department setting. *Journal of Oral & Maxillofacial Surgery, 68(6),* 1219-1224.	PURPOSE: Intimate partner violence (IPV) is a serious, under-reported public health problem in the United States. Pilot studies suggested that injury location, that is, head, neck, or face, was a sensitive but nonspecific marker for IPV-related injuries. This study's goal was to determine whether adding a second element to the diagnostic protocol-response to an IPV-screening questionnaire-improved the specificity of the protocol. MATERIALS AND METHODS: We used a cross-sectional study design and a sample composed of women presenting to the emergency department for evaluation and management of injuries of non-verifiable aetiology. The predictor study variables were injury location (head, neck, or face vs other), responses to a verbal questionnaire (Partner Violence Screen or Woman Abuse Screening Tool), and the combination of both elements. By combining both elements, the probability for IPV-related injury was classified as high or low. The outcome variable was self-report of injury aetiology (IPV or other aetiology). Appropriate univariate and bivariate statistics were computed, including estimates of sensitivity, specificity, positive and negative predictive values, and relative risk. RESULTS: The sample was composed of 300 women with a mean age of 36.5 years. The frequency of self-reported IPV-related injury was 32.3%. The sensitivities and specificities for injury location and the questionnaires combined ranged from 86.5% to 91.8% and 93.1% to 96.1%, respectively. CONCLUSIONS: The study findings suggest that combining information regarding injury location and the results of a screening questionnaire was a better predictor of a woman's likelihood to report IPV-related injuries than either modality alone.	Correlational study design
Peterman, L.M., & Dixon, C.G. (2001). Assessment and evaluation of men who batter women. *Journal of Rehabilitation, 67(4),* 38-42.	Reviews research on characteristics of batterers and encourages ethnically and culturally sensitive approaches to assessment that are to plan effective interventions. Includes considerations regarding assessments for substance abuse, homicide, and more.	Non-systematic review
Phelan, M.B. (2007). Screening for intimate partner violence in medical	Intimate partner violence (IPV) is associated with negative health consequences. Universal screening for IPV offers many opportunities for successful intervention, yet this practice in medical settings is controversial. This	Non-systematic review

settings. *Trauma Violence & Abuse, 8(2),* 199-213.	article examines the potential impact of the U.S. Preventive Services Task Force (USPSTF) recommendations for IPV screening and the emerging literature supporting measurable health benefits resulting from screening interventions in medical settings. Several screening tools and methods of administration that have been evaluated in various clinical settings, with goals to increase their sensitivity and to determine a best method of administration, are reviewed in this article. Mandatory reporting is closely linked to screening practices and may influence healthcare worker practice and patient disclosure. Mandatory reporting studies are lacking and show variable physician compliance, victim acceptance, and scant outcome data. Informed consent prior to screening, explaining the process of mandatory reporting statutes and victim options should be evaluated to increase sensitivity of screening tools.	
Quigley, L. (2000, May 16). Screen Test. *Community Care.*	To make the best use of services for older people facing abuse, people who may be having difficulties but are not being abused need to be filtered out. Leo Quigley advises on how to achieve a fair screening system. Social workers trying to help older people at risk of, or suffering from, abuse walk a difficult line. How do they recognise abuse and judge when to intervene? Definitions that try to encapsulate what we mean by elder (or adult) abuse in one or two sentences have been valuable in drawing policy-makers' attention to this significant social problem but they are often of much less use for workers trying to respond to abuse in the field. Recent efforts have concentrated on the search for a formulation broad enough to encompass all vulnerable adults in all settings. In the short term this has led to some muddled thinking as practitioners and theoreticians struggle to make sense of exactly what we are calling adult abuse. The struggle was neatly illustrated by the recent No Secrets consultation document.¬ Chapter two brought together all the key issues in defining adult abuse, but it failed to synthesize these elements into a coherent whole.	Does not evaluate the outcome of an intervention
Ramsden, C., & Bonner, M. (2002). A realistic view of domestic violence screening in an emergency department. *Accident & Emergency Nursing, 10(1),* 31-39.	Sutherland Hospital is a district hospital serving The Sutherland Shire, a metropolitan area of Sydney. It has a population of approximately 220,000 which is predominantly Anglo-Saxon in ethnic origin. The Emergency Department provides emergency services for 30,000 new patients per annum. New South Wales Department of Health obtained Commonwealth funding from Partnerships Against Domestic Violence to pilot routine screening for domestic violence within 2 Area Health Services. One of the participating sites was the Emergency Department in South East Sydney Area Health Service. The aim was for nursing and medical staff to screen, for three months, all women sixteen years old and over. Information cards on state-wide domestic violence resources and referral flow charts were developed for the pilot. Staff undertook training and issues were addressed prior to the screening. In this article we will discuss the findings, including the rate of screening by the staff, disclosure rate of domestic violence, and action taken on disclosure. We will then proceed to explain the difficulties in undertaking screening within an Emergency Department, and make recommendations for those Emergency Departments interested in commencing screening.	Describes client's preferences or acceptability of screening
Renker, P. R. and P. Tonkin (2007). Postpartum women's evaluations of an audio/video computer-assisted perinatal violence screen. Computers, Informatics, Nursing 25(3), 139-147.	For universal screening to become a reality, research must first validate the effectiveness and acceptability of violence screening. This study describes postpartum women's perceptions of an anonymous computer-assisted self-interview for perinatal violence screening. A sample of 519 postpartum women completed interviews that included audio and video enhancements. Post-response evaluations were positive with most women, indicating that they preferred computer interviews to face-to-face or written abuse screening. In addition, participants indicated that the computer format and associated anonymity positively influenced their willingness to answer the violence questions truthfully. Computer interviews offer an alternative approach to violence screening that may help women who are hesitant to disclose abuse directly to their healthcare providers.	Describes client's preferences or acceptability of screening
Rhodes, K.V., Frankel, R.M., Levinthal, N., Prenoveau, E., Bailey, J & Levinson, W. (2007). Improving patient care: "You're not a victim of domestic violence, are you?"	BACKGROUND: Women who are victims of domestic violence frequently seek care in an emergency department. However, it is challenging to hold sensitive conversations in this environment. OBJECTIVE: To describe communication about domestic violence between emergency providers and female patients. DESIGN: Analysis of audiotapes made during a randomized, controlled trial of computerized screening for domestic violence. SETTING: 2 socioeconomically diverse emergency departments: one urban and academic, the other	Does not evaluate the outcome of an intervention

Provider-patient communication about domestic violence. *Annals of Internal Medicine, 147(9),* 620-627	suburban and community-based. PARTICIPANTS: 1281 English-speaking women age 16 to 69 years and 80 providers (30 attending physicians, 46 residents, and 4 nurse practitioners). RESULTS: 871 audiotapes, including 293 that included provider screening for domestic violence, were analysed. Providers typically asked about domestic violence in a perfunctory manner during the social history. Provider communication behaviours associated with women disclosing abuse included probing (defined as asking > or=1 additional topically related question), providing open-ended opportunities to talk, and being generally responsive to patient clues (any mention of a psychosocial issue). Chart documentation of domestic violence was present in one third of cases. LIMITATIONS: Nonverbal communication was not examined. Providers were aware that they were being audiotaped and may have tried to perform their best. CONCLUSION: Although hectic clinical environments present many obstacles to meaningful discussions about domestic violence, several provider communication behaviours seemed to facilitate patient disclosure of experiences with abuse. Illustrative examples highlight common pitfalls and exemplary practices in screening for abuse and response to disclosures of abuse.	
Rhodes, K.V., Lauderdale, D.S., He, T., Howes, D.S., & Levinson, W. (2002). "Between me and the computer": Increased detection of intimate partner violence using a computer questionnaire. *Annals of Emergency Medicine, 40(5),* 476-484.	STUDY OBJECTIVE: The emergency department is a problem-focused environment in which routine screening for intimate partner violence (IPV) is difficult. We hypothesized that screening for IPV during computer-based health-risk assessment would be acceptable to patients and improve detection. METHODS: We performed a descriptive study of IPV data collected during a controlled trial of computer-based health promotion in an urban hospital ED. Patients received computer-generated health advice, and physicians received patient risk summaries. Outcomes were patient disclosure and physician documentation of IPV and associated risks. RESULTS: Two hundred forty-eight patients (69% female, 90% black, mean age 39 years) participated in a clinical trial of computer-based health promotion in the ED. Of 170 women, 53 (33%) disclosed emotional abuse, and 25 (15%) disclosed physical abuse. Of 78 men, 22 (29%) disclosed emotional abuse, and 5 (6%) disclosed physical abuse. Patients were also willing to self-report a history or concern of hurting someone close to them. This was true for 21 (14%) women and 15 (22%) men. Controlling for demographic factors, disclosures of victimization and perpetration were associated with multiple psychosocial risks. Computer screening resulted in chart documentation in 19 of 83 potential cases of IPV compared with 1 case documented in the group that received usual care. CONCLUSION: Providing an opportunity for patients to confidentially self-disclose IPV has the potential to supplement current screening efforts and to allow providers to focus on assessment, counselling, and referral for those at risk. However, further measures will be needed to ensure that information gathered through computer screening is adequately addressed during the acute care or follow-up visit.	Describes client's preferences or acceptability of screening
Rickert, V.I., Vaughan, R.D., Wiemann, C.M. (2002). Adolescent dating violence and date rape. *Current Opinion in Obstetrics & Gynecology, 14(5),* 495-500.	In this review we intend to examine recent literature on dating violence among female adolescents, including prevalence, risk factors, sequelae, screening practices, and potential interventions. RECENT FINDINGS: Dating violence is perpetrated by both males and females and occurs frequently within heterosexual dating relationships. Attitudes toward physical aggression, including those of peers, and abuse by siblings predict later violence as victim and perpetrator. Victims of childhood or dating violence may be at greater risk of developing eating disorders. New strategies and measures to promote screening are available. SUMMARY: Dating violence occurs among all groups of adolescents with common and unique risk factors for dating violence found across adolescents grouped by race/ethnicity, sex, and prior victimization. Efforts to decrease dating violence should (1) increase the use of screening tools that measure victimization as well as attitudes and contextual parameters that promote dating violence; (2) increase self-efficacy to negotiate safer sex; (3) reduce the use/abuse of alcohol and other drugs that facilitate dating violence; and (4) eliminate the influence of negative peer behaviour. Interventions to prevent dating violence will likely also reduce rates of unintended pregnancies, HIV, and sexually transmitted diseases among adolescents.	Non-systematic review
Rinard-Renker, P., & Tonkin, P.	For universal screening to become a reality, research must first validate the effectiveness and acceptability of	Describes client's

(2007). Postpartum women's evaluations of an audio/video computer-assisted perinatal violence screen. *CIN: Computers, Informatics, Nursing United States, 25(3).*	violence screening. This study describes postpartum women's perceptions of an anonymous computer-assisted self-interview for perinatal violence screening. A sample of 519 postpartum women completed interviews that included audio and video enhancements. Post-response evaluations were positive with most women, indicating that they preferred computer interviews to face-to-face or written abuse screening. In addition, participants indicated that the computer format and associated anonymity positively influenced their willingness to answer the violence questions truthfully. Computer interviews offer an alternative approach to violence screening that may help women who are hesitant to disclose abuse directly to their healthcare providers.	preferences or acceptability of screening
Robinson, L. & Spilsbury K. (2008). Systematic review of the perceptions and experiences of accessing health services by adult victims of domestic violence. *Health & Social Care in the Community, 16(1).*	This systematic review synthesizes evidence on the perceptions and experiences of adult victims of domestic violence when accessing healthcare services. The review was concerned with disclosure of domestic violence by adult victims when accessing health services, the responses of healthcare professionals to these victims, victims' perceived barriers to support, and the appropriateness of support and referrals. These aims required the review to focus on studies using in-depth qualitative methods to explore victims' perceptions and experiences. A comprehensive systematic search of 12 databases was carried out in June/July 2005. Application of the review protocol and inclusion criteria resulted in 10 studies (conducted in the UK, USA and Australia) being considered eligible for the review. Data were extracted from these studies and a quality assessment completed. Thematic analysis was carried out to enable the identification of recurrent themes within the included studies. Findings indicate that victims of domestic violence experience difficulties when accessing healthcare services. Victims perceive that these difficulties can be attributed to inappropriate responses by healthcare professionals, discomfort with the healthcare environment, perceived barriers to disclosing domestic violence, and a lack of confidence in the outcomes of disclosure to a health professional. The methodological quality of included studies was variable, but no papers were rejected based on quality issues. These results can contribute to and inform a comprehensive assessment of the experiences of adult victims of domestic violence when accessing healthcare services. The health service is in a unique position to contribute towards the assessment and identification of domestic violence and to provide access to appropriate support. The messages of this study are important for policy-makers and practitioners.	Non-systematic review
Robinson, S.P. (2001). Domestic violence screening rate leaves much to be desired. *Postgrad Medicine, 109(3)*, 16.	No abstract	Does not evaluate the outcome of an intervention
Salmon, D., Murphy, S., Baird, K., Price, S. (2006). An evaluation of the effectiveness of an educational programme promoting the introduction of routine antenatal enquiry for domestic violence. *Midwifery, 22(1).*	Research in the South West of England into the effectiveness of a programme to encourage community midwives to question patients about domestic violence. Changes in midwives' implementation of the policy and levels of knowledge after the Bristol Pregnancy and Domestic Violence Programme were evaluated.	Does not evaluate the outcome of an intervention
Sandmoe, A. (2007). How well can standardized instruments help nurses to identify abuse of older people? A literature review. *Nordic Journal of Nursing Research & Clinical Studies, 27(2).*	Abuse presents a serious threat to older peoples' health and quality of life. International studies estimate the rate to be 3-5% of the population over the age of 65 years as victims of abuse. Nurses in home and community care are well placed to identify older people suffering from abuse. The article focuses on the Indicators of Abuse Screen [IOA] and the Vulnerability to Abuse Screening Scale [VASS] and how appropriate these instruments are in practice. The IOA and the VASS have strengths and weaknesses in their ability to help nurses to detect abuse. The literature reviewed suggested that standardized instruments lack the capability to detect all the facets of the situation in which abuse occurs; therefore, their applicability in practice is problematic. On the other hand, awareness of indicators or signs related to the care recipient or the caregiver could help nurses to detect the occurrence of abuse amongst older people in home and community care,	Non-systematic review

	concomitant with nurses' professional knowledge and judgement.	
Saunders, K.M. (2008). *Development of the best practice guideline for elder abuse screening by health care providers.* University of South Carolina, Charlston SC.	No abstract	Non-systematic review
Scribano, P.V., Stevens, J., Marshall, J., Gleason, E., & Kelleher, K.J. (2011). Feasibility of computerized screening for intimate partner violence in a pediatric emergency department. *Pediatric Emergency Care, 27(8),* 710-716.	OBJECTIVES: This study aimed to evaluate the feasibility of caregiver-initiated computerized screening in a pediatric emergency department (ED) to identify home safety risks, with a specific emphasis on intimate partner violence (IPV). METHODS: Home safety screening kiosks were developed using information technology as the first step in a plan to decrease family violence. Caregivers self-initiated a standard-of-care screening process that included both non-IPV and IPV items. An ED social worker received an automated text page and printed summary of the findings when a caregiver endorsed IPV. System activity was tracked by comparing frequency of completed screens to the daily ED census and by determining the percentage of completed screens that were positive for IPV. The reliability of the technology was evaluated as percentage of days of system downtime. Meetings with ED personnel and direct observations of families were conducted to identify potential barriers and successes to the technology utilization. RESULTS: During a 15-month period, 13,057 computerized screens occurred, with a 4-fold increase in the computerized screening rate after ED triage nurses became champions of these efforts. Fourteen percent of the computerized screens were positive for IPV. The reliability of the technology was considered quite high, with rare system downtime (4.2% of days) reported during the 15 months. There were several themes identified by caregivers and providers regarding barriers to successful use of the safety screening. CONCLUSIONS: A reliable, caregiver-initiated system is possible to offer consistent opportunity to conduct unobtrusive, private screening for IPV and other home safety concerns.	Describes client's preferences or acceptability of screening
Sethi, D. (2002). Experience of 'screening' for domestic violence in women's services. Journal of Public Health Medicine 23(4), 349-350	This short paper presents the results of a prospective three month survey of women's experience of domestic violence presenting to hospital and community based women's services in North London.	Does not evaluate the outcome of an intervention
Shadigian, E.M. & Bauer, S.T. (2004). Screening for partner violence during pregnancy. *International Journal of Gynaecology & Obstetrics, 84(3)*, 273-280.	Objectives: An analysis of the international literature on partner violence provides insights for health care providers caring for women. Methods: The current literature on partner violence epidemiology, screening, and interventions was reviewed, focusing on pregnancy. Results: Adolescent girls and pregnant women are at highest risk for partner violence and homicide. Conclusion: Health care providers need to offer clinical screening and interventions to prevent consequences of partner violence, including homicide.	Non-systematic review
Sharps, P.W., Cambell, J., Baty, M.L, Walker, K.S., & Bair-Merritt, M.H. (2008). Current evidence on perinatal home visiting and intimate partner violence. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 37(4),* 480-490.	OBJECTIVE: To describe current evidence on home visiting interventions for pregnant or postpartum women with specific intimate partner violence assessment and content. DATA SOURCES: Online bibliographic databases including PubMed, CINAHL Plus, and Web of Science and a hand search of bibliographies of relevant articles. STUDY SELECTION: Original research and intervention studies were included that contained (a) a well-described prenatal and/or postpartum home visitation; (b) an assessment of perinatal intimate partner violence; and (c) quantitative data describing health outcomes for the women and their infants. DATA EXTRACTION: The search yielded 128 articles, and 8 relevant articles met all of the inclusion criteria. Nonresearch, nonintervention, and international articles were excluded. DATA SYNTHESIS: No perinatal home visiting interventions were designed to address intimate partner violence. Programs that screened for intimate partner violence found high rates, and the presence of intimate partner violence limited the ability of the intervention to improve maternal and child outcomes. CONCLUSIONS: Perinatal home visitation programs likely improve pregnancy and infant outcomes. Home visiting interventions addressing intimate partner violence in nonperinatal population groups have been effective in minimizing intimate partner violence and improving	Non-systematic review

	outcomes. This suggests that perinatal home visiting programs adding specific intimate partner violence interventions may reduce intimate partner violence and improve maternal and infant health. Continued rigorous research is needed.	
Shaw, D. (2003). Screening for domestic violence. *Journal of Obstetrics & Gynaecology Canada, 25(11)*, 918-921.	No abstract	Non-systematic review
Smith, A., & Winokur, K.P. (2004). What doctors and policymakers should know: Battered women's views about mandatory medical reporting laws. *Journal of Criminal Justice, 32(3),* 207-221.	Medical professionals in forty-five states and the District of Colombia are under a legal obligation to report a variety of injuries to the police, including those believed to be the result of domestic violence. Responses to these laws by doctors and battered women have been mixed. Using logistic regression analysis, this study explored battered women's views about mandatory medical reporting laws controlling for and examining a variety of demographic, situational, and legal factors. Three of the four dependent attitudinal measures (perceptions of general support for mandatory reporting as well as perceived benefits of the law for themselves and others) demonstrated little variation across all factors. The fourth measure - willingness to seek medical care in communities with a mandatory law - however, produced a number of significant relationships among the demographic, situational and legal factors. The results and policy implications of these findings are discussed.	Describes client's preferences or acceptability of screening
Snarr, J.D., Heyman, R.E., Slep, A.M., & Malik, J.(2011). Preventive impacts of reliable family maltreatment criteria. *Journal of Consulting & Clinical Psychology, 79(6),* 826-833.	OBJECTIVE: The U.S. Air Force recently implemented system-wide changes that both (a) clarified the criteria used to determine when family maltreatment has occurred and (b) made the process by which these decisions are made more consistent. The current study examined the effects of these changes on family maltreatment recidivism. METHOD: Official records were obtained from the Air Force Family Advocacy Programme. All cases decided during the last year of the old system and the first year of the new system at each base (total N=14,298) were examined. For each incident, it was determined (a) whether the incident met criteria and (b) whether the same offender committed family maltreatment again within 1 year of the initial incident. RESULTS: Overall substantiation rates were significantly lower (p=0.003) under the new system (47%) than the old (56%). After the change, significant interaction effects were obtained for both alleged (b=-.51, p=0.004) and substantiated (b=-.55, p=0.015) reoffense, in that 1-year reoffense rates decreased significantly among initially substantiated cases but remained unchanged among initially unsubstantiated cases. Indeed, rates of substantiated reoffense by substantiated offenders were cut in half (from 14% to 7%). CONCLUSIONS: Reductions in overall substantiation rates were most likely due to the use of more stringent criteria. The results of the recidivism analyses suggest that clear criteria and consistent decision processes can have secondary preventive effects on family maltreatment in their own right, possibly due to increases in informal community sanctions.	Intervention setting outside of health and social services (Military)
Sobel, R. (2001). Identifying and helping victims of spousal abuse. *Professional Medical Assistant, 34(6).*	No abstract	Does not evaluate the outcome of an intervention
Spangaro, J., Zwi, A.B., Poulos, R.G., & Man, W.Y. (2010). Six months after routine screening for intimate partner violence: Attitude change, useful and adverse effects. *Women & Health, 50(2),* 125.	This evaluative study measured self-reported changes in abuse-related measures six months after routine screening for intimate partner violence. Participants were 122 women who disclosed abuse and 241 who did not report abuse, screened in antenatal, substance abuse, and mental health services according to an existing standardized protocol used in New South Wales, Australia. Six months after initial screening, abused women were more likely to report increased agreement with a number of attitudes relating to abuse, in particular that being hurt by a partner affects a woman's health and that health services should ask about abuse. The proportion reporting current abuse was significantly lower after six months. While 6% (7/119) reported negative emotional reactions, 34% (41/120) reported useful effects most frequently re-evaluating their situation and reducing isolation. Women who had experienced abuse, but elected not to disclose it reported similar effects.	Describes client's preferences or acceptability of screening

	The results of this study lend support to the use of protocols for asking about abuse and responding to disclosures of abuse.	
Standing Together Against Domestic Violence (2004). *Health and domestic violence: Improving safety through screening.* London, UK: Standing Together Against Domestic Violence.	This report is a review of the Standing Together Crime Reduction Programme Health Project focusing on achievements and the complex issues encountered from July 2003 to March 2004. The Standing Together Trust was set up in July 2001 to manage, carry forward and develop the pioneering work of the Standing Together partnership. The objectives of the Standing Together Charitable Trust are to promote for the public benefit the provision of services directed towards the prevention of domestic violence and to meet the needs of survivors of domestic violence and their families.	Does not evaluate the outcome of an intervention
Stenson, K., Saarinen, H., Heimer, G., & Sidenvall, B.. (2001). Women's attitudes to being asked about exposure to violence. *Midwifery, 17(1),* 2-10.	OBJECTIVE: to examine women's attitudes to being questioned by their midwife, during and after pregnancy, about exposure to violence. DESIGN: an explorative study using content analysis of one open-ended question. SETTING: all antenatal clinics in Uppsala, a medium-sized Swedish university town. PARTICIPANTS: all women registered for antenatal care before 32 weeks of pregnancy, during a period of 6 months. MEASUREMENTS: all women were assessed regarding abuse, using the Abuse Assessment Screen (McFarlane 1993) twice during pregnancy and once again more than four weeks after the birth. On the last occasion the women were asked to respond to an open-ended written question worded: 'Please describe how you felt about being questioned by your midwife at the antenatal clinic concerning violence' Those women who reported violence and those who did not were compared regarding their attitude to being asked about violence. FINDINGS: 879 women were presented with the open-ended question. Eighty per cent found the questioning acceptable, 12% neither acceptable nor unacceptable, 5% both acceptable and unacceptable, and only 3% found it unacceptable. There was no difference between those who reported abuse and those who did not, as to whether the questioning was unacceptable. CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: the findings suggest that most pregnant women are not averse to being asked, by their midwife, about exposure to violence. As part of the identification of risk factors that is carried out in every pregnancy, the midwife should ask about exposure to violence at the antenatal clinic. To feel confident when raising the subject of abuse, midwives must be taught about the nature of intimate-partner violence, and appropriate referral and intervention strategies.	Describes client's preferences or acceptability of screening
Swahnberg, I.M.K., & Wijma, B. (2003). The NorVold Abuse Questionnaire (NorAQ), Validation of new measures of emotional, physical, and sexual abuse, and abuse in the health care system among women. *European Journal of Public Health, 13(4),* 361-366.	BACKGROUND: In the literature about abuse, large variations in prevalence rates exist. Validated research instruments are scarce and are needed urgently. Our aim was to validate the 13 questions concerning the experiences of abuse among women in the NorVold Abuse Questionnaire against an interview and two validated questionnaires. METHOD: Data collection was in two parts. i) The NorVold Abuse Questionnaire was sent to a random sample of 2000 women in Ostergötland. ii) A subsample of 64 women was interviewed, and filled in the Conflict Tactic Scale, the Sexual Abuse Questionnaire, and the NorVold Abuse Questionnaire for a second time. The interview had open questions about abuse and was considered our gold standard. RESULTS: The response rate was 61%. The abuse variables in The NorVold Abuse Questionnaire showed good test-retest reliability (84-95%). Specificity was 98% for all kinds of abuse except physical (85%). Sensitivity ranged from 75% (emotional) to 96% (physical). The likelihood ratio ranged from 38 to 43 for all kinds of abuse except physical (likelihood ratio 6). NorAQ performed better against the interview than against the Sexual Abuse Questionnaire and equally against the Conflict Tactic Scale. High lifetime prevalence rates of abuse were found: emotional 21.4%; physical 36.4%; sexual 16.9%; abuse in the health care 15.6%. Prevalence rates of abuse dropped considerably when a criterion of current suffering was added. CONCLUSIONS: The abuse variables in NorAQ have good reliability and validity.	Outcome of study not DV
Taft, A., Hegarty, K., Ramsay, J., Feder, G. (2008). Screening women for intimate partner violence in health care settings. *Cochrane Database of Systematic Reviews.*	This is the protocol for a review and there is no abstract. The objectives are as follows: To assess the effectiveness of screening interventions for intimate partner violence conducted within health care settings on identification, referral and health outcomes for women.	Protocol for systematic review (review not published).

Thackeray, J., Stelzner, S., Downs, S.M., & Miller, C. (2007). Screening for intimate partner violence: the impact of screener and screening environment on victim comfort. *Journal of Interpersonal Violence, 22(6),* 659-670.	The barriers that professionals face when screening victims for intimate partner violence (IPV) are well studied. The specific barriers that victims face however when being screened are not. The authors sought to identify characteristics of the screener and screening environment that make a victim feel more or less comfortable when disclosing a history of IPV. One hundred forty self-reported female victims of IPV completed a survey regarding their experiences with screening and degree of comfort with certain traits of the screener and the screening environment. Women demonstrated a preference to be screened by a woman, someone of the same race, a provider aged 30 to 50 years, and without anyone else present. Screeners should be aware of characteristics that impact victim comfort and should provide multiple opportunities for women to disclose IPV in a safe, respectful, and culturally effective environment.	Describes client's preferences or acceptability of screening
Thoelecke, H., Ortiz, S., Ramirez, S. (2008). 424: Improving Emergency Department Screening for Intimate Partner Violence: Effectiveness of a Brief Physician Training Programme. *Annals of Emergency Medicine, 52(4),* S171-S171.	Study Objectives: Identification of intimate partner violence (IPV) in the emergency setting is widely accepted as an important but somewhat elusive goal for emergency physicians. Victims of IPV frequently identify negative physician attitudes as a barrier to disclosure of abuse, with physicians being perceived as hurried and judgmental in their approach to IPV. This study seeks to determine emergency department (ED) patients' perceptions of their physician's attitudes toward IPV and whether physician training makes a difference in those perceptions. Methods: A survey was given to all patients who were admitted or discharged from a community teaching hospital ED during a series of randomly selected time periods. The survey requested information on demographics, IPV victimization (using the HITS screening tool), IPV screening during the ED visit, and views on the doctor's attitude toward IPV. Patients' level of agreement with a series of statements such as, "My doctor provided a supportive environment to discuss possible problems in my relationship(s)," was used as a marker of patients' perception of physician attitudes toward IPV. Midway through the study period, all ED physicians were subjected to a 1-hour training session designed to emphasize the importance of IPV screening and to sensitize physicians to the needs of IPV victims presenting to the ED. Patients' perceptions and the rates of IPV screening were compared before and after the training session. Results: Surveys were obtained from 90 patients pre-training and from 23 patients post-training, with data collection ongoing for the post-training group. Preliminary data analysis shows that the two groups are similar in rates of IPV, race, and education, but that the proportion of women surveyed was slightly higher in the post-training sample (not statistically significant). Most patients in both groups were either neutral or had somewhat positive views regarding their physician's approach to IPV, and there was no difference between the two groups in this regard. By contrast, physician training did positively impact rates of IPV screening. Before physician training, 11% (95% confidence interval 4.6%-17.6%) of patients remembered being asked about IPV, compared to 22% (95% confidence interval 4.8-38.6%) posttraining. Completion of data collection in the post-training group will determine whether or not this trend is statistically significant. Conclusion: A brief physician training programme does not impact patients' perceptions of their physician's attitude toward IPV, but it may increase rates of IPV screening in the emergency department.	Describes client's preferences or acceptability of screening
Thurston, W.E., Tutty, L.M., Eisener, A.E., Lalonde, L., Belenky, C., & Osborne, B. (2007). Domestic violence screening rates in a community health centre urgent care clinic. *Research in Nursing & Health, 30(6),* 611-619.	We describe the screening rates obtained in the first year of implementation of a universal domestic violence screening protocol by nurses in the urgent care clinic of a Canadian community health centre. Rates were calculated using data extracted from electronic patient health records, and a random patient chart pull. Qualitative methods provided additional information. Screening rates were considerably higher and were maintained longer than those recorded in similar settings reported in the literature. Leadership, including monitoring of documentation rates, was key to maintaining higher than average rates. Asking all patients in urgent care settings about domestic violence may improve overall screening rates and play an important role in public education.	Does not evaluate the outcome of an intervention
Todahl, J., & Walters, E. (2011). Universal screening for intimate partner violence: a systematic review. *Journal of Marital & Family*	Intimate partner violence (IPV) is known to be prevalent among therapy-seeking populations. Yet, despite a growing understanding of the dynamics of IPV and of the acceptability of screening, universal screening practices have not been systematically adopted in family therapy settings. A rapidly growing body of research data—almost entirely conducted in medical settings—has investigated attitudes and practices regarding	Non-systematic review

Therapy, 37(3), 355-369.	universal screening for IPV. This article is a systematic review of the IPV universal screening research literature. The review summarizes literature related to IPV screening rates and practices, factors associated with provider screening practice, the role of training and institutional support on screening practice, impact of screening on disclosure rates, client beliefs and preferences for screening, and key safety considerations and screening competencies. Implications for family therapy and recommendations for further inquiry and screening model development are provided.	
Waalen, J., Goodwin, M.M., Spitz, A.M., Petersen, R., & Saltzman, L.E. (2000). Screening for intimate partner violence by health care providers. Barriers and interventions. *American Journal of Preventive Medicine, 19(4)*, 230-237.	Routine screening for intimate partner violence (IPV) is endorsed by numerous health professional organizations. Screening rates in health care settings, however, remain low. In this article, we present a review of studies focusing on provider-specific barriers to screening for IPV and interventions designed to increase IPV screening in clinical settings. METHODS: A review of published studies containing original research with a primary focus on screening for IPV by health professionals was completed. RESULTS: Twelve studies identifying barriers to IPV screening as perceived by health care providers yielded similar lists; top provider-related barriers included lack of provider education regarding IPV, lack of time, and lack of effective interventions. Patient-related factors (e.g., patient nondisclosure, fear of offending the patient) were also frequently mentioned. Twelve additional studies evaluating interventions designed to increase IPV screening by providers revealed that interventions limited to education of providers had no significant effect on screening or identification rates. However, most interventions that incorporated strategies in addition to education (e.g., providing specific screening questions) were associated with significant increases in identification rates. CONCLUSION: Barriers to screening for IPV are documented to be similar among health care providers across diverse specialties and settings. Interventions designed to overcome these barriers and increase IPV-screening rates in health care settings are likely to be more effective if they include strategies in addition to provider education.	Non-systematic review
Waltermaurer, E. (2005). Measuring intimate partner violence (IPV), you may only get what you ask for. *Journal of Interpersonal Violence, 20(4),* 501-506.	With the goal of understanding the true extent of intimate partner violence (IPV), researchers have put tremendous effort over the past 20 years developing, revising, and assessing IPV screening instruments. The enhancements made in IPV instrumentation reflect our improved understanding of the nature of IPV. Unfortunately, as is often the case with progress, we are presently at the stage where IPV researchers have an arsenal of multiple IPV screens that are, in some cases, slightly different, whereas in others, the differences are sizeable. This article explores the evolution and variation of a sample of IPV screens. To further progress in IPV research, we must make conscious decisions concerning the best tool for our individual research. Simultaneously, we must enhance our understanding of how these IPV screening instruments overlap so that comparisons of IPV prevalence or incidence across time and population are possible.	Non-systematic review
Walton-Moss, J., & Campbell, J. (2002). Intimate partner violence: implications for nursing. *Online Journal of Issues in Nursing, 7(1).*	Intimate partner violence is responsible for 30% of female homicides in the U. S. and has multiple negative health consequences. It is identified as one of the objectives in Healthy People 2010. Women are more likely to be assaulted by a current or former intimate partner than an acquaintance, family member, friend, or stranger. Universal screening is advocated as an effective approach in identifying affected women. There exists a few states mandating report of women with injuries resulting from IPV but it is only clearly mandated in California. Interventions to address the problem include those focused on increasing identification and screening, and treatment of intimate partner violence. This paper reviews the epidemiology, identification and screening, and interventions for IPV. The role for nursing is discussed concluding with directions for further investigation.	Non-systematic review
Ward, S., & Spence, A. (2002) Training midwives to screen for domestic violence. *Midwifery Digest, S1:*S15-17.	No abstract	Does not evaluate the outcome of an intervention
Wathen, C.N., & MacMillan, H.L. (2008). Self-report, medical staff interview, and physician interview	QUESTION; What is the relative effectiveness of self-report, medical staff interview, and physician interview for screening for domestic violence (DV) in women?; METHODS; Design: randomised controlled trial.; Allocation: {concealed}.*; Blinding: {unblinded}.*; Follow-up period: end of healthcare visit.; Setting: 4 family practices {in	Based on same data as Chen (2007)

had similar effectiveness for screening for domestic violence in women. *Evidence Based Nursing 11(2),* 45-45	the US}.*; Patients: 523 women >/=18 years of age (mean age 36 y, 71% black) who were currently living with a partner. Intervention: self-report (n=173), medical staff {included nurses and medical assistants}* interview (n=169), or physician interview (n=181) for administering 2 questionnaires to screen for DV: Woman Abuse Screening Tool (WAST)-Short and Hurt-Insult-Threaten-Scream (HITS). WAST-Short had 2 questions ("In general, how would you describe your relationship? A lot, some, or no tension" and "Do you and your partner work out arguments with: great, some, or no difficulty?"); criteria for DV were met if women answered "a lot of tension or great difficulty." HITS had 4 questions: "How often does your partner physically hurt you?" "How often does your partner insult you?" "How often does your partner threaten you with harm?" and "How often does your partner scream or curse at you?"; patients could answer "never," "rarely," "sometimes," "fairly often," or "frequently." A score range of 4-20 could be computed for all possible answers, and a cut-off of 10.5 indicated exposure to DV. Patients with positive screening results received an intervention by physicians. Comfort level with screening was assessed in a post-screening questionnaire (scores of 1=not at all comfortable to 4=very comfortable).; Outcomes: included DV disclosure and patient comfort with screening. The study had >80% power to detect disclosure rates of 6%, 16%, and 9% for self-report, staff interview, and physician interview, respectively, and a 0.3 difference in comfort scores.; Patient follow-up: 100%.; MAIN RESULTS; Self-report, staff interview, and physician interview did not differ for rates of DV disclosure (table) or comfort with screening method (mean score 3.4 v 3.5 v 3.4, respectively; p=0.66).; CONCLUSION; Self-report, medical staff interview, and physician interview resulted in similar rates of domestic violence disclosure in women.	
Weaver, T. L., Allen, J., Bazile, A., Bullet, E., Herndon, J., Jackson, K., Nowell Pelletier, T., Pye, P., Surrell, J., Thekkedam, S., & wa Kimani, M. (2006). Pediatric-psychology partnership for abuse prevention. *Journal of Clinical Psychology in Medical Settings, 13(1),* 13-19.	Intimate partner violence (IPV) is a significant, albeit underreported and under-identified, public health problem that requires the informed and coordinated efforts of the health care system for appropriate recognition and intervention. In addition, health disparities are seen in the incidence, prevalence, and burden of IPV among specific population groups in the United States. Pediatric-Psychology Partnership for Abuse Prevention is a graduate psychology education training project focused on developing an integrated primary health-care based workforce that is culturally sensitive and competent in the identification and remediation of IPV. In addition, this project aimed to increase the number of health service psychologists from diverse backgrounds who are culturally competent and aware of health disparities. The training included clinical psychology trainees and pediatric residents working together in an ambulatory pediatric health care setting. Project methods, outcomes, and implications for pre-doctoral clinical psychology training programs are described.	Evaluates practitioner knowledge after training
Webster, J., Stratigos, S.M., & Grimes, K.M. (2001). Women's responses to screening for domestic violence in a health-care setting. *Midwifery 17(4).*	Interest in the health impact of domestic violence is increasing and routine screening for violence in health settings has been recommended. However, there are limited data about how women feel about such screening. The aim of the study was to investigate women's responses to being screened for domestic violence during a routine clinic visit. The method was a cross-sectional cohort study. Women (1,500) from five Queensland hospitals were asked to complete a self-report questionnaire during the visit following the consultation at which they had been screened for domestic violence. Sealable envelopes and a 'posting box' were provided to ensure anonymity of returned envelopes. Of the 1,313 respondents, 98% believed it was a 'good idea' to screen for domestic violence. Over 96% felt 'OK' during the process and 77% of the 30 women who felt uncomfortable still agreed that it was a good idea to screen. Women from rural and remote areas of Queensland had similar responses to those of their city counterparts. Women in Queensland found screening for domestic violence acceptable and, where health providers are suitably educated, it should be included when taking a routine health history.	Describes client's preferences or acceptability of screening
Weiss, S.J., Ernst, A.A., Cham, E., & Nick, T.G. (2003). Development of a screen for ongoing intimate partner violence. *Violence & Victims, 18(2),* 131-141.	A five-question Ongoing Abuse Screen (OAS) was developed to evaluate ongoing intimate partner violence. Our hypothesis was that the OAS was more accurate and more likely to reflect ongoing intimate partner violence than the AAS when compared to the Index of Spouse Abuse (ISA). The survey included the ISA, the OAS, and the AAS. During the busiest emergency department hours, a sampling of 856 patients completed all aspects of the survey tool. Comparisons were made between the two scales and the ISA. The accuracy,	Correlational study design

	positive predictive value, and positive likelihood ratio were 84%, 58%, and 6.0 for the OAS and 59%, 33%, and 2.0 for the AAS. The OAS was more accurate, had a better positive predictive value, and was three times more likely to detect victims of ongoing intimate partner violence than the AAS. Because the OAS was still not accurate enough, we developed a new screen, based on the ISA, titled the Ongoing Violence Assessment Tool (OVAT).	
Whitehead, K., & Bateman, W. (2004). Health visitors' domestic violence routine questioning tool: An exploration of women's experience, effectiveness and ACC. *International Journal of Health Promotion and Education, 42(1),* 14-22.	Research has demonstrated that heath visitors (HV) are in a unique position to routinely ask women about interpersona abuse (IPA) and violence wihin their relationships. Interpersonal violence (IPV) describes physical, sexual, emotional, psychological and financial abuse by a partner or ex-partner, a common healthcare issue. The present paper describes a qualitative study of women who consented to be questioned by health visitors in the City of Salford in relation to IPV. The aim of the study was to explore the experiences of domestic violence (DV) and the acceptability of a questioning tool, with women registered to HV services over a period of four months. A convenience sample was utilised conducting in-depth semi-structured interviews with 56 women. Thirty four per cent disclose IPA/IPV, with 16 per cent of incidents in the previous 12 months. HVs were surprised at women's comfort and acceptance of IPA questions. Thematic analysis identified concerns regarding the effects on children and the usage of not only obstetric/gynaecological and general practitioner clinics but also pre-hospital emergency healthcare provision. Therefore, this small pilot study recommends routine IPA questioning by HVs, within a safe environment.	Describes client's preferences or acceptability of screening
Wilde, J., & Doherty, W. (2011). Intimate Partner Violence Between Unmarried Parents Before and During Participation in a Couple and Relationship Education Programme. *Journal of Couple & Relationship Therapy, 10(2).*	No abstract	Does not evaluate the outcome of an intervention
Williams, G.B., Dou, M., & Leal, C.C. (2003). Violence against pregnant women. These two screening tools may prove valuable in identifying women at risk. *AWHONN Lifelines, 7(4),* 348-354.	No abstract	Non-systematic review
Williams, K.R. (2012). Family violence risk assessment: A predictive cross-validation study of the Domestic Violence Screening Instrument-Revised (DVSI-R). *Law and Human Behaviour, 36(2)*, 120-129.	This research was a cross-validation study of the Domestic Violence Screening Instrument-Revised (DVSI-R), using a diverse, statewide sample of 3,569 family violence perpetrators in Connecticut, assessed in February and March of 2007. It analysed re-arrest data collected during an 18-month period post assessment. Three issues were central, which have been ignored in previous research on family violence risk assessment: (1) analyzing five refined measures of behavioural recidivism, (2) determining whether perpetrator characteristics and types of family and household relationships (beyond just heterosexual intimate partners) moderate the empirical relations between the DVSI-R and the behavioural recidivism measures, and (3) determining whether structured clinical judgement about the imminent risk of future violence to the victim or to others corresponds with recidivism predicted by the DVSI-R total numeric risk scores. The empirical findings showed that the DVSI-R had significant predictive accuracy across all five measures of recidivism. With one exception, these relations did not vary by gender, age, or ethnicity; and again with one exception, no significant evidence was found that types of family or household relationships moderated those empirical relations. In short, the evidence suggested that the DVSI-R was a robust risk assessment instrument, having applicability across different types of perpetrators and different types of family and household relationships. Finally, the empirical findings showed that structured clinical judgement about imminent risk-to-victim and risk-to-others corresponded with the prediction of recidivism by the DVSI-R total numeric risk scores, but the effects of those	Screening of physical, sexual, and emotional abuse from all sources. Domestic or partner based violence not reported separately.

	scores were significantly stronger than the perceived risk-to-victim or the perceived risk-to-others.	
Wyszynski, M.E. (2000). Screening women for family violence in the maternal child healthcare setting. *Clinical Excellence for Nurse Practitioners, 4(2),*76-82	In the United States, a woman is battered in her home every 9 seconds, and up to 4,000 women are beaten to death every year, making family violence one of the most common crimes in the United States today. Family violence has been identified as a national health concern; however, long-standing societal belief, myths regarding family violence, and the lack of training for healthcare professionals have created barriers to identifying and caring for these women. There is no single profile of the victim or perpetrator of family violence. All women should be asked about family violence in a safe, nonthreatening manner at all healthcare visits, including when bringing children for pediatric visits. Family violence begins slowly and increases with time. Goals for caring for the battered woman include decreasing her isolation, increasing her safety, accurate documentation, and appropriate referrals.	Does not evaluate the outcome of an intervention
Zebrack, J.R., & Brown, K.W. (2008). Preventive Health for Women: Screening and Immunizations. *Medical Clinics of North America, 92(5),* 1011-1035.	Women's preventive health issues are frequently encountered in the outpatient setting. Many general internists feel uncomfortable meeting the needs of women due to a general lack of knowledge of women's health and inadequate training in the evaluation of female-specific care. In this article, the authors summarize evidence-based guidelines for preventive health and immunizations for women.	Non-systematic review
Zink, T., Levin, L., Putnam, F., & Beckstrom, A. (2007). Accuracy of five domestic violence screening questions with nongraphic language. *Clinical Pediatrics, 46(2),* 127-134.	To assess the accuracy of 5 domestic violence screening questions designed with less graphic language that they may be appropriate when children are present, mothers (n=400) were recruited from primary care waiting rooms. Sensitivities, specificities, and predictive values were calculated using the revised Conflict Tactic Scale. "How do you and your partner work out arguments?" was the best individual question (area under the receiver operating characteristics curve 0.82, sensitivity 25%, specificity 97.7%). The 3-question combination with the domains of argument, safety, and manner of treating you and the children had the best results (area under the receiver operating characteristics curve 0.86, sensitivity 45.5%, and specificity 94.6%). The high specificity suggests a less graphic and potentially more acceptable group of questions for introductory discussions about domestic violence.	Does not compare more than one screening test
Zink, T., Levin, L., Wollan, P., & Putnam, F. (2006). Mothers' comfort with screening questions about sensitive issues, including domestic violence. *Journal of the American Board of Family Medicine, 19(4),* 358-367.	PURPOSE: To assess patient ratings of comfort alone and in front of children with 5 domestic violence (DV) screening questions designed with less graphic language compared with questions about other sensitive issues. METHODS: A sample of mothers (n=200), including a small sample of Spanish-speaking women, were recruited from community locations. Mothers rated their perceptions of comfort for answering 13 sensitive issue screening questions (including sexual risk, substance abuse, depression, and DV questions). Logistic regression was performed to analyse participants' characteristics with respect to summary comfort scores. In addition, 40 mothers were asked to talk about their comfort in answering the DV questions. These interviews were audiotaped and analysed. RESULTS: Mothers preferred to answer all questions alone. Comfort with answering the DV screening questions in front of their children was higher than comfort with sexual risk or depression questions and was similar to comfort with substance abuse questions. Latina mothers had more discomfort with the DV questions than other ethnicities. CONCLUSIONS: Although mothers were more comfortable with answering sensitive questions alone than in the presence of children, this may not be feasible in busy offices. General DV questions may be appropriate to ask in front of children as an initial screen.	Describes client's preferences or acceptability of screening
Zink, T.M., & Jacobson, J. (2003). Screening for intimate partner violence when children are present: The victim's perspective. *Journal of Interpersonal Violence, 18(8),* 872-890.	Although intimate partner violence (IPV) is routinely encountered in health care, it often goes undetected. Medical organizations recommend routine screening of women alone without children of partner. Separating a mother from her children may not be feasible in busy practices. Therefore, screening may not occur. Little research has examined women's desires about IPV screening in front of their children. This study interviewed 32 mothers/survivors who were in either an IPV shelter or support group regarding their wishes about IPV screening and discussions in front of their children. Interviews were audio taped, transcribed, and analysed using thematic analysis techniques. Major themes included mothers' comfort with the use of general IPV screening questions in front of children ages 3 to 12 years. In summary, most mothers/survivors were comfortable with physicians using general questions to screen for IPV but preferred in-depth discussions about	Describes client's preferences or acceptability of screening

	the abuse and resource sharing in private.	

Table 12. Research Question 3 (Victim Interventions) Studies Excluded on Full Text

Study Details	Abstract	Reason for Exclusion
Abassi, K. (2011). *The IRIS case study: implementing a successful primary care domestic violence service: early experiences.* London, UK: The Health Foundation.	No abstract	One case study
Abel, E. (2000). Psychosocial treatments for battered women: a review of empirical research. *Research on Social Work Practice, 10(1).*	Despite the high incidence of domestic violence, information about the effectiveness of practice with battered women is scant. The purpose of this article is to critically review the research on practice effectiveness with abused women. Toward this end, the author examines the outcomes of practice research with battered women in terms of its conceptual adequacy, methodology, and findings. Implications for social work research and practice are drawn.	Systematic review, with all included studies prior to 2000
Against Violence and Abuse. (2006). *Sanctuary Projects Report.* London, UK: Against Violence and Abuse.	No abstract	Does not evaluate the outcome of an intervention
Andrews, C.M., Dingcai, C. Marsh, J.C., & Hee-Choon, S. (2011). The Impact of Comprehensive Services in Substance Abuse Treatment for Women With a History of Intimate Partner Violence. *Violence Against Women, 17(5)*, 550-567.	This study examines the impact of comprehensive services on post treatment substance use among women with a history of intimate partner violence. The sample includes 1,123 women from 50 treatment facilities derived from the National Treatment Improvement Evaluation Study (NTIES). Generalized linear mixed modeling was used to determine whether a history of intimate partner violence moderates the association between service receipt and posttreatment substance use. Significant interactions were found between history of intimate partner violence and concrete (p=0.016) and family services (p=0.023) in predicting substance use.	Correlational study design
Arinero, M., & Crespo, M. (2004). A treatment-outcome study of cognitive-behavioural therapy for battered women: Preliminary findings. *Psicologia Conductual, 12(2),* 233-249.	This paper describes a treatment-outcome study of a cognitive-behavioural therapy programme, lasting eight sessions and using a group format, for battered women with posttraumatic symptoms although not satisfying diagnostic criteria for posttraumatic stress disorder. The therapeutic programme included psychoeducation, breath control training, self-esteem improvement procedures, cognitive therapy, problem solving, pleasant activities planning and communication skills training, as well as specific strategies for relapse prevention. The sample consisted of 17 women (12 in the experimental treatment group and 5 in a waiting control group). Results showed an important decrease in posttraumatic and depressive symptoms, and an improvement in adaptation levels. Gains were maintained at 1, 3 and 6 month follow-up. Issues and clinical implications are discussed.	Study published in Spanish
Baker, C.K., Niolon, P.H., & Oliphant, H. (2009). A descriptive analysis of transitional housing programs for survivors of intimate partner violence in the United States. *Violence Against Women, 15(4),* 460-481.	The Violence Against Women Act (VAWA) of 2005 focuses on safe and independent housing for survivors of intimate partner violence (IPV). The focus on housing in the latest version of VAWA suggests recognition by Congress that removing barriers and increasing access to safe housing is critical to our nation's response to IPV, and that this type of systems-level response is necessary to reduce the link between IPV and subsequent homelessness. This study examines the current state of transitional housing programs (THPs) and discusses future programme considerations, including the need for evaluation studies that consider the possible impact that transitional housing programs have on the rates of violence toward women and their children, and on women's ability to achieve economic stability after separating from their abusive partners.	Does not evaluate the outcome of an intervention
Barner, J., & Carney, M. (2011). Interventions for Intimate Partner	Intimate partner violence (IPV), also known as domestic abuse or relationship violence, has generated a large research literature for the last half-century, particularly in the areas of criminal justice, psychology, and the	Non-systematic review

Violence: A Historical Review. *Journal of Family Violence, 26(3)*, 235-244.	social sciences. Interventions for victims and perpetrators of IPV have largely been sequestered to separately evolving efforts of law enforcement and the psychotherapeutic community (Chang et al. Women's Health Issues, 15(1), 21-30, ; Dalton Journal of Aggression, Maltreatment & Trauma, 15(1), 59-75, ; Dobash and Dobash ; Feder et al. ; Gerbert et al. Journal of Family Practice, 49(10), 889-895, ; Wathen and MacMillan. Journal of the American Medical Association, 289(5), 589-600,). This article presents a brief overview of the historical evolution and development of these discrete perspectives and identifies and assesses current collaborative interventions rooted in these historical precedents. In conclusion, the authors provide a summative discussion of the most current findings of research into IPV interventions, with a particular focus on the changing roles of race and gender in both the criminal prosecution of IPV and services provided to IPV perpetrators and victims.	
Bloom, T., Wagman, J., Hernandez, R., Yragui, N., Hernandez-Valvovinos, N., Dahlstrom, M., & Glass, N. (2009). Partnering with community-based organizations to reduce intimate partner violence. *Hispanic Journal of Behavioural Sciences, 31(2)*, 244-257.	Latinas experiencing intimate partner violence (IPV) often avoid formal resources due to fear, distrust, and cultural and language barriers, yet little research addresses culturally appropriate interventions for abused Latinas. To develop effective interventions, we must include abused Latinas' voices in research and collaborate with the community-based organizations (CBOs) that serve them. This article's team of academics and CBOs used a community-based participatory research (CBPR) approach to inform development of a culturally and linguistically appropriate IPV intervention for Latinas. The authors were able to reach abused Latinas (n=114) with a relatively low mean acculturation level in a state that is only 8% Latino. The authors share six recommendations from their successful experience to engage, enhance, and sustain research partnerships with CBOs, including strategies to share power and knowledge, and demonstrate accountability to the partnership and the community.	Intervention setting outside of health and social services (Workplace)
Borrego, J., Gutow, M. R., Reicher, S., & Barker, C.H. (2008). Parent-child interaction therapy with domestic violence populations. *Journal of Family Violence, 23(6),* 495-505.	Domestic violence continues to be a significant social problem impacting our society. Battered women and their children experience a myriad of negative consequences as a result of domestic violence. Of the possible negative sequelae that mothers and children experience, the disrupted parent-child relationship has received relatively little attention in the literature. Though psychosocial interventions are available to treat women who experience violence and children who witness violence, few interventions focus on the parent-child relationship. This article describes parent-child interaction therapy (PCIT), a relationship-based intervention. Although not initially developed to treat domestic violence, PCIT has unique characteristics that make it a promising intervention with this population. A rationale for the use of PCIT with battered women and their children is presented.	Does not evaluate the outcome of an intervention
Bybee, D.I., & Sullivan, C M. (2002). The process through which an advocacy intervention resulted in positive change for battered women over time. American *Journal of Community Psychology, 30(1),* 103-132.	A prior experimental evaluation of a community-based advocacy programme for women with abusive partners demonstrated positive change in the lives of women even 2 years postintervention (C M. Sullivan & D. I. Bybee, 1999). The current study explored the complex mediational process through which this change occurred, using longitudinal structural equation modeling and formal tests of mediation. As hypothesized, the advocacy intervention first resulted in women successfully obtaining desired community resources and increasing their social support, which enhanced their overall quality of life. This improvement in well-being appeared to serve as a protective factor from subsequent abuse, as women who received the intervention were significantly less likely to be abused at 2-year follow-up compared with women in the control condition. Increased quality of life completely mediated the impact of the advocacy intervention on later reabuse. Discussion places advocacy for women in the context of other efforts that are needed to build an effective community response to preventing intimate violence against women.	Does not evaluate the outcome of an intervention
Chronister, K.A., Linville, D., & Kaag, K.P. (2008). Domestic violence survivors' access of career counselling services - A qualitative investigation. *Journal of Career Development, 34,* 339-361.	The present study was a qualitative investigation of the impact of domestic violence on women's career development and the contextual barriers and supports that affect women's ability to access career counselling services. Our sample included 11 women who completed various stages of a community-based career counselling intervention programme. The primary aim of this sampling strategy was to provide career development scholars and counsellors with information about the contextual barriers and supports that influence women's decisions to access and complete career counselling services. Data indicated that	Does not evaluate the outcome of an intervention

	emotional consequences of abuse, fear of new situations, others' judgments, and practical constraints served as barriers to accessing and completing the career programme. Elements of the career group context and the career programme structure served as supports to accessing career services. Recommendations for research and practice are provided.	
Chronister, K.M., & McWhirter, E.H. (2006). An experimental examination of two career interventions for battered women. *Journal of Counselling Psychology, 53(2),* 151-164.	The authors tested the effectiveness of 2 group career interventions for 73 battered women who were randomly assigned to 1 of 2 treatment conditions or a wait-list control group. Both interventions included the 5 most effective career intervention components identified by S. D. Brown and N. E. Krane (2000), and 1 of the interventions also was designed to enhance critical consciousness (i.e., empowerment for self-protection and awareness of domestic violence impact; P. Freire, 1970; I. Martin-Baro, 1994). Relative to controls, standard participants had higher career-search self-efficacy, and standard-plus participants had higher critical consciousness at posttest. At follow-up, standard-plus participants had higher critical consciousness scores and made more progress toward goal achievement than standard participants.	Does not have outcomes relevant to research question
Cluss, P.A., Chang, J.C., Hawker, L., Hudson Scholle, S., Dado, D., Buranosky, R., & Goldstrohm, S. (2006). The process of change for victims of intimate partner violence. Support for a Psychosocial Readiness Model. *Women's Health Issues, 16(5),* 262-274.	Intimate partner violence (IPV) victimization is a women's health problem that imposes a significant health and health care cost burden. Although IPV victims cannot change the perpetrator's behaviour, they can take actions to reduce exposure to the partner's abuse. The process of change for IPV victims has been described using the transtheoretical model (TTM), among others. We report results of a qualitative study with current and past IPV victims to 1) explicate the process of safety-seeking behaviour change for female victims of IPV and 2) explore the fit of the TTM for explaining this process. Based on the results, we propose the psychosocial readiness model to describe the process of change for female victims of IPV. This model considers readiness as a continuum that ranges from robustly defending the status quo on 1 end to being ready to take action toward change on the other. Movement toward and away from change along the continuum results from a dynamic interplay of both internal factors and external interpersonal and situational factors. 2006 Jacobs Institute of Women's Health.	Does not evaluate the outcome of an intervention
Cole, S.A., & Hernandez, P.A. (2008). Crisis nursery outcomes for caregivers served at multiple sites in Illinois. *Children and Youth Services Review, 30,* 452-465.	The results of the first study of individual outcomes for caregivers accessing crisis nursery services at multiple sites in Illinois are reported in this paper. Using administrative data collected by the five crisis nurseries in Illinois, outcomes for individual caregivers accessing crisis nursery services were studied. Results showed that caregivers generally reported improved outcomes in stress reduction, risk of abuse, and enhanced parenting skills after receiving crisis nursery services. Ordinal regression analysis of caregiver stress change showed that those who were Caucasian and single, had higher incomes, had children aged four years of age or older, and sought crisis nursery services because of home, mental health, or family violence crises were more likely to report the greatest stress reductions. Service implications and future research are discussed.	Does not have outcomes relevant to research question
Constantino, R., Crane, P. A., Noll, B.S., Doswell, W.M., & Braxter, B. (2007). Exploring the feasibility of email-mediated interaction in survivors of abuse. *Journal of Psychiatric & Mental Health Nursing, 14(3),* 291-301.	There is a growing use of email-based provision of information, development of health-related skills and interventions; however, use of email to assist women and children experiencing abuse after receiving Protection from Abuse (PFA) court order has not been explored. The specific aim of this research was to test the feasibility of an email device called MIVO for use in interacting with women and children after receiving PFA. This qualitative design used a three-step recruitment, screening and email interaction with mothers and their adolescent child after obtaining informed consent and training in the use of an email device. Sample included six pairs of mother and child (n=12) who have received a PFA within the past 6 months. Demographic data were gathered using the sociodemographic questionnaire. Qualitative data were gathered using email messages from mother and child pairs. Results showed that email interaction is a feasible and acceptable way of providing support and information to survivors of abuse after their PFA. The following themes in their order and rank of appearance were found in the email interaction between the nurse and survivors: (1) safety issues; (2) job-related issues; (3) school-related issues; (4) parenting-related issues; and (5) health-related issues. Themes identified for the children were school work and friends. Privacy, confidentiality and respect for individual rights are paramount in email interactions. Email interaction is useful in education, screening, safety instructions and follow-up care. Technological devices such as MIVO may have usefulness as an email	Does not evaluate the outcome of an intervention

	interaction device among women, their child and a nurse to reduce their risk for further interpersonal violence/abuse and to increase disclosure of abuse. Healthcare providers need to identify technological developments, and through evidence-based research examine their feasibility and adaptability for translation into practice specifically, in caring for survivors of abuse.	
Davidson, M.M., Nitzel, C., Duke, A., Baker, C.M., & Bovaird, J.A. (2012). Advancing career counselling and employment support for survivors: An intervention evaluation. *Journal of Counselling Psychology, 59(2),* 321-328.	The purpose of this research was to conduct a replication-based and extension study examining the effectiveness of a 5-week career group counselling intervention, Advancing Career Counselling and Employment Support for Survivors (ACCESS; Chronister, 2008). The present study was conducted in a markedly different geographic region within a larger community as compared with the original investigation conducted by Chronister and McWhirter (2006). Women survivors of intimate partner violence (N=73) participated in ACCESS, with career-search self-efficacy, perceived career barriers, perceived career supports, anxiety, and depression assessed at preintervention, postintervention, and 8-week follow-up. Women survivors demonstrated significant improvements in career-search self-efficacy and perceived career barriers at postintervention. Moreover, these same improvements were maintained at the 8-week follow-up assessment with the addition of significant improvements in perceived future financial supports, anxiety, and depression compared with preintervention scores. This work replicates the initial findings regarding the effectiveness of ACCESS with respect to career-search self-efficacy (Chronister & McWhirter, 2006) as well as extends the initial research to include improvements in perceived career barriers and perceived career supports. Moreover, the present study extends the work to include the mental health outcomes of anxiety and depression; results demonstrated improvements in these areas at 8-week follow-up. This investigation begins to fill a critical need for evaluated career-focused interventions for the underserved population of women survivors of intimate partner violence.	Correlational study design
Department of Health (2009). *Safeguarding adults: report on the consultation on the review of 'No Secrets.'* London, UK: Department of Health	No abstract	Does not evaluate the outcome of an intervention
DePrince, A.P., Labus, J., Belknap, J., Buckingham, S., & Gover, A. (2012). The impact of community-based outreach on psychological distress and victim safety in women exposed to intimate partner abuse. *Journal of Consulting and Clinical Psychology, 80(2)*, 211-221.	Objective: Using a longitudinal, randomized controlled trial, this study assessed the impact of a community-based outreach versus a more traditional criminal justice system-based referral programme on women's distress and safety following police-reported intimate partner abuse (IPA). Method: Women (N=236 women) with police-reported IPA were randomly assigned to 1 of 2 interdisciplinary community-coordinated response programme conditions: Outreach (community-based victim advocate outreach) or Referral (criminal justice system-based victim advocate referrals to community-based agencies). Participants were interviewed 3 times over a 1-year period: within 26 (median) days of police-reported IPA, 6 months later, and 12 months later. Primary outcome measures included posttraumatic stress disorder and depression symptom severity (Posttraumatic Stress Diagnostic Scale; Beck Depression Inventory–II), fear appraisals (Trauma Appraisal Questionnaire), IPA revictimization (Revised Conflict Tactics Scale), and readiness to leave the relationship with the abuser. Results: One year after the initial interview, women in the Outreach condition reported decreased PTSD and depression symptom severity and fear compared with women in the Referral condition. Although both conditions were unrelated to revictimization in the follow-up year, women in the Outreach condition reported greater readiness to leave the abuser and rated services as more helpful than women in the Referral condition. Conclusions: This is one of the first studies to examine community-based outreach in the context of an interdisciplinary community coordinated response to police-reported IPA. The findings suggest that community-based outreach by victim advocates results in decreased distress levels, greater readiness to leave abusive relationships, and greater perceived helpfulness of services relative to system-based referrals.	Intervention setting outside of health and social services (Justice system)
Dienemann, J., Campbell, J., Wiederhorn, N., Laughon, K., &	OBJECTIVE: The authors developed an interdisciplinary critical pathway for intimate partner violence (IPV) assessment and intervention for use across health care settings. Intimate partner violence may be emotional,	Does not evaluate the outcome of an

Jordan, E. (2003). A critical pathway for intimate partner violence across the continuum of care. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 32(5),* 594-603.	physical, and/or sexual and involves coercion and control by one partner over the other. DESIGN: A pathway developed with input from focus groups of battered women was subjected to a modified Delphi technique to improve the pathway's scientific accuracy and feasibility. SETTING: The study was conducted in one urban, one suburban, and one rural hospital with IPV advocacy programs in the mid-Atlantic region of the United States. PATIENTS/PARTICIPANTS: Four researchers and 13 clinicians participated in the validation, with at least one physician, one nurse, and one social worker or IPV counsellor from each hospital. MAIN OUTCOME MEASURES: Each element of the pathway was analysed for the degree of consensus on scientific accuracy and feasibility. RESULTS: Consensus on the scientific accuracy and feasibility of the pathway was achieved after three rounds of the Delphi process. CONCLUSIONS: This is the first known critical pathway for IPV. It addresses physical and mental health and safety and has content validity affirmed by an interdisciplinary panel of experts. Further process and outcome evaluation is warranted and invited.	intervention
Dienemann, J., Glass, N., Hanson, G., & Lunsford, K. (2007). The Domestic Violence Survivor Assessment (DVSA): a tool for individual counselling with women experiencing intimate partner violence. *Issues in Mental Health Nursing, 28(8)*, 913-925.	The Domestic Violence Survivor Assessment (DVSA) was developed to measure survivor movement toward a violence free life over time. This paper reports our testing of the validity and reliability of the DVSA. Exploratory factor analysis (n=162) found a single factor explaining 66% of the variance. Hierarchical multiple regression indicated that physical abuse severity, survivor and perpetrator substance abuse, economic and citizenship dependency, and children under 18 at home explained 10% of the variance p>0.05. A second model examined the strength of interventions for survivors, controlling for influencing factors; R(2) was.24 (p<0.001). The strongest interventions were individual counselling (p<0.001) and resource referrals and other services (p<0.05). The DVSA was found to have construct validity, sensitivity to change over time, and reliability. A county agency that adopted the DVSA evaluated its programs using the DVSA change scores and used this evaluation for programme improvement.	Does not evaluate the outcome of an intervention
Dorfman, E. (2004). Ayelet Programme: Mentoring Women Leaving the Cycle of Violence. *Journal of Religion & Abuse, 6(3),* 101-108.	In 1998, the Haifa Battered Women's Hotline started Ayelet, a unique project, which provides long-term mentoring to women who are starting a new life outside the cycle of violence. From the studies of the shelters between 30% to as much as 60% of the women who leave their violent partners return to them within the first six months. The Ayelet project has had a 100% success rate. Al the women who have participated in the project have succeeded to rehabilitate their lives and live outside the cycle of violence. Furthermore, Ayelet works to stop the generational cycle of violence. By helping the mothers leave the cycle of violence and create a new non-violent family model, their children will hopefully free from the devastating effects of witnessing parental violence. [ABSTRACT FROM AUTHOR]; Copyright of Journal of Religion & Abuse is the property of Taylor & Francis Ltd and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use. This abstract may be abridged. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material for the full abstract.	Does not evaluate the outcome of an intervention
Doughty, J. (2009). The role of telecare in the protection of individuals from domestic violence. *Journal of Assistive Technologies, 3(4),* 44-48	Following a summary of the nature and scale of domestic violence, types of abuse and costs to society, the impact of domestic violence, housing based responses and the organisations with responsibilities for dealing with domestic violence, this article examines telecare applications and their potential to provide support and remote forms of monitoring for victims of domestic violence. It looks at forms of telecare available, including home units with silent dialling to open up two way telephone voice channel with a monitoring centre, video technologies such as camera doorbells, video recording, image collection, and remote video admission, and tracking and location devices, and includes figures showing the use made of technology including telecare by local authorities for managing domestic abuse. It concludes that local authorities should work more closely with the police and with other relevant agencies to produce more innovative approaches to support for victims of domestic violence, including significantly more use of telecare. Athens Full Text:: Athens users with appropriate permissions can access the full text via Emerald Insight: Search Journal of Assistive Technologies for "The role of telecare in the protection of individuals from domestic violence.	Does not evaluate the outcome of an intervention
El-Mohandes, A., Kiely, M., Gantz,	OBJECTIVE: To evaluate the efficacy of an integrated multiple risk intervention, delivered mainly during	Does not have

M. G., & El-Khorazaty, M. (2011). Very Preterm Birth is Reduced in Women Receiving an Integrated Behavioural Intervention: A Randomized Controlled Trial. *Maternal and Child Health Journal, 15,* 19-28.	pregnancy, in reducing such risks (cigarette smoking, environmental tobacco smoke exposure, depression, and intimate partner violence) postpartum. METHODS: Data from this randomized controlled trial were collected prenatally and on average 10 weeks postpartum in six prenatal care sites in the District of Columbia. African Americans were screened, recruited, and randomly assigned to the behavioural intervention or usual care. Clinic-based, individually tailored counselling was delivered to intervention women. The outcome measures were number of risks reported postpartum and reduction of these risks between baseline and postpartum. RESULTS: The intervention was effective in significantly reducing the number of risks reported in the postpartum period. In bivariate analyses, the intervention group was more successful in resolving all risks (47% compared with 35%, P=0.007, number needed to treat=9, 95% confidence interval [CI] 5-31) and in resolving some risks (63% compared with 54%, P=0.009, number needed to treat=11, 95% CI 7-43) as compared with the usual care group. In logistic regression analyses, women in the intervention group were more likely to resolve all risks (odds ratio 1.86, 95% CI 1.25-2.75, number needed to treat=7, 95% CI 4-19) and resolve at least one risk (odds ratio 1.60, 95% CI 1.15-2.22, number needed to treat=9, 95% CI 6-29). CONCLUSION: An integrated multiple risk factor intervention addressing psychosocial and behavioural risks delivered mainly during pregnancy can have beneficial effects in risk reduction postpartum.	outcomes relevant to research question
El-Mohandes, A., Kiely, M., Joseph, J.G., Subramanian, S., Johnson, A.A., Blake, S.M., Gantz, M.G., & El-Khorazaty, M. (2008). An intervention to improve postpartum outcomes in African-American mothers - A randomized controlled trial. *Obstetrics and Gynecology, 112(3)*, 611-620.	This study examines whether an integrated behavioural intervention with proven efficacy in reducing psycho-behavioural risks (smoking, environmental tobacco smoke exposure (ETSE), depression, and intimate partner violence (IPV)) in African-Americans is associated with improved pregnancy outcomes. A randomized controlled trial targeting risks during pregnancy was conducted in the District of Columbia. African-American women were recruited if reporting at least one of the risks mentioned above. Randomization to intervention or usual care was site and risk specific. Sociodemographic, health risk and pregnancy outcome data were collected. Data on 819 women, and their singleton live born infants were analysed using an intent-to-treat approach. Bivariate analyses preceded a reduced logistical model approach to elucidate the effect of the intervention on the reduction of prematurity and low birth weight. The incidence of low birthweight (LBW) was 12% and very low birthweight (VLBW) was 1.6%. Multivariate logistic regression results showed that depression was associated with LBW (OR=1.71, 95% CI:1.12-2.62). IPV was associated with preterm birth (PTB) and very preterm birth (VPTB) (OR 1.64, 95% CI:1.07-2.51, OR=2.94, 95% CI:1.40-6.16, respectively). The occurrence of VPTB was significantly reduced in the intervention compared to the usual care group (OR=0.42, 95% CI:0.19-0.93). Our study confirms the significant associations between multiple psycho-behavioural risks and poor pregnancy outcomes, including LBW and PTB. Our behavioural intervention with demonstrated efficacy in addressing multiple risk factors simultaneously reduced VPTB within an urban minority population.	Does not have outcomes relevant to research question
Flanakin, N., Walsh, C. (2005). When advocacy for domestic violence victims backfires. *Violence Against Women, 11(6)*, 822-827.	No abstract	Letter to the editor
Focht-New, G., Barol, B., Clements, P.T., & Milliken, T.F. (2008). Persons with developmental disability exposed to interpersonal violence and crime: approaches for intervention. *Perspectives in Psychiatric Care, 44(2),* 89-98.	PURPOSE: Psychoeducational and psychotherapeutic interventions, by psychiatric advanced practice registered nurses and caregivers working with people with developmental disabilities exposed to interpersonal violence and crime, are recommended to help the individual resolve the intrapsychic trauma. CONCLUSIONS: Persons with developmental disabilities experience the full affective range of the effects of trauma and may benefit from a variety of interventions. What may be different in comparison to other survivors are the ways psychotherapeutic and psychoeducational interventions are adapted so that emotions, resultant actions, and ongoing concerns can be effectively expressed and addressed. PRACTICE IMPLICATIONS: Advanced practice registered nurses have an important role in addressing the sequelae of trauma by employing flexible, creative, and direct therapy with individuals. Additionally significant is provision of educational and supportive measures for the caregivers, who have the potential to generate an ongoing socially therapeutic environment.	One case study

Ford-Gilboe, M., Merritt-Gray, M., Varcoe, C., & Wuest, J. (2011). A theory-based primary health care intervention for women who have left abusive partners. *Advances in Nursing Science, 34(3),* 198-214.	Although intimate partner violence is a significant global health problem, few tested interventions have been designed to improve women's health and quality of life, particularly beyond the crisis of leaving. The Intervention for Health Enhancement After Leaving is a comprehensive, trauma informed, primary health care intervention, which builds on the grounded theory Strengthening Capacity to Limit Intrusion and other research findings. Delivered by a nurse and a domestic violence advocate working collaboratively with women through 6 components (safeguarding, managing basics, managing symptoms, cautious connecting, renewing self, and regenerating family), this promising intervention is in the early phases of testing.	Does not evaluate the outcome of an intervention
Ford-Gilboe, M., Wuest, J., Varcoe, C., & Merritt-Gray, M. (2006). Translating research. Developing an evidence-based health advocacy intervention for women who have left an abusive partner. *Canadian Journal of Nursing Research, 38(1),* 147-167.	Although intimate partner violence is a significant global health problem, few tested interventions have been designed to improve women's health and quality of life, particularly beyond the crisis of leaving. The Intervention for Health Enhancement After Leaving is a comprehensive, trauma informed, primary health care intervention, which builds on the grounded theory Strengthening Capacity to Limit Intrusion and other research findings. Delivered by a nurse and a domestic violence advocate working collaboratively with women through 6 components (safeguarding, managing basics, managing symptoms, cautious connecting, renewing self, and regenerating family), this promising intervention is in the early phases of testing.	Non-systematic review
Gehart, D.R., & Morales, D.L. (2000). Reclaiming one's voice: A narrative intervention for women who have been battered. *Journal of Family Psychotherapy, 11(3),* 69-73.	Abuse in intimate relationships results in significant physical and psychological trauma for the women who are subjected to the experience. However, many women find that one of the most traumatic aspects of the abuse is that they eventually lose touch with themselves: they lose their voice.	One case study
Gillum, T.L. (2008). The benefits of a culturally specific intimate partner violence intervention for African American survivors. *Violence Against Women, 14(8),* 917-943.	In light of evidence and theorization of culturally specific factors contributing to intimate partner violence (IPV) within African American relationships and the Eurocentric approach many mainstream agencies take to service delivery, researchers have indicated a need for culturally appropriate IPV interventions for African American survivors to adequately address the issue of IPV within this community. The purpose of the current study was to qualitatively investigate how helpful a culturally specific IPV programme, which targets the African American community, has been to African American female survivors. Results suggest that this culturally specific agency is successfully meeting the needs of these survivors.	Does not evaluate the outcome of an intervention
Gillum, T.L. (2009). Improving services to African American survivors of IPV: from the voices of recipients of culturally specific services. *Violence Against Women, 15(1)*, 57-80.	Researchers have found that many services designed to assist survivors of intimate partner violence (IPV) take a mainstream, color-blind approach to their interventions. Several authors have indicated a need for culturally specific IPV interventions to adequately address the issue of IPV within the African American community. This exploratory study was designed to ascertain, from African American survivors, what their experiences were with mainstream IPV interventions and how their experience with a culturally specific domestic violence agency was different from those experiences. Overall, women described mostly problematic experiences with mainstream services and positive experiences with the culturally specific agency.	Does not evaluate the outcome of an intervention
Gillum, T.L., Sun, C.J., & Woods, A.B. (2009). Can a health clinic-based intervention increase safety in abused women? Results from a pilot study. *Journal of Women's Health, 18(8),* 1259-1264.	BACKGROUND: Intimate partner violence (IPV) has been related to a number of adverse physical and mental health consequences. Research has identified relatively high IPV victimization rates among women seeking care in primary healthcare and emergency department settings. Studies have shown the potential usefulness of screening and intervention in these settings. METHODS: This article reports results from a pilot study designed to assess the effect of a clinic-based intervention on women's engagement in safety-promoting behaviours. This study was conducted in a primary healthcare clinic for the uninsured in Baltimore, Maryland. Women who screened positive for recent IPV were randomly assigned to an intervention or control group. The intervention consisted of an on-site counselling session and six telephone counselling sessions over a 3-month period. Women in the control group received health information brochures, a list of community resources, and a monthly telephone call to confirm contact information. RESULTS: A total of 41 women participated in the study. Results demonstrated that women who received the clinic-based intervention engaged in significantly more safety-promoting behaviours than did women in the control group. CONCLUSIONS: The results of this	Correlational study design

	study and others indicate the potential usefulness of screening and intervention in a medical setting.	
Gregory, A., Ramsay, J., Agnew Davies, R., Baird, K., Devine, A., Dunne, D., Eldridge, S., Howell, A., Johnson, M., Rutterford, C., Sharp, D., & Feder, G. (2010). Primary care identification and referral to improve safety of women experiencing domestic violence (IRIS): protocol for a pragmatic cluster randomised controlled trial. *BMC Public Health, 10(54).*	BACKGROUND: Domestic violence, which may be psychological, physical, sexual, financial or emotional, is a major public health problem due to the long-term health consequences for women who have experienced it and for their children who witness it. In populations of women attending general practice, the prevalence of physical or sexual abuse in the past year from a partner or ex-partner ranges from 6 to 23%, and lifetime prevalence from 21 to 55%. Domestic violence is particularly important in general practice because women have many contacts with primary care clinicians and because women experiencing abuse identify doctors and nurses as professionals from whom they would like to get support. Yet health professionals rarely ask about domestic violence and have little or no training in how to respond to disclosure of abuse. METHODS/DESIGN: This protocol describes IRIS, a pragmatic cluster randomised controlled trial with the general practice as unit of randomisation. Our trial tests the effectiveness and cost-effectiveness of a training and support programme targeted at general practice teams. The primary outcome is referral of women to specialist domestic violence agencies. Forty-eight practices in two UK cities (Bristol and London) are randomly allocated, using minimisation, into intervention and control groups. The intervention, based on an adult learning model in an educational outreach framework, has been designed to address barriers to asking women about domestic violence and to encourage appropriate responses to disclosure and referral to specialist domestic violence agencies. Multidisciplinary training sessions are held with clinicians and administrative staff in each of the intervention practices, with periodic feedback of identification and referral data to practice teams. Intervention practices have a prompt to ask about abuse integrated in the electronic medical record system. Other components of the intervention include an IRIS champion in each practice and a direct referral pathway to a named domestic violence advocate. DISCUSSION: This is the first European randomised controlled trial of an intervention to improve the health care response to domestic violence. The findings will have the potential to inform training and service provision.	Does not evaluate the outcome of an intervention
Grodner, E., & Sweifach, J. (2004). Domestic violence in the Orthodox Jewish home: a value-sensitive approach to recovery. *Affilia: Journal of Women & Social Work, 19(3)*, 305-316.	Domestic violence, a once-hidden problem in the Orthodox Jewish community, is now acknowledged to occur in Orthodox Jewish families. Because this problem was not affirmed earlier, effective therapeutic techniques for working with battered Orthodox women have only recently begun to emerge. This article highlights one therapeutic technique-the value-sensitive approach-which uses ethnoculturalreligious factors as part of the therapeutic process and has generated positive results in working with battered Orthodox women.	One case study
Ham-Rowbottom, K.A., Gordon, E.E., Jarvis, K.L., & Novaco, R.W. (2005). Life constraints and psychological well-being of domestic violence shelter graduates. *Journal of Family Violence, 20(2),* 109-121.	Psychosocial adjustment and life constraints of 81 domestic violence shelter graduates were examined via field interviews in the community, assessing womens current life status, satisfaction with core life domains, and violence experience, pre- and post-shelter. Psychometric scales for depression and trauma symptoms were also administered. Participants had received extensive services in either an emergency or a transitional living shelter. Although fairly satisfied across life domains, many had serious post-shelter financial hardships. Most importantly, they reported remarkably little post-shelter violence exposure, either within or outside of romantic relationships. Despite now living independently, 43% and 75% reported clinical levels of depression and trauma symptoms, respectively. In hierarchical stepwise regressions, depression was related to womens childhood sexual abuse, dissatisfaction with housing and their own parenting, and experience of financial difficulties conjoined with public assistance. Trauma symptoms were associated with childhood sexual abuse and post-shelter financial difficulties. The impaired psychosocial functioning and life difficulties of these predominantly successful domestic violence survivors highlights the need for specialized shelter intervention and continuity of care in the community.	Does not evaluate the outcome of an intervention
Hathaway, J.E., Zimmer, B., Willis, G., & Silverman, J.G. (2008). Perceived changes in health and safety following participation in a	This descriptive study explores perceived changes in health and safety and the potential process by which these changes occur. Forty-nine women experiencing intimate partner abuse participated in a health care-based domestic violence (DV) advocacy programme for 6 months or more. An analysis of structured interviews in English and Spanish found that the majority of participants perceived positive changes in their personal	Does not have outcomes relevant to research question

health care-based domestic violence programme. *Journal of Midwifery & Women's Health, 53(6),* 547-555.	safety and emotional health because of their involvement in the programme. Some participants also perceived improvements in their physical health, unhealthy coping behaviours (e.g., overeating and smoking), and health care following programme involvement. Participants' responses suggest a process of change whereby DV advocacy services first contribute to improved safety and emotional health, which then facilitates behavioural changes. Behavioural changes may subsequently contribute to improvements in physical health, which may also benefit emotional health. Longitudinal evaluations are needed to evaluate the impact of DV advocacy and other interventions for partner abuse on women's health and safety over time.	
Hegarty, K.L., O'Doherty, L.J., Gunn, J., Pierce, D., & Taft, A.J. (2008). A brief counselling intervention by health professionals utilising the 'readiness to change' concept for women experiencing intimate partner abuse: The weave project. *Journal of Family Studies, 14(2),* 376-388.	This paper describes a brief counselling intervention based on the 'readiness to change' concept for women experiencing intimate partner violence, and an educational programme for training primary care health professionals in the delivery of such an intervention. We present a synthesis of the literature on the Transtheoretical Model of Behaviour and the Psychosocial Readiness to Change Model as applied to intimate partner violence. We describe the intervention used in the weave trial, which draws on the educational and partner violence literature, as well as integrating key theoretical insights from the field of behaviour change. Practical steps for training health professionals are outlined from the authors' experience and research.	Does not evaluate the outcome of an intervention
Helfrich, C.A., & Rivera, Y. (2006). Employment skills and domestic violence survivors: A shelter-based intervention. *Occupational Therapy in Mental Health, 22(1),* 33-48.	Domestic violence impacts women's ability to work. Women's ability to function and maintain employment skills are often diminished by the experience of repeated abuse. In domestic violence shelter settings, staff does not have enough time, adequate training, or sufficient materials available to develop or deliver life skills interventions related to employment. This article describes an occupational therapy intervention designed to increase skills needed for employment for domestic violence victims residing in a shelter. All women completed a self-assessment prior to participating in the four-week group and individual intervention. Challenges and strategies learned are discussed	Intervention setting outside of health and social services (Workplace)
Helfrich, C.A., Aviles, A.M., Badiani, C., Walens, D., & Sabol, P. (2006). Life skill interventions with homeless youth, domestic violence victims and adults with mental illness. Occupational *Therapy in Health Care, 20(3-4),* 189-207.	This paper presents three exploratory studies of life skills interventions (employment, money management or food/nutrition) with 73 homeless individuals from four shelters and supportive housing programs located in the urban Midwest for youth, victims of domestic violence and adults with mental illness. The Ansell Casey Life Skills Assessment was administered prior to the eight group and individual sessions. Quizzes and posttests indicated clinical change in all groups, with statistical significance in the domestic violence group. The intervention implementation, challenges encountered, and strategies developed for implementing shelter-based interventions are discussed. Recommendations for successfully providing collaborative university-shelter clinical interventions are provided.	Does not have outcomes relevant to research question
Hellbernd, H., Brzank, P., May, A., & Maschewsky-Schneider, U. (2005). The S.I.G.N.A.L.-Intervention Project to combat violence against women. *Bundesgesundheitsblatt, 48(3)*, 329-336.	Domestic violence has profound effects on the health of women. According to the World Health Organization, violence is a significant risk factor for morbidity and mortality in women. If violence is not taken into account as a cause of health problems, there is a high risk of inappropriate health care. More attention to the issue of domestic violence in medical history, diagnosis and therapy is the objective of the 'S.I.G.N.A.L. Intervention Project to Combat Violence Against Women'. The 'S.I.G.N.A.L. Project' is the first intervention project against violence in a medical setting in Germany. It was started in 1999 in the emergency room of Benjamin Franklin University Hospital (Charite Campus Benjamin Franklin). The goal of the project is to initiate prevention and intervention for violence against women by providing the abused women with appropriate support and treatment. The programme is based on the intervention objectives: ask about abuse, assess for danger, inform and refer victims to counselling programs and women's shelters, and document injuries and health problems for use in legal proceedings	Study published in Gernan
Houry, D., Hankin, A., Daugherty, J., Smith, L.S., & Kaslow, N. (2011). Effect of a targeted women's health intervention in an inner-city	Objective. To evaluate the effect of an Emergency Department (ED) based, educational intervention for at-risk health behaviours. Methods. A randomized trial over a one-year period. African American women, aged 21-55, presenting to the ED waiting room were eligible. Each participant took a computer-based survey on health risk behaviours. Participants who screened positive on any of four validated scales (for IPV, nicotine, alcohol, or	Does not have outcomes relevant to research question

emergency department. *Emergency Medicine International, 2011,* 1-7.	drug dependence) were randomized to standard information about community resources (control) or to targeted educational handouts based upon their screening results (intervention). Participants were surveyed at 3 months regarding contacts with community resources and harm-reduction actions. Results. 610 women were initially surveyed; 326 screened positive (13.7 for IPV, 40.1 for nicotine addiction, 26.6 for alcohol abuse, and 14.4 for drug abuse). 157 women were randomized to intervention and 169 to control. Among women who completed follow-up (n=71), women in the Intervention Group were significantly more likely to have contacted local resources (37 versus 9, P=0.04) and were more likely to have taken risk-reducing action (97 versus 79, P=0.04). Conclusion. Targeted, brief educational interventions may be an effective method for targeting risk behaviours among vulnerable ED populations.	
Howe, S., & Parris, S. (2011). Shape your life and embrace your aggression: a boxing project for female and trans survivors of violence. *Women in Sport & Physical Activity Journal, 20(1),* 66.	This article focuses on an action research project called Shape Your Life,; developed to teach women and transgendered survivors of violence; recreational boxing at the Toronto Newsgirls Boxing Club, Canada's only women-led boxing club. In this innovative project, participants were encouraged to explore healthy aggression as a means of initiating change in their lives. As most research on aggression in sport focuses on young men, the aggression of girls, women, and trans (transgendered and; transsexual) individuals remains a much under-studied topic. This article attempts to open up farther dialogue on gender, sport, and aggression by; providing an account of survivors' aggression as an important source of; empowerment, thereby moving beyond the narrow focus on female aggression as harm inducing and a cause for moral panic. The article also highlights the; need for practical approaches to physical activity and sport programming that address the needs of participants whose lives are affected by gender-based violence.	Conference abstract
Humphreys, C., & Thiara, R. (2003). Mental health and domestic violence: 'I call it symptoms of abuse'. *British Journal of Social Work, 33(2),* 209-26.	No abstract	Does not evaluate the outcome of an intervention
Javaherian-Dysinger, H., Underwood, R., & DeLany, J.V. (2011). Occupational Therapy Services for Individuals Who Have Experienced Domestic Violence. *American Journal of Occupational Therapy, 65.*	No abstract	One case study
Johnson, D.M., & Zlotnick, C. (2006). A cognitive-behavioural treatment for battered women with PTSD in shelters: findings from a pilot study. *Journal of Traumatic Stress, 19(4),* 559-564.	Despite the high rates of posttraumatic stress disorder (PTSD) among battered women in shelters, virtually no treatments for these women have been developed or tested. This study evaluated the initial feasibility and efficacy of an individual, cognitive-behavioural treatment for battered women with PTSD or subthreshold PTSD in shelters. Eighteen women participated in an open-trial where they received a new treatment, Helping to Overcome PTSD with Empowerment (HOPE). Intent-to-treat analyses indicate that participants experienced significant decreases in PTSD symptoms, depressive symptoms, in their loss of resources and degree of social impairment; and significant increases in their effective use of community resources. These gains were maintained over time. Results should be interpreted with caution due to the small sample size and lack of a control group.	Pilot of Johnson (2011)
Johnson, D.M., Zlotnick, C., & Perez, S. (2011). Cognitive behavioural treatment of PTSD in residents of battered women's shelters: results of a randomized clinical trial. *Journal of Consulting*	OBJECTIVE: This study was designed to explore the acceptability, feasibility, and initial efficacy of a new shelter-based treatment for victims of intimate partner violence (IPV; i.e., Helping to Overcome PTSD through Empowerment [HOPE]). METHOD: A Phase I randomized clinical trial comparing HOPE (n=35) with standard shelter services (SSS) (n=35) was conducted. Primary outcome measures included the Clinician-Administered PTSD Scale (CAPS; D. D. Blake et al., 1995) and the Conflict Tactic Scales-Revised (M. A. Straus, S. L. Hamby, S. Boney-McCoy, & D. B. Sugarman, 1996). Participants were followed at 1-week, 3- and 6-months	One case study

and Clinical Psychology, 79(4), 542-551.	postshelter. RESULTS: Participants reported HOPE to be credible and indicated a high degree of satisfaction with treatment. Only 2 women withdrew from treatment. Both intent to treat (ITT) and minimal attendance (MA) analyses found that HOPE treatment relative to SSS was significantly associated with a lower likelihood of reabuse over the 6-month follow-up period (OR=5.1, RR=1.75; OR=12.6, RR=3.12, respectively). Results of hierarchical linear model analyses found a significant treatment effect for emotional numbing symptom severity in the ITT sample, t(67)=-2.046, p<0.05, and significant treatment effects for effortful avoidance symptom severity, t(49)=-2.506, p<0.05, and arousal symptom severity, t(49)=-2.04, p<0.05, in the MA sample. Significant effects were also found for depression severity, empowerment, and social support. CONCLUSIONS: Results support the acceptability and feasibility of HOPE and suggest that HOPE may be a promising treatment for IPV victims in shelter. However, results also suggest that modifications to HOPE may be required to improve treatment outcomes.	
Johnstone, J. (2003). Domestic violence in pregnancy -- midwives can make a difference. *MIDIRS Midwifery Digest, 13(3),* 311-315.	This article focuses on the issue of domestic violence in pregnancy. It seeks to analyse the different social learning theories to explain domestic violence, and identifies societal influences on childbearing that relate to domestic violence. In addition, a range of strategies are evaluated which relate to the practice of midwifery within the context of domestic violence and the role of the midwife in detection and referral of women experiencing violence within the home. Consideration is also given to the midwife working as part of a multi-disciplinary team. Finally, attention is given to the ethical and legal strategies that safeguard the well-being of mother and baby.	Does not evaluate the outcome of an intervention
Kail, B.L. (2010). Motivating women with substance abuse and intimate partner violence. *Journal of Social Work Practice in the Addictions, 10(1),* 25-43.	Social workers working in substance abuse settings often find that their clients are also survivors of intimate partner violence. This article uses the conceptual frameworks of the transtheoretical model of behaviour change and associated motivational interviewing techniques to enhance practitioners' ability to intervene with women in a holistic manner. We describe specific strategies to increase clients' motivation and offer specific skills to address abusive relationships. We finish with a case example.	One case study
Kane, K.E. (2006). The phenomenology of meditation for female survivors of intimate partner violence. *Violence Against Women, 12(5),* 501-518.	An existential-phenomenological methodology was utilized to investigate the experience of meditation for female survivors of intimate partner violence. Six coresearchers were taught a form of concentrative meditation and were asked to meditate daily and to attend a weekly group meditation for 6 weeks. Semistructured interviews were utilized to gather the data. The essence of the experience that was revealed was the emergence of a centered awareness that is distinctly different from the usual mode of being in the world. Findings suggest the value of meditation as an intervention strategy with survivors and demonstrate the need for further research in this area.	Does not evaluate the outcome of an intervention
Kazimirski, A., Keogh, P., Kumari, V., Smith, R., Gowland, S., Purdon, S., & Khanum, N. (2009). *Forced Marriage: Prevalence and Service Response. In National Centre for Social Research (Ed.).* London, UK: Department for Children, Schools and Families.	No abstract	Does not evaluate the outcome of an intervention
Klaushofer, A. (2008, November 7). Male room (services for male victims of domestic violence). *Inside House.*	Looks at efforts to provide refuge facilities in England and Wales for male victims of domestic violence. Explains that such facilities are currently in short supply. Considers the root of the problem and the difficulties caused by lack of provision across the country. Finds that providing supported housing for male victims presents; specific challenges. Notes that finding is a major hurdle.	Does not evaluate the outcome of an intervention
Kubany, E.S., & Watson, S.B. (2002). Cognitive Trauma Therapy for Formerly Battered Women with PTSD: Conceptual bases and	This article describes the conceptual bases and treatment outlines of Cognitive Trauma Therapy for Formerly Battered Women with PTSD (CTT-BW), a psychoeducational, multicomponent, cognitive-behavioural intervention aimed at alleviating posttraumatic stress disorder (PTSD), depression, guilt, shame, and negative self-esteem in formerly battered women. CTT-BW is derived from psychological learning principles, and	Does not evaluate the outcome of an intervention

treatment outlines. *Cognitive and Behavioural Practice, 9(2),* 111-127.	emphasizes the role of irrational beliefs and evaluative language in posttraumatic stress. Assessment and assessment instrumentation used in CTT-BW are described. The main treatment components in CTT-BW include (1) exploration of partner abuse history and exposure to other trauma; (2) psychoeducation on PTSD; (3) negotiation of imaginal and in vivo exposure homework; (4) psychoeducation on maladaptive self-talk; (5) stress management and relaxation training; (6) cognitive therapy for trauma-related guilt (Kubany & Manke, 1995); (7) psychoeducation on assertiveness and responses to verbal aggression; (8) managing unwanted contacts with former partners; (9) learning to identify potential perpetrators and avoid revictimization; and (10) psychoeducation on positive coping strategies that focus on self-advocacy and self-empowerment (e.g., placing oneself first, decision-making that promotes self interest). Homework includes listening to audiotapes of the sessions, in-vivo and imaginal exposure to abuse-related reminders, playing a relaxation tape, and self-monitoring of negative self-talk. Initial evidence for the efficacy of CTT-BW is discussed, as are issues that need to be addressed before CTT-BW can be reliably implemented and evaluated by other clinicians.	
Kulkarni, S. J., Bell, H., & Rhodes, D. (2012). Back to Basics: Essential Qualities of Services for Survivors of Intimate Partner *Violence. Violence Against Women, 18(1),* 85-101.	Survivor voice is essential to effectively implement survivor-focused IPV (intimate partner violence) services. In this focus group study, domestic violence survivors (n=30) shared detailed perspectives as service seekers and recipients, whereas national hotline advocates (n=24) explored relationships between service providers and survivors based on their interactions with both. Four thematic categories related to enhancing IPV services emerged: providing empathy, supporting empowerment, individualizing care, and maintaining ethical boundaries. Advocates identified additional factors that interfered with quality services, including the following: inadequate organizational resources, staff burnout, lack of training, and poor integration with other community resources. Respectful, empowering relationships ar the centerpiece for quality IPV services.	Does not evaluate the outcome of an intervention
Leisey, M., Kupstas, P.K., & Cooper, A. (2009). Domestic violence in the second half of life. *Journal of Elder Abuse & Neglect, 21(2),* 141-155.	Providing an adequate and effective community response to women age 50 and older who experience domestic violence is complicated by the oftentimes disparate goals and expectations of service providers, emergency responders, and victims themselves. This article shares information provided by participants of focus groups designed to understand and identify what women age 50 and older want and need from agencies that provide services to enhance victim safety.	Does not evaluate the outcome of an intervention
Lev-Wiesel, R. (2000). RTE: Revealing transference exercises in short-term group therapy. *The Arts in Psychotherapy, 27(5),* 339-344.	Discusses a creative arts exercise, the Revealing Transference Exercise (RTE), which enables group members to reveal their transferences toward each other, and to confront conflicts with internal self-objects. Group members sculpt images of themselves, significant family members, and group members, then identify similarities in shape, color, and size between the sculptures, thereby revealing unconscious transferences. Group members then share their feelings, concerns, and insights with other group members. Three cases, a group of 15 3rd-yr social work students, a group of 8 female adult survivors of sexual abuse, and a group of 12 battered females, show the value of RTE. It is concluded that RTE can enable faster progression from the transition phase of the group to the working phase, especially in short-term group therapy.	Does not evaluate the outcome of an intervention
Levin, R. (2001). Less than ideal: the reality of implementing a welfare-to-work programme for domestic violence victims and survivors in collaboration with the TANF department. *Violence Against Women, 7(2),* 211-221.	As the clock on the receipt of Temporary Assistance to Needy Families (TANF) benefits continues to tick, TANF departments across the United States are being expected to address the needs of their harder to serve populations, including domestic violence victims and survivors. This article documents the experiences and learnings from a large TANF office in Chicago where a pilot programme was initiated 2 years ago to provide on-site domestic violence services to TANF participants. Despite considerable efforts, most TANF caseworkers resisted referring women for services, forcing the project to devise alternative means of gaining access to the women in the TANF office. Of the women who came to at least one follow-up session with the domestic violence advocates, 57% have been placed in work activities, demonstrating successful outcomes and indicating that it is critically important to solve the organizational issues raised by the demonstration project.	Does not evaluate the outcome of an intervention
Loeffen, M. J., Lo Fo Wong, S.H., Wester, F.P., Laurant, M.G., & Lagro-Janssen, A.L. (2011). Implementing mentor mothers in	BACKGROUND: Intimate partner violence is highly prevalent and mostly affects women with negative consequences for their physical and mental health. Children often witness the violence which has negative consequences for their well-being too. Care offered by family physicians is often rejected because abused women experience a too high threshold. Mentor mother support, a low threshold intervention for abused	Does not evaluate the outcome of an intervention

family practice to support abused mothers: study protocol. *BMC Family Practice, 12(113).*	mothers in family practice, proved to be feasible and effective in Rotterdam, the Netherlands. The primary aim of this study is to investigate which factors facilitate or hinder the implementation of mentor mother support in family practice. Besides we evaluate the effect of mentor mother support in a different region. METHODS/DESIGN: An observational study with pre- and posttests will be performed. Mothers with home living children or pregnant women who are victims of intimate partner violence will be offered mentor mother support by the participating family physicians. The implementation process evaluation consists of focus groups, interviews and questionnaires. In the effect evaluation intimate partner violence, the general health of the abused mother, the mother-child relationship, social support, and acceptance of professional help will be measured twice (t=0 and t=6 months) by questionnaires, reporting forms, medical records and interviews with the abused mothers. Qualitative coding will be used to analyse the data from the reporting forms, medical records, focus groups, interviews, and questionnaires. Quantitative data will be analysed with descriptive statistics, chi square test and t-test matched pairs. DISCUSSION: While other intervention studies only evaluate the feasibility and effectiveness of the intervention, our primary aim is to evaluate the implementation process and thereby investigate which factors facilitate or hinder implementation of mentor mother support in family practice.	
Lund, E.M. (2011). Community-based services and interventions for adults with disabilities who have experienced interpersonal violence: a review of the literature. *Trauma Violence & Abuse, 12(4),* 171-182.	This study provides a review of the peer-reviewed literature from 1995 to 2010 on violence-related service, prevention, and intervention programs for people with disabilities. A comprehensive literature search resulted in a total of 16 articles, 6 related to service programs and 10 related to intervention and prevention programs. The services articles revealed a noticeable disconnect between the violence services programs' perceived accessibility and the perception of their accessibility in the disability community. Most of the intervention and prevention articles focused exclusively on abuse prevention for adults with intellectual disabilities and generally had small samples and lacked controlled conditions. Very few methods of abuse treatment for people with disabilities have been empirically evaluated. Efforts should be made to improve accessibility and increase cross-collaboration between domestic violence services and disability service organizations, and there is a need for accessible, culturally sensitive, and rigorously tested abuse interventions and prevention programs for women and men with diverse disabilities.	Non-systematic review
Lyon, E., & Bradshaw, J. (2011). *Meeting survivors' needs through non-residential domestic violence services and supports: results of a multi-state study.* Washington, DC: National Institute of Justice.	No abstract	Does not evaluate the outcome of an intervention
Martinez, K.K., & Wong, S.E. (2009). Using prompts to increase attendance at groups for survivors of domestic violence. *Research on Social Work Practice, 19(4)*, 460-463.	Objectives: This study investigated the effects of multiple prompts, telephone calls, and written reminders on attendance at group support meetings in a long-term residential facility for survivors of domestic violence. Methods: Participants were 15 Hispanic women who were residing in the facility at the time of the study. Prompts to attend the support meetings were introduced, removed, and reintroduced within an ABAB single-system design. Results: Data from sign-in sheets showed that prompting procedures at least doubled attendance at the support meetings. Conclusions: Possible factors contributing to the effectiveness of social workers using prompts to promote attendance at group support meetings are briefly discussed.	Does not have outcomes relevant to research question
Mattson, S., Shearer, N., & Long, C. (2002). Exploring telehealth opportunities in domestic violence shelters. Journal of the American *Academy of Nurse Practitioners, 14(10),* 465-470.	PURPOSE: To determine the degree of interest in using a computer for the purpose of accessing services from a nurse practitioner (NP) at domestic violence shelters (DVSs); and to identify issues of privacy and confidentiality that might arise from participation by victims of intimate partner violence (IPV) in a Telehealth intervention. DATA SOURCES: Focus groups with 19 women residing in two DVSs. Interviews were recorded, transcribed and themes were identified that answered the questions posed in the interviews. CONCLUSIONS: Most of the women understood the term NP and were favourably inclined to seek services from one. Over half of the women were not familiar with computer use, but were willing to learn in order to receive health care	Does not have outcomes relevant to research question

	services, both for episodic needs and for maintenance of chronic conditions. After learning of the method proposed to allow them to access an NP through the internet while still protecting their privacy and confidentiality, the women felt comfortable with this approach to meeting their health care needs. IMPLICATIONS FOR PRACTICE: Results from this study can be used to support the development and testing of Telehealth interventions for these victims of IPV.	
McDonald, J., & Green, R. (2001). A dispersed refuge model for women escaping domestic violence: A regional case study. *Australian Journal of Primary Health, 7(1)*, 85-89.	Refuges for women escaping domestic violence have traditionally been communal residences located in metropolitan areas. More recently, alternative service models have been funded to provide for clients with multiple and complex needs. This paper evaluates the first year of operation of an innovative refuge model for women and their children. "Marg's Place" is a statewide, high security, dispersed accommodation support model located in a regional setting. Evaluation methods included interviews, surveys, and analysis of client databases and programme documents. Thirty-five women and 42 children used the service for an average stay of 20 days during the first 12 months. The main findings were that the dispersed model can cater for a wide range of service users, including those with multiple and complex needs, who would be unlikely to be successfully accommodated in a communal refuge. There was little evidence that the dispersed model contributes to feelings of isolation or loneliness for women or children. The regional setting presented both advantages and disadvantages for women wanting to resettle in the area. Women reported significantly enhanced levels of empowerment, and the high security provisions met their needs for safety. Overall, this refuge model provides an accessible, responsive and effective service.	Does not evaluate the outcome of an intervention
Mears, D.P. (2003). Research and interventions to reduce domestic violence revictimization. *Trauma Violence & Abuse, 4(2),* 127-147.	Despite decades of research on domestic violence, considerable challenges must be addressed to develop sound, theoretically and empirically based interventions for reducing domestic violence revictimization. Many basic and applied research issues remain unaddressed by existing studies, and evaluations frequently do not sufficiently highlight their limitations or programme or policy implications. Nonetheless, progress has been made, and practitioners and policy makers increasingly have a wide range of promising interventions from which to select. This article reviews research on domestic violence and focuses particular attention on interventions aimed at reducing revictimization among individuals known to have been abused. It also provides a conceptual framework for practitioners and policy makers to situate existing evaluation research and highlights the need for better data to understand and assess efforts to reduce domestic violence revictimization. The author concludes by discussing directions for future research and recommendations for practice and policy.	Non-systematic review
Melbin, A., Sullivan, C. M., & Cain, D. (2003). Transitional supportive housing programs: battered women's perspectives and recommendations. *Affilia: Journal of Women & Social Work, 18(4)*, 445-460.	Finding safe, affordable housing is one of the greatest obstacles that women who leave abusive partners face. In response, advocates for battered women have begun to offer transitional supportive housing (TSH) programs. This article reports on interviews with 55 key stakeholders of these programs (direct service staff, current participants, former participants, and shelter residents) to examine the degree to which TSH programs fulfill the needs of the women who use them. Consistent with other research on empowerment-based services, the study found that the women were most satisfied when services were provided in a respectful and individualized manner. The women's recommendations included the implementation of safety protocols and the need for a variety of support services that should be offered but not mandated.	Does not evaluate the outcome of an intervention
Menard, A. (2001). Domestic violence and housing: key policy and programme challenges. *Violence Against Women, 7(6),* 707-720.	This article identifies key policy and programme recommendations that have emerged from recent analysis and national discussions on housing and domestic violence, and urges continued attention by policy makers, community leaders, and housing and domestic violence advocates to battered women's short- and long-term safety and housing needs. Three primary courses of action are highlighted: reviewing, and modifying as necessary, existing housing policy and programs to increase their responsiveness to women with abusive partners or ex-partners; promoting policies and programs that increase all women's access to safe, affordable, and stable housing as well as housing assistance and support services, when necessary; and widely publicizing information on available subsidized and nonsubsidized housing and housing assistance programs as well as services and protections available to domestic violence victims.	Does not evaluate the outcome of an intervention

Mendelsohn, M., Zachary, R.S., & Harney, P.A. (2007). Group therapy as an ecological bridge to new community for trauma survivors. *Journal of Aggression, Maltreatment and Trauma, 14(1-2),* 227-243.	Group therapy counteracts the isolating effects of interpersonal trauma and enables survivors to connect with sources of resilience within themselves and others. By providing an alternative relational experience in which the survivor and her safety are valued, groups empower members to establish self-affirming and supportive relationships in their outside lives. The current paper reviews the psychological impact of chronic interpersonal violence and the relevant literature regarding group therapy for trauma survivors. We describe an approach to group treatment for complexly traumatized patients developed at the Victims of Violence Programme, and through a clinical vignette, illustrate some of the ways in which group therapy can expand the relational world of survivors.	One case study
Morash, M., & Hoan, B. (2008). The Connection of U.S. Best Practices to Outcomes for Vietnamese American Women Abused by Intimate Partners. *International Journal of Comparative and Applied Criminal Justice, 32(2)*, 221-241	A grounded theory approach and sensitizing concepts were used to study U.S. best practices for addressing intimate partner violence against 55 Vietnamese American women interviewed at the beginning and end of a twelve-month period. Advocacy agency, police, and court contact were associated with women's decisions to leave abusive relationships. Also associated were Vietnamese-speaking professionals and referrals between helping sources. Women's observation of the deterrent effect of the law and of justice-system involvement explained the stopping of abuse in several but not all cases. Women who stayed in abusive situations received social work help from Vietnamese-speaking staff who understood their cultures, and those with emotional abuse tended to receive no assistance. All women initially had high levels of feeling controlled, frightened, and depressed. The greatest improvements were for women whose abuse stopped or who left. Best practices (coordinated community responses, culturally competent services) appeared to be effective, but nationally they are not uniformly available to many cultural and linguistic groups. [ABSTRACT FROM AUTHOR]; Copyright of International Journal of Comparative & Applied Criminal Justice is the property of Taylor & Francis Ltd and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use. This abstract may be abridged. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material for the full abstract.	Does not evaluate the outcome of an intervention
Morrison, A., Ellsberg, M., & Bott, S. (2007). Addressing gender-based violence: A critical review of interventions. *World Bank Research Observer, 22,* 25-51.	This article highlights the progress in building a knowledge base on effective ways to increase access to justice for women who have experienced gender-based violence, offer quality services to survivors, and reduce levels of gender-based violence. While recognizing the limited number of high-quality studies on programme effectiveness, this review of the literature highlights emerging good practices. Much progress has recently been made in measuring gender-based violence, most notably through a World Health Organization multicountry study and Demographic and Health Surveys. Even so, country coverage is still limited, and much of the information from other data sources cannot be meaningfully compared because of differences in how intimate partner violence is measured and reported. The dearth of high-quality evaluations means that policy recommendations in the short run must be based on emerging evidence in developing economies (process evaluations, qualitative evaluations, and imperfectly designed impact evaluations) and on more rigorous impact evaluations from developed countries.	Non-systematic review
Netto, G., Pawson, H., & Sharp, C. (2009). Preventing Homelessness due to Domestic Violence: Providing a Safe Space or Closing the Door to New Possibilities? *Social Policy & Administration, 43, 7*19-735.	Domestic violence has been recognized as a major contributory factor to homelessness in the UK and elsewhere, with women more likely to be affected. In the UK and other countries undergoing welfare reform, moves toward 'active citizenship' increase the complexity of the relationship between states and citizens and open up new strategies for both. However, analysts have noted some strategies can create new forms of inequality, including gender-based ones. This article considers the impact of prevention-centred homelessness policy responses to domestic violence, with specific reference to the 'Sanctuary' model. Sanctuary schemes support women facing homelessness due to domestic violence to remain in their current residence, protected against attack from outside the home. Drawing on analysis of the literature and empirical work, we compare the experiences of women who have used traditional forms of support and Sanctuary services. We argue that while the model has the potential to provide greater autonomy to some women in these circumstances, it is not appropriate for all. Increased emphasis on Sanctuary schemes could make it more difficult for women who	Does not evaluate the outcome of an intervention

	might prefer to move. We conclude that more attention needs to be paid to addressing the origin of women's homelessness due to domestic violence.	
Niolon, P.H., Rollins, C.M., Glass, N., Billhardt, K., Connor-Smith, J., & Baker, C. (2009). An innovative approach to serving the needs of IPV survivors: description of a CDC-Funded study examining the Volunteers of America Home Free rent assistance programme. *Journal of Women's Health, 18(6)*, 775-778.	Abstract The purpose of this paper is to describe a CDC-funded study examining the effectiveness and cost-effectiveness of the Volunteers of America Home Free programme, an innovative programme that offers survivors of intimate partner violence (IPV) permanent housing rent assistance coupled with client-centered advocacy. We briefly discuss the challenges and barriers faced by women who try to separate from abusive partners and who have an immediate need for housing, describe the innovative approach to service provision adopted by the Volunteers of America Home Free programme in Portland, Oregon, and describe the CDC-funded cooperative agreement to compare the effectiveness and cost-effectiveness of this approach with the usual housing services available to women fleeing abusive relationships.	Does not evaluate the outcome of an intervention
Olive, P. (2008). Care for emergency department patients who have experienced domestic violence: a review of the evidence base. *Journal of clinical nursing, 16(9).*	A literature review was conducted to identify and evaluate the research base underpinning care for emergency department patients who have experienced domestic violence. The extent of domestic violence in the general population has placed it high on health and social policy agendas. The Department of Health has recognised the role of health care professionals to identify and provide interventions for patients who have experienced domestic violence. The method was a systematic review. The results were at least six percent of emergency department patients have experienced domestic violence in the previous 12 months although actual prevalence rates are probably higher. Simple direct questioning in a supportive environment is effective in facilitating disclosure and hence detecting cases of abuse. Although routine screening is most effective, index of suspicion screening is the current mode of practice in the UK. Index of suspicion screening is likely to contribute to under-detection and result in inequitable health care. Patients with supportive networks have reduced adverse mental health outcomes. Women will have negative perceptions of emergency care if their abuse is minimalised or not identified. Women want their needs and the needs of their children to be explored and addressed. Access to community resources is increased if patients receive education and information. The conclusion was domestic violence is an indisputable health issue for many emergency department patients. Practitioners face challenges from ambiguity in practice guidelines and the paucity of research to support interventions. Recommendations for practice based on the current evidence base are presented. The relevance to clinical practice was the nursing care for patients in emergency and acute health care settings who have experienced domestic violence should focus on three domains of: (1) Providing physical, psychological and emotional support; (2) Enhancing safety of the patient and their family; (3) Promoting self-efficacy. Cites numerous references.	Non-systematic review
Olson, L.M., & Parekh, A. (2010). Evaluating services for immigrant and refugee families who experience abuse. *Injury Prevention, 16,* 175-176.	Introduction Surveys from around the world indicate that 10% to 69% of women experience violence from an intimate male partner. We evaluated the Family Justice Centre (FJC), a confidential walk in centre with co-located services supporting families experiencing abuse concentrating on the experiences of refugee and immigrant families. Methods Four structured focus groups with English, Spanish and Arabic speaking women. Results Before visiting the FJC, participants felt apprehensive, confused, scared and unsure how to stop the abuse. Participants expressed that domestic violence was normal and the abuse should be tolerate and hope that the abuser will change. After receiving services, participants reported feeling empowered, knowledgeable and more secure. We are women with needs that should be met; we should be entitled to those resources regardless of race, or legal status. It shouldn't hold us back from seeking protection. Participants needed and recognised the diverse array of services offered at the FJC. A lot of people speak different languages or can't read or write in English. I feel more secure and have more direction (after visiting the FJC). Participants reported receiving help with protective orders, child support, housing, translation of legal and other documents and group counselling. Most participants reported following a safety plan including escape routes and packing a bag with essentials. Conclusions The information is an important first step in understanding issues facing immigrant and refugee families and provides a basis to modify and continue services including translation to	Does not evaluate the outcome of an intervention

	meet the changing needs of the community.	
Parsons, R.J. (2001). Specific practice strategies for empowerment-based practice with women: a study of two groups. *AFFILIA, 16(2),*159-179	Presents a qualitative study of two groups - a political advocacy group and a group for survivors of domestic violence - that identifies specific behaviours of social workers and experiences of clients that facilitate the empowerment of women.	Does not evaluate the outcome of an intervention
Pearson, J., Griswold, E.A., & Thoennes, N. (2001). Balancing safety and self-sufficiency: lessons on serving victims of domestic violence for child support and public assistance agencies. *Violence Against Women, 7(2),* 176-192.	This article reports on three demonstration projects involving efforts to address the needs of public assistance applicants/recipients who are domestic violence victims while also developing effective methods to improve cooperation with child support agencies. Through various approaches, such as direct questioning, screening and referrals, and domestic violence specialists, the projects explore ways to identify victims of domestic violence, levels of interest in child support and exemptions, barriers to cooperation, and clients' responses to specialists and referrals for community-based services.	Does not evaluate the outcome of an intervention
Pennell, J., & Francis, S. (2005). Safety conferencing: toward a coordinated and inclusive response to safeguard women and children. *Violence Against Women, 11(5),* 666-692.	To reach out to women from different backgrounds, the battered women's movement needs to place women and their informal supports at the centre of a coordinated response. This article shares the views of domestic violence survivors, staff, and supporters on how to create such a coordinated and inclusive response, lays a conceptual foundation for a decision-making forum called safety conferencing, and sets forth guidance for its practice. Safety conferencing is proposed as one means of building the individual and collective strength to reshape connections, make sound choices, and promote the safety of women and children from diverse cultures.	Does not evaluate the outcome of an intervention
Petersen, R., Moracco, K.E., Goldstein, K.M., & Clark, K.A. 2003 Women's Perspectives on Intimate Partner Violence Services: The Hope in Pandora's Box. *Journal of the American Medical Women's Association, 58(3),* 185-190.	OBJECTIVE:To explore women's perspectives about how to enhance services for those who experience intimate partner violence (IPV) and how to improve the links between such services and the health care setting. METHODS: We conducted 6 focus groups involving 67 women in both rural and urban settings in North Carolina. A standardized interview guide was used to investigate the women's perspectives on the study objectives. Coding and theme analyses were conducted to assess new ideas and/or common themes among the groups. RESULTS: Participants identified currently available services for women experiencing IPV, including health care providers, police and the legal system, domestic violence shelters, and churches. Participants discussed existing barriers to addressing violence within the health care system, including cost of medical services, risk of having social services remove their children, violence being too personal to discuss, and doctors' inability to provide what they thought victims really needed. Participants agreed that the most important role for providers would be referrals to useful services (advocacy, job training, and financial support). Participants also emphasized the need for community-based prevention efforts. CONCLUSION: We found a striking lack of support among women participants in our study for using the health care setting as part of the service response to IPV. Participants believed that the health care system is not set up to allow providers to provide the level of individual assistance that they thought would be most useful. Participants did have hope that women's risk of future IPV would decrease if they were provided with useful community-based services and if community-wide prevention efforts were implemented.	Describes client's perspectives on services
Pompa, L. (2007). The Family Violence Option in Texas: Why it is failing to aid domestic violence victims on welfare and what to do about it. *Texas Journal of Women & the Law, 16(2),* 241-259.	The article focuses on the failure of the welfare benefits from the government in solving the domestic violence in Texas. The programme Temporary Assistance for Needy Families (TANF) and the Family Violence Option is an essential tool for the economic independence for victims but it does not meet the expected end. It is suggested that the notification to victims on welfare should be increased, inclusion of domestic violence advocates in the welfare process and the welfare law should be changed.	Does not evaluate the outcome of an intervention
Poole, N., Greaves, L., Jategaonkar, N., McCullough, L., & Chabot, C. (2006). Connecting	No abstract	Based on same data as Poole (2008)

systems, supporting change: transition houses, women experiencing partner violence and substance use. *Research Bulletin of the Centres of Excellence for Women's Health, 5(1),* 16-18.		
Postmus, J.L. (2010). *Economic empowerment of domestic violence survivors.* Nataional Resource Centre on Violence Against Women.	Every day, women survive physical or sexual violence. Some survive as a result of services they receive in the aftermath of the abuse. The study presented here explored women's experiences of victimization and their use of and perceptions about the services they received. It is learned that what providers usually prioritize and what the women in this study used-namely emotional, psychological, and legal support-are not what these women identified as the most helpful. Instead, tangible supports, such as food, housing, and financial assistance, were viewed as the most helpful, along with religious or spiritual counselling.	Non-systematic review
Postmus, J.L., Severson, M., Berry, M., & Yoo, J.A. (2009). Women's experiences of violence and seeking help. *Violence Against Women, 15(7),* 852-868.	Every day, women survive physical or sexual violence. Some survive as a result of services they receive in the aftermath of the abuse. The study presented here explored women's experiences of victimization and their use of and perceptions about the services they received. It is learned that what providers usually prioritize and what the women in this study used—namely emotional, psychological, and legal support—are not what these women identified as the most helpful. Instead, tangible supports, such as food, housing, and financial assistance, were viewed as the most helpful, along with religious or spiritual counselling.	Does not have outcomes relevant to research question
Preston, S.L. (2002). Claiming our place: women with serious mental health issues and support groups for abused women. *Canadian Journal of Community Mental Health, 21(1),* 101-113.	Many women with serious mental health issues also deal with abuse and have difficulty accessing services. Despite the fact that groups have been found to be one of the most useful tools in healing from the effects of abuse, many professionals see women with serious mental health issues as unable to benefit from counselling and, in particular, from groups for abused women. This study indicates that, when mental health issues are addressed and the group structures and expectations are modified to allow women control over their participation, serious mental health issues are not a barrier to participation in groups.	Does not have outcomes relevant to research question
Roberts, A.R., & Lewis, S.J. (2000). Giving them shelter: National organizational survey of shelters for battered women and their children. *Journal of Community Psychology, 28(6),* 669-681.	This article examined several important issues related to helping of battered women who often come to shelters in a state of acute crisis. These vulnerable women have often experienced repeated violent battering incidents, medical injuries, psychological harm, sleep disturbances, and terroristic threats. Authors highly recommend that shelter counsellors and victim advocates be fully trained in using Seven-Stage Crisis Intervention Model which is based on a strengths perspective and integrates solution focused therapy. Findings of this study indicated that some shelters are suffering from under-funding. Many respondents in this study were proud of the comprehensive services that their programs offered.	Does not have outcomes relevant to research question
Rodgers, C.S., & Norman, S.B. (2004). Special report: trauma, violence and victimization. Considering PTSD in the treatment of female victims of intimate partner violence. *Psychiatric Times, 21(4),* 68.	No abstract	Non-systematic review
Rountree, M.A. (2010). HIV/AIDS risk reduction intervention for women who have experienced intimate partner violence. *Clinical Social Work Journal, 38,* 207–216	This qualitative pilot study researched women who have experienced intimate partner abuse (IPA) in order to develop a HIV/AIDS risk reduction intervention unique to their circumstances. This pilot study explored the critical components of such an intervention among a racially/ethnically stratified (African-American, Mexican-American and Anglo) intimate partner abuse IPA. Focus groups were conducted amongst a racially/ethnically stratified sample of 43 women. Content analysis was used to identify major themes. In all five focus groups, participants viewed the research as interesting, good, beneficial, and/or important based on their perceptions of risk for infection. Respondents felt that they knew of ways to protect themselves from infection in non-abusive relationships; however, acknowledged the difficulties of doing so given the context of their abusive	Does not evaluate the outcome of an intervention

	relationships. Examining the racial/ethnic differences across focus groups showed that the language used by women is quite variable. The ways in which survivors define rape, sexual abuse, and their own experiences are all unique; however, their actual experiences have many similarities. Discussed at length are the topics participants shared as critical in informing the design of an intervention and the relevance of the findings to social work clinical practice is explained.	
Saylors, K. (2003). The Women's Circle comes full circle. *Journal of Psychoactive Drugs, 35(1),* 59-62.	Women have been the backbone of service provision for health and healing in the Native American community in the San Francisco Bay Area. The contributions of Native women are exemplified in the Women's Circle of the Native American Health Centers in San Francisco and Oakland. Women receive a broad range of services through the Women's Circle--in a coed residential substance abuse treatment facility (Friendship House), in groups, in one-on-one counselling, and at the Friendship House American Indian Lodge, a residential women and children's facility in Oakland. This article will look at lessons learned, using both quantitative outcome measures and ethnographic means to examine the impact of the Women's Circle and how the circle was completed. Programme staff were interviewed to gain insight into how the programme impacted female clients. The article juxtaposes the programme elements clients identified as important to their healing and staff's perceptions about the growth of the programme. Distinct women's health issues--physical, emotional, mental and spiritual-sculpted programme development. Significant findings and lifestyle changes that occurred around involvement in the Women's Circle are examined.	Does not have outcomes relevant to research question
Short, L.M., & Hadley, S.M. (2002). Assessing the success of the WomanKind programme: An integrated model of 24-hour health care response to domestic violence. *Women and Health, 35(2-3),* 101-119.	Purpose: The WomanKind programme, a non-profit health care based programme for victims of domestic/intimate partner violence (IPV), seeks to enable and motivate health care providers to identify victims of such violence and refer them to WomanKind's in-house services. An evaluation designed to assess client referral to WomanKind services and the impact of health care provider training was carried out. Methods: Data were collected at three intervals over a 2-year period at 3 intervention and 2 comparison hospitals located in Minneapolis, MN. The focus of data collection efforts was to assess the providers' knowledge, attitudes, beliefs, and behaviours (KABB) concerning identification and referral of victims of IPV. Hospital staff and volunteer advocate training programs also were evaluated. Chart reviews were conducted and client referrals assessed. Results: Providers at WomanKind hospitals demonstrated significantly higher knowledge, attitudes, beliefs and behaviours than those at comparison hospitals throughout the study. During the data collection period, 1719 IPV victims were identified and referred to the Woman-Kind programme, while only 27 IPV victims were referred to trained social workers at the comparison hospitals. Chart reviews indicated that emergency staff at the intervention sites provide documentation of IPV in patient records twice as frequently as emergency staff at the comparison sites. Conclusion: This research underscores the efficacy of a well-structured, multidisciplinary effort to deliver services to IPV victims. The results demonstrate that specialized training and on-site client services create a significant positive impact on the KABB of health care providers.	Does not evaluate the outcome of an intervention
Stanistreet, P. (2003). Before She Came Here She Couldn't Sleep, She Was So Depressed. Now She Has the Confidence To Lead a Separate Life. *Adults Learning, 14(10)*, 15-16.	A domestic violence support group in England helps women get out of abusive situations and develop the confidence and skills to live independently. A key feature is language support for limited-English-speaking women in diverse communities. (SK)	Does not evaluate the outcome of an intervention
Stenius, V.M.K., & Veysey, B.M. (2005). "It's the little things" women, trauma, and strategies for healing. *Journal of Interpersonal Violence, 20(10),* 1155-1174.	Women recover and heal from traumatic violent experiences in many different ways. This study, which is part of the Franklin County Women and Violence Project, explores the healing experiences of 18 women who have histories of violence, substance abuse, and involvement in the mental health and/or substance abuse treatment system. Ethnographic interviews suggest that while professional intervention can be beneficial, it may not be adequate. In fact, it can be retraumatizing. The means of service delivery and treatment by individuals, service providers and others, may be more important than the actual service. Often women find that caring individuals and a safe environment yield the greatest benefit. It is not so much what people do to	Does not have outcomes relevant to research question

	help, but how they do it.	
Stover, C.S., Meadows, A.L., & Kaufman, J. (2009). Interventions for intimate partner violence: Review and implications for evidence-based practice. *Professional Psychology: Research and Practice, 40(3)*, 223-233.	The objective of this article was to survey available intimate partner violence (IPV) treatment studies with (a) randomized case assignment, and (b) at least 20 participants per group. Studies were classified into 4 categories according to primary treatment focus: perpetrator, victim, couples, or child-witness interventions. The results suggest that extant interventions have limited effect on repeat violence, with most treatments reporting minimal benefit above arrest alone. There is a lack of research evidence for the effectiveness of the most common treatments provided for victims and perpetrators of IPV, including the Duluth model for perpetrators and shelter–advocacy approaches for victims. Rates of recidivism in most perpetrator- and partner-focused treatments are approximately 30% within 6 months, regardless of intervention strategy used. Couples treatment approaches that simultaneously address problems with substance abuse and aggression yield the lowest recidivism rates, and manualized child trauma treatments are effective in reducing child symptoms secondary to IPV. This review shows the benefit of integrating empirically validated substance abuse and trauma treatments into IPV interventions and highlights the need for more work in this area.	Non-systematic review
Stover, C.S., Poole, G., & Marans, S. (2009). The domestic violence home-visit intervention: impact on police-reported incidents of repeat violence over 12 months. *Violence & Victims, 24(5),* 591-606.	The domestic violence home-visit intervention (DVHVI) provides home visits by police-advocate teams within 72-hours of domestic incident to provide safety, psychoeducation, mental health, legal, or additional police assistance. Clinical and police record data were collected for 512 cases, and repeat calls to the police were tracked for 12 months. Analyses revealed that women who engaged with the DVHVI were more likely to contact the police for subsequent events than those who received no or minimal DVHVI contact. Hispanic women served by Spanish-speaking advocate-officer teams were the most likely to utilize services and call the police for subsequent incidents.	Intervention setting outside of health and social services (Justice system)
Sullivan, C.M. (2003). Using the ESID model to reduce intimate male violence against women. *American Journal of Community Psychology, 32(3-4),* 295-303.	Described how the Experimental Social Innovation and Dissemination (ESID) model was successfully used to reduce intimate male violence against women. Following the principles of ESID, the experimental social innovation involved providing trained paraprofessional advocates to work one-on-one with women who had been assaulted by partners or ex-partners. Advocates worked with women for 10 weeks, assisting them in obtaining needed community resources such as legal assistance, housing, education, and employment. Two hundred seventy eight women who had exited a domestic violence shelter programme were randomly assigned to the experimental or control condition. Participants were interviewed 6 times over a period of 2 years: pre- and postintervention (10 weeks later), and at 6, 12, 18, and 24-month follow-up. Women who received the intervention reported less violence over time as well as higher social support and perceived quality of life. The relevance of the ESID model in addressing this as well as other significant social problems is discussed.	Does not evaluate the outcome of an intervention
Taft, A.J., Small, R., Hegarty, K.L., Lumley, J., Watson, L.F., & Gold, L. (2009). MOSAIC (MOthers' Advocates In the Community): protocol and sample description of a cluster randomised trial of mentor mother support to reduce intimate partner violence among pregnant or recent mothers. *BMC Public Health, 9(159).*	BACKGROUND: Intimate partner violence (IPV) is prevalent globally, experienced by a significant minority of women in the early childbearing years and is harmful to the mental and physical health of women and children. There are very few studies with rigorous designs which have tested the effectiveness of IPV interventions to improve the health and wellbeing of abused women. Evidence for the separate benefit to victims of social support, advocacy and non-professional mentoring suggested that a combined model may reduce the levels of violence, the associated mental health damage and may increase a woman's health, safety and connection with her children. This paper describes the development, design and implementation of a trial of mentor mother support set in primary care, including baseline characteristics of participating women. METHODS/DESIGN: MOSAIC (MOtherS' Advocates In the Community) was a cluster randomised trial embedded in general practice and maternal and child health (MCH) nursing services in disadvantaged suburbs of Melbourne, Australia. Women who were pregnant or with infants, identified as abused or symptomatic of abuse, were referred by IPV-trained GPs and MCH nurses from 24 general practices and eight nurse teams from January 2006 to December 2007. Women in the intervention arm received up to 12 months support from trained and supported non-professional mentor mothers. Vietnamese health professionals also referred Vietnamese women to bilingual mentors in a sub-study. Baseline and follow-up surveys at 12 months measured IPV (CAS),	Does not evaluate the outcome of an intervention

	depression (EPDS), general health (SF-36), social support (MOS-SF) and attachment to children (PSI-SF). Significant development and piloting occurred prior to trial commencement. Implementation interviews with MCH nurses, GPs and mentors assisted further refinement of the intervention. In-depth interviews with participants and mentors, and follow-up surveys of MCH nurses and GPs at trial conclusion will shed further light on MOSAIC's impact. DISCUSSION: Despite significant challenges, MOSAIC will make an important contribution to the need for evidence of effective partner violence interventions, the role of non-professional mentors in partner violence support services and the need for more evaluation of effective health professional training and support in caring for abused women and children among their populations.	
Thomas, C.R., Miller, G., Hartshorn, J.C., Speck, N.C., & Walker, G. (2005). Telepsychiatry programme for rural victims of domestic violence. *Telemedicine Journal & E-Health, 11(5),* 567-573.	Domestic violence is a significant public health problem and is correlated with serious mental and physical disorders. Victims' fear and isolation seriously limit access to psychiatric evaluation and treatment. Telemedicine provides a means to overcome these obstacles. This article describes a telemedicine programme that provides psychiatric screening, evaluation, treatment, and referral for ongoing care to clients of a rural women's crisis centre. Psychiatric evaluation and treatment were provided to a rural women's shelter programme using telepsychiatry. The shelter programme had difficulty accessing traditional mental health service. All new clients entering the programme were screened for mental health problems. Those requiring further evaluation received a physical examination with medical history and initial psychological interview on site, followed by psychiatric evaluation by videoconference. Appropriate treatment was initiated, and referral for ongoing psychiatric care through the local community mental health clinic was arranged. Of the 38 women referred for mental health services by clinic staff, 35 completed a psychiatric evaluation using telepsychiatry and 31 entered treatment. The most commonly identified disorders were anxiety and major affective disorders, followed by substance use disorders. Telepsychiatry can provide rapid crisis intervention and effective mental health services to victims of domestic violence in a rural setting.	Correlation study design
Thorpe, C. (2006). Safe From Harm. Retrieved Mar 10, 2012 from http://www.safefromharm.org.uk/	Looks at the issues surrounding the problem of domestic violence. Discusses the role that housing providers are playing in rehousing and rehabilitating people who have; experienced domestic abuse. Suggests that the way local authorities collect statistics relating to homelessness is unsatisfactory and does not reveal the impact of domestic; violence and homelessness. Outlines the support that Look Ahead Housing and Care is providing including four schemes in the south east. Reports the views of Vicky Stark,; chief executive of Look Ahead, who sees a change in attitude toward and a higher profile for domestic violence issues. Includes an example of a client who has been helped out; of a domestic violence situation. Highlights the work of the Sanctuary Project based in Harrow.	Webpage; Does not evaluate the outcome of an intervention
Thorpe, C. (2007, February 16). Protected places (refuge for abused Asian women). *Inside Housing, 79.*	Looks at the provision of a specialist refuge for Asian women who have suffered domestic violence. Notes that there are very few refuges offering sanctuary specifically for; Asian women and highlights the high demand upon this service as a result. Considers some of the problems specific to Asian women, such as arranged marriages and honour; crimes. Outlines the services that the refuge provides to help abused women. Provides examples of how the refuge has helped women to escape domestic abuse.	Does not evaluate the outcome of an intervention
Turnage, B.F., Jacinto, G.A., & Kirven, J. (2003). Reality Therapy, Domestic Violence Survivors, and Self-Forgiveness. International *Journal of Reality Therapy, 22(2)*, 24-27.	Demonstrates how practitioners can use reality therapy to assist survivors through the self-forgiveness process to shift their definition of themselves. Enright (1996) described self-forgiveness as "fostering compassion, generosity, and love toward oneself" (p. 116). Self-forgiveness, as a process, repairs domestic violence survivors' feelings about the self and prepares them for new healthy relationships. This certainly is the case with many domestic violence survivors. Self-forgiveness interventions can be used to help survivors of domestic violence forgive themselves for selection of partners who inflicted pain on them, and the time they spent in violent relationships. The purpose of this article is to contribute to the intervention literature that aims to help domestic violence survivors. This article will present self-forgiveness as a framework for practitioners to use in helping survivors of domestic violence forgive themselves for the harm they experienced. Applying reality therapy, the practitioner can facilitate the therapeutic environment as the domestic violence survivor is guided through the self-forgiveness process	Does not evaluate the outcome of an intervention

Valentine, P.V., & Smith, T.E. (2001). Evaluating traumatic incident reduction therapy with female inmates: A randomized controlled clinical trial. *Research on Social Work Practice, 11(1),* 40-52.	An experimental outcome study with trauma-related symptoms was conducted to examine the effectiveness of traumatic incident reduction (TIR). It is a brief memory-based therapeutic intervention and was used to treat symptoms of posttraumatic stress disorder (PTSD), depression, anxiety, and low expectancy of success (i.e., low self-efficacy). A randomized pretest-postest control group design with 123 female inmates (mean age 32 yrs) in a federal prison, was used to evaluate the efficacy of the interventive procedure. Results showed significant differences between treatment and comparison control conditions on all measures at postest and 3-mo follow-up intervals except for the PTSD Intrusion subscale at the postest interval. The marked improvement of the treatment condition by comparison to those in the control condition supports the contention that TIR is an effective intervention with female inmates. The significant results on all measures at the follow-up time interval provide persuasive evidence of the stability of the interventive effects. The significance of this therapy model for use by practitioners with social work populations is highlighted.	Intervention setting outside of health and social services (Justice system)
Wachter Morris, C.A., Shoffner, M.F., & Newsome, D.W. (2009). Career Counselling for Women Preparing to Leave Abusive Relationships: A Social Cognitive Career Theory Approach. *Career Development Quarterly, 58(1)*, 44-53.	Career counsellors work with people from varied segments of society. For battered women, some of the challenges they face from intimate partner violence may significantly influence their career exploration and decision making. Social cognitive career theory (SCCT; R. W. Lent, S. D. Brown, & G. Hackett, 1994) is a framework that has important implications for working with these women. In this article, the authors present the unique career needs of battered women terminating abusive relationships, the relevance of SCCT to this population, strategies for using SCCT when working with these women, and a case study illustrating effective use of SCCT.	One case study
Walker, S. (2001). Domestic violence: analysis of a community safety alarm system. *Child Abuse Review, 10,* 170–182	This paper presents the findings of an analysis of the trial period of a local authority community alarm system adapted to protect adult and child victims of domestic violence and enable them to remain living in their own homes. The system was augmented as a response to government guidance on promoting interagency initiatives to tackle the crime of domestic violence. Qualitative and quantitative research methods were employed to seek the perceptions and experiences of referrers, service users and potential service users in the context of the administration, resource implications and cost-effectiveness of the new system. The evaluation discovered that potential service users were anxious about police and social services involvement in relation to child care. The system was considered to be protective, enabling women and children to remain in their own homes, and relatively cheap to operate. It has the potential to provide a deterrent to perpetrators and enhance interagency cooperation in protecting children, subject to further refinement and longer-term evaluation.	Non-comparative study design
Weissbecker, I., & Clark, C.. (2007). The impact of violence and abuse on women's physical health: Can trauma-informed treatment make a difference? *Journal of Community Psychology, 35(7),* 909-923.	A history of traumatic experiences has been associated with poor physical health. This study examined associations between trauma and physical health, as well as changes in physical health over time, in women with co-occurring disorders and histories of violence who received either integrated trauma-informed services or usual care. Results revealed that women who had experienced more severe trauma also suffered worse physical health and were more likely to engage in poor health behaviours. Receiving behavioural health care services was associated with improved physical health and health behaviours. Predictors of physical health improvements included reduced interpersonal abuse, reduced severity of posttraumatic symptoms, improved health behaviours, and adequate access to medical care. Implications for primary, secondary, and tertiary prevention are discussed.	Does not have outcomes relevant to research question
Westbrook, L. (2007). Digital information support for domestic violence victims. Journal of the American Society for Information *Science & Technology, 58(3),* 420-432.	With domestic violence directly impacting over 5 million victims in the United States annually, the growing e-health and e-government networks are developing digitally based resources for both victims and those who aid them. The well-established community information and referral role of public libraries dovetails with this digital referral network model; however, no study of the actual service provided by public libraries is available. This examination of e-mail reference responses to requests for safe-house contact information revealed major gaps in cyber-safety awareness and uneven implementation of professional standards for virtual reference service. Implications for information system design, professional standards, education, and future research are discussed.	Does not have outcomes relevant to research question

Wilson, K.S., Silberberg, M.R., Brown, A.J., & Yaggy, S.D. (2007). Health needs and barriers to healthcare of women who have experienced intimate partner violence. *Journal of Women's Health, 16(10),* 1485-1498.	BACKGROUND: This study assessed the health needs and barriers to healthcare among women with a history of intimate partner violence (IPV) as told by women themselves. METHODS: Qualitative interviews were conducted with 25 women clients and 10 staff members at a crisis centre in metropolitan North Carolina. Clients also completed a structured survey. RESULTS: Eleven shelter clients and 14 walk-ins completed the survey and interview. Client participants were demographically mixed, and 20% were Spanish-speaking immigrants. Most clients were unemployed and uninsured. Women reported worse health in the interviews than on the surveys; clients' major health needs were chronic pain, chronic diseases, and mental illness. Reported barriers to healthcare were cost, psychological control by the abuser, and low self-esteem and self-efficacy. Staff's perceptions of clients health needs differed from clients,' focusing on reproductive health, HIV/sexually transmitted infection (STI), mental illness, and inadequate preventive healthcare. Staff and clients' perceptions of barriers to healthcare were more congruent. Suggestions for improving the centre's response were to offer more health education groups and more health-related staff trainings. Agency barriers to implementing these changes were limited funding, focus on crisis management, and perceived disconnect with the healthcare system. CONCLUSIONS: Health needs of women who have experienced IPV are significant and include physical and mental concerns. IPV creates unique barriers to accessing healthcare, which can be addressed only partially by a crisis centre. Greater coordination with the healthcare system is needed to respond more appropriately to the health needs of women who have experienced IPV.	Does not have outcomes relevant to research question
Wozniak, D.F., & Allen, K.N. (2012). Ritual and performance in domestic violence healing: From survivor to thriver through rites of passage. *Culture, Medicine and Psychiatry, 36(1),* 80-101.	This article describes a group for domestic violence survivors to help them move past a "liminal" state in which their social identity is characterized by being "victim" or "survivor" to one of "incorporation" defined by "thriving" and joy. Through the creation and use of healing rituals, blessings, poetry, art and music, the women in the group establish "communitas" and support each other in the work of self-reclamation and healing. The group, "Rites of Passage" is intended for women who have completed shelter-based crisis interventions, and uses a structured curriculum that integrates theoretical and philosophical concepts from anthropology, post-modernism, humanistic psychology, social work, and existentialism. Through the Rites of Passage group, women identify and traverse a healing trajectory to construct an identity founded on strength and fulfillment. Patterned after non-western sex-segregated rites of transition, those who go through the group celebrate its conclusion with a defining ritual that publically marks their change in identity and status.	Does not evaluate the outcome of an intervention
Yoshida, K.K., Odette, F., Hardie, S., Willis, H., & Bunch, M. (2009). Women living with disabilities and their experiences and issues related to the context and complexities of leaving abusive situations. *Disability & Rehabilitation, 31(22)*, 1843-1852.	The health of women with disabilities, like other women, is affected by experiences of violence and abuse. However, the experiences of women living with disabilities is less well known and an important issue for rehabilitation professionals. In this paper we focus on presenting women's knowledge and experiences of violence and abuse regarding where abuse takes place, the forms of abuse; and the complexities associated with 'taking action'. Women participants for this study had to be: 18 years of age or older; a Canadian citizen; able to participate in English; self-defined with a disability; and, be living in an urban area of Canada. Data presented is based on an innovative community-academic research study in which focus groups discussions using electronic technology (i.e. blackboard and chat rooms) were conducted with women living with disabilities across the country on important health issues. Participants' recommendations are also presented. Discussion of the findings focus on policy and practice implications related to dedicated resources, access to information and training initiatives for rehabilitation professionals and women themselves.	Does not have outcomes relevant to research question
Zust, B.L. (2006). Meaning of INSIGHT participation among women who have experienced intimate partner violence. Issues *in Mental Health Nursing, 27(7),* 775-793.	This phenomenological study explored the meaning that women with violent partners found in participating in a 20-week group cognitive therapy programme called INSIGHT. Through a two-step interview process, ten women who had experienced intimate partner violence described what it meant to them to decide to participate in INSIGHT; what was meaningful about the programme; and what influence the programme had on their lives. Findings indicated an overarching theme that described a process of Rescuing Self. This study adds support for the utility of interventions, such as INSIGHT, that nurture self-emergence among women who have experienced intimate partner violence.	Does not have outcomes relevant to research question
Zweig, J.M., Schlichter, K.A., & Burt,	This study examines the extent to which programs for domestic violence and sexual assault gear services	Does not evaluate the

M.R. (2002). Assisting women victims of violence who experience multiple barriers to services. *Violence Against Women, 8(2),* 162-180.	toward women facing multiple barriers (i.e., substance abuse disorders, mental health problems or learning disabilities, incarceration, and prostitution) and the unique problems such women encounter when accessing services. As part of a national evaluation, the authors interviewed staff from 20 programs focusing their service efforts on multibarriered women. Problems encountered by such women include lack of services dealing with multiple barriers, uneducated service providers, and batterers using women's barriers to further control or victimize them. This article describes the strategies programs use to meet these women's distinct needs.	outcome of an intervention

Table 13. Research Question 3 (Perpetrator Interventions) Studies Excluded on Full Text

Study Details	Abstract	Reason for Exclusion
Adams, D. (2003). Certified batterer intervention programs. *Clinics in Family Practice, 5(1).*	No Abstract	Non-systematic review
Aguirre, R., Lehman, P., & Patton, J. (2011). A Qualitative Look at the Perceived Strengths of Male Batterers: Implications for Intervention Programs. *Journal of Family Social Work, 14(2),* 125-143.	Currently, batterer intervention programs tend to focus on education and confrontation, with outcomes being less than promising. Limitations of current interventions have encouraged development of alternative treatment forms aimed at ending relationship violence. An emerging trend in the fields of social work and positive psychology is to build on strengths and competencies of offenders. The purpose of this qualitative study was to introduce an alternative position within the treatment field by identifying self-disclosed strengths of men who had been charged with a domestic violence offense and who were being evaluated for a voluntary batterer diversion programme. A content analysis revealed competencies useful for helping men be accountable and end violence against their partners through redirecting negative behaviour and identifying resources and strengths.	Does not evaluate the outcome of an intervention
Aldarondo, E. (2009, November). *Assessing the Efficacy of Batterer Intervention Programs in Context.* Paper presented at Batterer Intervention: Doing the work and measuring the progress, National Institute of Justice, U.S Department of Justice and the Family Violence Prevention Fund with the support of "The Woods" Charitable Foundation, Bethesda, MD.	This paper was prepared to facilitate an informed group discussion about the efficacy of batter intervention programs (BIPs). As it would become obvious from the structure of the paper, I am of the opinion that BIPs should be viewed as part of a broader systemic response designed to curb and eliminate men's use of violence against their female partners. With this in mind, I review data from studies on the effectiveness of court orders of protection for abuse victims, pro-arrest policies, "no-drop" prosecution policies, educational programs for men who batter, and coordinated community response initiatives. A systemic view on the effectiveness of interventions for men who batter is presented here as an antidote to what I consider to be a misguided proclivity by some IPV researchers to approach interventions with men who batter as discrete medical procedures rather than as social policies and practices intended to respond to individual, domestic, and social needs.	Non-systematic review
Aldarondo, E. (2010). Understanding the Contribution of Common Interventions with Men who Batter to the Reduction of Re-assaults. *Juvenile and Family Court Journal, 61,* 87-101	The justice system plays a prominent role in curbing and eliminating men's use of violence against their female partners. Court orders of protection for abuse victims, pro-arrest policies, programs for men who batter, and coordinated community responses are the most common strategies used in the justice system for these purposes. Although the effectiveness of these interventions in reducing violence has been the subject of considerable attention by social science researchers, this research and information on its applicability is often not adequately disseminated among judges, police officers, lawyers, and probation officers. Moreover, specialized reports tend to present individual studies and modes of intervention in isolation. This practice has the unfortunate effect of promoting the view of interventions with men who batter as discrete procedures rather than as social policies and programs intended to respond to individual, domestic, and social needs, and leading many within the legal system to undervalue the contribution of a properly implemented systemic response to the problem. This article takes a different approach by bringing together the research literature on the effectiveness of the most common interventions on re-assault rates and evaluating their relative contribution to a broader systemic response to domestic violence. The article concludes with recommendations	Non-systematic review

	for improving current interventions.	
Arias, I., Dankwort, J., Douglas, U., Dutton, M., & Stein, K. (2002). Violence against women: the state of batterer prevention programs. *Journal of Law, Medicine & Ethics, 30(3),* 157-165.	While both men and women can be victims, domestic violence usually consists of assaults on women, and most violence against women occurs within an intimate relationship. In the past twenty years, numerous state and provincial programs to intervene in domestic violence cases have developed. The programs tend to focus on treating batterers, although they also offer counselling to domestic violence victims. The jury remains out on the effectiveness of these programs. A major issue is whether the programs use appropriate standards. After an overview of the prevalence and nature of domestic violence, this article provides a discussion of those standards--their nature, effectiveness, and limitations. Another section discusses use of a batterer intervention programme in an urban setting. Yet another section explores the implications of intimate partner violence and looks again at the effectiveness of batterer treatment within intervention programs. The article closes with a look at the way one state addresses domestic violence and treats it as a crime. An inescapable conclusion to be drawn from the discussion is that violence against women has its roots in cultural assumptions that must undergo change if the incidence of that violence is to be reduced.	Does not evaluate the outcome of an intervention
Augusta-Scott, T., & Dankwort, J., (2002). Partner abuse group intervention: lessons from education and narrative therapy approaches. *Journal of Interpersonal Violence, 17(7),* 783-805.	Since the time that work with men who batter was expanded to include psychosocial intervention, the question of victim safety and effective practice has been one of its most prominent themes. Over the decades, an education model evolved that embodied both sociopolitical concerns about woman abuse and practice expertise from community workers and the helping professions. In reviewing that development and current intervention, this article proposes that a narrative therapy approach in group intervention with men who batter might be promising in effectively engaging this population to end their abuse. Mindful of the need for committed participation, programme and client accountability, and safety for victimized partners, current practice is examined in findings from a recent qualitative study conducted in Nova Scotia, Canada, with domestic violence group facilitators.	Does not evaluate the outcome of an intervention
Babcock, J.C., Green, C.E., & Robie, C. (2004). Does batterers' treatment work? A meta-analytic review of domestic violence treatment. *Clinical Psychology Review, 23(8)*, 1023-1053.	This study tests the immediate impact of two interventions for intimate partner violent (IPV) men in affecting behavioural and emotional change during arguments with their partners. Couples with an abusive male partner (N=100) discussed an area of conflict twice, interrupted by a brief intervention. Men were randomly assigned to receive (a) an editing-out-the-negative skills training, (b) an accepting influence skills training, or (c) a time-out. IPV men in both skills-training conditions showed greater decreases in aggressive feelings than IPV men in the time-out condition based on their self-report and observed affective behaviour. Women also reported feeling less aggressive when their husbands were assigned to one of the skills-training conditions as compared to the control (time-out) condition. Results suggest that IPV men can learn to adopt new communication skills and that they do appear to have a positive impact on the emotional tone of their arguments. Clinically, communication skills training may be a useful addition to battering intervention programs, although these skills may need to be taught to both men and women involved in violent relationships.	Non-systematic review
Bennett, L., & Williams, O. (2001). *Controversies and recent studies of batterer intervention programme effectiveness.* Harrisburg, PA: National Online Resource Centre on Violence Against Women.	No Abstract	Non-systematic review
Bennett, L., Hsieh, C., & Stoops, C. (2010). Underclass men in batterer intervention programs: Disorders and disparities. *Families in Society, 91(4),* 394-400.	The criminal justice system has come to rely on a batterer intervention programme (BIP) in sentences for domestic violence offenders, but BIPs suffer from a reputation problem, with both completion and reoffense rates hovering around 50%. The role of social class in battering and in legally mandated BIPs, although indirectly referenced in most studies, is rarely examined as an explanatory factor. This article discusses the results of a study of 540 men arrested for domestic violence and sentenced to a BIP. Results suggest that social class is a significant predictor of programme completion, with programme completion for those categorized as overclass being twice those categorized as underclass. The authors discuss implications for	Correlational study design

	community and criminal justice response to domestic violence.	
Bowen, E. (2010). Therapeutic environment and outcomes in a U.K. Domestic violence perpetrator programme. *Small Group Research, 41(2),* 198-220.	This study examines the extent to which variations in programme delivery affect the therapeutic environment and whether the therapeutic environment is associated with psychological and behavioural outcomes in a domestic violence perpetrator programme. Seventy seven offenders and 31 probation group tutors participated. It was found that groups with longer sessions were perceived more favourably by offenders than those with shorter sessions. A positive correlation was identified between group organization and offender attendance. No association between the therapeutic environment and posttreatment alleged reoffending within an 11-month follow-up period was identified. A supportive leader style was positively associated with the extent of clinically significant change identified on a range of psychological measures. These findings suggest that profeminist programs may exert a meaningful therapeutic effect.	Correlational study design
Brewster, A., Milner, J., Mollerstrom, W., Saha, B., & Harris, N. (2002). Evaluation of spouse abuse treatment: description and evaluation of the Air Force Family Advocacy Programs for spouse physical abuse. *Military Medicine, 167(6),* 464-469.	Data are reported from a sample of 2,991 spouse physical abusers who received Air Force Family Advocacy Programme (FAP) services and who volunteered to complete programme evaluation measures that were administered before and after treatment and at 6-month follow-up. As expected, after treatment compared with before treatment, professionals rated offenders as less at risk and the offenders indicated general satisfaction with the Family Advocacy Programme services. Additionally, as predicted, objective measure indicated that offenders showed significant ($p<0.001$) decreased in family conflict and child abuse risk and significant increases ($p<0.001$) in family cohesions, family expression and marital satisfaction. An analysis of the available follow-up data indicated that each of the post-treatment improvements were mandated at the time of the follow-up evaluation.	Intervention setting outside of health and social services (Military)
Bullock, K. Sarre, S., Tarling, R., & Wilkinson, M. (2010). *The delivery of domestic abuse programmes: an implementation study of the delivery of domestic abuse programmes in probation areas and Her Majesty's Prison Service*. London, UK: Ministry of Justice.	No Abstract	Intervention setting outside of health and social services (Justice system)
Carney, M., & Buttell, F. (2004). A multidimensional evaluation of a treatment programme for female batterers: a pilot study. *Research on Social Work Practice,14(4),* 249-258.	The purpose of the study was to conduct a preliminary evaluation of a batterer intervention programby investigating changes in psychological variables related to abuse (i.e., truthfulness, violence, lethality, control, and stress coping abilities) between pretreatment and posttreatment assessments in a sample of women involuntarily placed in treatment. This study evaluated arrest records for a period of 12 months following treatment completion to determine the association between changes on these psychological variables and recidivism. The study employed a secondary analysis of 26 treatment completers involuntarily referred into treatment for domestic violence offenses. Analysis indicated that treatment completers were less passive/aggressive and less likely to use physical force on their partners at the conclusion of the treatment programme. Implications of the findings for social workers providing treatment services to female domestic violence offenders are explored and discussed.	Based on same data as Carney (2006)
Carney, M., Buttell, F., & Dutton, D. (2007). Women who perpetrate intimate partner violence: A review of the literature with recommendations for treatment. *Aggression and Violent Behaviour, 12(1),* 108-115.	The purpose of this article is to review the literature on women as perpetrators of violence in their intimate relationships (i.e., domestically violent women) and summarize the scant literature on intervention programs for these women. Particular attention is paid to the cultural influences that shape our conceptualization of "domestic violence" and the fact that empirical research suggests that domestic violence has been falsely framed as exclusively male initiated violence. The article concludes with a discussion of the similarities and differences between male and female domestic violence offenders and identifies areas where treatment for female offenders might be improved.	Non-systematic review
Chovanec, M. (2009). Facilitating change in group work with abusive	A major challenge for facilitators of domestic abuse programs is engaging men who abuse their partners in the change process. This article reports on a qualitative study that explores how group workers engage men who	Does not evaluate the

men: examining stages of change. *Social Work with Groups, 32,* 125-142.	abuse. Interviews were conducted with 15 facilitators from three different programs during a 1-year period. A stage of change model was used to examine the change process. The study addresses the process of change for individuals in group and on interventions used, from the facilitator's perspective. Three questions guided this exploratory study: How do group workers engage men in changing their abusive behaviours? What group interventions are most helpful in supporting client change? and To what extent do interventions reflect an awareness of individuals' stages of change?	outcome of an intervention
Cismaru, M., & Lavack, A. (2011). Campaigns targeting perpetrators of intimate partner violence. *Trauma Violence & Abuse, 12(4),* 183-197.	Intimate partner violence (IPV) is a global public health concern with significant physical, emotional, and economic costs. Persuading IPV perpetrators to change their behaviour could play an important role in ending violence. This article reviews and analyses 16 campaigns targeting IPV perpetrators, created in the United States, Canada, United Kingdom, Australia, and New Zealand. Two well-known models, the Transtheoretical (Stages of Change) model and Protection Motivation theory (PMT), are combined to create the analytical framework. For each stage of change, the most salient PMT variables are outlined, the people found in that stage are described, and the most effective strategies for persuasion are posited. Together, these two models would suggest that future campaigns targeting IPV perpetrators should place a stronger emphasis on the benefits of changing and place a greater focus on increasing perpetrators' confidence that they can abstain from violence.	Non-systematic review
Contrino, K., Dermen, K., Nochajski, T., Wieczorek, W., & Navratil, P. (2007). Compliance and learning in an intervention programme for partner-violent men. *Journal of Interpersonal Violence, 22(12),* 1555-1566.	Although research has yielded mixed findings regarding the effectiveness of intervention programs for partner-violent men, it appears that greater participant compliance with such programs is associated with better outcomes. However, no research to date has jointly examined compliance with intervention programs and the extent to which partner-violent men learn specific information presented during the programs. The current study makes use of existing data to evaluate general and specific elements of partner-violent men's compliance with (i.e., active, appropriate participation in) an intervention programme and recall of key points from the programme. Results from a subsample of 22 men indicate that at programme termination, those rated as having been "process conscious" during intervention group sessions, having self-disclosed during sessions, having evidenced awareness and use of techniques to avoid violence, and having used respectful language show greater recall of material taught in the programme. This finding points to the potential benefit of taking steps to increase men's active participation in programs and of studying active engagement as a mediator of programme effects on men's violence toward partners.	Correlational study design
Corvo, K., Dutton, D., & Chen, W. (2008). Toward evidence-based practice with domestic violence perpetrators. *Journal of Aggression, Maltreatment and Trauma, 16(2)*, 111-130.	The review found that within the existing policy framework of mandated interventions for male perpetrators of domestic violence, there is a lack of political support for a serious effort to reframe treatment for such offenders so that implementing an evidence-based approach is feasible. Although the U.S. Department of Justice's National Institute of Justice has funded a number of batterer intervention programme evaluations, the findings are prevented from being implemented by jurisdictional restrictions against using evaluation findings and other pertinent data in developing programme innovations. Criminal justice agencies formulate and implement policies that regulate what structure, duration, and form of intervention is required as a condition of probation for persons found guilty of domestic assault, thereby determining which form of intervention is deemed acceptable by the courts. Consequently, programme funding is only available for those programs that conform to these policies. The current best evidence does not support investing substantial public funds in the continuation or mandating of the standard domestic violence programme model. This literature review suggests that a thorough, individualized assessment and treatment approach holds promise for more effective programme outcomes for domestic violence offenders. Within the existing context of same-sex, group, court-mandated therapy, there are several ways to increase treatment effectiveness. Many rely on established cognitive-behavioural therapy techniques used for other problem areas. Research to date has identified the emotions, perceptions, and situational factors that combine to produce and maintain abusive behaviour. Issues that must be addressed in individual assessment include a patriarchal sociocultural perspective, intergenerational transmission of intimate-partner violence, early trauma, borderline personality, attachment	Non-systematic review

	disorder, and drug and alcohol abuse.	
Corvo, K., Dutton, D., & Chen, W. (2009). Do Duluth model interventions with perpetrators of domestic violence violate mental health professional ethics? *Ethics & Behaviour, 19(4),* 323-340.	In spite of numerous studies of programme outcomes finding little or no positive effect on violent behaviour, the Duluth model remains the most common programme type of interventions with perpetrators of domestic violence. In addition, Duluth model programs often ignore serious mental health and substance abuse issues present in perpetrators. These and other issues of possible threat to mental health professional ethics are reviewed in light of the court-mandated, compulsory nature of most Duluth model programs and client and victim expectations for programme efficacy.	Does not evaluate the outcome of an intervention
Coulter, M., & Vandeweerd, C. (2009). Reducing domestic violence and other criminal recidivism: effectiveness of a multilevel batterers intervention programme. *Violence & Victims, 25(2),* 139-152	This study evaluated whether the use of a multilevel system of intervention based on batterer assessment resulted in lowered risk of re-arrests for both domestic violence and other crimes. The study conducted analysis of data from 1995 to 2004, including initial arrest and programme placement information and re-arrest rates for 17,999 individual batterers. The study found that recidivism rates were substantially lower for participants who completed the programs when compared to those who did not and that the re-arrest rates were substantially lower than are generally found in the literature on batterer recidivism. The study provides guidance to batterers intervention programs in approaches to designing countywide programs that are most effective in reducing recidivism in domestic violence batterers.	Correlational study design
Craig, M., Robyak, J., Torosian, E., & Hummer, J. (2006). A study of male veterans' beliefs toward domestic violence in a batterers intervention programme. *Journal of Interpersonal Violence, 21(9),* 1111-1128.	Domestic violence in intimate relationships is a ubiquitous social problem. This study addresses a gap in the research literature on batterers intervention programs with heterosexual male batterers by evaluating whether or not self reported attitudes about partner abuse and sexist beliefs could be modified over time as a result of participation in a Batterers Intervention Programme (BIP). Using the Inventory of Beliefs about Partner Abuse (IBAPA) to measure attitudes toward domestic violence and the Ambivalent Sexism Inventory (ASI) to measure sexist beliefs, results of the study provide empirical support for the notion that participation in BIPs affects the self-reported beliefs about their rights to physically and emotionally abuse their partner. These selfreported scores were adjusted for response bias by the long version of the Marlowe–Crowne Social Desirability Scale (MCD). Response bias and how it is treated in self-report measures with batterers is also discussed.	Does not evaluate the outcome of an intervention
Dalton, B. (2007). What's going on out there? A survey of batterer intervention programs. *Journal of Aggression, Maltreatment and Trauma, 15(1)*, 59-74.	This national survey reports the current state of batterer intervention programs (BIP) and the provision of batterer intervention services. BIP directors (N=150) provide data regarding programme structure, service characteristics, referral processes, client characteristics, evaluation activities, and recidivism. Results indicate that BIP have become more independent of parent agencies and two-thirds are completely selfsupporting from client fees. Current development of specific treatment tracks and the screening of clients for these tracks are judged to be inadequate. This survey is believed to be the largest to date and the first on a national scale in 20 years. Recommendation is made for national coordination of BIP efforts.	Does not evaluate the outcome of an intervention
Day, A., Chung D., O'Leary, P., & Carson, E. (2009). Programs for men who perpetrate domestic violence: an examination of the issues underlying the effectiveness of intervention programs. *Journal of Family Violence, 24(3)*, 203-212.	This review paper seeks to explore some of the reasons why rehabilitation programs for male perpetrators of domestic violence appear to be less effective in reducing recidivism than programs for other offender groups. It is argued that whilst the model of systems response to domestic violence has predominated at the inter-agency level, further consideration might be given to way in which men's intervention groups are both designed and delivered. It is concluded that the programme logic of men's domestic violence programs is rarely articulated leading to low levels of programme integrity, and that one way to further improve programme effectiveness is to incorporate some of the approaches evident in more general violence prevention programs and from what is know about good practice in general about offender rehabilitation.	Non-systematic review
Day, A., Chung D., O'Leary, P., & Justo, D. (2009). Domestic violence: working with men: research, practice experiences and integrated responses. Annandale, AU: Federation Press.	No Abstract	Book

Donovan,R., Gibbons, L., Francas, M., & Zappelli, R. (2006). Impact on callers to a men's domestic violence helpline. *Australian & New Zealand Journal of Public Health, 30(4)*, 384-385.	No Abstract	Does not evaluate the outcome of an intervention
Dowd, L., & Leisring, P. (2008). A framework for treating partner aggressive women. *Violence & Victims, 23(2),* 249-263.	Women are increasingly referred to intervention programs to address their use of physical violence against intimate partners. This article reviews the scant treatment outcome and attrition literature for partner aggressive women and describes important characteristics of partner aggressive women that must be taken into consideration in designing treatment. Recommended treatment modules are described in detail and include skill-building to enhance safety planning, conflict management, emotional regulation, communication and negotiation, and stress management. Additional modules should be included for some women based on individualized needs. These may include parenting skills and education and referral for treatment of conditions that undermine emotional stability, such as posttraumatic stress symptoms, substance abuse, and mood disorders. Treatment structure is outlined and pragmatic issues regarding the implementation of treatment are discussed. Interventions for partner aggressive woman must be designed to address women's victimization experiences as well as their perpetration.	Non-systematic review
Dutton, D. (2003). Treatment of assaultiveness. *Journal of Aggression, Maltreatment and Trauma, 7(1-2),* 7-28.	Assaultiveness and abusiveness have a psychology that must be addressed in therapy; they are not merely the product of "bad attitudes" or social roles, nor can they be narrowly defined as the robotic imitation of action. Perceptions and feelings about the world of intimate relationships both sustain and are sustained by abusive actions. These provide points of intervention for cognitive behavioural therapy (CBT). Given the tendency to shame easily, abusive men must not be confronted too quickly or too strongly. On the other hand, given their well-established denial system and tendency to minimize the consequences of their abusiveness, some confrontation must occur. Hence a "Zen" line of least resistance must be found between the opposites of acceptance and confrontation. Treatment outcome studies indicate moderate success for cognitive behavioural treatment (CBT) for batterers. Treatment is less successful with men who have personality disorders, especially psychopathy.	Does not evaluate the outcome of an intervention
Eckhardt, C., Murray, C., Black, D., & Suhr, L. (2006). Intervention programs for perpetrators of intimate partner violence: conclusions from a clinical research perspective. *Public Health Reports, 121(4),* 369-381.	In this article, the authors consider the empirical status of batterer intervention programs (BIPs) for male perpetrators of intimate partner violence (IPV). Recent reviews have reported only small average effect sizes for BIPs, with the small number of randomized trials showing little benefit of BIP attendance in preventing future abuse. The most widely adopted BIP intervention model has little empirical justification to support this dominance, yet states with standards governing the content of BIPs often mandate this approach as a contingency for state funding. Little data exist concerning the moderators and mediators of BIP effects on IPV recidivism, and a variety of factors threaten to impede future design advancements, including "turf" battles regarding the causes of IPV and limited funding outlets. Given this discouraging summary, the authors argue that research efforts concerning BIP effectiveness should borrow the design strategies and programmatic research efforts that have proven successful in psychotherapy research, in which significant advances have been made with regard to the evaluation and validation of empirically supported treatments for a wide variety of mental health problems. They conclude by calling for a new generation of IPV researchers to work across professional boundaries in a multidisciplinary manner to design the sophisticated evaluation studies that funding agencies would readily support, and that would provide the substantive answers to the many IPV-related public health questions that remain.	Non-systematic review
Edleson, J. (2012, February). *Groupwork with men who batter: What the research literature indicates.* Harrisburg, PA: National	Historically, there have been many efforts to help end domestic violence; however it was only in the late 1970s that the first group treatment programs for men who batter were founded. Currently, there is wide variation in content, style, and length of batterer intervention programs, from small group treatment programs to universal prevention efforts. This paper focuses on the research on small group treatment programs for men who batter.	Non-systematic review

Online Resource Centre on Violence Against Women.	There is controversy over which, if any, programs are the most effective. This paper first provides a brief overview of the history and current practice of groupwork with men who batter, and then focuses on key findings from the published research on batterer group programs.	
Gadd, D. (2004). Evidence-led policy or policy-led evidence? Cognitive behavioural programmes for men who are violent towards women. *Criminal Justice: International Journal of Policy and Practice, 4(2),* 173-197.	This article critiques the move towards establishing standardized cognitive behavioural interventions for violent men within the National Probation Service of England and Wales. The article queries the persuasiveness of the research evidence informing this policy decision, and argues that in practice a narrow focus on cognition can detract from those aspects of masculinity that are implicated in the perpetration of domestic violence. Having first explored the limits of the evaluation research that has been conducted on cognitive behavioural programmes for domestic violence perpetrators in the UK, the article utilizes a case study to illustrate the complex challenges confronting those who wish to help violent men to change. In particular, the notion that denial is only implicated in mitigating responsibility for violence is exposed as unduly simplistic. The article concludes that without greater acknowledgement of the criminal justice system's tendency to further brutalize violent offenders, court-mandated perpetrators will continue to expect probation interventions to provide 'cures', and become increasingly resistant to engage when no such cures are found.	One case study
Gelles, R. (2008). Standards for programs for men who batter? Not yet. Journal of Aggression, Maltreatment and Trauma, 5(2), 11-20.	Programs for men who batter their intimate partners were developed in the late 1970s. Since that time, mandatory and presumptive arrest policies have increased the number of men arrested for domestic violence. Diversion into programs for batterers evolved into a standard part of a coordinated community intervention for domestic violence. Recently, a number of states have begun to establish standards for batterers' programs. While having standards makes sense, especially as it could assure quality of programs, this article argues that it is premature to establish such standards. The article reviews evaluation data on programs for men who batter and concludes that we know too little about what types or features of programs are effective for which men under what circumstances. Establishing rigorous standards may actually produce more harm than good.	Non-systematic review
Goldenson, J., Spidel, A., Greaves, C., & Dutton, D. (2009) Female Perpetrators of Intimate Partner Violence. *Journal of Aggresssion, Maltreatment, and Trauma, 18(7),* 752-769.	Female perpetrators of intimate partner violence (IPV) are now beginning to receive some scholarly attention both in Canada and the United States, particularly with zero tolerance policies and the increasing number of female arrestees. This article reviews research on the relative prevalence of IPV (comparing males and females) and the context and motivation for perpetration and female perpetrators' general psychopathology (e.g., their attachment issues, trauma experiences, and personality organization). We not only examine intergroup comparisons between women and men, but also highlight some of the intragroup heterogeneity within female perpetrators of the IPV population. The aim of this review is also to describe some of current treatment approaches and provide recommendations for the future.	Non-systematic review
Gondolf, E. (2004). Evaluating batterer counselling programs: A difficult task showing some effects and implications. *Aggression and Violent Behaviour, 9(6),* 605-631.	Over 40 published programme evaluations have attempted to address the effectiveness of "batterer programs" in preventing reassaults. Summaries and meta-analysis of these evaluations suggest little or no "programme effect." Methodological shortcomings, however, compromise most of these quasi-experimental evaluations. Three recent experimental studies appear to confirm little or no effect, but implementation problems, intention-to-treat design, and sample attrition limit these results. A longitudinal 4-year follow-up evaluation in four cities poses additional considerations and evidence of at least a moderate programme effect. There is a clear deescalation of reassault and other abuse, the vast majority of men do reach sustained nonviolence, and about 20% continuously reassault. The prevailing cognitive–behavioural approach appears appropriate for most of the men, but the following enhancements are warranted: swift and certain court response for violations, intensive programming for high-risk men, and ongoing monitoring of risk. Programme effectiveness depends substantially on the intervention system of which the programme is a part.	Non-systematic review
Gondolf, E. (2010). Lessons from a successful and failed random assignment testing batterer programme innovations. *Journal of Experimental Criminology, 6(4*) 355-	With increasing pressure to conduct experimental evaluations of domestic violence interventions, it is important to weigh further the most challenging aspect of experimental designs: the implementation of random assignment. This paper reviews two attempted experimental evaluations of counselling programs for domestic violence offenders, and formulates implications for conducting and interpreting programme evaluations. The two case studies offer an instructive comparison of a maximally implemented experiment and a failed one at	Does not evaluate the outcome of an intervention

376.	the same setting. In the first study, the random assignment was introduced within the counselling programme and with implicit leverage of court sanctions for non-compliance to the assignment. In the second, random assignment was disrupted by unforeseeable events and interagency breakdowns in the complex referral system. Interestingly, implementation issues in both studies raised divergent interpretations from researchers and practitioners. They appear to imply a need for more disclosure of implementation problems in experimental evaluations and for more caution about over interpreting the existing experimental evaluations in the field.	
Gondolf, E.(2004). Regional and cultural utility of conventional batterer counselling. *Violence Against Women, 10(8),* 880-900.	Batterer counselling has become the centerpiece of batterer intervention in the United States but faces questions about its utility across regions and cultures.Amultisite evaluation of conventional gender-based cognitive-behavioural counselling produced comparable reassault rates across three regions of the United States. Preliminary results from a clinical trial of specialized counselling for African American men also show similar outcomes for the conventional counselling and specialized counselling. Some basic counselling principles may have broader application than expected. Variations in the intervention systems, however, may help adapt batterer programs to different regions, and specialized counselling may be beneficial for men with high cultural identification.	Based on preliminary data presented in Gondolf (2008)
Gregory, C., & Erez E. (2002). The effects of batterer intervention programs: the battered women's perspectives. *Violence Against Women, 8(2),* 206-232.	This article presents the perspectives of battered women, whose partners have been court-ordered to participate in a batterer intervention programme, on the programme's effects on their partners, themselves, and their families. Through in-depth interviews, 33 women described their experiences, expectations, and feelings before, during, and after their partner participated in the programme. The interviewees also discussed the impact of the programme on their batterers' behaviour and on their own lives. The study sheds light on the effects of programme participation on batterers' behaviour and the way in which referral and programme participation affect their female partners. The results underscore the value of incorporating battered women's perspectives and experiences in evaluating the effects of batterer intervention programs and designing their service delivery.	Does not evaluate the outcome of an intervention
Hall, J. (2011). A Narrative Approach to Group Work with Men Who Batter. *Social Work with Groups, 34(2)*, 175-189.	A narrative approach to group work with men who batter is presented with case examples. The approach is based in feminist and constructionist theory and seeks to expose and undermine the effects of patriarchal discourse in the lives and relationships of group members. The approach emphasizes an understanding of gender discourse, taking responsibility for actions, and exploring new definitional possibilities for participants and their relationships. The techniques of radical listening, the principle of least contest, breaking the allure of male entitlement and its effects, and cocreating a new male way of being are discussed with case examples.	Does not evaluate the outcome of an intervention
Hester, M., Westmarland, N., Gangoli, G., Wilkinson, M., O'Kelly, C., Kent, A., & Diamond, A. (2006). *Domestic Violence Perpetrators: identifying needs to inform early intervention*. Bristol, UK: University of Bristol, Northern Rock Foundation and Home Office.	No Abstract	Does not evaluate the outcome of an intervention
Jayasekara, R. (2008). Review Summaries: Smedslund G., Dalsbø T.K., Steiro A.K., Winsvold A. & Clench-Aas J. (2007) Cognitive behavioural therapy for men who physically abuse their female partner. *Journal of Advanced Nursing 64(2)*, 129–130.	No Abstract	Summary of Cochrane review

Jones, A.S., D'Agostino, R.B., Gondolf, E.W., & Heckert, A. (2004). Assessing Effect of the Batterer Programme Completion on Reassault Using Propensity Scores. *Journal of Interpersonal Violence, 19(9),* 1002-1020.	Recent experimental evaluations have suggested little or no effect of batterer programs on reassault but are compromised by methodological and analytical issues. This study assesses programme effect using propensity score analysis with a quasi-experimental sample in an attempt to address these issues. The sample consisted of 633 batterers and their partners from three geographically dispersed batterer programs and a 15-month follow-up with their female partners. Subclassification on propensity scores was used to balance programme completers and programme dropouts. The propensity score was estimated as the probability of completing the batterer programme conditional on observable characteristics. Direct adjustment indicates that programme completion reduced the probability of reassault during the 15-month follow-up by 33% for the full sample, and by nearly 50% for the court-ordered men.	Does not evaluate the outcome of an intervention
Kelly, E. (2002). *Working with men as part of a multi-agency approach to tackling domestic abuse: final report*. Edinburgh, UK: City of Edinburgh Council.	No Abstract	Does not evaluate the outcome of an intervention
Kiyoshk, R. (2003). Integrating spirituality and domestic violence treatment: Treatment of aboriginal men. *Journal of Aggression, Maltreatment and Trauma, 7(1-2),* 237-256.	This article provides a brief reflection on how the Change of Seasons treatment model developed and the reasons for its success with Aboriginal men. Parallels between Aboriginal perspectives, or worldviews, and Ken Wilber's transpersonal psychology, Rupert Sheldrake's fields theory, and Peter Senge's systems thinking are also discussed. Practical rituals and ceremonies that have been successfully integrated into psycho-educational group counselling as practiced in the Change of Seasons model are explained. These musings are included to initiate further dialogue on holistic approaches to counselling and other community initiatives.	Does not evaluate the outcome of an intervention
Klein, A., & Crowe, A. (2008). Findings from an outcome examination of Rhode Island's specialized domestic violence probation supervision programme: do specialized supervision programs of batterers reduce reabuse? *Violence Against Women, 14(2),* 226-246.	An examination of specialized domestic violence probation supervision compared to traditional mixed case supervision of domestic violence probationers finds significant differences in several areas, including victim satisfaction, probationer accountability, and reabuse and rearrest rates. Lower-risk abusers, constituting almost half of the probation abuser caseload supervised by the specialized unit, were significantly less likely to be rearrested for domestic violence and nondomestic violence crimes than were those supervised in the traditional mixed caseloads. Victims' satisfaction appeared to be higher, and abusers were held more accountable. Researchers suggest what may account for these different outcomes and the limits of the specialized supervision programme in affecting the behaviour of high-risk abusers.	Intervention setting outside of health and social services (Justice system)
La Violette, A. (2001). Batterers' treatment: Observations from the trenches. *Journal of Aggression, Maltreatment and Trauma, 5(2),* 45-56.	Group treatments for men who abuse their female partners are relatively recent phenomena. These groups were developed with the encouragement of the battered women's movement, and in the mid- to late-1970s, were seen by advocates as a crucial component in the reduction of violence toward women. In the 1980s, batterer treatment groups often became a mandatory consequence of criminal prosecution, treatment groups proliferated, and their effectiveness was questioned. In the 1990s, the value, form, and success rates of these groups came under scrutiny. This article includes a historical perspective of batterers' intervention programs, a description of the Alternatives to Violence programme, and the experiences, perceptions, and opinions of its founder.	Does not evaluate the outcome of an intervention
Laing, L. (2002). *Responding to men who perpetrate domestic violence: controversies, interventions and challenges.* Sydney, AU: Australian Domestic and Family Violence.	No Abstract	Non-systematic review
Laing, L. (2003). *What is the evidence for the effectiveness of perpetrator programmes?* Sydney,	No Abstract	Non-systematic review

AU: Australian Domestic and Family Violence. Clearinghouse .		
Langlands, T., Ward, T., & Gilchrist, E. (2009). Applying the good lives model to male perpetrators of domestic violence. *Behaviour Change, 26(2), 1*13-129.	Domestic violence is a pervasive social problem that has devastating emotional, physical, psychological, and financial costs for individuals, families, and communities. Despite the widespread use of current intervention programmes, recent reviews have demonstrated that these have only a small impact on the reduction of recidivism. In this article, we briefly summarise the features identified in the literature that distinguish domestically violent men from those who do not engage in such behaviours. We then explore the most common interventions used to treat domestic violence offenders and discuss the limitations of these interventions, before outlining the assumptions of the Good Lives Model (GLM), a strengths based approach to the treatment of offenders. We discuss the advantages of using the GLM compared to existing approaches and finally, we consider future directions for the use of the GLM in domestic violence interventions	Does not evaluate the outcome of an intervention
Larance, L.Y. (2006). Serving women who use force in their intimate heterosexual relationships - An extended view. *Violence Against Women, 12,* 622-640.	This article explores the author's practice observations while working with women who use force (WWUF) in their intimate heterosexual relationships. The VISTA Programme's approach to assessment, education and support, and advocacy frames a description of the impact services have had on the lives of WWUF. By contextualizing a woman's experiences, with the aid of the ecological nested model, VISTA staff tailor services to member needs. This article's purpose is to provide an extended view of serving WWUF, one grounded in a "healing place" approach that builds on traditional survivors support group strengths and is distinctly different from batterers' intervention.	Does not evaluate the outcome of an intervention
Lawson, D., Kellam, M., Quinn, J., & Malnar, S. (2012). Integrated cognitive–behavioural and psychodynamic psychotherapy for intimate partner violent men. *Psychotherapy, 49(2),* 190-201.	Intimate partner violence (IPV) continue to have widespread negative effects on victims, children who witness IPV, and perpetrators. Current treatments have proven to be only marginally effective in stopping or reducing IPV by men. The two most prominent treatment approaches are feminist sociocultural and cognitive–behavioural therapy (CBT). The feminist sociocultural approach has been criticized for failing to adequately consider the therapeutic alliance, personality factors, and sole focus on patriarchy as the cause for IPV, whereas CBT has been criticized for failing to attend to motivation issues in treatment protocols. This article reviews the effectiveness of current treatments for partner-violent men, examines relationship and personality variables related to IPV and its treatment, and presents an emerging IPV treatment model that combines CBT and psychodynamic therapy. The article addresses how psychodynamic therapy is integrated into the more content-based elements of CBT.	Non-systematic review
Lee, M.Y., Sebold, J., & Uken, A. (2002). Brief solution-focused group treatment with domestic violence offenders: listening to the narratives of participants and their partners. *Journal of Brief Therapy, 2(1)*, 3-26.	This study utilized qualitative methodology to understand domestic violence offenders' experiences of a solution-focused treatment programme. Building on a strengths perspective, a solution-focused approach holds a person accountable for solutions instead of focusing on problems. Such a treatment approach uses the language and symbols of 'solution and strengths' as opposed to the language of 'deficits and blame.' Content analyses were conducted on responses of 90 group participants and their spouses and partners. Consumers' narratives described helpful and unhelpful treatment components, beneficial therapeutic and relational behaviours of facilitators that contribute to positive changes in offenders and learning generated from attending the treatment programme. Implications for treatment and research with domestic violence offenders are discussed	Does not evaluate the outcome of an intervention
Levesque, D., Driskell, M., Prochaska, J., & Prochaska, J. (2008) Acceptability of a Stage-Matched Expert System Intervention for Domestic Violence Offenders. *Violence and Victims, 23(4),* 432-445.	Most interventions for men who batter are standardized and "one-size-fits-all," neglecting individual differences in readiness to change. A multimedia expert system intervention based on the transtheoretical model (the "stage model") was developed as an adjunct to traditional court-mandated programs. The expert system assesses stage of change, decisional balance, self-efficacy, and processes of change and provides immediate individualized stage-matched feedback designed to increase readiness to end the violence. Fifty-eight male batterer intervention programme clients were invited by agency staff to complete an expert system session and an evaluation of the programme; 33 men were recruited at programme intake and the remainder from ongoing groups. Responses to the intervention were very positive. For example, 87% of participants reported that they found the programme to be easy to use, and 98% said it could probably or definitely help them change their	Does not evaluate the outcome of an intervention

	attitudes or behaviours. Findings provide encouraging evidence of the acceptability of this stagematched approach to intervention for domestic violence offenders.	
Levesque, D.A., Driskell, M-M., Castle, P.H., Greene, N.R., Prochaska, J.O., & Prochaska, J.M. (2005). *Efficacy of a computerized stage-matched intervention for domestic violence offenders: Preliminary findings.* Philadelphia, PA: American Public Health Association.	Most interventions for men who batter are standardized and "one-size-fits-all." A randomized clinical trial is underway to assess the efficacy of a computerized Transtheoretical Model (TTM) based multimedia intervention and print manual developed as an adjunct to traditional batterer programs. The tailored treatment group, at programme intake and at 2 and 5 months follow-up, received computer-administered assessments and feedback matched to stage of change and other TTM variables. The standard care group received computer assessments at intake and 5 months follow-up. Data from the first 200 subjects in their final computer session suggest that the intervention promotes progress through the stages of change and increases help-seeking. For example, compared to standard care participants, tailored treatment participants were significantly more likely to be in the Action stage (37% vs. 12%), and to have sought other group counselling (37% vs. 18%) and talked to a medical professional (40% vs. 22%) in their efforts to stay violence-free. Based on victims' reports (N=74), offenders in the tailored treatment group were less likely to engage in psychological aggression (74% vs. 87%) and physical aggression (40% vs. 54%) at 6 months follow-up, though these findings did not reach statistical significance. However, group differences on several key behaviours were quite dramatic. For example, tailored treatment participants were significantly less likely to have beat up (3% vs. 23%) or slapped (9% vs. 28%) their partner than standard care participants. These findings provide preliminary support for the efficacy of the stage-matched intervention.	Conference abstract
Lindsay, J., Roy, V., Montminy, L., Turcotte, D., & Genest-Dufault, S. (2008). The emergence and the effects of therapeutic factors in groups. *Social Work With Groups, 31(3-4),* 255-271.	This article explores the emergence of therapeutic factors in domestic violence men's group, as well as their effects on participants and the group. The authors conducted semistructured interviews with 72 men from groups in Quebec, after their fourth session. Thirty-eight of these men were met again, following their 16th session. A critical incident technique permitted us to identify various therapeutic factors. Three key factors are discussed: imparting information, hope, and cohesion. The authors found different processes influencing their development, particularly the roles of the worker, other members, and the group as a whole. These factors helped members meet their objectives and by their interdependency also contributed to group development. The authors made links with mutual aid and identified implications for research and practice.	Does not evaluate the outcome of an intervention
Lindsay, J., Roy, V., Turcotte, D. & Montminy, L. (2006). Therapeutic factors in the first stage of men's domestic violence groups: Men talk about universality and how it becomes operational in the group. *Groupwork, 16(1),* 29-47.	This article reports on the qualitative findings of a Québec study on therapeutic factors (TFs) in three ongoing men's domestic violence groups. The study's aim was to discover which TFs are important for male group members in their first stage of the group, and in particular, to explore how these men experienced and described universality. A content analysis was performed on interviews conducted with 72 group members following their third group session. We found that what was most important to the men was the knowledge they acquired about domestic violence, being able to share common concerns, and helping other members. The second part of the article reports on our qualitative analysis of universality, one of the most important TFs: how it was experienced by group members and how it became operational in the group. We believe that the methods of analysis developed in this study – examining symbols, characteristics, processes, and effects of TFs – can contribute to our understanding of the underlying elements of group work as an intervention method.	Does not evaluate the outcome of an intervention
Maiuro, R.D., Hagar, T.S., Lin, H.H., & Olson, N. (2001). Are current state standards for domestic violence perpetrator treatment adequately informed by research? A question of questions. *Journal of Aggression, Maltreatment and Trauma, 5(2)*, 21-44.	An empirical review and critique of existing state standards for batterer programs in the domestic violence field appeared timely, given the current debate about their status and utility. Although there has been a considerable amount of polemic discussion of the topic, relatively limited data whave been reported. The present article surveyed the content of standards developed in 30 states within the United States. Five categories of interest were examined including: (1) the minimum length of treatment specified; (2) specification of treatment orientation, methods, and content; (3) preferred or allowable modalities of treatment; (4) whether research findings were mentioned or endorsed as a basis for development of treatment standards; and (5) methods for developing and revising standards. A related area, the minimum education required for providers, was also included as an area of interest to further describe the current pool of practitioners targeted for regulation. An analysis of the content of these standards was then performed with regard to existing peer-reviewed research	Does not evaluate the outcome of an intervention

	in the field. The results are discussed in terms of the strengths and weaknesses of current standards, the areas in which further research is needed, and specific recommendations regarding steps that might be taken to improve existing efforts.	
Mankowski, E., Haaken, J., & Silvergleid, C. (2002). Collateral damage: An analysis of the achievements and unintended consequences of batterer intervention programs and discourse. *Journal of Family Violence, 17(2),* 167-184.	This paper reviews and critiques two prevailing programme models for batterer intervention in order to highlight both their valuable achievements and attendant costs and consequences. We analyse these batterer intervention programme models at 3 levels. First, we describe the historical development and basic programme components of the intervention models. Second, we trace differences in the models to their grounding in different psychological assumptions and theories about behaviour change, masculinity, and violence. Third, differences between the models are mapped onto contrasting approaches to the regulation of human deviance in the criminal justice and mental health systems. Based on this analysis, we conclude that further attention to structural and contextual factors, such as class, race, economic stress, and substance abuse in explanations of domestic violence is needed, together with alternative approaches to collaboration between victim advocates and batterer intervention providers.	Does not evaluate the outcome of an intervention
Mbilinyi, L., Zegree, J., Roffman, R., Walker, D., Neighbors, C., & Edleson, J. (2008). Development of a marketing campaign to recruit non-adjudicated and untreated abusive men for a brief telephone intervention. *Journal of Family Violence, 23(5),* 343-351.	Although voluntary enrollment by abusive men in domestic violence perpetrator treatment programs occurs, most men enter treatment only after they have injured a partner or family member and have been arrested, convicted and sentenced. This leaves a serious gap for those who engage in abusive behaviour but who have not been served by the legal or social service systems. To address this gap, the researchers applied social marketing principles to recruit abusive men to a telephone-delivered pre-treatment intervention (the Men's Domestic Abuse Check-Up—MDACU), designed to motivate non-adjudicated and untreated abusive men who are concurrently using alcohol and drugs to enter treatment voluntarily. This article discusses recruitment efforts in reaching perpetrators of intimate partner violence, an underserved population. Informed by McGuire's communication and persuasion matrix, the researchers describe three phases of the MDACU's marketing campaign: (1) planning, (2) early implementation, and (3) revision of marketing strategies based on initial results. The researchers' "lessons learned" conclude the paper.	Does not evaluate the outcome of an intervention
Milner, J., & Jessop, D. (2003). Domestic violence: narrative and solutions. *The Journal of Community and Criminal Justice, 50(21)*, 27-141.	This article reports on the first year of a pilot programme based on solution-focused and narrative approaches to working with violent adults who were not receiving assistance to change their behaviour. These adults constituted two groups: violent women for whom there was no service provision at all; and violent men who were either unwilling or unable to attend any of the existing programmes.	Pilot of Milner (2008)
Morran, D. (2006) Thinking Outside The Box: Looking Beyond Programme Integrity. *British Journal of Community Justice, 4(1)*, 7-18.	No Abstract	Does not evaluate the outcome of an intervention
Mullender, S., & Burton, A. (2001) Good practice with perpetrators of domestic violence. *Probation Journal, 48,* 260-268.	No Abstract	Non-systematic review
Muprhy, C., & Ting, L. (2010). The effects of treatment for substance use problems on intimate partner violence: A review of empirical data. *Aggression and Violent Behaviour, 15*, 325-333.	Population and clinical studies document an association between intimate partner violence (IPV) and substance use problems. The current review addressed the question of whether, and to what extent, treatment for substance use problems is associated with reductions in partner abusive behaviour. Data from naturalistic studies were used to examine the prevalence and frequency of IPV before and after substance use treatment, IPV among stably remitted versus relapsed cases after treatment, and factors that may explain observed reductions in partner violence. On average, the prevalence of IPV was 2–3 times higher before substance use treatment than after treatment, and the relative risk for IPV after treatment was 2–3 times greater for relapsed versus remitted cases. Small to moderate effect sizes were observed for reductions in the frequency of IPV after substance use treatment, with large effects observed for reductions in psychological aggression. Both	Non-systematic review

	reduced alcohol consumption and improved relationship functioning appear to account for observed reductions in partner abuse.	
Murphy, C. (2001). Toward empirically based standards for abuser intervention: The Maryland model. *Journal of Aggression, Maltreatment and Trauma, 5(2)*, 249-264.	This article describes the development of operational guidelines for Abuser Intervention Programs in Maryland. Unlike in many states which have adopted quite specific standards regarding programme format, duration, etc., the Maryland guidelines address a fairly narrow range of issues. These include outreach to victims, communication with the courts, and the need for intervention programs to address domestic abuse directly in their programme content. Maryland has also established a research task force on Abuser Intervention Programs, whose goal is to use empirical data to inform the use of best practices in the state, to facilitate empirical research at abuser intervention programs in Maryland, and to develop more detailed programme standards in the future.	Does not evaluate the outcome of an intervention
Murphy, C., & Meis, L. (2008). Individual treatment of intimate partner violence perpetrators. *Violence & Victims, 23(2),* 173-186.	This article outlines a rationale for investigating the individual (one-on-one) treatment format and individualized (case-tailored) services for partner abuse perpetrators. Many state standards caution against or prohibit individual services in abuser intervention. However, initial research indicates that motivational interviewing, conducted individually, can increase abusive clients' engagement in the change process. Challenges of using the group format in treatment development are discussed along with potential benefits of individual treatment for this population. Notably, individual treatment can be adapted to the client's stage of change, can address a range of presenting concerns (such as substance abuse and mood disorders) that may influence outcome, and can be used to focus clinical attention on case-specific change targets while avoiding potentially negative and antisocial peer influences in the group format. Nevertheless, individual treatment has been almost entirely ignored to date in clinical research with this population.	Non-systematic review
Musser, P., & Murphy, C. (2009). Motivational interviewing with perpetrators of intimate partner abuse. *Journal of Clinical Psychology, 65(11),* 1218-1231.	Recent controlled trials have shown promising benefits of motivational interviewing (MI) as a pretreatment intervention for perpetrators of intimate partner violence (IPV). A 2-session intake, containing motivational interviewing and structured assessment feedback, was developed for this predominantly court-mandated clientele. The goals were to reduce initial hostility toward treatment, facilitate verbalization of motivation to change, resolve ambivalence, and increase receptivity to structured group therapy for IPV. An extended case report illustrates the value of MI spirit and techniques, including empathic reflection, evocative questions, affirmation, and rolling with resistance, in achieving these intervention goals.	One case study
Novo, M., Rivera, F., Seijo, M., & Arce, R. (2012). Assessment of a community rehabilitation programme in convicted male intimate-partner violence offenders. *International Journal of Clinical and Health Psychology, 12,* 219-234.	In Spain, the mandatory community rehabilitation of convicted male intimate-partner violence offenders opens new avenues for the treatment of these offenders. To determine the effectiveness of an experimental cognitive-behavioural treatment programme with content adjusted to target the specific cognitive limitations or deficits of each individual intimate-partner violence offender, a field study was designed to assess the rehabilitation effects on the underlying internal mechanisms that foster offending. 130 convicted intimate-partner violence offenders underwent pre- and postintervention assessment of the internal underlying mechanisms that spur offending. The pre-rehabilitation results showed that convicted intimate-partner violence offenders exhibited, in comparison with the normative population, hostility (i.e., aggression, anger, fury, irritability, rage, resentment), persecutory ideas (i.e., suspicious, fear of losing autonomy, need of control, difficulties in expressing their hostility), and depressive symptoms. The rehabilitation effects were significant, positive and with a moderate effect size for depressive symptoms, large for hostility, and moderate for persecutory ideas. In conclusion, the results substantiate the effectiveness of this rehabilitation programme for the treatment of violent thinking.	Study conducted in Spain
O'Farrell, T., Murphy, M., Fals-Stewart, W., & Murphy, C. (2003). Partner violence before and after individually based alcoholism treatment for male alcoholic patients. *Journal of Consulting and Clinical Psychology, 71(1),* 92-102.	This study examined partner violence in the year before and the year after individually based, outpatient alcoholism treatment for 301 married or cohabiting male alcoholic patients and used a demographically matched nonalcoholic comparison sample. In the year before treatment, 56% of the alcoholic patients had been violent toward their female partner, 4 times the rate of 14% in the comparison sample. In the year after treatment, violence decreased significantly to 25% of the alcoholic sample but remained higher than in the comparison group. Among remitted alcoholics after treatment, violence prevalence of 15% was nearly identical to the comparison sample and half the rate among relapsed patients (32%). Thus, partner violence decreased	Does not evaluate the outcome of an intervention

	after alcoholism treatment, and clinically significant violence reductions occurred for patients whose alcoholism was remitted after treatment.	
Pandya, V. (2009). A study of change processes in domestically violent men in group therapy. *Journal of Evidence-Based Social Work, 6(2),* 127-146.	models, the transtheoretical model (TTM) and the affective change process model (ACPM), to understand the change processes reported by 14 domestically violent men (DVM) in group therapy. This article reports how DVM change (or not change) in group therapy. Out of biographies of 14 DVM, one is presented here in detail, and summaries of all biographies are given. The study found that themes from both change process models could be found in all biographies. Change processes described by DVM with alcohol and substance use problems patterned more closely to TTM, whereas DVM with emotional and behavioural symptoms patterned more closely to ACPM. This evidence, grounded in data, indicates a need for integration of these two models, adding a focus on changing communication patterns for further development of clinical group practice with DVM.	Does not evaluate the outcome of an intervention
Pascal-Leone, A., Bierman, R., Arnold, R., & Stasiak, E. (2011). Emotion-focused therapy for incarcerated offenders of intimate partner violence: a 3-year outcome using a new whole-sample matching method. *Psychotherapy Research, 21(3),* 331-347.	A 3-year follow-up was conducted for Relating Without Violence, an emotion-focused group psychotherapy programme for incarcerated men who have a history of intimate partner violence. This is the only known manualized experiential treatment for incarcerated batterers. A sample of 66 men who completed the treatment was compared to 184 men from the same prison. Although the initial research design was quasi-experimental, new procedures were used to match the groups' averages on all known pre-treatment variables. At 7 and 8 months post-release, the treatment group recidivated by assault and/or sexual assault significantly less than controls. Treatment effects are comparable to those of best practices. The study also demonstrates methodological developments for statistically creating matched groups not previously used in psychotherapy research.	Setting of intervention not health services (Prison)
Pitts, W., Givens, E., & McNeely, S. (2009). The Need for a Holistic Approach to Specialized Domestic Violence Court Programming: Evaluating Offender Rehabilitation Needs and Recidivism. *Juvenile and Family Court Journal, 60(3)*.	This quasi-experimental historical outcome study is based on the Domestic Violence Repeat Offender Programme (DVROP) housed within the Bernalillo County Metropolitan Court in Albuquerque, New Mexico. The treatment group includes data for 100 male domestic violence offenders collected between July 1, 2004 and November 30, 2006. A strictly matched group of 100 males who were technically eligible but who were not served by the DVROP made up the comparison. Using NCIC data as an outcome measure, the results of the study show that DVROP participants are significantly less likely to receive subsequent charges for domestic violence, other violent offenses, or any other criminal offense. The study draws conclusions about the extensive collateral needs of the offender population and draws attention to the need for a holistic approach to special offender populations.	Intervention setting outside of health and social services (Justice system)
Polaschek, D. (2011). High-intensity rehabilitation for violent offenders in New Zealand: Reconviction outcomes for high- and medium-risk prisoners. *Journal of Interpersonal Violence, 26(4)*, 664-682.	As the empirical evidence accumulates, so does confidence that carefully designed and delivered rehabilitation approaches can reduce risk. Yet little is known about how to rehabilitate some specialized groups, such as high risk violent offenders: career criminals with an extensive history of violent behaviour. Since 1998, New Zealand's Rimutaka Violence Prevention Unit (RPVU) has provided intensive cognitive-behavioural rehabilitation to violent men. In this evaluation, 112 medium- and high-risk prisoners who entered the programme after 1998 are case matched to 112 untreated men. Reconviction outcome data over an average of 3.5 years postrelease show that 10% to 12% fewer programme completers were reconvicted for violence compared to their untreated controls. High-risk completers also are less likely to be reconvicted for any offense. Those men who opted out of the study are a slightly higher-risk group than those who completed it, but noncompletion does not further increase their risk. Given the lack of programme theory, and formidable practical challenges involved in working with such a high-risk group, these results are very promising.	Intervention setting outside of health and social services (Justice system)
Price, B., Rosenbaum, A. (2009). Batterer intervention programs: a report from the field. *Violence & Victims, 24(6)*, 757-770.	Over the past 25 years, batterer intervention has become the most probable disposition following a plea or conviction on domestic battery charges and, consequently, batterer intervention programs (BIPs) have proliferated. Despite their popularity, and recent attempts by states to regulate practice, little is known about the actual programs operating in the field. The aim of this study was to examine the philosophy, structure, leadership, curricula, and support systems of BIPs. Respondents from 276 batterer intervention programs in 45 states described their programs via an anonymous, Web-based survey. The results provide some insight	Does not evaluate the outcome of an intervention

	regarding the workings of actual BIPs and also point out problems such as the dearth of programs in languages other than English and the failure to translate recommendations for prescriptive approaches into practice.	
Respect UK (2010). *Respect Briefing Paper: Evidence of Effects of Domestic Violence Perpetrator Programmes on Women's Safety.* London, UK: Respect.	No Abstract	Non-systematic review
Rivett, M., & Rees, M. (2006). Treatment for perpetrators of domestic violence: controversy in policy and practice. *Criminal Behaviour & Mental Health, 16(4),* 205-210.	No Abstract	Does not evaluate the outcome of an intervention
Rivett, M., & Rees. A. (2004). Dancing on a razor's edge: systemic group work with batterers. *Journal of Family Therapy, 26,* 142–162.	This paper describes a systemic approach to working with domestic violence which does not focus upon couple therapy but rather adapts the Duluth 'co-ordinated community response' model. It proposes that this model may be understood from a systemic perspective by drawing upon the 'levels of context' ideas prevalent within systemic therapy. The paper then demonstrates the practice of group work with men who are violent to their partners from this systemic perspective. The group work undertaken with these men may be understood as 'systemic' from a number of viewpoints. These include constructing the work within a systemic context, retaining a systemic perspective in the work, and adapting various systemic methods in the group work itself. In describing this approach to work with men who have abused their women partners, the authors hope to contribute to the domestic violence literature, to the understanding of group work methods within systemic work, and to the knowledge of practitioners who need to engage and work with abusive men.	Does not evaluate the outcome of an intervention
Rivett, M., & Rees. A. (2005). 'Let a hundred flowers bloom, let a hundred schools of thought contend': towards a variety in programmes for perpetrators of domestic violence. *Probation Journal, 59(3),* 277-288.	As the new probation services' Integrated Domestic Abuse Programmes (IDAP) are being rolled out over the country, this article seeks to argue that we should retain a variety of approaches to domestic abuse perpetrators. This argument is based on a number of themes and is supported by case examples from a programme that until April 2005 has worked with both voluntary and mandated perpetrators in Cardiff. These themes can be summarized into: those that relate to the state of knowledge about such perpetrators; those that relate to the limits of a criminal justice approach to the problem of domestic violence; and lastly to the ability of programmes not placed in the criminal justice arena to more effectively engage perpetrators in change. The particular programme from which case examples are drawn is one which combines a systemic (Duluth) approach with a cognitive behavioural one but which also integrates therapeutic group work methods.	Does not evaluate the outcome of an intervention
Roffman, R., & Edleson, J., Neighbors, C., Mbilinyi, L., Walker, D. (2008). The men's domestic abuse check-up: a protocol for reaching the nonadjudicated and untreated man who batters and who abuses substances. *Violence Against Women, 14(5),* 589-605.	Batterer intervention programs primarily work with individuals mandated to participate. Commonly, attrition is high and outcomes are modest. Motivational enhancement therapy (MET), most widely studied in the substance abuse field, offers a potentially effective approach to improving self-referral to treatment, programme retention, treatment compliance, and posttreatment outcomes among men who batter and who abuse substances. A strategy for using a catalyst variant of MET (a "check-up") to reach untreated, nonadjudicated perpetrators is described in detail. Unique challenges in evaluating the success of this approach are discussed, including attending to victim safety and determining indicators of increased motivation for change.	Does not evaluate the outcome of an intervention
Ronel, N., Claridge, S. (2003). The powerlessness of control: a unifying model for the treatment of male battering and substance addiction. Journal of Social Work Practice in	The high incidence of partner abuse among substance addicted men calls for a unified model of treatment. Grace Therapy is an approach for the treatment of male batterers based on the 12-Step Programme of AA/NA. Clinical evidence relates the internal processes of male batterers and substance-addicted men to similar issues in which feelings of powerlessness arise. Powerlessness has three levels: behavioural, mental, and spiritual. By addressing the behavioural and mental levels, men can become abstinent by avoiding the situations,	Study conducted in Israel

the Addictions, 3(1), 57-76.	behaviours, and mental motives that lead them to violence and substance abuse. Recovery and healing occur within the spiritual level through a transformation of the men's attitudes towards the world and themselves–a transformation from self-centeredness to God-centeredness, which produces a growing capacity within the men to care for others unconditionally.	
Rosenbaum, A. & Gearan, P., Ondovic, C. (2001). Completion and recidivism among court- and self-referred batterers in a psychoeducational group treatment programme: Implications for intervention and public policy. *Journal of Aggression, Maltreatment and Trauma, 5(2),* 199-220.	Batterers treatment has become a central component in efforts to curb relationship aggression. However, debate continues over the relative effectiveness of batterers treatment both independent of, and in concert with, legal interventions. The present study examined the relationship between referral source (i.e., self-referred vs. court-mandated), participant characteristics, treatment length (i.e., 7, 10, and 20 weeks), treatment completion, and recidivism in a sample of 326 men who had completed at least one session of a batterers treatment programme. Results indicated that court-referred men had a significantly higher treatment completion rate than self-referred men in the 20-session condition, but not in either of the shorter treatment lengths. Men who were exposed to their fathers' physical abuse of their mothers and men who have been aggressive in past relationships had significantly lower completion rates. Recidivism was lowest for men who had been court-referred and completed treatment. Treatment completion was associated with significantly lower rates of recidivism for court-referred but not self-referred participants. Participants in the 10- and 20-session treatment programs had significantly lower rates of recidivism than those in the seven-session programme, but were not significantly different from one another. No participant characteristics were found to be significantly associated with recidivism. Implications of these findings for the structure of batterers treatment and public policy are discussed.	Correlational study design
Rosenbaum, A., & Leisring, P. (2001). Group intervention programs for batterers. *Journal of Aggression, Maltreatment and Trauma, 5(2)*, 57-71.	Batterer intervention programs are extremely diverse yet share many common strategies. This article summarizes the relevant issues, and provides an overview of the intervention strategies most commonly included in these programs. Issues discussed include confidentiality, group structure and length, partner contacts, leadership configuration, and programme goals. In the second part of the paper, topics and strategies are presented. These include power and control, anger management, time-out, feelings underlying anger, stress reduction, parenting, and the costs of aggression, substance abuse, communication, and cognitions. Finally, brief descriptions of two frequently modeled, pro-feminist programs, Duluth and Emerge, are presented. Similarities and differences between pro-feminist and cognitive-behavioural programs are discussed.	Non-systematic review
Salazar, L.F., Cook, & Sarah L. (2006). Preliminary Findings from an Outcome Evaluation of an Intimate Partner Violence Prevention Programme for Adjudicated, African American, Adolescent Males. *Youth Violence and Juvenile Justice, 4(4),* 368-385.	This study evaluated the efficacy of a five-session intimate partner violence (IPV) prevention programme for adjudicated African American male adolescents. The programme was guided by feminist theory and was culturally focused and gender specific. An experimental design was used to assess changes in knowledge of IPV and patriarchal attitudes at posttest and to test for the moderating effects of committing IPV and witnessing parental IPV. Results indicated higher levels of knowledge and less patriarchal attitudes among the intervention group as compared to the control group. Committing violence was not a significant moderator of intervention effectiveness; a witnessing parental violence by group interaction revealed that adolescents in the intervention group had significantly lower patriarchal attitudes compared with adolescents in the control group, but only for those who witnessed high levels of parental male-to-female violence.	Intervention setting outside of health and social services (Justice system)
Saunders, D. (2008). Group interventions for men who batter: a summary of programme descriptions and research. *Violence & Victims, 23(2),* 156-172.	This article provides a summary of the latest research on men's group interventions for men who batter their intimate partners. The major components of current programs are described, along with studies on treatment effectiveness. Evidence for the effectiveness of treatment combined with a coordinated community response is also presented. Several related topics are covered, in particular methods for enhancing treatment motivation and culturally competent practice.	Non-systematic review
Scott, K. (2004). Predictors of change among male batterers: application of theories and review of empirical findings. *Trauma Violence*	The efficacy of batterer treatment is a concern of clinicians, researchers, and policy makers. Most past research on batterer treatment has defined success as a cessation of men's physical abuse against their intimate partner. Although clearly an important outcome, focus on assault leaves many questions unanswered about the broader impact of batterer treatment and the processes through which successful change may be	Does not evaluate the outcome of an intervention

& Abuse, 5(3), 260-284.	promoted. With the aim of encouraging complexity in the consideration of change among batterers, the current article reviews studies that go beyond dichotomous outcomes. First, evidence for the success of batterer treatment is considered from multiple perspectives: men's, women's, and the intervention system. Next, an in-depth review of research on factors relating to change in abusive men is completed using feminist, family systems, individual, and typology theories as an organizing framework. Numerous recommendations are made for integrating theories of change with investigations of treatment success in future work.	
Scott, K. (2004). Stage of change as a predictor of attrition among men in a batterer treatment programme. *Journal of Family Violence, 19(1),* 37-47.	This study assessed the contribution of the men's stage of change to the prediction of attrition among men attending a batterer treatment programme. As outlined by the transtheoretical model of change, men were classified into the precontemplation, contemplation, or action stage based on their level of change motivation and behaviour. It was hypothesized that men in the precontemplation stage would dropout of treatment at higher rates than men in later stages of change. Participants were 308 men who enrolled in a batterer treatment programme over the course of 1 year, 61.4% of whom dropped out of treatment. Counsellor rated, but not self-rated stage of change significantly predicted treatment completion once traditionally used demographic, contextual, and personality variables were taken into account. Specifically, men identified by counsellors as being in the precontemplation stage were 2.3 times as likely as men rated in the contemplation stage and 8.8 times as likely as men rated in the action stage to dropout of treatment. Referral source, age, and history of arrest also made significant contributions to the prediction of attrition. The best combination of predictors led to the successful classification of 72% of the cases, 98% of the dropouts but only 19% of the completers. Discussion focuses on the limitations of current findings and their implications for the use of the transtheoretical model to predict attrition from batterer treatment.	Does not evaluate the outcome of an intervention
Scott, K., King, C., McGuinn, H., & Hosseini, N. (2011). Effects of motivational enhancement on immediate outcomes of batterer intervention. *Journal of Family Violence, 26(2),* 139-149.	This article presents results of a quasiexperimental trial of a 6 week motivation enhancing intervention for batterers highly resistant to intervention. One hundred and forty one (29%) highly resistant batterers were identified from a consecutive sample of 486 men referred to a large batterer intervention programme. Resistant batterers attended either standard intervention (16 weeks) or a specialized 6 week motivation enhancing group followed by 10 weeks of standard intervention. Observation of counsellor behaviours confirmed significant differences in rates of confrontation across groups. Analyses of immediate programme outcomes provide some support for the value of motivation enhancing intervention. Resistant batterers who attended specialized intervention completed intervention at a significantly higher rate (84.2%) than both resistant clients in standard intervention (46.5%) and non-resistant clients (61.1%). Differences were maintained even after controlling for demographic and lifestyle related predictors of attrition. Advantages of specialized intervention did not extend to counsellor-rated success at meeting core treatment goals. Discussion focuses on the implications of these results for the use of motivation enhancing intervention strategies to improve attendance at batterer intervention programs.	Does not evaluate the outcome of an intervention
Selwood, A. Cooper, C., Owens, C., Blanchard, M., Livingston, G. (2009). What would help me stop abusing? International Psychogeriatrics, 21(2), 309-313.	Background: A third of family members caring for people with dementia report acting abusively towards them, but there are currently no evidence-based interventions to reduce or prevent such behaviour. Family carers who act abusively have not previously been consulted about what may help to reduce abuse. Method: We prospectively recruited a consecutive sample of 220 family carers of people with dementia referred to secondary psychiatric services. We asked carers who reported any abusive behaviour in the previous three months to select from a list of services and potential interventions those that they thought might help to reduce or prevent this abusive behaviour. Carers were also asked to suggest other interventions that might help prevent abuse. Results: 113/115 carers who reported any abusive behaviour answered questions about possible interventions. The three most frequently endorsed interventions were: medication to help the care recipient's memory (n=54; 48.2%); written advice on understanding memory problems and what to do (n=48; 42.9%) and more information from professionals caring for the person with dementia (n=45; 40.2%). When asked which interventions were most important, medication to help memory (n=21; 18.6%), home care (n=17; 15.0%), residential respite and sitting services (both n=12; 10.6%) were most frequently endorsed. Conclusion:	Does not have outcomes relevant to research question

	To prevent abuse, family carers prioritized medication for memory, good communication from professionals, written advice on memory problems, home care, residential respite and sitting services. As no interventions to reduce abuse by family carers have yet been formally evaluated, a good starting point may be the expressed wishes of family carers.	
Shamai, M., & Buchbinder, E. (2010). Control of the self: partner-violent men's experience of therapy. *Journal of Interpersonal Violence, 25(7)*, 1338-1362.	This study explores the experience of men who participated in programs for partner-violent men by understanding their perceptions of the treatment process, the treatment outcomes, and the meaning they attached to it. The sample included 25 men who completed these programs in agencies that specialized in treating domestic violence in Israel. A qualitative methodology was used to collect and analyse the data. The findings revealed that most of the men experienced therapy as positive and meaningful and underwent personal changes, especially the acquisition of self-control. Deeper analysis of the data, however, shows that the men still used a power scheme in understanding and creating relationships with others, especially with their woman partner. The findings are discussed in light of the complex and contradictory impact of the treatment process as it appears in the participants' experiences and in the meaning they attached to it.	Study conducted in Israel
Smith Stover, C., Medows, A.L., & Kaufman, J. (2009). Interventions for intimate partner violence: Review and implications for evidence-based practice. *Professional Psychology, 40(3),* 223-233.	The objective of this article was to survey available intimate partner violence (IPV) treatment studies with (a) randomized case assignment, and (b) at least 20 participants per group. Studies were classified into 4 categories according to primary treatment focus: perpetrator, victim, couples, or child-witness interventions. The results suggest that extant interventions have limited effect on repeat violence, with most treatments reporting minimal benefit above arrest alone. There is a lack of research evidence for the effectiveness of the most common treatments provided for victims and perpetrators of IPV, including the Duluth model for perpetrators and shelter–advocacy approaches for victims. Rates of recidivism in most perpetrator- and partner-focused treatments are approximately 30% within 6 months, regardless of intervention strategy used. Couples treatment approaches that simultaneously address problems with substance abuse and aggression yield the lowest recidivism rates, and manualized child trauma treatments are effective in reducing child symptoms secondary to IPV. This review shows the benefit of integrating empirically validated substance abuse and trauma treatments into IPV interventions and highlights the need for more work in this area.	Non-systematic review
Smith, M. (2008). Reducing the harm of domestic violence. *Healthcare Counselling & Psychotherapy Journal, 8(4).*	No Abstract	One case study
Stuart, G.L. (2005). Improving violence intervention outcomes by integrating alcohol treatment. *Journal of Interpersonal Violence, 20(4)*, 388-393.	There is extensive empirical and theoretical support for a link between alcohol use and intimate partner violence. Recent innovations in the assessment of these constructs have shown a strong temporal link between alcohol use and intimate partner violence. The majority of men participating in batterer intervention programs have alcohol problems, and these men are at very high risk for violence recidivism. Research has shown substantial decreases in partner violence among alcoholics subsequent to obtaining alcohol treatment. It is likely that violence outcomes could be significantly improved by incorporating alcohol treatment as a standard component of batterer intervention programs.	Non-systematic review
Stuart, G.L. (2007) Improving batterer intervention programs through theory-based research. *JAMA, 298(5)*, 560-562.	No Abstract	Does not evaluate the outcome of an intervention
Taft, C.T., & Murphy, C.M. (2007). The working alliance in intervention for partner violence perpetrators: recent research and theory. J*ournal of Family Violence, 22(1*), 11-18.	The working alliance consists of therapist and client agreement on the goals and tasks of therapy, and the therapeutic bond. Measures of theworking alliance, assessed during the course of therapy, have consistently predicted positive therapeutic change across various client populations and treatment approaches. This paper reviews recent research highlighting the importance of the working alliance with respect to treatment compliance and outcome in interventions for perpetrators of partner violence. The common promotion and use of confrontational intervention tactics in these interventions and the potentially negative impact of	Non-systematic review

	confrontational tactics on the working alliance is also discussed.	
Tollefson, D.R, & Gross, E.R. (2006). Predicting Recidivism Following Participation in a Treatment Programme for Batterers. *Journal of Social Service Research, 32(4)*, 39-62.	This study examined recidivism rates for 197 batterers who participated in a state-sponsored domestic violence treatment programme. The primary objective of the study was to identify factors associated with post-intervention recidivism. Significant factors identified through bivariate analyses were analysed through logistic regression for the purpose of developing predictive models. Bivariate analyses identified 10 factors associated with post-intervention recidivism. Of these factors, logistic regression identified four factors that were predictive of recidivism. These four factors–psychopathology (personality disorders), psychiatric history, substance abuse, and child abuse in family of origin– were able to predict 84% of all outcomes and 97% and 28% of abstainers and reoffenders, respectively. The data suggest that batterer characteristics, particularly batterer pathology and substance abuse, are more influential determinants of recidivism than systemic and programmatic factors. These findings are discussed with respect to their implications for policy, practice, and future research.	Correlational study design
Tollefson, D.R., Web, K., Shumway, D., Block, S.H., & Nakamura, Y. (2009). A mind-body approach to domestic violence perpetrator treatment: programme overview and preliminary outcomes. *Journal of Aggression, Maltreatment & Trauma, 18(1)*, 17-45.	Conventional interventions with perpetrators of domestic violence are marginally effective. Given these results, researchers and practitioners are beginning to focus on identifying ways to improve domestic violence treatment outcomes. This article describes how a rural state-sponsored domestic violence offender programme utilizes a treatment approach known as Mind-Body Bridging to help its clients overcome their abusive behaviours. Preliminary findings from an ongoing outcome study are also reported. According to these findings, the programme has a high completion rate coupled with a low recidivism rate. Ninety-three percent (82 of 88) of the clients who have participated in this programme completed the programme, and just 7% (6 of 82) of those who completed the programme reoffended during the follow-up period, which ranged from 9 to 27 months.	Does not evaluate the outcome of an intervention
Tolman, R.M. (2001). An ecological analysis of batterer intervention programme standards. *Journal of Aggression, Maltreatment and Trauma, 5(2),* 221-233.	Many states and local jurisdictions have drafted and implemented standards for batterer intervention programs. This article first presents a review of the arguments for and against the current standards. The author argues that the extant empirical research on batterer intervention is, at best, a limited source of knowledge for setting standards. The author then uses Bronfenbrenner's (1972, 1975) ecological framework to analyse existing standards, and to guide recommendations for future research on batterer intervention.	Non-systematic review
Tonkin, T., & Michell, D. (2010) The Reverse Role Play-An Innovative Way of Confronting Men. *Australian Social Work, 63(4),* 460-465.	The need to confront men who behave violently toward women is still very much in evidence in Australian society. In this article we discuss an innovative activity, called the Reverse Role Play, which was designed as a conversation with the partners of violent men. During the Reverse Role Play, violent men have the opportunity to walk around in their partners' shoes for awhile and by doing so they often become aware, perhaps for the first time, of the consequences of their damaging behaviour. This can lead to the development of empathy in violent men, which in turn can motivate them to begin the process of taking responsibility for and changing their behaviour.	Does not evaluate the outcome of an intervention
Townend, M., & Smith, M.E. (2007). A case study of cognitive-behavioural psychotherapy with a perpetrator of domestic abuse. *Clinical Case Studies, 6(5)*, 443-453.	This is a case study of a male perpetrator of domestic abuse who voluntarily sought help for abusive behaviour toward his partner. The case is described, highlighting a 20-week treatment plan underpinned by an interacting cognitive subsystem-based conceptualization. Evaluation of the therapy is by self-report measures of aggression, assertiveness, and dysfunctional attitude that were administered pre- and posttherapy and at 9-month follow-up. The results are a reduction in aggressive behaviour and improved assertiveness, whereas dysfunctional attitudes changed to a profile of greater psychological strengths. Implications for therapeutic intervention and development are also discussed.	One case study
Walker, D.D., Neighbors, C., Mbilinyi, L.F., O'Rourke, A., Zegree, J., Roffman, R.A., & Edleson, J.L. (2010). Evaluating the Impact of Intimate Partner Violence on the Perpetrator: The Perceived	Surprisingly, little is known about how IPV perpetrators perceive the consequences of their violent behaviour. This article describes the development and evaluation of the Perceived Consequences of Domestic Violence Questionnaire (PCDVQ). The PCDVQ is a 27-item self-report instrument designed to assess the consequences of intimate partner violence (IPV) as perceived by the perpetrator. Data from 124 nontreatment seeking, male, IPV perpetrators recruited from the community provided support for the internal consistency of the PCDVQ. Participants reported an average of 9.97 (SD=4.57) consequences. Scores on the PCDVQ	Does not evaluate the outcome of an intervention

Consequences of Domestic Violence Questionnaire. *Journal of Interpersonal Violence, 25,* 1684-1698.	significantly predicted motivation for change, b=0.19, t(113)=2.03, p<0.05, and treatment seeking, x2(df=1)=10.79, p<0.01, odds ratio=1.27 (95% CI: 1.10-1.46). Clinical implications of this instrument are discussed.	
Welland, C., & Ribner, N. (2010). Culturally specific treatment for partner-abusive Latino men: a qualitative study to identify and implement programme components. *Violence & Victims, 25(6)*, 799-813.	Research based on a demographic survey and qualitative interviews of Latino intimate partner violence perpetrators in Southern California forms the basis of a Spanish-language treatment programme designed to be culturally appropriate for Latino immigrant men, and piloted for 4 years with their input. Culturally-specific c topics emphasized by participants and integrated into the programme are: effective parenting skills for men; gender roles; discussion of discrimination towards immigrants and women; immigration and changing gender roles; marital sexual abuse; and spirituality as related to violence prevention. Attention is given to alcohol abuse and childhood trauma. Results suggest the desirability of an empathic and culturally-sensitive approach, without diminishing responsibility. This programme was designed to help clinicians refine their skills and effectiveness in working with this rapidly expanding population.	Does not evaluate the outcome of an intervention
Westmarland, N., & Hester, M. (2007). *Time for change: an assessment of services for domestic abuse perpetrators in Bristol*. Bristol, UK: University of Bristol.	No Abstract	Does not evaluate the outcome of an intervention
White, R.J., & Gondolf, E.W. (2000). Implications of personality profiles for batterer treatment. *Journal of Interpersonal Violence, 15(5),* 467-486.	Research on men who batter women has recently given a great deal of attention to personality types of batterers. Treatment recommendations for batterer types have relied primarily on aggregated statistical analyses of the Millon Clinical Multiaxial Inventory (MCMI), but may be misleading because the MCMI is designed to be interpreted using individual profiles. The authors employed a profile analysis with MCMI-III results of 100 batterers randomly drawn from 840 men enrolled in four batterer programs. Case examples are used to illustrate the personality profiles and their treatment implications. The profile analysis suggests six major personality groupings that in part reflect previously established types. However, the majority of batterers exhibit narcissistic or avoidant traits that are well suited for the prevailing cognitive-behavioural group treatment approach. A smaller proportion of men evidence personality problems that may warrant adjunctive psychiatric services or individual psychotherapy. In sum, “one size” of treatment appears to fit most.	Does not evaluate the outcome of an intervention
Willis, D.G., & Porche, D.J. (2004). Male battering of intimate partners: theoretical underpinnings, intervention approaches, and implications. *Nursing Clinics of North America, 39(2),* 271-282.	No Abstract	Non-systematic review
Wilson, M. (2003). *Perpetrator programmes for male domestic violence offenders: what do we know about effectiveness?* Edinburgh, UK: Criminal Justice Social Work Development Centre for Scotland.	No Abstract	Non-systematic review
Zellerer, E. (2003). Culturally competent programs: The first family violence programme for aboriginal men in prison. *Prison Journal, 83,* 171-190.	Given the severity and extent of woman abuse, calls are being made to mandate treatment for abusive men. Attention has focused on Caucasian populations; few programs are culturally competent. This article discusses the first Aboriginal family violence programme for inmates within the federal correctional system in North America. The Correctional Service of Canada funded a project operated by a community agency, Ma Mawi Wi Chi Itata Centre, for offenders at Stony Mountain Institution in Manitoba. Numerous issues, including cultural	Intervention setting outside of health and social services (Justice system)

	competence, training, and evaluation, are highlighted.	

Table 14. Research Question 3 (Elder Interventions) Studies Excluded on Full Text

Study Details	Abstract	Reason for Exclusion
Brandl, B., Hebert, M., Rozwadowski, J., & Spangler, D. (2003). Feeling safe, feeling strong: support groups for older abused women. *Violence Against Women, 9(1),* 1490-1503.	Too often, older women experience the heartache of being hurt by someone they love. These women may be isolated and unaware of community resources. Support groups can provide older abused women with support, information, friendship, and hope—a place to feel safe and strong. Based on interviews with 34 support group facilitators, this article describes (a) the logistics of identifying projects, (b) the benefits of support groups for older abused women, (c) the characteristics of existing groups, (d) the challenges of starting a support group, and (e) principles for working with older abused women.	Does not evaluate the outcome of an intervention
Desmarais, S.L., & Reeves, K.A. (2007). Gray, black, and blue: the state of research and intervention for intimate partner abuse among elders. *Behavioural Sciences & the Law, 25(3),* 377-391.	Though not as common as in younger populations, intimate partner abuse (IPA) among elders is a significant and often overlooked problem. In this article, we focus on problems for research and intervention. We begin with a brief review of the phenomena of elder abuse and IPA, highlighting problems resulting from definitional issues and inconsistencies in research methodology. The balance of the paper comprises a discussion of problems for intervention. Drawing from the IPA and elder abuse literatures, risk factors unique to IPA among elders are presented, and limitations of existing screening and risk assessment instruments for use within this context are identified. The focus then shifts to legal considerations when working with elders who have experienced or perpetrated IPA. Our goals are to synthesize the elder abuse and IPA literatures, identify limitations within both, and to reflect upon the state of knowledge regarding IPA among elders.	Does not evaluate the outcome of an intervention
Dodd, K., & Lamb, L. (2004). Recommendations into practice: implementing the results of local research into adult protection. *Journal of Adult Protection, 6(1),* 20-26.	A research study carried out in Surrey to look at staff knowledge of and attitudes towards adult protection highlighted issues that may underpin the reasons for low levels of reported abuse with particular service user groups. This article looks at how the Surrey Adult Protection Committee has dealt with the recommendations of the research.	Does not evaluate the outcome of an intervention
Fraser, A. (2006). Psychological therapies in the treatment of abused adults. *The Journal of Adult Protection, 8(2),* 34-44.	As a practitioner working in the field of adult protection I became aware that, although the responses to reports of abuse have become more effective and consistent, access to treatment or therapy is limited. I therefore decided to explore the idea of using psychological approaches as interventions. My background is as a registered nurse and CAT (cognitive analytical therapy) practitioner. From some limited experience I have found that CAT can be a successful approach. In the course of this article I will examine the background to adult protection work in the UK, focusing on elder abuse, including self-neglect, in domiciliary settings, to show the need to explore new approaches to treatment for both those who have been abused and those who are in the position of abuser. A selection of psychological therapies are explored to determine their potential to offer support for this group and the article concludes with examples of the use of CAT with adult protection referrals and a summary of the benefits and obstacles to this approach.	Non-systematic review
Holkup, P.A., Salois, E.M., Tripp-Reimer, T., & Weinert, C. (2007). Drawing on Wisdom from the Past: An Elder Abuse Intervention with Tribal Communities. *Gerontologist, 47(2),* 248-254.	PURPOSE: The Family Care Conference (FCC) is an elder-focused, family-centered, community-based intervention for the prevention and mitigation of elder abuse. It is based on a family conference intervention developed by the Maori people of New Zealand, who determined that Western European ways of working with child welfare issues were undermining such family values as the definition and meaning of family, the importance of spirituality, the use of ritual, and the value of non-interference. The FCC provides the opportunity for family members to come together to discuss and develop a plan for the well-being of their elders. DESIGN AND METHODS: Using a community-based participatory research approach, investigators piloted and implemented the FCC in one northwestern Native American community. The delivery of the FCC intervention has grown from having been introduced and facilitated by the researchers, to training community members to	Study population outside of inclusion criteria (Aboriginal population, not applicable to UK setting)

	facilitate the family meetings, to becoming incorporated into a Tribal agency, which will oversee the implementation of the FCC. RESULTS: To date, families have accepted and appreciated the FCC intervention. The constructive approach of the FCC process helps to bring focus to families' concerns and aligns their efforts toward positive action. IMPLICATIONS: The strength-based FCC provides a culturally anchored and individualized means of identifying frail Native American elders' needs and finding solutions from family and available community resources.	
Huba, G.J., Melchior, L.A., Philyaw, M.L., & Northington, K.R. (2010). The Archstone Foundation Elder Abuse and Neglect Initiative: outcomes and lessons learned in three years from 2006 to 2008. *Journal of Elder Abuse & Neglect, 22(3-4),* 231-246.	An independent evaluation of the Archstone Foundation Elder Abuse and Neglect Initiative was conducted to identify major outcomes and lessons learned collectively by 20 funded projects, as well as to document innovative programme models for dissemination. Data from the first three years of this initiative show these projects have been productive and have had a measurable impact on services for elder abuse and neglect. Major lessons learned address issues in recruiting, engaging, and maintaining active involvement of diverse stakeholders, as well as innovative and effective models of education, training, and direct services for elder abuse and neglect.	Does not evaluate the outcome of an intervention
Humphries, R. (2011). Adult safeguarding: early messages from peer reviews. *Journal of Adult Protection, 13(2),* 89-99.	Purpose – This report aims to summarise the principal conclusions from the pilot reviews and key learning points to assist the improvement of safeguarding policy and practice. Design/methodology/approach – A pilot programme of peer reviews of adult safeguarding arrangements was carried out in four English local authorities by Local Government Improvement and Development in 2009-2010. The pilot programme sought to customise, test and adapt this established peer review methodology to adult safeguarding. Findings – Key messages from the peer reviews of the adult safeguarding arrangements include: outcomes and experience of people who use services; leadership, strategy and commissioning; service delivery, effective practice and performance and resource management; and working together. Originality/value – Councils may need to revisit how they develop their safeguarding arrangements in the light of major policy, financial and demographic shifts over the next few years.	Does not evaluate the outcome of an intervention
Imbody, B., & Vandsburger, E. (2011). Elder Abuse and Neglect: Assessment Tools, Interventions, and Recommendations for Effective Service Provision. *Educational Gerontology, 37(7),* 634-650.	With our communities rapidly aging, there is always a clear need for greater knowledge on how to serve elders. Professionals must be able to recognize cases of abuse and neglect and provide appropriate follow up services. Through reviewing recent literature, this paper surveys existing assessment tools and interventions, describes characteristics of effective service provision, and offers recommendations for best practice and future research. There lacks an instrument that fulfills the need for brevity, thoroughness, and user-friendliness. Best practices for service provision to maltreated elders were reviewed including the need for multidisciplinary collaboration, cultural competency, professional training, and responding to ageism.	Non-systematic review
Juklestad, O. (2004). Elderly people at risk: a Norwegian model for community education and response. *Journal of Adult Protection, 6(3),* 26-33.	Awareness of the problem of elder abuse was aroused in Norway in the early 1980s.A pilot project conducted between 1991 and 1994, described here, established an important body of knowledge based on casework. Central authorities believe that improved knowledge and competence will result in local change and further development to help the victims of violence.	Does not evaluate the outcome of an intervention
Kaye, L., Kay, D., & Crittenden, J.A. (2007). Intervention with abused older males: conceptual and clinical perspectives. *Journal of Elder Abuse & Neglect, 19(1-2),* 153-172.	Men and women experience abuse in different ways and older men have particular treatment needs that must be addressed by clinicians. The current design and configuration of clinical services may create barriers to abused older men receiving treatment fully suited to their needs. In this article, the unique experiential dynamics and help seeking behaviours of older men who experience abuse are delineated and recommendations are given for structuring services to better meet their needs. Gender sensitive clinical techniques and modalities are described and suggestions for interventions that could prove particularly efficacious in the treatment of older men are offered.	Does not evaluate the outcome of an intervention
Nerenberg, L. (2006). Communities Respond to Elder Abuse. *Journal of Gerontological Social Work, 46(3-4),*	This article traces the development of services to prevent and treat elder abuse over a twenty-year time span. It begins by describing the various forms of elder abuse and the challenges they pose to service providers and programme developers. Also described are abuse reporting statutes, the roles of various agencies involved in	Does not evaluate the outcome of an

5-33.	abuse investigations and responses, services commonly needed by victims, funding sources, and common impediments to service delivery.	intervention
Parra-Cardona, J.R., Meyer, E., Schiamberg, L., & Post, L. (2007). Elder abuse and neglect in Latino families: an ecological and culturally relevant theoretical framework for clinical practice. *Family Process, 46(4),* 451-470.	There is a scarcity of theoretical frameworks capable of describing precursors and dynamics associated with elder abuse and neglect in Latino families. The present manuscript seeks to address this gap in the literature by presenting an integrative theoretical framework that fosters an ecological and cultural understanding of elder abuse and neglect among Latinos. The proposed model rests on the premise that Latino families caring for elder adults have the ability to adapt to the demands of aging only if they are supported by nurturing environments. The usefulness of the model is threefold. First, the proposed model describes elder abuse and neglect as multifactorial phenomena and identifies specific risk factors associated with the aetiology and maintenance of elder abuse and neglect in Latino families. Second, the model provides clinical applications, including reflections about the therapists' need to extend their scope of practice beyond traditional family therapy interventions. A brief case study is presented that illustrates the clinical application of the model with a Latino family. Implications for future research are discussed.	Non-systematic review
Podnieks, E. (2008). Elder abuse: the Canadian experience. *Journal of Elder Abuse & Neglect, 20(2)*, 126-150.	Abuse and neglect of older adults occurs in all Canadian communities and solutions require the coordinated efforts of society at large. Amelioration entails more than a legislative approach. Prevention of this growing problem is a social responsibility that requires networking and collaboration between different disciplines in all sectors of the community. This article will discuss elder abuse in Canada from a historical perspective, as well as current legislation, model programs, and research initiatives. It is intended to allow for comparison from the various countries presented in this volume. Hopefully, readers will find some models, or ideas, they may wish to explore or even replicate within their own jurisdictions.	Non-systematic review
Stolee, P., Hiller, L.M., Etkin, M., & McLeod, J. (2012). Flying by the Seat of Our Pants: Current Processes to Share Best Practices to Deal With Elder Abuse. *Journal of Elder Abuse & Neglect, 24(2)*, 179-194.	We examined current processes used to identify, communicate, and adopt "best practices" in the field of elder abuse using an iterative process involving literature and Internet reviews, surveys completed by stakeholders, and key informant interviews. Results indicate minimal research evidence exists to support current assessment and intervention strategies; there is an immediate need for more evaluation and research in this area and for improved knowledge exchange and translation. Two strategic directions are recommended: to (a) build capacity for research and programme evaluation to advance knowledge of effective practices, and (b) build capacity for knowledge exchange to enhance professionals' efforts.	Does not evaluate the outcome of an intervention
Tapper, L. (2010). Using family group conferences in safeguarding adults. *Journal of Adult Protection, 12(1),* 27-31.	Following the UK Study of Abuse and Neglect of Older People, (O'Keeffe et al, 2007) Comic Relief funded 15 projects across England and Wales to enable them to trial different methods to combat elder abuse. In 2007, Daybreak received three years funding to pilot the use of family group conferences for this age group across Hampshire, Southampton and Portsmouth. This trial is now nearing the end, and is being evaluated for effectiveness and value. Hampshire County Council are currently working with Daybreak to expand the provision of family group conferences to all vulnerable adults where there are safeguarding concerns, particularly within the context of personalisation and self-directed support.	Does not evaluate the outcome of an intervention
Tetterton, S., & Farnsworth, E. (2011). Older women and intimate partner violence: effective interventions. *Journal of Interpersonal Violence, 26(14),* 2929-2942.	Women above the age of 60 who have experienced intimate partner violence (IPV) have specific needs compared with younger victims. More research is emerging that assists counsellors and other helping professionals with identification of these needs and aids to promote the mental health and well-being of this population. Professionals must consider the generational values held by older IPV victims and understand how values may impact decision making. Integrating safety planning and risk assessment into the counselling process is vital. Older IPV victims may seek counselling for posttraumatic stress or depressive symptoms as a result of the abuse. Others may participate in counselling for issues unrelated to IPV. Therefore, a thorough assessment process should include questions related to relationship dynamics so that the counsellor has a complete understanding of all factors impacting the client's functioning. Helping professionals must also have an understanding of available community resources, as well as barriers that these clients face as they take steps toward recovery from trauma. This research uses qualitative analysis of case studies to assist helping professionals in understanding the most effective interventions when working with this population. We found	One case study

	that a contextual approach focusing on the restoration of self-confidence is a constructive means of initiating recovery from trauma.	
Vierthaler, K. (2008). Best Practices for Working with Rape Crisis Centers to Address Elder Sexual Abuse. *Journal of Elder Abuse & Neglect, 20(4),* 306-322.	Sexual violence perpetrated on elders is a significant problem. Elder sexual assault victims often need more assistance than younger victims, yet they typically receive fewer services. Rape crisis centers have faced a multitude of barriers in addressing elder sexual abuse. This article provides an overview of the rape crisis movement and discusses why elders have been both overlooked as potential targets of sexual assault and underserved as victims. Recommendations are made to encourage collaboration between elder and rape crisis advocates. This article describes a Pennsylvania project to cross-train Department of Aging protective service workers and rape crisis advocates.	One case study
Wolf, R.S. (2001). Support groups for older victims of domestic violence. *Journal of Women & Aging, 13(4),* 71-83.	A 1997 nationwide (US and Canada) search to identify support groups for older victims of domestic violence located 16 sponsored by domestic violence programs and 14 sponsored by aging services. Interviews with group leaders indicated more similarities than differences between the two types of sponsorship in group purpose, leadership, numbers served, content of support group sessions, and success in accomplishing goals. Resistance of elders to participate in a group experience was cited by leaders as a major barrier. Recommendations for future groups include insuring accessibility of meeting site; using a leader and co-leader, at least one of whom is older or familiar with aging issues; allocating resources for recruitment; and seeking a steady source of funding. A policy of collaboration among the state's domestic violence coalition, state unit on aging, adult protective services, and victim assistance programme may help in promoting support group development and utilization.	Does not evaluate the outcome of an intervention
Wolf, R.S., & Pillemer, K. (2000). Elder abuse and case outcome. *Journal of Applied Gerontology, 19(2),* 203-220.	Throughout the health and human service systems, interest in the outcome of interventions has been gaining momentum. The purpose of this article is to investigate case resolution, a common social service outcome measure, as it is applied to cases of elder abuse. An in-depth assessment and reassessment (at 6 months) of 59 abuse cases revealed that resolved cases were more likely than unresolved cases to be associated with neglect, increased social support to the victim, reduction in stress, reduction in the interdependency of the victim and perpetrator, and change in the living situation of the victim. For victims of psychological, physical, or financial abuse, as well as those victims who are not willing to accept services or change their living arrangements, the analysis suggests that the level of future risk of abuse may be a more appropriate outcome measure than case resolution.	Correlational study design
World Health Organization (2011). *European Report on Preventing Elder Maltreatment.* Copenhagen, Denmark: World Health Organization:	Elder maltreatment is pervasive in all countries in the WHO European Region, and estimates suggest that at least 4 million people in the Region experience elder maltreatment in any one year. Most countries in the Region have an ageing population, and one third of the population is forecast to be 60 years and older in 2050, putting more people at risk of elder maltreatment. Elder maltreatment has far-reaching consequences for the mental and physical well-being of tens of millions of older people, and if left unchecked will result in their premature death. Estimates suggest that about 2500 older people may lose their lives annually from elder maltreatment. The report highlights the numerous biological, social, cultural, economic and environmental factors that interact to influence the risk and protective factors of being a victim or perpetrator of elder maltreatment. There is some evidence of effectiveness, and examples include psychological programmes for perpetrators and programmes designed to change attitudes towards older people, improve the mental health of caregivers and, in earlier life, to promote nurturing relationships and social skills learning. The evidence base needs to be strengthened, but much can be done by implementing interventions using an evaluative framework. Prevention and social justice for older people can only be achieved by mainstreaming this response into health and social policy. Surveys show that the public and policy-makers are increasingly concerned about the problem, and the policy response needs to be strengthened to meet this demand.	Does not evaluate the outcome of an intervention

Table 15. Research Question 3 (Interventions for Couples) Studies Excluded on Full Text

Study Details	Abstract	Reason for Exclusion
Anderson, S. (2001).Clinical evaluation of violence in couples: the role of assessment instruments. *Journal of Family Psychotherapy, 12(1)*, 1310-1324.	Initial efforts to develop a battery of self report measures that could be used in assessing violent couple subtypes are presented. The goal was to determine whether such data could be used as a basis for treatment planning and assignment of clients to differing treatment approaches. Preliminary results and several case examples are presented to illustrate the utility of the approach.	One case study
Association Of Directors (2004).*Young people and vulnerable adults facing forced marriage: practice guidance for social workers.* Great Britain: Foreign and Commonwealth Office.	No abstract	Does not evaluate the outcome of an intervention
Beckerman, N., & Sarracco, M. (2002). Emotionally focused couple therapy: intervening with an emotionally abusive couple. J*ournal of Couple and Relationship Therapy, 1(3),* 57-70.	Working with couples who are both survivors of emotional abuse and are currently in an emotionally abusive relationship can be particularly challenging for the clinician. This article focuses on Emotionally Focused Couple Therapy as a recommended practice approach for clients who are caught in emotionally abusive patterns with one another. The article reviews relevant literature on this approach and illustrates the specific interventions applied lo an emotionally abusive couple.	One case study
Bell, J., & Stanley, N. (2005). T*ackling domestic violence at a local level: an evaluation of the Preston Road Domestic Violence Project.* Hull, UK: University of Hull.	No abstract	Book
Brown, J., & Languedoc, S. (2004). Components of an aboriginal-based family violence intervention programme. The *Journal of Contemporary Social Services, 85(4),* 477-483.	Describes the essential elements of an aboriginal-based family violence intervention programme in Canada. Twenty-one aboriginal family violence programme administrators and service providers were asked 'What programme components are essential in an aboriginal family violence prevention programme?' Respondents identified the need for sound administrative structure and function, qualified and healthy staff, and consistent programme funding. Co-ordinated service delivery with other community agencies was described. Programme components should be based on traditional teachings, create awareness of personal and family dynamics and change and educate about family violence. There were needs for components for partners separately, partners and their children, partners together, and the whole family. These coincided with aboriginal traditional teachings. Describes implications for programme development.	Does not evaluate the outcome of an intervention
Brown, P., & O'Leary, K. (2000). Therapeutic alliance: predicting continuance and success in group treatment for spouse abuse. *Journal of Consulting & Clinical Psychology, 68(2),* 340-345.	This study examined the role of the therapeutic alliance between client and therapist on group treatment outcome in 70 husband-to-wife violent couples. Strength of husbands' alliance assessed at Session I was positively associated with treatment outcome, as measured by decreased husband-to-wife mild and severe psychological and physical aggression. Strength of wives' alliance was unrelated to treatment outcome. Finally, although alliance was related to treatment outcome, it was unrelated to treatment completion.	Does not evaluate the outcome of an intervention
Browne, C. (2002). *What works in reducing domestic violence? A comprehensive guide for professionals.* London, UK: Whiting and Birch.	No abstract	Book

Bueno, J. (2009). Responding to domestic violence. *Therapy Today, 20(9),* 12-19.	No abstract	Does not evaluate the outcome of an intervention
Carr, A. (2009).The effectiveness of family therapy and systemic interventions for adult-focused problems. *Journal of Family Therapy, 31(1)*, 46-74.	This review updates a similar paper published in this Journal in 2000. It presents evidence from meta-analyses, systematic literature reviews and controlled trials for the effectiveness of couples and family therapy for adults with various relationship and mental health problems. The evidence supports the effectiveness of systemic interventions, either alone or as part of multimodal programmes, for relationship distress, psychosexual problems, domestic violence, anxiety disorders, mood disorders, alcohol abuse, schizophrenia and adjustment to chronic physical illness.	Does not have outcomes relevant to research question
Chalk, R. (2000). Assessing family violence interventions: Linking programs to research-based strategies. *Journal of Aggression, Maltreatment and Trauma, 4(1),* 29-53.	The introduction of family violence treatment and prevention programs during the past few decades has occurred in the absence of scientific evidence that could indicate the types of benefits to be gained by the use of these programs as well as the types of clients who would benefit from them. Although a broad patchwork of interventions has emerged in social service, law enforcement, and health care settings, few of these programs have been evaluated in a systematic manner. The use of comparison groups in family violence programme evaluation studies is also rare. As a result, evaluation studies currently provide limited guidance in the design of family violence prevention and treatment programs. Violence in Families: Assessing Prevention and Treatment Programs is a recent report on family virulence prepared by the National Research Council and the Institute of Medicine that identifies a set of methodological issues designed to improve the quality of family violence evaluation research. The report provides an in-depth analysis of 114 evaluation studies of interventions in the area of child maltreatment, domestic violence, and elder abuse and includes policy and research recommendations designed to improve the quality of evaluation studies in this field. Two key areas-research infrastructure and the development of appropriate theories, measures, and datasets that can support more rigorous evaluations-require attention to improve the capacity of the evaluation research field to inform family violence policy and practice. The lack of opportunities for long-term collaboration between researchers and service providers presents an important challenge in developing research on the multiple pathways to services and the implementation and effects of service interventions.	Non-systematic review
Chamberlain, L. (2008).Ten lessons learned in Alaska: Home visitation and intimate partner violence. *Journal of Emotional Abuse, 8(1/2),* 205-216.	Home visitation programs to prevent child maltreatment and improve child outcomes have proliferated throughout the United States. Intimate partner violence (IPV) is highly correlated with child maltreatment and disproportionately affects home-visited families. An evaluation of home visitation programs in Alaska identified deficits in working with families experiencing IPV. A special IPV initiative provided training and technical assistance to these programs over a 2-year period. Several themes emerged, including the need for skill-based training and assessment tools designed for home visitation, the benefits of building partnerships between home visitors and IPV advocates, and the need for protocols that explicitly address IPV.	Does not evaluate the outcome of an intervention
Chutter, K. (2009). Healthy Relationships for Youth: A Youth Dating Violence Intervention. *Relational Child & Youth Care Practice, 22(4),* 39-46.	Child and Youth Care Counsellors are situated in a unique position to intervene in the alarming course of the use of violence in relationships. Youth dating violence often begins in adolescence and subsequently carries over into adult relationships unless there is a therapeutic intervention. Youth dating violence is defined, lifetime prevalence rates of abusive relationships are explored, and the gap in interventions for youth dating violence is addressed. Risk factors, protective factors, and gender differences are reviewed along with the recommended components and process guidelines for an effective intervention strategy. These components include information regarding violence, substance abuse issues, and gender deconstruction. Additional components that are fundamental in building competence in healthy relationships are communication skills, emotional intelligence and somatic intelligence.	Non-systematic review
Cismaru, M., Jensen, G., & Lavack, A. (2010). If the noise coming from next door were loud music, you'd do	Up to one-third of intimate partner violence incidents involve witnesses. Bystanders play a significant role when it comes to reporting the incidents to authorities, but are often hesitant to get involved in domestic disputes. In this review paper, 12 advertising campaigns that encourage bystander intervention against intimate partner	Non-systematic review

something about it: Using mass media campaigns encouraging bystander intervention to stop partner violence. *Journal of Advertising, 39(4)*, 69-82.	violence are evaluated in relation to Latané and Darley's (1970) model of the bystander decision-making process. The evaluation shows that these campaigns are sometimes contradictory or ambiguous, which may limit their effectiveness. Recommendations are provided.	
Clement, D. (2010).Practice matters: innovative practice in family violence. *Journal of Child Youth and Family, 45,* 26-28.	The practice challenges presented by family violence create significant opportunities for developing innovative practice initiatives. This article describes the Whakakotahitanga programme was developed in Taumarunui, New Zealand, in 2006 and is founded on the idea that to address family violence, communities and couples need to come together. The article states that in having a genuine concern for those struggling to overcome family violence, couples can be supported by their community to make changes in their lives that will result in a reduction of violence in their relationship. This type of approach is referred to as a harm reduction programme. 'Whakakotahitanga' is defined as coming together or sharing, principles that underpin the Whakakotahitanga Family Violence Programme. At the core of the programme is a three-day residential camp. Couples for whom violence is an issue are invited to attend the camp, which provides them with an opportunity, free from distractions, to reflect and work on their issues in a supportive environment.	Does not evaluate the outcome of an intervention
Cole, M., & Caron, S. (2010). Exploring factors which lead to successful reunification in domestic violence cases: interviews with caseworkers. *Journal of Family Violence, 25(3),* 297-310.	This exploratory study investigated factors that Child Protective Service caseworkers believe lead to change for the domestic violence abuser and victim, and ultimately lead to success in terms of reunifying children who have been removed from their parents due to domestic violence. In-depth interviews with six caseworkers examined both successful reunification cases and unsuccessful reunification cases. The interview was structured around three areas of interest: services, the caseworker's relationship with the parents, and social supports, in order to identify variables that may influence the family's ability (or inability) to make the necessary changes for reunification with their children. Results revealed that successful reunifications took place within the families who fully engaged in services, admitted the issues within the family home, set clear boundaries with each other, and sought and maintained an appropriate support system. Implications for caseworkers involved with families experiencing domestic violence, as well as directions for future research, are discussed.	Intervention setting outside of health and social services (Justice system)
Cook-Daniels, L. (2007). Review of Family Interventions in Domestic Violence. *Victimization of the Elderly & Disabled, 10(4),* 53-68.	No abstract	Non-systematic review
Erez, E., & Ibarra, P. (2007). Managing your home a shelter: electronic monitoring and victim re-entry in domestic violence cases. *British Journal of Criminology, 47(1)*, 100-120.	The development of bilateral electronic monitoring (BEM) exemplifies how shifts in the "culture of control" (Garland, 2001), including a focus on domestic violence (DV) victims' emotional welfare and integration into proceedings, can alter abused partners' everyday lives. As a protective strategy, BEM provides DV victims with an alternative to relocating to a shelter. The subjective sense of safety engendered by programme involvement emerges gradually, as everyday environments are re-evaluated in light of an estranged partner's absence; through social interactions with family members, friends, and justice agents; and as the understanding of what it means to be "protected" develops. The use of BEM technology to promote victim welfare rather than as a strictly evidentiary tool suggests that this expression of the new paradigm of justice is oriented toward victim re-entry into civil society.	Intervention setting outside of health and social services (Justice system)
Evanston, T. (2006). Addressing domestic violence through maternal-child health home visiting: what we do and do not know. *Journal of Community Health Nursing, 23(2)*,	Domestic violence (DV) has been described as a public health epidemic. Health care providers of all disciplines encounter victims of DV in every practice setting. However, the vast majority of DV health care research has focused on care provided to victims in traditional acute care and clinic settings. Few investigators have conducted studies with community health nurses (CHNs) who visit DV victims in their homes. CHNs, providing preventive maternal–child health (MCH) care through home visits with families, have been described by some	Non-systematic review

95-111.	as key providers in DV prevention. However, there is a dearth of knowledge about the actual practice and related outcomes of these nurses when working with families experiencing DV. The purpose of this article is to provide a baseline view of the current state of knowledge on which nurses may begin building future research that leads to evidence-based practice. The article describes the potential role of home-visiting MCH nurses in DV prevention and intervention, provides a critical review of the existing research, identifies primary gaps in scientific knowledge, proposes future research priorities, and makes recommendations for practice.	
Farrall, M., & Wellaway, R. (2011). Choosing to change. *Therapy Today, 22(4),* 24-27.	No abstract	One case study
Harris, G. (2006). Conjoint therapy and domestic violence: Treating the individuals and the relationship. Counselling Psychology Quarterly, 19(4), 373-379.	Domestic violence is a common complaint encountered by counselling psychologists and other mental health professionals. Common psychological treatment practices separate perpetrators and victims into individual intervention modalities. However, there is some research that has been emerging that suggests in some cases a couples treatment approach may be a useful adjunct to existing treatments. The present paper examines research and considerations in making the decision to employ a conjoint approach to treating domestic violence issues.	Non-systematic review
Heyman, R., & Schlee, K. (2003). Stopping wife abuse via physical aggression couples treatment. *Journal of Aggression, Maltreatment and Trauma, 7(1-2),* 135-157.	The purpose of this article is to provide an overview of an empirically tested programme for physical aggression: Physical Aggression Couples Treatment (PACT). Although we do not advocate standard “marital therapy” when there is ongoing husband-to-wife interspousal aggression, we present the rationale for, description of, and empirical support for a conjoint treatment approach to wife abuse abatement.	Does not evaluate the outcome of an intervention
Humphreys, C., & Harrison, C. (2003). Focusing on safety: domestic violence and the role of child contact centres. *Child and Family Law Quarterly, 15(3),* 237-253.	A research project based in child contact centers in the UK is used to explore the issues that arise when domestic violence is a factor in child contact arrangements. The conflict between the need for safety and dominant pro-contact practices is explored.	Does not evaluate the outcome of an intervention
Jack, S., Gilboe, F., Wathen, C., Davidov, D., & McNaughton, D. (2012). Development of a nurse home visitation intervention for intimate partner violence. *BMC Health Services Research, 29,* 12-52.	Despite an increase in knowledge about the epidemiology of intimate partner violence (IPV), much less is known about interventions to reduce IPV and its associated impairment. One programme that holds promise in preventing IPV and improving outcomes for women exposed to violence is the Nurse-Family Partnership (NFP), an evidence-based nurse home visitation programme for socially disadvantaged first-time mothers. The present study developed an intervention model and modification process to address IPV within the context of the NFP. This included determining the extent to which the NFP curriculum addressed the needs of women at risk for IPV or its recurrence, along with client, nurse and broader stakeholder perspectives on how best to help NFP clients cope with abusive relationships.	Does not evaluate the outcome of an intervention
Jamieson, S., & Wendt, S. (2008). Exploring men's perpetrator programs in small rural communities. *Rural Society, 18(1),* 39-50.	This paper outlines the findings of an exploratory study conducted in a small rural community in South Australia in 2006. Human service providers, experienced in working with victims and/or perpetrators of domestic violence, were asked about their experiences and perceptions of perpetrator programs in small rural communities. Specifically, questions about the value of, and the factors impacting on, the availability of perpetrator programs in the rural context were explored. Alternative intervention options to address domestic violence perpetration were also discussed. The key findings of the research were that concerns about anonymity, and community attitudes, which condoned male control of female partners, would prevent men from using behaviour change programs in small rural communities, and therefore impact on their viability. The implications for human service providers are outlined in the paper.	Does not evaluate the outcome of an intervention
Johnson, S., & Sullivan, C. (2008). How child protection workers support or further victimize battered	This study explored battered mothers' perceptions of their interactions with child protective services (CPS) workers to increase understanding about how child welfare workers and policies can have negative as well as positive impacts on women's and children's lives. The research was guided by two feminist frameworks:	Intervention setting outside of health and

mothers. *Journal of Women & Social Work, 23(3),* 242-258.	structured action theory and social entrapment theory. Twenty women participated in the in-depth, qualitative interviews. Most felt mi understood and unsupported by their CPS workers and thought that this treatment directly harmed them and their children. Many batterers manipulated caseworkers and escaped sanctions, which contributed to negative consequences. Some women received helpful response from their caseworkers and viewed such support as invaluable. Implications for social work practice are discussed.	social services (Justice system)
Jones, A., Bretherton, J., Roger, B., & Croucher, K. (2010). *The effectiveness of schemes to enable households at risk of domestic violence to stay in their own homes: research report.* London: Department of Communities and Local Government.	A Sanctuary Scheme is a multi-agency victim centred initiative which aims to enable households at risk of violence to remain safely in their own homes by installing a 'Sanctuary' in the home and through the provision of support to the household. This evaluation was carried out in 2009/10 and involved interviews with national stakeholders, local case studies (interviews with service providers, support providers, local stakeholders, and service users), and a cost-benefit analysis. It shows that overall Sanctuary Schemes were thought to have been successful in their main aim of providing a safe alternative for households at risk of domestic violence, and preventing the disruption associated with homelessness. It also highlights that there are different types of installation and security measures and also variation in the way schemes operate post installation. Nevertheless, respondents in all areas reported similar outcomes and, for the most part, service users reported positive experiences. A summary of this research report and also a practice guide have also been published.	Does not evaluate the outcome of an intervention
Kanuha, V., Erwin, P., & Pence, E.(2004). Strange bedfellows: feminist advocates and US Marines working to end violence. *Journal of Women & Social Work, 19(4),* 358-375.	The incidence of intimate partner abuse among couples in the military, as throughout all social life, has been well documented. In the early 1990s, there were a number of dramatic domestic-violence-related cases, including homicides of military wives. In response, the U.S. Marines partnered with an advocacy-based domestic violence organization to implement a coordinated community response to domestic violence throughout the U.S. Marine Corps. This article presents a case study describing the processes, activities, policies, accomplishments, and challenges of the project from 1992 to 1998.	Does not evaluate the outcome of an intervention
Kethineni, S., Blimling, L., Bozarth, J., & Gaines, C. (2004). Youth violence: an exploratory study of a treatment programme in a central Illinois county. *International Journal of Offender Therapy & Comparative Criminology, 48(6),* 697-720.	A local treatment provider has developed an OPTIONS programme to prevent adolescent aggression. The programme is designed for youths who displayed threatening or abusive behaviours, particularly toward family members. This study described the characteristics of juveniles and their families who were referred to the programme and if the programme participation helped reduce the severity of violence and improve the communication skills among programme participants. Referrals came from law enforcement, juvenile court services, school resource officers, and parents. Information on 100 juveniles and their families were provided by the counsellors of the programme. The findings showed that a large percentage of juveniles came from unstable families with a family history of criminal convictions, substance abuse, or mental illness. Programme participants showed an improvement in communication skills and reduction in their levels of dangerousness.	Study population outside of inclusion criteria
Kieffer, L. & Turell, S. (2011). Child Custody and Safe Exchange/Visitation: An Assessment of Marginalized Battered Parents' Needs. *Journal of Child Custody, 8(4),* 301-322.	During a 2-year project, the researchers examined supervised visitation and safe exchange (SEV) programs in the context of family violence in an upper Midwest state. The overall purpose was to determine the current and best practices of SEV to be implemented into future services. Data were obtained from ethnically diverse parents (N=77) whose families experienced abuse or violence, SEV service providers (N=17), and SEV referral sources (N=128). Themes that emerged confirmed the complex relationship between both the criminal justice system and SEV programs and client needs, centering on accessibility, resources, power dynamics, and cultural (in)competency.	Intervention setting outside of health and social services (Justice system)
Kindsvatter, A., Nelson, J., & Desmond, K. (2009). An Invitation to between-Session Change: The Use of Therapeutic Letters in Couples and Family Counselling. *Family Journal: Counselling and Therapy for Couples and Families, 17(1),* 32-38.	No abstract	Does not have outcomes relevant to research question
Kinsworthy, S., & Garza, Y. (2010).	This research study examined the perceptions of parents, and victims of domestic violence, after receiving filial	Does not evaluate the

Filial therapy with victims of family violence: a phenomenological study. *Journal of Family Violence, 25(4),* 423-429.	therapy. Specifically, parents were trained in a 10-week filial therapy model, Child–Parent Relationship Training. At the completion of the study, parents were given a semi-structured, open-ended style interview to gather information about their experiences. Themes emerged from the data participants provided, such as: experiencing increased warmth and trust in the child–parent relationship, changed parenting style, and decreased parental stress. Additionally, narratives reflect the positive influence the training had on parents' perceptions of violence. A summary of the essence of the parent's experiences is included.	outcome of an intervention
Klostermann, K., Kelley, M., Mignone, T., Pusateri, L., & Fals-Stewart, W. (2010). Partner violence and substance abuse: Treatment interventions. *Aggression and Violent Behaviour, 15(3),* 162-166.	Partner violence is a serious public health issue. For couples who enter treatment for drug and alcohol abuse, rates of partner aggression are alarmingly high, with 53% to 63% of couples reporting one or more episodes of partner violence in the year prior to programme entry (Murphy & O'Farrell, 1994; Murphy, O'Farrell, Fals-Stewart, & Feeham, 2001; Stuart et al., 2003). Indeed, one of the most challenging clinical issues faced by therapists who treat substance-abusing patients is intimate partner violence (IPV). This review describes the link between substance abuse (alcohol and drug) and partner violence and identifies treatment strategies for providers working with these clients.	Non-systematic review
Klostermann, K., Kelley, M., Mignone, T., Pusateri, L., & Wills, K. (2011). Behavioural Couples Therapy for Substance Abusers: Where Do We Go From Here? *Substance Use & Misuse, 46,* 1502-1509.	Behavioural couples therapy (BCT) is an evidence-based family treatment for substance abuse. The results of numerous investigations over the past 30 years indicate that participation in this treatment by married or cohabiting substance-abusing patients, compared with more traditional individual-based interventions, results in greater reductions in substance use, higher levels of relationship satisfaction, greater reductions in partner violence, and more favourable cost outcomes. This review examines the rationale for using BCT, the empirical literature supporting its use, methods used as part of this intervention, and future research directions.	Does not have outcomes relevant to research question
LaTaillade, J., Epstein, N., & Werlinich, C. (2006). Conjoint treatment of intimate partner violence: A cognitive behavioural approach. *Journal of Cognitive Psychotherapy, 20(4),* 393-410.	The purpose of this article is to describe the rationale and methods of couple-based interventions designed to treat and prevent intimate partner violence. Cognitive, affective, and behavioural individual and couple risk factors for violence are reviewed, as are therapeutic concerns regarding the use of conjoint treatment. Current conjoint treatments that are intended to reduce the incidence of abusive behaviour among couples in which one or both partners have engaged in forms of psychological and/or mild to moderate physical aggression, do not engage in battering or severe violence, and desire to improve their relationships and stay together are described. We focus on our Couples Abuse Prevention Programme (CAPP) that compares the efficacy of cognitive-behavioural couple therapy procedures and treatment as usual at a university-based couple and family therapy clinic. Outcomes from the CAPP project and evaluations of the other programs demonstrate the potential of judiciously applied conjoint interventions for aggressive behaviour in couple relationships.	Non-systematic review
Lowenstein, L. (2005). Domestic Violence: Recent research Part 3. *Justice of the Peace, 169(39*), 758-761.	The causes of and reasons for spousal abuse are many. There is the need to abuse in order to control and hence to assert power by preventing the victim from seeking a greater say in the relationship. Abusers are often jealous and possessive, preventing their partners from having contacts outside their relationship. Abusers often belittle and isolate their partner and make them feel inept, worthless and dependent. Sometimes abusers have alcohol or substance abuse problems. The reaction of the victims is to become dependent, fearful and to develop low self-esteem. Numerous psychological problems also develop in victims. The following important individualised goals must be achieved to protect victims. First, and most importantly, is to safeguard victims from abuse, providing treatment for the victim and children as well as for the abuser. This must be done individually rather than as a couple. Perpetrators must not only accept that what they do is wrong, and that there must be zero tolerance in relation to this, but they must also learn to develop the capacity to change both attitudes and behaviour. They need to learn to deal with their anger and to attend treatment on the basis of this. Legal action is also vital.	Does not evaluate the outcome of an intervention
Macy, R., Giattina, M., Sangster, T., Crosby, C., & Montijo, N. (2009). Domestic violence and sexual assault services: Inside the black	Research examining the efficacy of community-based domestic violence and sexual assault services is yielding promising findings; however, little is known about the structure, components, and content of these services. Although service guidelines exist, a critical gap persists because review, comparison, and synthesis of these recommendations have not been undertaken. This research addresses this knowledge gap through a review of	Non-systematic review

box. *Aggression and Violent Behaviour, 14(5)*, 359-373.	the domestic violence and sexual assault services literature. We gathered relevant literature by conducting systematic searches of databases, and by soliciting the service guidelines and training manuals from all the Domestic Violence and Sexual Assault Coalitions in the United States. These efforts yielded 43 articles, books, or manuals for review. The findings show strong consensus on core services for survivors, including crisis services, legal and medical advocacy, support groups, individual counselling, and shelter. This article presents the review results in tables comparing the service goals, intervention strategies, and recommendations for service delivery. We also found areas of contention (e.g., whether to continuously staff domestic violence shelters, and whether combined agencies can effectively offer both domestic violence and sexual assault services). Building upon the review findings, we discuss the implications for domestic violence and sexual assault services and intervention research.	
Macy, R., Johns, N., Rizo, C., Martins, S., & Giattina, M. (2011). Domestic violence and sexual assault service goal priorities. *Journal of Interpersonal Violence, 26(16),* 3361-3382.	We investigated agency directors' perspectives about how service goals should be prioritized for domestic violence and sexual assault service subtypes, including crisis, legal advocacy, medical advocacy, counselling, support group, and shelter services. A sample of 97 (94% response rate) North Carolina domestic violence and/or sexual assault agency directors completed a survey asking participants to rank the importance of service goals. Overall, participants considered emotional support provision to be a critical service goal priority across all service types. Social support and self-care service strategies were deemed less important. However, prioritization of other service goals varied depending on the service type. Statistically significant differences on service goal prioritization based on key agency characteristics were also examined, and agency characteristics were found to relate to differences in service goal prioritization.	Does not evaluate the outcome of an intervention
Macy., R., Giattina, M., Montijo, N., & Ermentrout, D. (2010). Domestic violence and sexual assault agency directors' perspectives on services that help survivors. *Violence Against Women, 16(10),* 1138-1161.	Community-based domestic violence and sexual assault service providers need sound knowledge regarding services that work well to improve the lives of survivors. This exploratory, qualitative research aimed to help provide such knowledge by investigating domestic violence and sexual assault agency executive directors' (n=14) opinions regarding what services are most helpful for survivors. In-depth interviews with directors provided findings about (a) critical services for survivors; (b) essential service delivery practices; (c) ideal services that are challenging to deliver because of funding and other barriers; and (d) areas of service delivery practice uncertainty due to a lack of best practices.	Does not evaluate the outcome of an intervention
McCollum, E., & Stith, S. (2007). Conjoint couple's treatment for intimate partner violence: controversy and promise. *Journal of Couple & Relationship Therapy, 6(1/2),* 71-82.	This manuscript addresses an important controversy in the intimate partner violence (IPV) field, treating couples experiencing IPV conjointly. Some advocates who work with victims of violence believe that conjoint treatment is never appropriate if there has ever been IPV. Others take a more moderate position and believe that it may be appropriate for some couples after the offender has completed a comprehensive batterer intervention programme. Because of these concerns, many IPV offender standards expressly prohibit the funding of any programme that offers couples or family counselling. However, the case against couple's therapy may not be as simple as these standards suggest. Many couples choose to stay together after experiencing IPV. Enhancing these couples' abilities to resolve conflict non-violently may, rather than endanger victims, actually enhance safety of couples and children in these homes. In this paper we address the ideological, theoretical, empirical and practical foundations of the arguments in the controversy and the impact of the controversy on research, policy and practice. Finally, we suggest ways the controversy should be bridged and propose guidelines for selecting situations in which conjoint treatment most appropriately addresses IPV in a relationship.	Non-systematic review
McCollum, E., & Stith, S.(2008). Couples treatment for interpersonal violence: a review of outcome research literature and current clinical practices. *Violence & Victims, 23(2),* 187-201.	Conjoint couples treatment for interpersonal partner violence (IPV) remains controversial despite a growing body of research and practice experience indicating that it can be effective and safe. In addition, developing typologies of couples who are violent suggest that a "one-size-fits-all" treatment approach to IPV is not appropriate and conjoint treatment may have a place in the treatment of at least some couples. In this article, we review the experimental studies and clinical practices of conjoint treatment. Based on this review, we suggest current best practices for this approach to treatment. Best practices include couples treatment as part of a larger community response to IPV, careful screening of couples for inclusion in couples treatment,	Non-systematic review

	modification of typical conjoint approaches to promote safety and ongoing assessment of safety with contingency plans for increased risk.	
McInnes, K., & Newman, T. (2006). *Domestic Abuse In North Somerset: A Scoping Exercise.* London, UK: Barnardo's Policy and Research Unit.	No abstract	Does not evaluate the outcome of an intervention
McIntosh, K. (2006, July 26). Ending attacks down to all of us (domestic violence). *Local Government Cronicle.*	No abstract	Does not evaluate the outcome of an intervention
Morrissette, P. (2007). Unmasking dual victimization: an engagement intervention to enhance participation in couple therapy. *Journal of Couple & Relationship Therapy, 6(3),* 69-80.	This paper describes an intervention designed to enhance treatment participation with couples who are embroiled in longstanding conflicted interactions. Through the use of metaphor and externalization, couples are prompted to re-conceptualize their conflict and preempt typical interaction styles. Through this intervention, covert patterns that contribute to ineffective communication, emotional distance, and a lack of intimacy are exposed. When left unattended, these patterns can fester and result in ongoing forms and levels of relationship violence and/or dissolution. This intervention has also been useful in helping therapists appreciate the recursive nature of relationships and thus, maintain a systemic orientation.	One case study
O'Leary K. (2001). Conjoint therapy for partners who engage in physically aggressive behaviour: Rationale and research. *Journal of Aggression, Maltreatment and Trauma, 5(2)*, 145-164.	Debates have appeared in professional journals and conferences about which interventions/treatments are appropriate and effective for men and women in physically aggressive relationships. Gender specific and conjoint treatments have been the most frequently discussed interventions, and they are the focus of this review. At present, there is a need to recognize that physical aggression in intimate relationships is very common, especially in young individuals, and that the very commonly observed physical aggression in young people has different causes than the severe, longstanding aggression that engenders fear in women. It is also important to recognize that whatever the intervention, a therapist needs to be concerned about safety planning. Finally, given that there is increasing recognition of different types of partner abuse and causes thereof, it is time to address the need for multiple interventions in certain cases, e.g., gender specific, conjoint, substance abuse. Arguments and data are presented regarding the circumstances in which conjoint treatment is associated with marked reductions in psychological and physical aggression.	Non-systematic review
Olson, L., & Parekh, A. (2010). Evaluating services for immigrant and refugee families who experience abuse. *Injury Prevention, 16,* A175-6.	Introduction Surveys from around the world indicate that 10% to 69% of women experience violence from an intimate male partner. We evaluated the Family Justice Centre (FJC), a confidential walk in centre with co-located services supporting families experiencing abuse concentrating on the experiences of refugee and immigrant families. Methods Four structured focus groups with English, Spanish and Arabic speaking women. Results Before visiting the FJC, participants felt apprehensive, confused, scared and unsure how to stop the abuse. Participants expressed that domestic violence was normal and the abuse should be tolerate and hope that the abuser will change. After receiving services, participants reported feeling empowered, knowledgeable and more secure. We are women with needs that should be met; we should be entitled to those resources regardless of race, or legal status. It shouldn't hold us back from seeking protection. Participants needed and recognised the diverse array of services offered at the FJC. A lot of people speak different languages or can't read or write in English. I feel more secure and have more direction (after visiting the FJC). Participants reported receiving help with protective orders, child support, housing, translation of legal and other documents and group counselling. Most participants reported following a safety plan including escape routes and packing a bag with essentials. Conclusions The information is an important first step in understanding issues facing immigrant and refugee families and provides a basis to modify and continue services including translation to meet the changing needs of the community.	Conference abstract
Panzer, P., Phillip, M., & Hayward,	Domestic violence is a dangerous and prevalent social problem affecting up to 4 million women and countless	Non-systematic review

R. (2000). Trends in domestic violence service and leadership: implications for an integrated shelter model. *Administration & Policy in Mental Health, 27(5),* 339-352.	children annually. Shelters offer safety and an opportunity for change during the crisis of family violence. These individuals also have the potential for retraumatization if leadership within the programme recapitulates the abuse and coercion felt at home. This article reviews three related trends through the lens of power and control—domestic violence policy and service, models of leadership, and the study of traumatic stress disorders and recovery—and describes their implications for modern shelter service delivery.	
Parker, T., Rogers, K., Collins, M., & Edleson, J. (2008). Danger zone: battered mothers and their families in supervised visitation. *Violence Against Women, 14(11),* 1313-1325.	Supervised visitation centers (SVCs) have developed rapidly across the United States. Increasingly, courts are restricting contact between abusive intimate partners and their children by ordering visitation or exchanges to occur at SVCs. This article describes some of the key lessons the authors learned over 18 months of planning and then another 18 months of implementation at a SVC developed specifically to serve families for whom domestic violence was their primary reason for referral. The authors have organized their experiences around five major themes: (a) battered women in supervised visitation, (b) how battering continues during supervised visitation, (c) how rules at the SVC evolved over the first 18 months of implementation, (d) the importance of well-trained visit monitors, and (e) the need to embed SVCs within a larger context of coordinated community responses to domestic violence.	Intervention setting outside of health and social services (Justice system)
Part, D. (2006). A flexible response to domestic abuse: findings from an evaluation. *Practice, 18(1),* 47-58.	An initiative for victims of domestic abuse was evaluated and the views and experiences of some of those who had been involved were sought. The initiative, between Tayside Police and Barnardo's in Scotland, responds to all calls and referrals to the Police where domestic abuse is an issue. Legal and safety advice by visit, letter or telephone contact is provided by the Police and further flexible support offered from the Barnardo's project workers. Those using the support, then or later, can receive legal, financial, housing, education, safety and psychological help and support as they require. Questionnaires were used and a sample of respondents, police and project workers was interviewed. All respondents rated the initiative highly. The main strength identified was the individualised support, which is not time-limited but driven by individual need; the help and involvement for each person and their family, building up their self-esteem and confidence while supporting them to make their own choices. The length of time that support is needed is also discussed.	Intervention setting outside of health and social services (Justice system)
Perilla, J., Serrata, J., Weinberg, J., & Lippy, C. (2012). Integrating Women's Voices and Theory: A Comprehensive Domestic Violence Intervention for Latinas. *Women & Therapy, 35(1),* 93-105.	Using both academic theories and two decades of experience in community, this article presents the work conducted by Caminar Latino (Latino Journey), a comprehensive intervention for Latino families affected by domestic violence. Having developed in both analogous and independent ways from theories in the academic field, Caminar Latino provides a unique opportunity to explore ways in which ecological theory and tenets of feminist therapy can be combined within a social justice framework to address this severe social problem. Of particular relevance to therapists, advocates and others working in this field is the ongoing inclusion of the voices of women participants as a central tenet of the intervention.	Does not evaluate the outcome of an intervention
Petch, A. (2010). The benefits of domestic violence advisers. *Community Care, 30(31),* 1803 - 1810.	The article examines the effectivity of independent domestic violence advisers (IDVAs) schemes in Great Britain. It highlights the focused areas of evaluation including the outcomes of the support, resources used for the individuals, and the demographic profile of the victims. Furthermore, it presents recommendations based on the findings of the evaluation.	Summary article of Howarth (2009) Safety in Numbers
Pfeil, M., & Howe, A. (2004). Ensuring primary care reaches the 'hard to reach'. *Quality in Primary Care, 12(3),* 185-190.	The provision of primary care services to homeless people, travellers, sex workers, victims of domestic violence, asylum seekers and refugees is a recognised problem in the UK. It is of national importance to explore new and innovative approaches to improve this situation. Following the creation of a new primary care service for 'hard-to-reach' groups in Norwich, a consultative approach to its evaluation was initiated. Methods were review of local and central policy documents, semi-structured interviews with local health service managers for context, interviews with agency workers in close contact with the client groups, and questionnaires to access the views of the healthcare professionals providing front-line clinical services. Five evaluation criteria emerged that embraced all views. These address access to healthcare for the target groups; service responsiveness to the healthcare needs of the client groups; the efforts of the service to overcome any existing barriers; effective involvement of service users and their representatives, and promotion of multi-agency co-operation; and successful (re-)integration of patients into mainstream general practice. These	Does not evaluate the outcome of an intervention

	criteria will be employed in the ongoing evaluation of the service.	
Pickles, J., & Robinson, A. (2007). Safety in numbers. *Community Care, 19(4),* 34-35.	The MARAC model of intervention involves risk assessment in all reported cases of domestic abuse to identify those at highest risk so that a multi-agency approach may be taken. This article reports on the model and briefly comments on an evaluation of Cardiff MARACs. Evidence from the evaluation suggests that this reduces recidivism even among those most a risk.	Does not evaluate the outcome of an intervention
Puchala, C., Paul, S., Kennedy, C., & Mehl-Madrona, L. (2010). Using Traditional Spirituality to Reduce Domestic Violence within Aboriginal Communities. *Journal of Alternative & Complementary Medicine, 16(1),* 89-96.	OBJECTIVES: We report the results of involving traditional healing elders (THE) in the clinical care of aboriginal families who were involved in domestic violence in the context of a clinical case series of referrals made for domestic violence. METHODS: Psychiatric consultations were requested from senior author L.M.M. for 113 aboriginal individuals involved with domestic violence as recipients or perpetrators (or both) between July 2005 and October 2008. As part of their clinical care, all were encouraged to meet with a THE, with 69 agreeing to do so. The My Medical Outcomes Profile 2 scale was being used as a clinical instrument to document effectiveness. Elders used traditional cultural stories and aboriginal spirituality with individuals, couples, and families to transform the conditions underlying domestic violence. RESULTS: For those people who met with the THE, a statistically significant change ($p<0.0001$) occurred in symptom severity from baseline to final interview of 4.6-1.52 on a scale of 0-6. The most common presenting symptom was being beaten (39 people), followed by drinking (37 people), drugs (13 people), grudges and anger (12 people), sadness (9 people), hates self (8 people), fear (7 people), sleep problems (6 people), anxiety (5 people), and lost spirituality (2 people). Each person chose two primary symptoms to rate. CONCLUSIONS: Including elders in the care of people who are the recipients of domestic violence is effective. We speculate that it helps by providing traditional stories about relationships and roles that do not include violence. Spiritual approaches within aboriginal communities may be more effective than more secular, clinical approaches. Research is indicated to compare elder-based interventions with conventional clinical care.	Study population outside of inclusion criteria (Aboriginal population, not applicable to UK setting)
Regan, L. (2005). *Final report of the Portsmouth Domestic Violence Early Intervention Project evaluation*. London, UK: London Metropolitan University.	No abstract	Does not evaluate the outcome of an intervention
Renzetti, C. (1996). The poverty of services for battered lesbians. *Journal of Gay & Lesbian Social Services, 4(1),* 61-68.	This paper addresses the poverty of services available to lesbian victims of partner abuse, despite the need for such services. Drawing on data from a survey of 1,505 help providers (to which 566 responded), the paper focuses on the services that the help providers themselves claim to offer. The data reveal a serious disparity in help providers' rhetoric and official policies and the reality of the services available. The paper concludes with suggestions for improving services to battered lesbians.	Published prior to 2000
Roddy, J. (2011). From trainee to specialist: learning about domestic violence counselling. *Therapy Today, 22(6),* 17-19.	Research suggest that more than half the women in psychiatric services in the UK have suffered from domestic violence during their life, evidence of the long-term psychological harm that living in an abusive relationship can cause. Despite this, working with domestic violence survivors is not generally taught within counselling courses. This article describes the findings from the author's efforts to identify the most effective ways of working with domestic violence survivors. Literature searches were only able to identify a small body of research evidence, which she reviews in this article. From this she concludes that a client-focused, flexible, integrated counselling approach, utilising specialist domestic violence knowledge, probably provides current best practice. She argues that, in the UK, specialist counselling services need to be made more available to the survivors of domestic abuse. Finally she concludes that more research is needed to provide information on the client's views of counselling.	One case study
Sar, B., Antle, B., Bledsoe, L., Barbee, A., & Van Zyl, M. (2010). The importance of expanding home visitation services to include	Although home visiting programs effectively address risks of maltreatment related to the mother and infant through providing services such as medical care, education/vocational support, and training on positive infant parenting practices, little programmatic attention has been paid to couple relationships, father involvement, and parenting interactions in the context of new parenthood. These relationships within the family system, if not	Does not have outcomes relevant to research question

strengthening family relationships for the benefit of children. *Children and Youth Services Review, 32(2),* 198-205.	nurtured, can heighten the risks for maltreatment. Therefore, the research on the impact of these relationships for children's wellbeing are reviewed, examples of evidence-based programs to strengthen these relationships are provided, and changes to existing home visiting policies and programs to include strengthening family relationships for the benefit of children are recommended.	
Sartin, R., Hansen, D., & Huss, M. (2006). Domestic violence treatment response and recidivism: A review and implications for the study of family violence. *Aggression and Violent Behaviour, 11(5),* 425-440.	Although domestic violence is a significant societal problem, which continues to receive public and private sector attention, intervention and treatment programs have proven inconsistent in their success. This paper reviews the published literature on domestic violence treatment efficacy and post-treatment recidivism and explores the related factors. In addition, challenges in the assessment of domestic violence are briefly discussed. Finally, recent developments are discussed along with their potential benefits, and an appeal is made for the need to study domestic violence in the broader context of family violence.	Non-systematic review
Saunders, D., Holter, M., Pahl, L. & Tolman, R. (2006). Welfare workers' responses to domestic violence cases: the effects of training and worker characteristics. F*amilies in Society: The Journal of Contemporary Social Services, 87(3),* 328-338.	This study evaluated a one-day domestic violence training for Temporary Assistance for Needy Families (TANF) workers and analysed the relationship between worker characteristics and the use of work exemptions. In a post-only evaluation, trained workers reported a greater tendency than untrained workers to refer clients to couples counselling, make a safety plan, and file a report to child protection services. In a pre/post evaluation, workers reported after training that they would be less likely to refer clients to couples counselling, and more likely to ask about the emotional and physical impact of abuse, make a safety plan, and ask about access to weapons. Workers most likely to offer a waiver from work requirements reported a higher likelihood of making referrals for a variety of services.	Does not evaluate the outcome of an intervention
Schofield, M., & Walker, R.(2008). Innovative approaches to family violence*. Journal of Family Studies, 14(2),* 160-166.	This editorial evaluates innovative methodologies of responding to various types of family violence. Issues such as child abuse, violence against women and abuse of the elderly are discussed in terms of incidence and psychological impact. The author then discusses how the issue will address systematic and governmental methods of dealing with family violence, as well as therapeutic responses to the issue..	Does not evaluate the outcome of an intervention
Shepard, M., Falk, D., & Elliott, B. (2002). Enhancing coordinated community responses to reduce recidivism in cases of domestic violence. *Journal of Interpersonal Violence, 17(5)*, 551-569.	This study evaluated the effectiveness of a project designed to enhance coordinated community responses by examining recidivism rates. Project enhancements included expanded danger assessment and information sharing among criminal justice practitioners and advocates. When compared to a baseline period, results indicated that offenders had significantly lower rates of recidivism after the project was implemented. There were steady declines in the number of recidivists over 3 years of the project, beginning in the pilot year and decreasing significantly during the intervention years. Logistic regression procedures found two variables that were significantly related to offenders not having recidivated during all years of the study: the offender having been court mandated to attend the Men's Nonviolence Programme and the offender having completed the programme. There was evidence to support the use by probation officers of a danger assessment tool to predict recidivism	Does not evaluate the outcome of an intervention
Short, L., Surprenant, Z., & Harris, J. (2006). A community-based trial of an online intimate partner violence CME programme. *American Journal of Preventive Medicine, 30(2),* 181-185.	BACKGROUND: There is a broad need to improve physician continuing medical education (CME) in the management of intimate partner violence (IPV). However, there are only a few examples of successful IPV CME programs, and none of these are suitable for widespread distribution. DESIGN: Randomized controlled trial beginning in September 2003 and ending in November 2004. Data were analysed in 2005.SETTING/PARTICIPANTS: Fifty-two primary care physicians in small (fewer than eight physicians), community-based medical offices in Arizona and Missouri. INTERVENTION: Twenty-three physicians completed a minimum of 4 hours of an asynchronous, multi-media, interactive, case-based, online CME programme that provided them flexibility in constructing their educational experience ("constructivism"). Control physicians received no CME.MAIN OUTCOME MEASURES: Scores on a standardized self-reported survey, composed of ten scales of IPV knowledge, attitudes, beliefs, and self-reported behaviours (KABB) administered before randomization and repeated at 6 and 12 months following the CME programme. RESULTS:Use of the online CME programme was associated with a significant improvement in eight of ten KABB outcomes, including physician self-efficacy and reported IPV management practices, over the study period. These measures did not improve in the control group. CONCLUSIONS: The Internet-based CME	Does not evaluate the outcome of an intervention

	programme was clearly effective in improving long-term individual educational outcomes, including self-reported IPV practices. This type of CME may be an effective and less costly alternative to live IPV training sessions and workshops.	
Stith, S., McCollum, E., Amanor-Boadu, Y., & Smith, D. (2012). Systemic Perspectives on Intimate Partner Violence Treatment. *Journal of marital and Family Therapy, 38,* 220-240.	This article reviews changes in the research literature on intimate partner violence (IPV) since our earlier review (Stith, Rosen, & McCollum, 2003). A rationale for systemic treatment of IPV has emerged from research that has continued to document the limited effectiveness of single-gender treatment approaches for offenders and that has identified subtypes of abusive relationships, including situational couple violence, which often includes the reciprocal use of violence. Consistent findings from the available outcome research have demonstrated that for carefully screened couples who choose to stay together, systemic interventions decrease incidences of IPV and decrease the risk factors for IPV with no increase in risk. Implications for research and treatment are offered.	Non-systematic review
Stith, S., Rosen, K., & McCollum, E. (2002). Developing a manualized couples treatment for domestic violence: overcoming challenges. *Journal of Marital & Family Therapy, 28(1),* 21-25.	This paper describes challenges faced in a four-year project to develop a manualized couples treatment programme for domestic violence. The couples treatment programme is an add-on to a male batterer programme where the male partner has perpetrated mild-to-moderate violence, yet both partners want to remain together. The project involved the cooperation of a variety of community agencies and referrals from key domestic violence programs. While some anticipated challenges did not materialize over the course of the project, unanticipated challenges did. Qualitative data collected from therapists and clients throughout the project was used to refine the treatment approach.	Does not evaluate the outcome of an intervention
Stith, S., Rosen, K., & McCollum, E. (2003). Effectiveness of couples treatment for spouse abuse. J*ournal of Marital & Family Therapy, (29)3*, 407-426.	Despite its controversy, carefully conceptualized and delivered couples treatment appears to be at least as effective as traditional treatment for domestic violence, and preliminary data suggests that it does not place women at greater risk for injury. However, the body of research on which these conclusions rest is sparse. Only six experimental studies have been done, each using different eligibility criteria, outcome measures, and treatment approaches. Thus, further study of this modality is warranted. Marriage and family therapists have an important part to play in continuing to develop and test innovative ways of helping couples end violence and improve their relationships-an endeavour that promises to improve the quality of the partners' lives as well as those of their children.	Non-systematic review
Stuart, G., O'Farrell, T., & Temple, J. (2009). Review of the association between treatment for substance misuse and reductions in intimate partner violence. S*ubstance Use & Misuse, 44(9-10),* 1298-1317.	A substantial body of research supports a strong cross-sectional and longitudinal association between substance misuse and perpetration of intimate partner violence (IPV). This article briefly addresses the theoretical connection between substance use and intimate partner violence and research on the association between substance misuse and IPV. Studies examining the effect of individual and couples-based addiction treatments on IPV are reviewed. The implications of this work and future directions for research are discussed.	Non-systematic review
Stuart, G., Ramsey, S., Moore, T., Kahler, C., Farrell, L., Recupero, P., & Brown, R. (2003). Reductions in marital violence following treatment for alcohol dependence. *Journal of Interpersonal Violence, (18)10*, 1113-1131.	The impact of an intensive, individually based, partial hospitalization treatment for alcohol dependence on alcohol use, marital violence, psychological abuse, and marital satisfaction among 24 heterosexual male patients and their partners was assessed. Patients received 5 to 6 days of substance abuse treatment in a partial hospital. Patient and partner assessments were conducted at baseline and 6- and 12-month follow-up. Results revealed decreased alcohol use in patients and significant declines in husband-to-wife marital violence and psychological abuse from baseline to 6- and 12-month follow-up. Men reported no significant changes in their marital satisfaction. Results also showed significant decreases in wife-to-husband violence from baseline to 6- and 12-month follow-up. Female partners reported a significant increase in marital satisfaction from baseline to 6- and 12-month follow-up. Overall, the study suggests that marital violence perpetrated by male patients and their partners declined following the males' substance abuse treatment. The clinical implications of the findings are discussed.	Does not evaluate the outcome of an intervention
Sullivan, M., Harris, E., Collado, C., & Chen, T. (2006). Noways tired: perspectives of clinicians of color on	The authors demonstrate through case material the clinical benefits of utilizing a culturally competent approach to crisis intervention. The focus here is on intervention with racial/ethnic minorities, in particular Black Americans, Latino Americans and Asian Americans; but the authors also address the importance of culturally	Two case studies

culturally competent crisis intervention. *Journal of clinical psychology, 62(8)*, 987-999.	competent crisis intervention praxis for all clients.	
Taket, A., Beringer, A., Irvine, A., & Garfield, S. (2004) .*Tackling domestic violence: exploring the health service contribution. Home office and development report No. 54*. London: Home Office.	No abstract	Does not evaluate the outcome of an intervention
Toft, C. (2011). *Embracing alcohol, domestic abuse and families: A new approach.* London, UK: Alcohol Concern.	The report can assist alcohol services in assessing what additional training their staff might need and what changes are required to prepare them to safely screen and risk assess for parental alcohol misuse, domestic abuse and its impact on children and families. It also highlights the challenges and barriers the pilot sites experienced during the process and how these challenges can be turned into learning and pointers for further development.	Does not evaluate the outcome of an intervention
Tucker, N., Stith, S., Howell, L., & McCollum, E. (2000). Meta-dialogues in domestic violence-focused couples treatment. *Journal of Systemic Therapies, 19(4),* 56-72.	In this article we describe how meta-dialogues are used in the context of a domestic violence-focused couples treatment programme. The couples treatment programme is an add-on to male batter programme for couples in which the male partner has perpetrated mild to moderate violence, yet both partners want to remain together. Meta-dialogues allow co-therapists to comment on the couple's process, de-escalate rising conflicts in the session, explore and challenge gender role stereotypes, shift the couple's focus from problems to strengths, model alternative conflict resolution skills, and introduce difficult material without directly challenging the couple. Case examples are presented to illustrate the value of meta-dialogues in this treatment context.	One case study
Ucko, L. (2010). Storieswork: Interactive storytelling and domestic abuse. Storytelling, Self, Society: An Interdisciplinary *Journal of Storytelling Studies, 6(2),* 94-106.	Domestic violence is a serious public health issue that cries out for new measures to protect families and communities. Interactive storytelling, an innovative technique developed by the nonprofit organization Stories Work, promotes empowerment, insight, and sound decision making while easing the confusion, isolation, shame, and secrecy that surround domestic violence. The technique involves narrating a short folktale followed by a probing question and answer period in a safe, nonthreatening, and nonjudgmental environment. StoriesWork holds interactive storytelling workshops for staff and volunteers, abused women, allied professionals, and the general public. Transcript excerpts from a StoriesWork interactive storytelling workshop for staff and volunteers reveal provocative questions about a folktale and insightful answers that uncover layers of meaning hidden in a folktale on the subject of domestic abuse. Testimonials from workshop "graduates" and anecdotal incidents speak to the value of this technique.	One case study
Wahab, S., & Olson, L. (2004). Intimate partner violence and sexual assault in Native American communities. *Trauma, Violence & Abuse, 5(4),* 353-366.	Previous studies indicate that Native American women experience the highest rate of violence of any ethnic or racial group in the United States. This article addresses the prevalence of intimate partner violence and sexual assault among Native Americans. We present significant substantive and methodological issues that inform research on violence in the lives of Native Americans, as well as existing interventions. Interventions discussed in this article fall within three major categories including those that are community based, those grounded in the public health and health care systems, and those grounded in federal and national organizations. We provide some examples of interventions from each of these three levels of direct service, including a brief discussion of barriers to service accessibility. We conclude with substantive and methodological recommendations for research and practice.	Non-systematic review
Wells, W., Ren, L., & DeLeon-Granados, W. (2010). Reducing intimate partner homicides: The effects of federally-funded shelter service availability in California. *Journal of Criminal Justice, 38(4),*	Over twenty-five years of policy and scholarly attention to the problem of intimate partner violence appears to have generated greater victim safety. Intimate partner homicides, the most serious form of violence between intimates, have been declining for nearly three decades in many contexts, but not all. This study built on a small number of studies that had advanced knowledge about the policy-relevant factors behind the intimate partner homicide decline. The analysis described here utilized a set of county-level data from California from 1987 to 2000 to estimate the effects of shelter-based service availability on race/ethnicity-specific female	Does not evaluate the outcome of an intervention

512-519.	intimate partner homicide victimization. The study relied on a new measure of service availability in an attempt to overcome limitations with previously used indicators. This analysis did not reveal an effect of shelter-based service availability and criminal justice system responses on changes in female intimate partner homicide victimizations. Reasons for these findings and suggestions for future research are discussed.	
Wharne, S. (2005).Assertive outreach teams: their role and functions. *Journal of Interprofessional Care, 19(4)*, 326-337.	This critical evaluation considers research literature on Assertive Outreach Teams (AOTs). The extensive examination of this multi-professional service configuration is contrasted with the under-defined and untested nature of the service interventions that are provided by these teams. An audit of crisis management work in an AOT is reported and twelve areas of "life difficulties" are identified. An attempt to measure these life difficulties is then described. The use of this measurement for prioritizing referrals, managing workloads, agreeing care plans and measuring outcomes is discussed. Finally, the inadequacy of existing research approaches and associated problems in the separation of management and clinical practices are considered.	Does not evaluate the outcome of an intervention
Wikstrom, E., & Ghazinour, M. (2010). Swedish experience of sheltered housing and conflicting theories in use with special regards to honour related violence (HRV). *European Journal of Social Work, 13(2),* 245-259.	One aspect of violence against women and children is what is referred to as honour related violence. Honour related violence (HRV) is a form of violence which is now on the agenda in several countries as a violation of human rights. From 2002 the Swedish government started paying serious attention to this issue. The aim of this paper is to present the Swedish government programme dealing with HRV with special focus on sheltered housing as the prevalent measure to safeguard victims of HRV. Our results indicate that sheltered housing without doubt plays an important role for victims in the sense of providing short term safety. Notwithstanding the adequacy of sheltered housing as a means to provide support and safety, the outcome of the support is ambivalent in the long run. Our qualitative interviews of girls with previous experiences of staying at sheltered housing demonstrate the risk of the practice, turning one kind of control and isolation into another kind. The ambivalence of sheltered housing is further analysed in terms of conflicting logics of social work practices reflecting the Swedish conflicting discourses on HRV.	Does not evaluate the outcome of an intervention
Witte, T., Lohr, J., Parker, L., & Hamberger, K. (2007). Research evidence for the efficacy of psychosocial interventions for intimate partner violence: A critical review of the literature. *Scientific Review of Mental Health Practice, 5(2),* 8-16.	Intimate partner violence (IPV) occurs with shocking frequency. The alarmingly high estimated prevalence rates underscore the need for effective treatment interventions. Current treatment models aimed toward reducing relationship violence differ widely across theoretical orientation and mode of service provision. However, based on the review of the extant studies investigating the efficacy of IPV intervention, current treatment models are not more effective at reducing violence compared with no-treatment control conditions. In an effort to improve such interventions, the present article reviews the literature on treatment outcome research and proposes possible ways to improve interventions.	Non-systematic review
Zachary, M., Schechter, C., Kaplan, M., & Mulvihill, M. (2002). Provider evaluation of a multifaceted system of care to improve recognition and management of pregnant women experiencing domestic violence. *Women's Health Issues, 12(1),* 41-44.	This article describes the provider evaluation of a multifaceted system of care for pregnant women experiencing domestic violence and who receive prenatal care in an urban family practice site, one of four national demonstration projects. Providers reported changes in their own self-efficacy and behaviour, but showed little improvement in overall attitudes or knowledge. Focus groups revealed that an easily accessible domestic violence coordinator was important, whereas providers stated that most domestic violence protocol materials were not useful. Guidelines that rely on training and protocols have had limited national success, suggesting that additional systems of care such as written chart prompts, quality improvement, and on-site domestic violence services may be necessary. This intervention was well received by providers, a key factor in any effort to alter provider behaviour.	Does not evaluate the outcome of an intervention
Zun, L.S., Downey, L., & Rosen, J. (2006). The effectiveness of an ED-based violence prevention programme. *American Journal of Emergency Medicine, 24(1),* 8-14.	BACKGROUND: Youth violence continues to be a problem in the United States, most prominent in the inner-city minority youth population. The recurrence rate for repeat violence has been reported from 6% to 44% with a 5-year mortality of 20%. This study describes the results of a programme to reduce violence recurrence based in the ED. METHODS: Patients aged 10 to 24 years who were victims of interpersonal violence (excluding child abuse, sexual assault, and intimate partner violence) were randomly enrolled in the study in level 1 trauma centre. The control group was given a written list of services, and the treatment group received an assessment and case management for 6 months. Both groups were evaluated 6 and 12 months after	Does not have outcomes relevant to research question

	enrolment in the study. The primary indicators of the success of the intervention were reduction of self-reported revictimization or arrest and state-reported incarceration and reinjury. The study was approved by the institutional review board. The results compared the change in treatment and control groups over the time using a combination of chi(2) and analysis of covariance. RESULTS: One hundred eighty-eight victims of interpersonal violence met the criteria and had the initial evaluation completed. By chi(2) analysis, the treatment group (96 subjects) and the control group (92 subjects) were similar in age, sex, and racial composition. The average age was 18.6 years (range, 11-24), and 82.5% were boys. Most youth were African Americans (65.4%), followed by Hispanic (31.4%), whites (1.6%), or others (1.5%). A reduction in the self-reported reinjury rate was significantly reduced over time in the treatment group (chi(2) 3.87, P=0.05). There were no differences between the groups in the number of self-reported arrests, state-reported reinjuries via the trauma registry, or state-reported incarcerations (P<0.05). CONCLUSIONS: The results of this study demonstrated a reduction in self-reported reinjury rate in the intervention group. Further research is needed to confirm if ED-based violence prevention programs are effective in reducing other determinants for revictimization.	

Table 16. Research Question 4 (Children Exposed to DV) Studies Excluded on Full Text

Study Details	Abstract	Reason for Exclusion
Audit Commission. (2000). *Seeing the light: innovation in local public services: London Borough of Sutton: helping children who have witnessed domestic violence.* London, UK: Local Government.	The development of the Community Group Treatment Programme used in the London Borough of Sutton to help children who have witnessed domestic violence is briefly described. The programme is delivered by a wide and varied number of professionals from across the borough. It runs over a 12 week period for children aged 4 to 16, with children divided into age-specific groups to address a range of issues. These include validation of the children's experiences, understanding abuse, reducing self-blame, safety planning and managing appropriate and inappropriate expressions of emotion. The programme offers a concurrent component for mothers to attend groups and the sessions have been most successful when both mothers and children attend. Mothers are supported to understand how the violence has impacted on the child and how best to help them through the healing process. In the first year Sutton ran six groups for children. The results were excellent. This paper briefly describes how the programme came about, what helped sustain it, shared learning, and challenges encountered It is planned to extend the programme across London.	Does not evaluate the outcome of an intervention
Barraclough, S. (2005). *Assessment and intervention for pre-school children exposed to domestic violence.* London, UK: Refuge.	Presents the results of a pioneering study which examined pre-school responses to domestic violence within a refuge setting, and identified ways of assessing and supporting; young children to overcome the effects of domestic violence. Discusses the extent of the problem and looks at the consequences for the child who is exposed to violence or; trauma, including post traumatic stress, emotional and behavioural difficulties, and impaired hearing and speech development. Concludes that early intervention and support is; not currently recognized and that provision is inadequate. Recommends individual support sessions for pre-school children, child-mother individual focused support sessions; for mothers, and empathy groups for pre-school children.	Does not evaluate the outcome of an intervention
Barron, J. (n.d.). *Kidspeak: Giving Children and Young People a Voice on Domestic Violence.* Bristol, UK: Women's Aid.	No abstract	Does not evaluate the outcome of an intervention
Bennett, L., & Ryan, S. (2006). Using Theraplay in shelter settings with mothers & children who have experienced violence in the home. *Journal of Psychosocial Nursing & Mental Health Services,* 44(10), 38-	This article describes a group programme for women and children exposed to violence in the home. The programme is primarily based on Theraplay, an attachment-based intervention approach for working with both adults and children who have a variety of emotional and behavioural difficulties. The theoretical and research bases, as well as the guiding principles of Theraplay, will be outlined and discussed, and the rationale for its application to a shelter setting will be highlighted. Finally, the benefits of and challenges to implementing such a programme and the implications for practice and further evaluation will be explored.	Does not evaluate the outcome of an intervention

48.		
Bowyer, S. (2008). Better outcomes in domestic abuse cases. *Community Care,*1739, 26.	Review of recent research on the impact of domestic violence on children, to provide an evidence base for good practice. Key messages from the child's perspective are highlighted, and multi-agency responses to domestic violence involving children are discussed	Does not evaluate the outcome of an intervention
Buschel, B. (2006). Strengthening connections between mothers and children: Art therapy in a domestic violence shelter. *Journal of Aggression, Maltreatment and Trauma, 13(*1), 87-108.	This paper presents a programme in a domestic violence shelter that focuses on strengthening the connections between mothers and children. The programme draws on trauma theory, art therapy, and a recursive model of communication. The paper describes how psychoeducation about the physiological and psychological effects of trauma is helpful to the families. It illustrates how art therapy is used to help the children express and communicate their experience of family violence. The recursive model of sharing information is explained and demonstrated, using examples of issues that frequently arise in the art therapy sessions. These three components used together promote communication within the family and strengthen safe connections.	Does not evaluate the outcome of an intervention
Cohen J., Mannarino, P., & Igelman, R., (2006). Psychosocial interventions for maltreated and violence-exposed children. *Journal of Social Issues, 62*(4), 737-766.	Child sexual, physical, and emotional abuse as well as child neglect and domestic violence, community violence, and Childhood Traumatic Grief may result in significant and long-lasting emotional and behavioural difficulties. This article reviews randomized controlled studies that have assessed child mental health outcomes for maltreated and violence-exposed children. Key points of this review include the following: (1) maltreated and violence-exposed children typically experience more than one of these types of traumas; (2) effective psychosocial treatments are available to address Posttraumatic Stress Disorder (PTSD), depression, anxiety, and behavioural problems in these children; (3) it is likely that treatments which effectively reduce mental health symptoms in children exposed to one type of child maltreatment or violence exposure will also be effective for other or multiple types; and (4) mental health outcomes are not the only important outcomes to address in future treatment or intervention efforts. These future directions for treatment intervention research are addressed.	Non-systematic review
Cohen, J., & Iyengar, S. (2011). Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: a randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine, 165*(1), 16-21.	OBJECTIVE: To evaluate community-provided trauma-focused cognitive behaviour therapy (TF-CBT) compared with usual community treatment for children with intimate partner violence (IPV)-related posttraumatic stress disorder (PTSD) symptoms. DESIGN: Randomized controlled trial conducted using blinded evaluators. SETTING: Recruitment, screening, and treatment were conducted at a community IPV centre between September 1, 2004, and June 30, 2009. PARTICIPANTS: Of 140 consecutively referred 7- to 14-year-old children, 124 participated. INTERVENTIONS: Children and mothers were randomly assigned to receive 8 sessions of TF-CBT or usual care (child-centered therapy). MAIN OUTCOME MEASURES: Total child PTSD symptoms assessed using child and parent structured interview (Kiddie Schedule for Affective Disorders and Schizophrenia, Present and Lifetime Version [K-SADS-PL]) and self-report (University of California at Los Angeles PTSD Reaction Index [RI]). Secondary child outcomes were scores on the K-SADS-PL (PTSD symptom clusters), Screen for Child Anxiety Related Emotional Disorders (SCARED) (anxiety), Children's Depression Inventory (depression), Kaufman Brief Intelligence Test (cognitive functioning), and Child Behaviour Checklist (total behaviour problems). RESULTS: Intent-to-treat analysis using last observation carried forward showed superior outcomes for TF-CBT on the total K-SADS-PL (mean difference, 1.63; 95% confidence interval [CI], 0.44-2.82), RI (mean difference, 5.5; 95% CI, 1.37-9.63), K-SADS-PL hyperarousal (mean difference, 0.71; 95% CI, 0.22-1.20), K-SADS-PL avoidance (0.55; 0.07-1.03), and SCARED (mean difference, 5.13; 95% CI, 1.31-8.96). Multiple imputation analyses confirmed most of these findings. The TF-CBT completers experienced significantly greater PTSD diagnostic remission ([chi](2)=4.67, P=0.03) and had significantly fewer serious adverse events. CONCLUSIONS: Community TF-CBT effectively improves children's IPV-related PTSD and anxiety.	Systematic review on a variety of child maltreatment; Small section on DV with only one already included primary study
Conradi, L. W. (2010). Managing traumatized children: A trauma systems perspective." Current	Purpose of Review: To review the current research on trauma-informed child-serving systems. Research on this topic, although sparse, is critically important because most children who come into contact with systems, including the child welfare and juvenile justice systems, have experienced at least one traumatic event. Recent	Does not evaluate the outcome of an

opinion in pediatrics 22(5), 621-625.	Findings: Very little research has actually been done on this topic area. Although it makes intuitive sense to integrate a trauma-informed approach into child-serving systems, much more research needs to be conducted in order to determine the efficacy of trauma-informed thinking in child-serving systems. Summary: A number of research studies have been conducted that focus on adults with co-occurring disorders who have received trauma-informed treatment. These results suggest that a 'trauma-informed' approach is a helpful and effective way to implement services. These same principles may be applied to work with children in order to create a 'trauma-informed child-serving system'. Twelve literature-supported and research-supported components of such a system are introduced in this review, ranging from the importance of specialized knowledge about trauma to trauma assessment and the value of trauma-informed policy.	intervention
Cragie, E. (2011). Violence in families - the experience and needs of the child. *Social Work Now: The Practice Journal of Child, Youth and Family, 47,* 27-34.	Violence in families has the potential to seriously harm a child or young person and affect the course of their life. It is the role of the child protection worker to ensure the wellbeing of those children and young people who are living with violence in their families. This article explores existing research in the area of family violence in order to examine the most critical considerations for practice and how to shape social work interventions to assist children, young people and their families to find the right pathways of support to improve their life outcomes. It underlines the importance of involving and listening to children who are affected by violence in their family, in order to both understand the impact of the situation for them and to make plans about what happens next. In particular, the article focuses on the key areas of: the impact of family violence on children; cumulative harm caused by ongoing violence; and what constitutes effective intervention for children and families.	Does not evaluate the outcome of an intervention
Crowther, K., & Cowen, G. (2011). *Effective Relationships with Vulnerable Parents to Improve Outcomes for Children and Young People: Final Study Report.* Leeds, UK: York Consulting.	No abstract	Does not evaluate the outcome of an intervention
DeVoe, E., Traube, D., & McKay, M.M. (2005). The SURVIVE community project: a family-based intervention to reduce the impact of violence exposures in urban youth. *Journal of Aggression, Maltreatment & Trauma, 11(*4), 95-116.	The purpose of this article is to describe the development of a family-based intervention designed to target the harmful effects of exposure to family and community violence on urban youth and their parents. The programme, "Supporting Urban Residents to be Violence-Free in a Violent Environment (SURVIVE)," is a 12-week multiple family group (MFG) intervention modeled upon similar children's mental health programs implemented with urban youth of color and their families in several major U.S. cities. The design and implementation of the SURVIVE Community Project were guided by a collaborative partnership between community members, including mental health professionals, teachers, and parents from the Bronx, and an interdisciplinary team of university-based researchers. In order to establish the feasibility and relevance of the programme for urban communities, 25 families with children ages 7-11 participated in a pilot test of the curriculum. The description of the SURVIVE Community Project provided here is based on this work, and includes a discussion of facilitation issues. Implications for family-based intervention targeting urban children and families affected by violence are highlighted.	Does not evaluate the outcome of an intervention
Drotar, D., Day, E., Friedman, S., Creeden, R., Gartland, H., McDavid, L., Tame, C., & MaTaggart, M.J. (2003). Identifying and responding to the mental health service needs of children who have experienced violence: A community-based approach. *Clinical Child Psychology and Psychiatry, 8*(2), 187-203.	Children's exposure to violence, their psychological response to the violence, and their participation in a community-based intervention service were described. This article describes the provision of mental health services and the process evaluation for the initial phase of the programme (1999-2000). A large number (N=1739) children were referred to the programme over a 17.5-month period for mental health intervention immediately after witnessing and experiencing a range of violent acts, the majority of which (N=1355) involved domestic violence. A majority of referred children and adolescents (N=946) directly witnessed such violence, and the majority of those who were old enough to provide self-report indicated that they perceived the event as a direct threat to their safety. Many of these children and adolescents also reported high levels of trauma symptoms. The majority of children (N=1117) who were referred to the programme participated. The findings	Does not evaluate the outcome of an intervention

	underscore the feasibility of developing mental health services to meet the needs of children who are exposed to violence, especially family violence, at a critical time following violence exposure.	
Eckenrode, J., Ganzel, B., Henderson, C.R., Smith, E., Olds, D.L., Powers, J., Cole, R., Kitzman, H., & Sidora, K. (2000). Preventing child abuse and neglect with a programme of nurse home visitation: the limiting effects of domestic violence. *Journal of the American Medical Association, 284(11),* 1385-1391.	CONTEXT: Home visitation to families with young children has been promoted as an effective way to prevent child maltreatment, but few studies have examined the conditions under which such programs meet this goal. OBJECTIVE: To investigate whether the presence of domestic violence limits the effects of nurse home visitation interventions in reducing substantiated reports of child abuse and neglect. DESIGN: Fifteen-year follow-up study of a randomized trial. SETTING: Semirural community in upstate New York. PARTICIPANTS: Of 400 socially disadvantaged pregnant women with no previous live births enrolled consecutively between April 1978 and September 1980, 324 mothers and their children participated in the follow-up study. INTERVENTIONS: Families were randomly assigned to receive routine perinatal care (control group; n=184 participated in follow-up), routine care plus nurse home visits during pregnancy only (n=100), or routine care plus nurse home visits during pregnancy and through the child's second birthday (n=116). MAIN OUTCOME MEASURES: Number of substantiated reports over the entire 15-year period involving the study child as subject regardless of the identity of the perpetrator or involving the mother as perpetrator regardless of the identity of the child abstracted from state records and analysed by treatment group and level of domestic violence in the home as measured by the Conflict Tactics Scale. RESULTS: Families receiving home visitation during pregnancy and infancy had significantly fewer child maltreatment reports involving the mother as perpetrator (P=0. 01) or the study child as subject (P=0.04) than families not receiving home visitation. The number of maltreatment reports for mothers who received home visitation during pregnancy only was not different from the control group. For mothers who received visits through the child's second birthday, the treatment effect decreased as the level of domestic violence increased. Of women who reported 28 or fewer incidents of domestic violence (79% of sample), home-visited mothers had significantly fewer child maltreatment reports during the 15-year period than mothers not receiving the longer-term intervention (P=0.01). However, this intervention did not significantly reduce child maltreatment among mothers reporting more than 28 incidents of domestic violence (21% of sample). CONCLUSIONS: The presence of domestic violence may limit the effectiveness of interventions to reduce incidence of child abuse and neglect.	Does not have outcomes relevant to research question
Edenborough, M.J., Mannix, J., & Wilkes, L.M. (2008). Living in the red zone: the experience of child-to-mother violence. *Child & Family Social Work, 13,* 464-473.	This paper is drawn from a larger Australian study that aimed to explore child-to-mother violence in a high risk geographical area and describes a qualitative theme developed from 185 participating women's narratives, 'Living in the red zone: the experience of child-to-mother violence'. Evidence suggests that the issue is complex, that mothers often struggle in silence and that the issue is often minimised or devalued by family and community members, which may prevent women seeking support. Mothers were generally found to have limited ideas about or access to the help and support that could have improved their situation.	Does not evaluate the outcome of an intervention
Fowler, D., & Chanmugam, A. (2007). A critical review of quantitative analyses of children exposed to domestic violence: lessons for practice and research. *Brief Treatment and Crisis Intervention,* 7, 322-344.	Increased recognition of the unique needs of children exposed to domestic violence (CEDV) is evidenced by the evolving knowledge base on this issue. The breadth of quantitative research that exists has laid a foundation upon which to build effective time-limited intervention strategies. Still, intervention research in this area has yet to move toward advanced practice models. Definitional and methodological limitations have also impeded knowledge advancement. This paper uses a novel approach to critically review 5 quantitative meta- and mega-analyses on the effects of childhood exposure to domestic violence. Research and practice implications derived from these quantitative analyses that may assist child welfare professionals, domestic violence advocates, and researchers interested in providing effective intervention and services to CEDV are discussed.	Does not evaluate the outcome of an intervention
Garboden, M. (2010). Blackpool Illuminates Victims of Violence. *Community Care, 1817,* 20.	No abstract	Short commentary
Georgiades, S.D. (2008). A solution-focused intervention with a youth in	This article reports on a 4-year therapeutic intervention combining in-person and email communication with a 13-year-old Greek-Cypriot teenager who witnessed and later was the victim of severe domestic violence. The	One case study

a domestic violence situation: Longitudinal evidence. *Contemporary Family Therapy, 30*(3), 141-151.	intervention is based on an empowerment philosophy and solution-focused strategies, and its usefulness is evaluated by three standardized measures at five time points between the years 1999 and 2003. Pertinent cultural and ethical dynamics of the interventional context are highlighted. The intervention may have helped to produce better perpetrator-youth relations, remission of the client's depression and post-traumatic stress symptoms, and improvement in his academic performance. Implications and limitations are discussed.	
Graham-Bermann, S. (2003). Intervention for children exposed to interparental violence (IPV): Assessment of needs and research priorities*. Clinical Child and Family Psychology Review, 6*(3), 189-204.	In this paper we review the development of interventions for children who have been exposed to interparental violence (IPV), assess current needs in the evaluation of interventions, and provide suggestions for research priorities in this area. Interventions for negative outcomes associated with exposure to IPV only recently have been carefully designed and evaluated, thus knowledge regarding programme effectiveness is minimal. Three of the most comprehensive interventions that have been evaluated are presented. Each has demonstrated effectiveness, and focuses on children with different levels of symptoms and distress. However, many questions remain regarding which interventions are beneficial for diverse children with different kinds and intensities of problems. A number of research priorities and suggestions for further improvements in the evaluation of effectiveness of interventions are identified.	Non-systematic review
Graham-Bermann, S. A. (2000). Evaluating interventions for children exposed to family violence. *Journal of Aggression, Maltreatment and Trauma, 4(*1), 191-215.	This paper presents a critical overview of the state of evaluation research with regard to intervention programs for children who witness family violence. The range and types of programs include universal preventive interventions as well as targeted interventions designed to prevent problems for at-risk children who have observed and experienced violence in their families. While few programs have been assessed to date, a summary of what appear to be the best ways to intervene in the prevention of and aftermath of family violence with children is offered, followed by ten suggestions for improving research in this area.	Non-systematic review
Graham-Bermann, S., & Kanukollu, S.N. (2011). Is disclosure therapeutic for children following exposure to traumatic violence? *Journal of Interpersonal Violence, 26*(5), 1056-1076.	Trauma theory suggests that to recover from exposure to traumatic events, such as exposure to violence, therapeutic interventions should include opportunities to disclose and to process the fearful and stressful events. Yet little is known about the circumstances that foster disclosure of such information in therapeutic environments by children and related mental health outcomes for those children. In this study, the process of disclosure was examined among children ages 6 to 12 years (N=121) in a community-based intervention programme for children exposed to intimate partner violence (IPV). Therapists documented children's spontaneous disclosure in their group. Mothers and children completed demographic and standardized attitudinal and mental health questionnaires. Fifty-two percent of children spontaneously disclosed during therapy. Child ethnicity, harm to the child, internalizing behavioural adjustment problems, and engagement in therapy predicted disclosure. Disclosure within the group was associated with gains for individual children in internalizing behavioural adjustment problems and improvement in attitudes and beliefs concerning the acceptability of violence.	Does not evaluate the outcome of an intervention
Groves, B. & Gannon J. (2000). Building community capacity to protect young children and families: The Massachusetts Child Witness to Violence Project*. Zero to Three: Bulletin of Zero to Three, National Centre for Infants, Toddlers, and Families, 20(5),* 34-41.	No abstract	Does not evaluate the outcome of an intervention
Hopkins, G. (2005). Shrinking violence. *Community Care,*1582.	Reports on an innovative partnership with education in Cheshire aims to help children deal with domestic abuse.	Does not evaluate the outcome of an intervention
Howard, J. (2011). *Adolescent violence in the home: the missing*	No abstract	Intervention setting outside of health and

link in family violence prevention and response. Sydney, AU: Australian Domestic and Family Violence Clearinghouse.		social services (Justice system)
Hyde, M., & Chavis, D. (2008). Safe Start: Promising Practices from the Evaluation of the Demonstration Project Association for the Study and Development of Community. *Journal of Emotional Abuse, 8*(1), 175-186.	Several activities were used to evaluate the Safe Start Demonstration Project (2000-2006). Findings from two of the evaluation activities (i.e., process evaluations, promising practices reports) have been combined in this article to discuss systems change strategies implemented to better serve children exposed to violence and the promising practices that supported them. Together, these two evaluation processes yield valuable information for practitioners on how to engage families, systems, and communities to create more responsive systems capable of meeting the needs of children exposed to violence. These findings and examples also provide useful strategies and practices for future efforts focused on children exposed to violence.	Does not evaluate the outcome of an intervention
Jeyasingham, D. (2011). *Evaluation of Trafford Children and Young People Service Targeted Mental Health in Schools Project.* Telford, UK: Telford and Wrekin Council.	This report provides information about the evaluation of Trafford's Targeted Mental Health in Schools project. The evaluation is based on data from interviews with professionals working in schools and other agencies involved with TaMHS and a small number of observations of the project's work. Children and families who used the service were asked whether they wanted to take part in the evaluation but no service users chose to do so.	Does not have outcomes relevant to research question
Kelley, B.R., & Beauchesne, M.A. (2002). Interventions for Violence in Children and Adolescents. *School Nurse News, 19(3),*36-39.	Suggests violence prevention strategies that can be adapted for school health offices. The activity teaches school nurses to: recognize at least four steps in identifying family violence in a health history; discuss at least three parent, child, family, and community activities to reduce family violence; and identify at least three resources to help children and families prevent violence.	Does not evaluate the outcome of an intervention
Kerig, P., Brown, C., & Warren, M. (2000). Assessment and intervention for PTSD in children exposed to violence. *Journal of Aggression, Maltreatment and Trauma, 3*(1), 161-184.	Recent research has established that exposure to domestic violence is a major risk factor for posttraumatic stress disorder (PTSD) in children. However, one issue that has been relatively neglected in research conducted to date concerns developmental differences: both in the expression of PTSD symptoms across childhood and adolescence, and in the techniques appropriate for assessing and intervening with PTSD in children at different ages. The available literature is reviewed concerning the conceptualization, measurement, and treatment of PTSD in children, with special attention to the case of children of battered women. Guidelines are provided for developmentally sensitive approaches to assessment and treatment.	Systematic review that does not include any interventions meeting inclusion criteria (All references prior to 2000)
Kerig, P., Cuellar, R.E.M, Vanderzee, K.L., & Elfstrom, J.L. (2010). Implementing trauma-focused CBT with fidelity and flexibility: a family case study. *Journal of Clinical Child & Adolescent Psychology, 39(5),* 713-722.	Effective approaches for the treatment of childhood posttraumatic stress disorder and traumatic grief are needed given the prevalence of trauma and its impact on children's lives. To effectively treat posttraumatic stress disorder in children, evidence-based practices should be implemented with flexibility and responsiveness to culture, developmental level, and the specific needs of the family. This case study illustrates flexibility with fidelity in the use of a manualized treatment, describing the implementation of Trauma Focused-Cognitive Behaviour Therapy with three traumatized family members-a caregiver and two children. Particular attention is paid to the use of creative strategies to tailor interventions to the individual clients while maintaining fidelity to the principles and components of this evidence-based treatment.	One case study
Kozlowska, K., & Hanney, L. (2001). An art therapy group for children traumatized by parental violence and separation. *Clinical Child Psychology and Psychiatry, 6(1),* 49-78.	This article describes the treatment of five traumatized children (aged 4-8 years) using adjunctive group art therapy, and reviews the theoretical basis for such a treatment strategy. All the children had been exposed to cumulative traumatic experiences involving threats to caregivers in the context of conflictual, violent and unresolved parental separation. All presented with symptoms of post-traumatic stress, developmental problems related to trauma, had difficulties with any discussion of traumatic events or family concerns, and reacted with hyperarousal and/or an 'emotional shutdown' response. Previous treatments included a combination of social, family, psychological and biological interventions including: outpatient family therapy, medication, admission to a therapeutic day programme, inpatient family work and home visits by nurses, with partial response. The group, a structured, low anxiety, interactive setting, was a therapeutic intervention developed by a child psychiatrist and an art therapist to facilitate further therapeutic change. The therapeutic use of artworks facilitated exposure to traumatic cues in a less direct manner, allowed for desensitization of anxiety and	One case study

	unpleasant body sensations, helped the children recount the story of the parental separation and to label and articulate affective states using art and narrative. Positive family changes and coping skills the children were using to manage ongoing stresses were made overt. Positive expectations of the future were promoted. Key therapeutic and theoretical aspects of the group intervention are described.	
Kracke, K., & Cohen, E.P. (2008). The Safe Start Initiative, building and disseminating knowledge to support children exposed to violence. *Journal of Emotional Abuse, 8(1-2),*155-174.	The Safe Start Initiative promotes community investment in evidence-based strategies for preventing and reducing children's exposure to violence in the home and the community. This article describes the implementation of practice innovation in 26 communities across the United States and provides information on the national research, evaluation, training, and technical assistance, resource development, and broad dissemination components of the initiative. Evaluation of the initiative is expanding the knowledge of the elements needed to implement comprehensive service delivery systems and improve access to, delivery of, and quality of services both for children at high risk of being exposed to violence and for those who have already been exposed.	Does not evaluate the outcome of an intervention
Lang, J.M., & Fitzgerald, M.M. (2010). An algorithm for determining use of trauma-focused cognitive-behavioural therapy. *Psychotherapy, Theory, Research, Practice, Training, 47(4),* 554-569.	The shift toward dissemination of evidence-based practices has led to many questions about who is appropriate for a particular treatment model, particularly with complex clients, in diverse community settings, and when multiple evidence-based models have overlapping target populations. Few research-based tools exist to facilitate these clinical decisions. The research on trauma-focused cognitive-behavioural therapy (TF-CBT), an evidence-based treatment for children suffering from posttraumatic stress reactions, is reviewed to inform development of an algorithm to assist clinicians in determining whether a particular client is appropriate for TF-CBT. Recommendations are made for future research that will facilitate matching TF-CBT and other evidence-based practices to particular child clients.	Does not have outcomes relevant to research question
McKinney, C.S., Agliata, A.K., & Renk, K. (2006). Children's exposure to domestic violence, Striving toward an ecological framework for interventions. *Journal of Emotional Abuse, 6(1)*, 1-23.	The frequency with which children are exposed to domestic violence is unsettling. Children's exposure to domestic violence can have adverse effects on their functioning, including the promotion of emotional and behavioural difficulties as well as other difficulties. A number of factors, such as the age of the children when they are exposed and the psychological well being of their mothers, may have mediating and moderating effects on the outcomes for children. Although interventions have been based on the individual, family, and community, few interventions have combined these approaches. Given the widespread effects of domestic violence, interventions for the effects of domestic violence should be framed within an ecological framework. This paper reviews the current issues concerning children's exposure to domestic violence and discusses interventions within an ecological framework that may be applied to counteract the adverse effects suffered by children.	Non-systematic review
McWhirter, P. (2010). Community and School Violence and Risk Reduction, Empirically Supported Prevention. *Group Dynamics-Theory Research and Practice, 14(3),* 242-256.	The development, implementation, and research of two separate psychoeducational group programs are described. One of the programs, Project FREE (Family Rejuvenation. Education and Empowerment; developed by Paula T. McWhirter and her colleagues) focuses on mothers who have suffered domestic violence and their children as witnesses. The project includes parallel psychoeducational group sessions with battered mothers and a simultaneous psychoeducational group session with the children followed by a conjoint session with both mothers and children. The pilot and the initial studies were conducted in a clinic/hospital setting and later studies in temporary domestic homeless shelters. The second programme, GOPEP (Group Oriented Psychoeducation Prevention; developed by J. Jeffries McWhirter and his colleagues) includes four separate school based interventions designed to reduce anger, diminish depression, reduce anxiety, and build positive peer and adult relationships. Each programme includes 15 1 hour sessions for classroom group or as a pullout group programme. Both Project FREE and GOPEP utilized group process is to reduce future problems and to promote well-being and positive mental health. Following programme description and implementation, research process and group programme efficacy are presented.	Non-systematic review
Mullender, A. (2004). *Tackling domestic violence: providing support for children who have*	This report provides good practice recommendations and suggestions for a range of practitioners and professionals who have a role in commissioning, developing or delivering initiatives to support children who have in the past or are currently witnessing domestic violence. Once domestic violence has been identified and	Does not evaluate the outcome of an

witnessed domestic violence. London, UK: Great Britain Home Office.	disclosed, children may need direct support to help them cope and move on from what has or is happening. Examples of the type of support work include: counselling, play therapy, life story work, crisis work and safety planning, and this can either be provided on a one-to-one basis or as part of group work. These interventions are often conducted in parallel with support work with the mother. The report draws upon the evaluations of a number of projects which were funded under the remit of the Crime Reduction Programme (CRP) Violence Against Women Initiative (VAWI), as well as the available published literature. More information about the evidence base for this guidance is detailed at the end of this report.	intervention
Nolas, S.M., Neville, L., & Sanders-McDonagh, E. (2012). Evaluation of the Community Group Programme for Children & Young People: Final Report. Sussex, UK: University of Sussex.	The report presents findings from the evaluation of the Community Group Programme (CGP). The CGP is a 12-week psycho-educational, group work programme for children and young people who have experienced domestic violence. The Programme was developed in Canada and is now being rolled out in England across 32 London boroughs. The Programme is unique in working with children and their mothers concurrently and in a child-focused way.	Conference abstract
Nygren, P., Nelson, H.D., & Klein, J. (2004). Screening Children for Family Violence: A Review of the Evidence for the Us Preventive Services Task Force. *Annals of Family Medicine, 2(2),* 161-169.	BACKGROUND We wanted to evaluate the benefits and harms of screening children in primary health care settings for abuse and neglect resulting from family violence by examining the evidence on the performance of screening instruments and the effectiveness of interventions. METHODS We searched for relevant studies in MEDLINE, PsycINFO, CINAHL, ERIC, Cochrane Controlled Trials Register, and reference lists. English language abstracts with original data about family violence against children focusing on screening and interventions initiated or based in health care settings were included. We extracted selected information about study design, patient populations and settings, methods of assessment or intervention, and outcome measures, and applied a set of criteria to evaluate study quality. RESULTS All instruments designed to screen for child abuse and neglect were directed to parents, particularly pregnant women. These instruments had fairly high sensitivity but low specificity when administered in high-risk study populations and have not been widely tested in other populations. Randomized controlled trials of frequent nurse home visitation programs beginning during pregnancy that address behavioural and psychological factors indicated improved abuse measures and outcomes. No studies were identified about interventions in older children or harms associated with screening and intervention. CONCLUSIONS No trials of the effectiveness of screening in a health care setting have been published. Clinician referrals to nurse home visitation during pregnancy and in early childhood may reduce abuse in selected populations. There are no studies about harms of screening and interventions.	Non-systematic review
Overlien, C. (2011). Women's Refuges as Intervention Arenas for Children Who Experience Domestic Violence. *Child Care in Practice,17(4),* 375-391.	For over 30 years, children have been accompanying their mothers to women's refuges. We now know that these children are at risk of developing an array of behavioural and psychological difficulties. We also know the importance for children of keeping active and playing while at the refuge, and to be given the possibility of addressing and dealing with their own experiences of violence. However, we know very little about how children experience these interventions. This study analyses children's discourse about their everyday lives at refuges in Norway. The questions asked are: what interventions do children in refuges in Norway receive and how do the children experience those interventions? The analysis shows that the children focus on two forms of interventions as particularly helpful, activities (trips, "outings", and so on) and individual counselling. Furthermore, as the most important intervention for a child who experiences domestic violence is to remove him/her from a seriously violent environment, the refuge stay in itself can be perceived as an intervention. In the discussion, the author describes how and why refuges represent a unique opportunity for interventions with children.	Does not evaluate the outcome of an intervention
Pearl, E.S. (2008). Parent-child interaction therapy with an immigrant family exposed to domestic violence. *Clinical Case*	Parent-child interaction therapy (PCIT) is an empirically supported treatment to enhance the parent-child relationship and to help parents learn how to effectively manage disruptive behaviour in young children. PCIT has been shown to be effective with various populations. However, few reports have documented its use with children exposed to domestic violence in families who have recently immigrated to the United States. A mother	One case study

Studies, 7(1), 25-41.	and 3-year-old child who immigrated to the United States from Africa were identified as an appropriate family for PCIT. The child had reportedly been exposed to domestic violence and presented with both internalizing and externalizing behaviours and symptoms. Specific challenges and successes related to this case are presented.	
Poole, A., Beran, T., & Thurston, W.E. (2008). Direct and indirect services for children in domestic violence shelters. *Journal of Family Violence, 23(8),* 679-686.	The majority of women entering battered women's shelters bring children with them and those children often require specialized programs that address the ways in which witnessing domestic violence has affected them. Several programs have been developed and implemented; however, few have been empirically evaluated. The current article critically examines several intervention strategies and their effectiveness. Barriers to service are also identified. Although there is a paucity of research in this area, the present review suggests that intervening with children may show promise for breaking the cycle of violence.	Systematic literature review, but includes no relevant studies that were not already included by Rizo (2011).
Routt, G., & Anderson, L. (2011). Adolescent violence towards parents. *Journal of Aggression, Maltreatment & Trauma, 20*, 1-19.	Violence towards parents by young people is a rarely studied event by family violence researchers. However, there is growing evidence that indicates it is a widespread phenomenon. Knowledge about this type of violence is incomplete, and few established interventions exist. This paper describes an intervention, the Step-Up programme, for young people who assault their parents in King County, Washington. It investigated the risk factors for young offenders and characteristics of victimised parents and families. Three sources of data are used to describe young offenders and their families: statistics from the King County Prosecutor's Office, data from interviews with these youth and their parents, and clinical observations of the Step-Up staff who have worked closely with youth and parents for 10 years. The findings suggest that adolescent-to-parent violence is a serious problem. The authors concluded that an integrated approach that combines the efforts of interested professionals could begin to address this form of family violence.	Does not evaluate the outcome of an intervention
Samuelson, K.W. (2011). Trauma-Focused CBT reduces anxiety and post-traumatic stress disorder in children exposed to intimate partner violence. *Evidence-Based Mental Health, 14(2),* 56-56.	No abstract	Does not evaluate the outcome of an intervention
Seaborn, B. (2006). Working constructively with children who have experienced domestic violence. *Australian Journal of Psychology, 58,* 99-100.	No abstract	Does not evaluate the outcome of an intervention
Smith, C., Grimes, M., Morrison, F., Houghton, C., & Stafford, A. (2008). *Consultation with children and young people with experience of domestic abuse on the Scottish Government national domestic abuse delivery group draft proposals: Main report.* Scotland, UK: Scottish Government Social Research.	This document reports findings from three events held to consult with children and young people with experience of domestic abuse on the Scottish Government National Domestic Abuse Delivery Group Draft Proposals. The aim of the engagement was to give children and young people who have experienced domestic abuse the opportunity to provide their views on the NDADG proposals, drawing on their own experiences, priorities and concerns. Specific objectives were to engage with children and young people with experience of domestic abuse aged between and 8 and 16 years old from across Scotland, facilitate small groups using a variety of methods to enable the children and young people to discuss the proposals, and to analyse and report on the results of the events. Consultation events were held in October 2007 in Glasgow, Edinburgh and Inverness. Children and young people with experience of domestic abuse were invited to participate via Women's Aid Children's Support workers. A total of 33 young people took part in the events: a mix of boys and girls; young people from urban and rural areas; and from a range of ethnic origins. Findings are presented.	Does not evaluate the outcome of an intervention
Social Services Improvement Agency. (2011). *What works in promoting good outcomes for*	This paper aims to provide commissioners and practitioners with key messages arising from research and best practice about how best to promote improved outcomes for children in need where there is domestic violence. It sets these findings within the national context in Wales, drawing on experiences from across the UK and	Does not evaluate the outcome of an

children in need who experience domestic violence? Cardiff, UK: Social Services Improvement Agency.	further afield. The paper describes a model identifying tiers of need and intervention, and also highlights tools for assessing risk as part of making effective decisions about the types of interventions needed. The paper also identifies main providers of services for children and families and the kinds of support they provide. Support for families in the UK has focused around 3 areas: work with (primarily) women survivors of domestic violence and their children; work with parents still living in circumstances of domestic violence; and work with (usually male) perpetrators. Examples of notable practice in these areas are outlined. The paper also highlights good practice indicators which relate to: the use of definitions of domestic violence; the use of screening indicators; the development of tools to assure practice; the development of safety measures and safety-orientated practice; training; evaluation; multi-agency service coordination; and specific interventions with children and women.	intervention
Stalford, H., Baker, H., & Beveridge, F. (2004). Children and Domestic Violence: Evaluating Service Provision in Rural Areas. London, UK: Save the Children.	No abstract	Non-systematic review
Statham, J. (2004). Effective services to support children in special circumstances. *Child, Care, Health & Development, 30(6),* 589-598.	BACKGROUND: Children living in special circumstances, defined as those who are at risk of achieving poorer outcomes than their peers, have a particular need of good quality, accessible services to promote their health and well-being, yet may be least likely to receive them. AIMS: This review considers the evidence for effective services to support children living in five kinds of special circumstances: (1) those at risk of offending; (2) teenage parents; (3) children whose parents have drug, alcohol or mental health problems; (4) children living with domestic violence; and (5) children who have been abused or neglected. In practice, there is often considerable overlap between these groups, and many children face multiple disadvantage. The review also aims to identify effective strategies for making support services more accessible to hard-to-reach groups. METHODS: Relevant literature was identified through searches of databases and websites, and consultation with experts. Given the broad scope of the topic, the aim was to provide an overview of best evidence rather than to undertake a systematic review. RESULTS: Similar themes underpin the most promising approaches to supporting children in special circumstances. These include: (1) a holistic, multi-agency approach addressing the needs of the whole child rather than compartmentalising children's social, educational, health and care needs; (2) the importance of links between adults' and children's services so that children who are in need because of their parents' circumstances can be identified and supported; and (3) the value of providing children in special circumstances with intensive, targeted support within a framework of universal provision. CONCLUSIONS: Overall, there is a lack of well-designed evaluations of the effectiveness of UK services and programmes for children in special circumstances. The existing evidence base would be strengthened by the development of better outcome measures, by exploring the characteristics of effective services from the perspective of different stakeholders (including children and young people themselves) and by extending the current problem-oriented approach to consider the factors that promote resilience and coping.	Does not evaluate the outcome of an intervention
Stewart, J., Todd, N., & Kopeck, C. (2010). A clinical model in action in intensive residential treatment: Meeting the needs of adolescent boys who have experienced domestic violence. *Journal of Child and Family Studies, 19(4),* 419-428.	The Habitat Programme at Wood's Homes, Calgary, Alberta, is an eight bed residential treatment programme for conduct-disordered youth who have been exposed or subjected to high levels of violence in their family home. The programme was based on the assumption that working effectively with such youth requires consideration of the background experiences of family violence, yet traditional treatment models often ignore or minimize the importance of these experiences. We present a clinical model which incorporates aspects of milieu treatment, relationship-based daily interventions and elements of Jenkins' invitational approach to working with men and boys who use violence as well as Wade's response-based approach to counselling with victims and perpetrators of violence. The model also incorporates ideas based on Maruna's research into recidivism and excuse-making. The purpose of the model is twofold: to be broad enough to structure an overall treatment strategy based on the assumption that successful treatment results from the cumulative effect of many interactions over time, and to be specific enough to guide staff in developing strategies for specific	One case study

	situations that typically arise in daily interaction with the youth. We use a case example format to illustrate how staff has utilized the model to engage youth in exploring both their experiences of violence in the family home and in developing new ways of thinking and talking about behavioural choices.	
Thompson, E. H. (2011). The Evolution of a Children's Domestic Violence Counselling Group, Stages and Processes. *Journal for Specialists in Group Work, 36(3),*178-201.	The purpose of this qualitative case study is to illuminate the lived experiences of 4 young children between 6 and 7 years old who witnessed domestic violence while revealing the complex relationship between group process and stage development in their 18-week counselling group. Data revealed that processes occurring between and among group members shaped the evolution of the counselling group through a series of stages that are similar to those seen in adult counselling groups. The data also revealed developmental differences between group processes occurring between these young members and the ways in which group processes unfold in adult counselling groups.	One case study
US Department of Justice, & US Department of Health and Human Services. (2011). *Evidence-Based practices for children exposed to violence: A selection from federal databases.* Retrieved from http://www.futureswithoutviolence.org/userfiles/file/Children_and_Families/Complete%20Matrix%20Booklet%2011FEB02.pdf	No abstract	Non-systematic review
Vickerman, K.A., & Margolin, G. (2007). Posttraumatic stress in children and adolescents exposed to family violence: II. Treatment. *Professional Psychology, Research and Practice, 38(6),* 620-628.	Interventions for youth exposed to family violence recently have incorporated a trauma focus with the objective of reducing posttraumatic stress disorder symptoms along with alleviating other wide-ranging childhood disorders. This article describes generally agreed-upon treatment components for youth exposed to violence in the home (specifically, children who are physically abused or witnesses to interparental violence), including reexposure interventions, education about violence and cognitive restructuring, processing of emotional cues, social problem-solving skills, and parenting interventions. Information is drawn from clinical intervention descriptions, expert consensus, and empirical treatment outcome evaluations. Empirically evaluated treatment programs for different developmental stages (preschool, school-age, and adolescence) are summarized, and remaining questions about how to best focus treatment efforts for youth traumatized by family violence are presented.	Systematic literature review, but includes no relevant studies that were not already included by Rizo (2011).
West Sussex Daphne Research Project Team. (2004). *Does witnessing domestic violence determine a child or young persons pattern of offending and are available interventions effective in reducing these patterns?* Littlehampton, UK: West Sussex Youth Offending Team.	This project assessed the effects that witnessing domestic violence can have on patterns of offending during childhood and adolescence. The topic was chosen due to a distinct lack of research looking at the relationship between witnessing domestic violence and future offending. Most research on domestic violence has focused on the perpetrator or the adult victim and little has been done to assess the effects of domestic violence on children in the home and even less work has been done to assess the possible links to offending during adolescence. The research was also commissioned in order to highlight any effective interventions that are currently being used and to address areas where future resources and services could and should be aimed.	Does not evaluate the outcome of an intervention
Wetmore, M., & Fairbairn, C.D. (2003). A regional California programme to screen adolescent patients for intimate partner violence. *Journal of Emergency Nursing, 29(4)*, 373-376.	No abstract	Does not evaluate the outcome of an intervention
Willis, D., Hawkins, J.W., Pearce,	Children are witnesses to violence far too often in their daily lives. To elicit information on the needs of children	Does not evaluate the

C.W., Phalen, J., Keet, M., & Singer, C. (2010). Children who witness violence: What services do they need to heal? *Issues in Mental Health Nursing, 31(9),* 552-560.	and adolescents living in the United States who have witnessed violence in their homes, neighbourhoods, or communities, we held focus groups with mothers who have survived interpersonal violence and whose family included child witnesses to violence (CWV), professionals who work with families affected by violence, and with adolescents who have witnessed violence. Based on four separate focus group discussions held in Massachusetts, involving a total of 45 participants, recommendations for screening, programming, and the development of healing interventions are offered to mental health professionals.	outcome of an intervention

Table 17. Research Question 5 (Partnerships) Studies Excluded on Full Text

Study Details	Abstract	Reason for Exclusion
Allo, J., & Ptak, A. (2009). *If I knew then what I know now: Project leadership in multi-system change efforts to address the co-occurrence of domestic violence and child maltreatment.* Reno, NV: National Council of Juvenile and Family Court Judges	No abstract	Does not have outcomes relevant to research question
Anetzberger, G.J., Dayton, C., Miller, C.A., McGreevey, J.F.J., & Schimer, M. (2005). Multidisciplinary teams in the clinical management of elder abuse. *Clinical Gerontologist, 28*(1-2), 157-171.	Multidisciplinary teams (M-teams) promote elder abuse detection and intervention. They vary by auspice, intent, and abuse orientation. However, their benefits, structure, and organization are fairly uniform. This article initially describes and classifies M-teams. Then the five authors of this publication are assembled as a community/consortium elder-specific M-team to collectively analyse the three case studies earlier presented.	Does not have outcomes relevant to research question
Australian Domestic and Family Violence Clearinghouse. (2010). *Understanding Domestic Violence and Integration in the NSW Context: A Literature Review.* Sydney, AU: Australian Domestic and Family Violence Clearinghouse.	No abstract	Non-systematic review
Baker, C. K., Billhardt, K. A., Warren, J., Rollins, C., & Glass, N.E. (2010). Domestic violence, housing instability, and homelessness: A review of housing policies and programme practices for	Evidence suggests that domestic violence is among the leading causes of housing instability (including homelessness) nationally for women and children. In this paper, we focus on housing policies and practices that may inadvertently make it more difficult for women to secure stable housing after having left an abusive partner. We review the types of housing options available for survivors of domestic violence, as well as housing policies and practices, including their strengths and limitations. In addition, the level of coordination between domestic violence and housing/homeless service systems is discussed. Our rationale for this review is to highlight not only the intent of specific policies and programs but also the effect of their implementation on women's ability to secure stable housing. Finally, we explore alternatives to current housing policies and programme practices that may serve as models for how to think "outside	Does not evaluate the outcome of an intervention

meeting the needs of survivors. *Aggression and Violent Behaviour, 15*(6), 430-439.	the box" so that women's housing and safety needs can be better met.	
Banks, D., Hazen, A.L., Coben, J.H., Wang, K., & Griffith, J.D. (2009). Collaboration between child welfare agencies and domestic violence service providers: Relationship with child welfare policies and practices for addressing domestic violence. *Children and Youth Services Review, 31*(5), 497-505.	The purpose of this paper was to examine collaborative activities occurring between child welfare agencies and domestic violence service providers and to investigate whether there was a relationship between collaborative efforts and domestic violence policy and practice in child welfare agencies. Data were derived from the Children and Domestic Violence Services study, which obtained cross-sectional data from a large sample of child welfare agencies across the United States, and from the Greenbook evaluation, which conducted a longitudinal case study investigation of a federal initiative that provided support to several communities to establish collaborative mechanisms aimed at improving the effectiveness of child welfare policy related to domestic violence. Findings from the cross-sectional data revealed that in almost three-quarters of the communities, formal collaborative activities existed between child welfare and domestic violence agencies. However, the data did not demonstrate a relationship between these activities and child welfare policy and practice related to domestic violence. Longitudinal case study findings from the Greenbook evaluation did reveal some changes in child welfare policy and practice in association with the implementation of activities that increased collaboration between child welfare and domestic violence service providers. Improvements were found in child welfare agency screening and assessment, advocacy for adult domestic violence victims and multidisciplinary approaches to case planning. The extent to which changes were observed varied across the sites, however, and appeared to be related to the specific planning approach undertaken in each community. Additional work is needed to identify optimal collaborative strategies to enhance domestic violence policy and practice and improve outcomes for families.	Does not have outcomes relevant to research question
Bennett, L., & O'Brien, P. (2007). Effects of coordinated services for drug-abusing women who are victims of intimate partner violence. *Violence Against Women, 13*(4), 395-411.	This article summarizes outcomes from a demonstration project on collaboration between substance abuse and domestic violence agencies. Researchers recruited women seeking services for substance abuse or intimate partner violence at 1 of 6 participating agencies. Admitted women were both victims of domestic violence and abusing alcohol or drugs. Following an initial screening, participants were interviewed at programme entry (n=255) and again 4 to 6 months later (n=128, 50%). Key outcomes were the number of days substances were used in the past 30 days, women's perceptions of harm from battering, and domestic violence self-efficacy. Results suggest participants used substances less frequently and experienced themselves as more efficacious following services, but they were also more fearful of the consequences of domestic violence. Repeated-measures MANOVA found that substance abuse days and domestic violence self-efficacy significantly contributed to the multivariate function. Implications for services for women with co-occurring substance abuse and domestic violence victimization are discussed.	Does not have outcomes relevant to research question
Bennett, L.W., & Vincent, N. (2001). Standards for batterer programs: A formative evaluation of the Illinois protocol. *Journal of Aggression, Maltreatment and Trauma, 5*(2), 181-197.	Our article reports data from a three-year formative study of the Illinois Protocol for Domestic Abuse Batterers Programs. This evaluation research is guided by three questions: (1) How do standards affect the way batterer programs deliver services to men who batter? (2) How do standards impact community efforts to prevent violence? and (3) How do standards affect judicial referral for domestic violence intervention? Data include: (1) surveys of 50 victim service agencies, 63 batterer programs, and 823 men in 27 batterer programs, and (2) structured interviews with 146 key informants, including judges and prosecutors, battered women's advocates, and batterer programme staff. Results suggest that standards meet the goals set for them, although with some unintended consequences. The primary effects of the Illinois standards are providing a structure for programs working with men who batter, structuring collaboration between batterer programs and victim service agencies, increasing judicial confidence that batterers are being served appropriately, and forcing victim programs to think about batterer programs.	Does not evaluate the outcome of an intervention
Brackley, M.H. (2008). Safe family project: a training model to improve care to victims of domestic violence. *Journal for Nurses in Staff*	Hospitals must implement staff development programs to assure that nurses and other staff have requisite knowledge, attitudes, and skills to provide quality care for patients who are victims of domestic violence. The author describes a community campus partnership designed to improve care through use of a logic model which follows these steps: needs and assets assessment, capacity building, programme selection, implementation and assessment, and final evaluation. The analysis has implications for other health institutions.	Does not evaluate the outcome of an intervention

Development - JNSD, 24(1), E16-27.		
Brandl, B., & Dawson, L. (2011). Responding to victims of abuse in later life in the United States. *Journal of Adult Protection, 13*(6), 315-322.	Purpose - Millions of older adults in the USA are being abused, neglected, and exploited. Older victims who are abused by a spouse, partner, family member, or caregiver experience unique barriers and challenges. The Department of Justice's Office on Violence Against Women (OVW) funds a small but promising Abuse in Later Life Programme. This article seeks to briefly describe the dynamics of abuse in later life and the design and outcomes experienced by local grantees funded by the OVW Abuse in Later Life Programme. Design/methodology/approach - This paper is designed to describe the key components of the OVW's Abuse in Later Life programme and outcomes experienced by local practitioners. Findings - The paper describes lessons learned by local practitioners who use a multidisciplinary approach to respond to abuse in later life. Practical implications - Collaboration and a coordinated community response are vital to enhance older victim safety and quality of life. Originality/value - This paper describes model programming in the USA that could be replicated in Britain and elsewhere.	Non-systematic review
Brown, S. (2011, May). Making the connection. *Mental Health Today, 16(7).*	Impact of domestic abuse on women's mental health and the benefits of referring victims to specialist services. The work of independent domestic violence advisors, the multi-agency risk assessment conference (MARAC), Next Link and Coordinated Action Against Domestic Abuse (CAADA) is described. The need for linked, multi-agency services is discussed.	Non-systematic review
Busch-Armendariz, N.B., Johnson, R.J., Buel, S., & Lungwitz, J. (2011). Building community partnerships to end interpersonal violence: a collaboration of the schools of social work, law, and nursing. *Violence Against Women, 17*(9), 1194-1206.	The article discusses the University of Texas at Austin's (UT Austin) Institute on Domestic Violence and Sexual Assault (IDVSA), an institution that was established in 2001. IDVSA is a collaboration of the Schools of Social Work, Law, and Nursing, and 150 community affiliates. Recognizing that interpersonal violence does not occur in a vacuum, the IDVSA operates within an ecological framework in which explanations for interpersonal violence acknowledge that individuals and families are nested in larger mezzo and macro systems, and factors such as gender, poverty, ethnicity, religion, disability, sexual orientation, and immigration status play influential roles in our understanding of these issues. The overarching goal is to advance knowledge and meaningful practice in the field through partnerships with survivors and community practitioners. Specifically, the mission is to advance the knowledge related to domestic violence and sexual assault in order to end interpersonal violence. IDVSA seeks to achieve its mission by focusing on three key areas: (1) rigorous research and scholarship on domestic violence and sexual assault; (2) comprehensive training, technical assistance, and information dissemination to the practitioner community and the community at large; and (3) substantial collaboration with our community partners. This article summarizes the authors' pursuit.	Non-systematic review
Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J., & Whelton, B. (2011). Adult protection: The processes and outcomes of adult protection referrals in two English local authorities. *Journal of Social Work, 11*(3), 247-267.	Summary: This article examines the processes and outcomes of adult protection referrals in two local authorities in England using adult protection monitoring data collected between 1998 and 2005, identifying learning for the use and development of adult protection monitoring. Findings: Associations were found between aspects of process and outcome in adult protection case management; police and regulatory agency involvement increased over time, over four-fifths of referrals resulted in investigations which were associated with higher levels of inter-agency involvement, abuse was confirmed for over two-fifths of referrals, there was significant territorial variation across a range of process and outcome measures and specialist adult protection coordinators were associated with higher levels of monitoring and post-abuse work. The study concluded that more work is needed to improve and standardize adult protection monitoring data if it is to more effectively inform case management and inter-authority comparisons. Applications: The evidence from the study suggests that adult protection monitoring data can be used to help review and organize adult protection work at agency, team and case levels and is consequently of potential value to team managers, social workers and specialist co-ordinators working in adult protection.	Intervention setting outside of health and social services (Justice system)
Chang, V.N., & Greene, R. (2001). Study of service delivery by community mental health centers as perceived by adult protective services investigators.	This article provides the results of a qualitative research study to determine the views of Indiana Adult Protective Service (APS) investigators regarding the services and staff of Indiana Community Mental Health Centers (CMHC) with which they interact. Service difficulties and strengths are identified as well as recommendations for improving coordination between the two programs. Many of the problems experienced by APS investigators relate to gaps in services for older adults. Multidisciplinary teams providing in-home evaluations, referral, and treatment are recommended.	Does not have outcomes relevant to research question

Journal of Elder Abuse & Neglect, 13(3), 25-42.		
Cleaver, H., Nicholson, D., Tarr, S., & Cleaver, D. (2006). The response of child protection practices and procedures to children exposed to domestic violence or parental substance misuse. London, UK: Department for Education and Skills.	This study explored how children's social care responds to family problems that require both adult and children's services, identify factors for successful inter-agency working, and explore the perceptions of children and parents on the intervention.	Does not have outcomes relevant to research question
Colombini, M., Mayhew, S., & Watts, C. (2008). Health-Sector Responses to Intimate Partner Violence in Low-and Middle-Income Settings: A Review of Current Models, Challenges and Opportunities. *Policy and Practice, 86*(8).	There is growing recognition of the public-health burden of intimate; partner violence (IPV) and the potential for the health sector to identify and support abused women. Drawing upon models of health-sector integration, this paper reviews current initiatives to integrate responses to IPV into the health sector in low- and middle-income settings. We present a broad framework for the opportunities for integration and; associated service and referral needs, and then summarize current promising; initiatives. The findings suggest that a few models of integration are; being replicated in many settings. These often focus on service provision; at a secondary or tertiary level through accident and emergency or women's health services, or at a primary level through reproductive or; family-planning health services. Challenges to integration still exist at all levels, from individual service providers' attitudes and lack of; knowledge about violence to managerial and health systems' challenges such as insufficient staff training, no clear policies on IPV, and lack of; coordination among various actors and departments involved in planning integrated services. Furthermore, given the variety of locations where; women may present and the range and potential severity of presenting health; problems, there is an urgent need for coherent, effective referral within; the health sector, and the need for strong local partnership to facilitate effective referral to external, non-health services.	Non-systematic review
Cook-Daniels, L. (2009) National Coalition of Anti-Violence Programs. *Victimization of the Elderly & Disabled, 12(1),* 1-16.	No abstract	Does not evaluate the outcome of an intervention
Cooley, B., & Craig, F. (2006). Children and domestic violence: a system of safety in clinical practice. *Australian Social Work, 59*(4), 462-473.	The present paper provides a framework for working with children and families where there are domestic violence and child protection concerns. A model of practice developed by the St George Domestic Violence Counselling Service and the St George Child and Adolescent Mental Health Service in the South East Sydney and Illawarra Health Service (NSW, Australia) is outlined. The present paper includes a discussion on a recently developed service agreement between the two services and a case study focusing on a 'system of safety' when working with children. The present paper focuses on the effects of domestic violence on women and children by male perpetrators.	One case study
Cordis Bright Consulting. (2011). *Research into multi-agency assessment conferences (MARACs).* London, UK: Great Britain Home Office.	Multi-Agency Risk Assessment Conferences (MARACs) are multi-agency meetings where statutory and voluntary agency representatives share information about high risk victims of domestic abuse in order to produce a coordinated action plan to increase victim safety. This study was commissioned by the Home Office as part of a wider review of MARACs which aimed to improve understanding of how MARACs are working and potential areas of development. The findings of this report are based on a national online survey of MARAC chairs, MARAC coordinators and Independent Domestic Violence Advisors (IDVAs). The survey received 636 responses from participants in over 90% of the approximately 250 MARACs across England and Wales. The survey explored: the characteristics of the MARAC; understanding multi-agency contributions of MARAC partners; the involvement of IDVAs and victim involvement; agency attendance at MARACs; the MARAC operating model; referrals and caseload levels; working practices; barriers and levers to achieving an effective MARAC; links to other local public protection arrangements;	Does not evaluate the outcome of an intervention

	impacts of future funding on MARACs; and whether MARACs should be on a statutory footing. In addition, in-depth interviews were conducted with 47 MARAC stakeholders which explored their views in relation to: their role and responsibilities; the local MARAC operating model; stakeholder attendance levels; referral and caseload levels; local MARAC action planning processes; how effectively the MARAC is working; whether MARACs should be placed on a statutory footing; and engaging with the victim.	
Cox, P.J., Finkelstein, D.M., Perez, V.E., & Rosenbach, M.L. (2010). Changes in capacity among local coordinated community response coalitions (CCRs) supported by the DELTA programme. *Journal of Family Social Work, 13*(4), 375-392.	Coalitions are often the means through which communities plan and coordinate services for individuals and address larger environmental issues associated with social problems. Since 2003, the Centers for Disease Control and Prevention (CDC) has supported local coordinated community response coalitions (CCRs) in 14 states to prevent intimate partner violence (IPV) through its Domestic Violence Prevention Enhancements and Leadership Through Alliances (DELTA) Programme. Utilizing quantitative and qualitative evaluation data from 2003 and 2006 from DELTA-funded CCRs (N=59), this article reports on improvements in internal CCR capacity and external supports that can affect the ability of CCRs to prevent IPV. Data are examined through the Interactive Systems Framework for Dissemination and Implementation (ISF) to convey how CCR internal capacity and external supports contribute to the substantial infrastructure needed to effectively address IPV. Family social workers will gain an understanding of the capacities needed by CCRs to prevent IPV, the multiple organizations and systems that support the work of these CCRs, and how they themselves can work to strengthen the capacities of local coalitions that address IPV.	Does not evaluate the outcome of an intervention
Craig, Y. (2002). Advisers, advocates, counsellors and mediators in elder abuse casework. *Quality in Ageing, 3*(2), 39-46.	Complex conflicts in elder abuse, its causes, typology, protection and prevention, suggest that co-operation by multi-disciplinary social services should be a major consideration in policy decision-making, planned intervention and support. Casework of the Elder Mediation Project (EMP for empowerment), and related agencies, provides some practical evidence for this view. There are shared casework values and similar as well as different skills. However, when service user interests are paramount, the professional concerns of service providers for defined roles and boundaries raise ethical issues. Are there conflicts between old people's needs for trusting, confidential relationships with one worker, and case co-ordinators' promotion of varied specialist input? Could approaching elder abuse through a multi-skilled key worker, as well as by multi-disciplinary social service workers, offer complementary and co-operative interventions? Brief anonymised case notes suggest that practitioners may face professional conflicts about social intervention as casework diversifies and service user involvement in decision-making increases, but some guidelines to good practice are offered.; Key words: elder abuse; conflict; empowerment; service users; co-operation; service providers	Non-systematic review
David, N. (2007). *Exploring the use of domestic violence fatality review teams. Issues Paper (Vol. 15).* Sydney, AU: Australian Domestic & Family Violence Clearinghouse.	Every year in the USA between 1000 and 1600 women are killed in domestic violence-related homicides (Websdale 2003), a phenomenon only recognised by law enforcement and victims' groups in the past few decades. This paper discusses the establishment of Domestic Violence Fatality Review Teams (DVFRTs) in California and the US, the first of which was established in California in 1991. Since that time, DVFRTs have become widespread across the country. DVFRTs have proven invaluable in identifying common weaknesses in systems and protocols responding to domestic violence that have led to a fatality. Teams have gone on to recommend solutions and to identify patterns of weapons used, manner of death and even the number of previous domestic violence calls made to police prior to the fatality, providing an excellent resource about helpseeking behaviour, and constantly identifying potential improvements in service delivery. Through an examination of DVFRTs in the USA (where they have had the longest history and most extensive expansion), this paper explores the purpose and operation of DVFRTs, and considers the potential value of their application in Australia. The paper specifically examines the existing local response to domestic homicide and the potential contribution that DVFRTs could make to the prevention of fatalities.	Non-systematic review
Dayton, C. (2011). Becoming Partners: Researchers and Practitioners Responding to Elder Abuse. *Victimization of the Elderly & Disabled,*	No abstract	Does not evaluate the outcome of an intervention

13(6), 81-91.		
DeHart, D.D. (2010). Collaboration Between Victim Services and Faith Organizations: Benefits, Challenges, and Recommendations. *Journal of Religion & Spirituality in Social Work, 29*(4), 349-371.	Although many crime victims seek support from members of the faith community, faith leaders may feel unsure of their abilities to assist. This paper describes findings from a descriptive needs assessment that preceded a national project to link faith-based organizations and victim service programs in five high-crime neighbourhoods. Approximately 90 participants were interviewed, including faith leaders, victim service providers, and other professionals. A majority saw positive implications of faith-secular collaboration but also identified concerns. Findings focus on perceived obstacles and facilitators of collaboration, addressing climate for faith-secular collaboration, disciplinary differences, community engagement, and church-state separation. Implications for collaboration are explored and recommendations are provided for future efforts to link faith communities and secular services.	Does not have outcomes relevant to research question
Diamond, A., Parmar, A., & Sampson, A. (2005). *Tackling domestic violence: providing advocacy and support to survivors of domestic violence.* London, UK: Great Britain Home Office, Research Development and Statistics Directorate.	The aim of this report is to provide concise guidance to those practitioners who directly work with female victims of domestic violence; whose role is to provide information, advice and support to help enable women to access a range of legal and non-legal services and resources, and ultimately to help them and their children, to move safely towards living violence-free lives. These specialist practitioners are sometimes referred to as 'advocates'; 'support workers'; 'victim workers'; 'outreach workers'; or 'navigators'. This report draws upon the independent evaluations of a number of multi-agency projects which aimed to support female victims of domestic violence, and which were ended under the remit of the Crime Reduction Programme (CRP) Violence Against Women Initiative (VAWI).	Does not evaluate the outcome of an intervention
Dines, C. (2011). Using A&E data to prevent violence in communities. *Nursing Times, 107*(13).	Cardiff model of collecting data about patients presenting in A&E following violent assaults and sharing the information with the Community Safety Partnership to identify problem areas relating to alcohol use and crime. An algorithm for collecting essential assault data and the implementation of the model in Thames Valley are described. The impact on violence and abuse in communities is discussed.	Does not have outcomes relevant to research question
Echlin, C., & Osthoff, B. (2000). Child protection workers and battered women's advocates working together to end violence against women and children. *Journal of Aggression, Maltreatment and Trauma, 3*(1), 207-219.	Child protection workers and battered women's advocates are challenged to stop working against one another and to start working together to end violence against women and children. Recognizing that there are many difficulties in working collaboratively, the authors maintain that because the issues of child protection and violence against women are intertwined, the need for a collaborative response is imperative. Examples of this collaboration are described.	Non-systematic review
Eddy, T., Kilburn, E., Chang, C., Bullock, L., & Sharps, P. (2008). Facilitators and barriers for implementing home visit interventions to address intimate partner violence: town and gown partnerships. *Nursing Clinics of North America, 43*(3), 419-435.	Pregnant women involved in violent relationships represent a population that is vulnerable for poor pregnancy and infant outcomes on several levels. This article describes the development of a "town and gown" partnership to assist pregnant women in violent relationships. Barriers and facilitating factors for research and home visitor (HV) nurse partnerships working with this vulnerable population were identified by HV participants in a qualitative focus group session. Methods used to develop and maintain the reciprocal relationship between the community (town) and academic researchers (gown) are described.	Does not evaluate the outcome of an intervention
Fantuzzo, J.W., Mohr, W.K., & Noone, M.J. (2000). Making the invisible victims of violence against women	The absence of scientifically credible information about the nature and extent of children exposed to abuse of their mothers is an impediment to effective intervention and prevention efforts. This article proposes a research agenda based upon guiding principles of a public health surveillance model. Three major principles are presented and applied to this social problem. Additionally, a concrete example of the application of these principles is drawn from an ongoing	Does not evaluate the outcome of an intervention

visible through university/community partnerships. *Journal of Aggression, Maltreatment and Trauma, 3*(1), 9-23.	university/community partnership in Philadelphia.	
Fleck-Henderson, A. (2000). Domestic violence in the child protection system: Seeing double. *Children and Youth Services Review, 22*(5), 333-354.	As we recognize the child welfare implications of domestic violence, complex issues of practice and policy result. Training child protective workers on domestic violence is a necessary but insufficient response. We are at an early point in our learning about the dynamics of family violence seen as both a child welfare and a woman's issue. Best practice for families where children and women are both at risk benefits from "seeing double," drawing from the knowledge, and values of both a child protective and a women's advocacy perspective. To this end, on-going collaborative relationships with the opportunity for case-specific consultation are important. This paper draws on experience with the Domestic Violence Unit of the Massachusetts Department of Social Services to illustrate issues that arise as we work toward child protective practices that attend to the rights and safety of children and their nonabusive parent.	Non-systematic review
Flintoff, P., & Wilkinson, K. (2008). Prison staff and voluntary sector working together to break the cycle of domestic violence: a case study. *Prison Service Journal, 176,* 26-33.	This article provides an overview of a person-centred counselling service provided by a voluntary sector counselling centre in a local remand prison. The two year funded pilot project was provided specifically for male prisoners who have been affected by issues of domestic violence. The article reports on the successful partnership formed between these two agencies, the successful engagement with the services aims by prison staff and the positive effects on prisoners accessing the service. It reports on the views of the prison population, those both living and working in the prison sector, in their own words regarding the effectiveness of the provision of this service in its first year of delivery.	Does not evaluate the outcome of an intervention
Garner, J.H., & Maxwell, C.D. (2008). Coordinated Community Responses to Intimate Partner Violence in the 20th and 21st Centuries. *Criminology & Public Policy, 7*(4), 525-535.	This essay provide a historical overview of the development of the coordinated community response (CCR) approach to intimate partner violence (IPV) and a summary of the results of prior evaluations of coordinated interventions. It suggests that more and better research is needed and note that conclusions about the effectiveness of policies and programs can change as research designs are improved and as evidence from research accumulates.	Non-systematic review
Gray, B. (2002). Working with families in Tower Hamlets: an evaluation of the Family Welfare Association's Family Support Services. *Health and Social Care in the Community, 10*(2), 112-122.	This paper describes an evaluation carried out by South Bank University of the work of the Family Welfare Association's (FWA's) Family Support Services (FSSs) in Tower Hamlets, London. Tower Hamlets is a multi-racial area in east London that, according to the 1991 census, has high levels of poverty, overcrowding and unemployment. The evaluation reported here examined three projects: Family Support, Building Bridges and Quality Protects, referred referred to collectively as FSSs. The evaluation shows that FSSs are innovative services that demonstrate effective ways of working with vulnerable families affected by experiences of racism, bullying, mental health difficulties, domestic violence or child abuse. In common with other successful initiatives in the UK and abroad, FSSs are aimed to be non-stigmatising, non-intrusive and responsive to the ethnicity, views and specific needs of families. This article focuses on the participatory work of FSSs with families to illustrate effective methods of quality support, detail outcomes, and draw lessons for policy and practice. Athens Full Text: Athens users with appropriate permissions can access the full text via CINAHL: Search Health and Social Care in the Community for "Working with families in Tower Hamlets: an evaluation of the Family Welfare Association's Family Support Services."	Does not have outcomes relevant to research question
Great Britain Department for Children Schools and Families. (2010). *Think family pathfinders: research update.* England, UK: Department for Children	This report is the first in a series of updates from the Think Family Pathfinders Evaluation. This update provides: background information on Family Pathfinders' Programme; an overview of families the Pathfinders are working with, their needs and levels of risk; the models of delivery that have been adopted and common approaches to delivery; examples of the new ways of working with families at risk of poor outcomes; emerging evidence of impact. Children experiencing very poor outcomes often come from families who face multiple and complex problems, such as poverty, domestic abuse, poor mental health or substance misuse. Co-ordinated, multiagency interventions can be a cost-	Does not evaluate the outcome of an intervention

Schools and Families.	effective way of improving outcomes for both the children and adults within these families, whilst reducing the burdens they may place on a number of local services and, potentially, the care system. The emerging findings of this programme provide practical examples of how local authorities from across the country are restructuring service provision and developing new working practices in response to the challenges of improving outcomes for these families.	
Hamberger, L.K., & Ambuel, B. (2000). Community collaboration to develop research programs in partner violence. *Journal of Aggression, Maltreatment and Trauma, 4*(1), 239-272.	Effective research and intervention into family violence require interdisciplinary collaboration between professionals in traditional research settings and grass-roots community leaders and advocates. Such interdisciplinary collaboration is frequently difficult. We identify a number of potential barriers to effective collaboration between academic researchers, community agencies and grass roots activists. These include (a) different professional identities, values, world views and motivations for working in the field, (b) social status related to formal degree status vs. lived experience, (c) economic resources, (d) gender, (e) race, (f) ownership of the field and data, and (g) being an unknown quantity. Strategies for overcoming these barriers are described and discussed. Examples of both successful and unsuccessful collaborative efforts illustrate key points.	Non-systematic review
Harris, M.H., & Weber, M. (2002). Providing crisis counsellors on-site to victims of domestic violence in the emergency department: a report of a local pilot project. *South Dakota Journal of Medicine, 55*(4), 147-149.	In order to facilitate appropriate referral and aftercare for victims of domestic violence who present to Sioux Falls hospital emergency departments, Children's Inn (a local domestic violence shelter) and city hospitals collaborated to develop a programme to provide crisis counsellors to these patients during their ED visits. This programme, which has been in place for over two years, has provided services to 63 patients. These services include on-site counselling to the victims, assistance with filling out protection orders and with making police reports and referral of many of the women to shelter and/or support groups. Having the crisis counsellors meet and talk with these patients during the ED visit has facilitated the provision of these services to victims who otherwise may have been unable or hesitant to avail themselves of local resources.	Does not evaluate the outcome of an intervention
Harvie, P., & Manzi, T. (2011). Interpreting multi-agency partnerships: Ideology, discourse and domestic violence. *Social & Legal Studies, 20*(1), 79.	This article examines local multi-agency responses to local domestic violence, in particular considering how the introduction of local Crime and Disorder Reduction Partnerships (CDRP) in the UK in the late 1990s affected service provision. Using a longitudinal case study, the article considers how feminist ideologies have been supplanted by a combination of judicial processes and bureaucratic politics. These developments are represented by three dominant discourses: 'criminal justice', 'managerialism' and 'equalities'; discourses that have had a number of consequences in the implementation of domestic violence policy. The first is that a one-dimensional criminal justice discourse has displaced a feminist political, power and control, analysis. Second, the ascendancy of managerialism has allowed prescriptive short-term performance measurement to prevail over long-term 'sufferer-orientated' responses, and finally an 'equalities' discourse prioritized perpetrator initiatives and discouraged dissent. The result has been the dominance of the statutory sector, a marginalization of voluntary agencies and a partial alienation of women's groups; a process which has proved detrimental both to the interests of female sufferers (who form approximately 90 per cent of victims of domestic violence) as well as voluntary agencies.	Does not have outcomes relevant to research question
Hawkins, J.W., Pearce, C.W., Skeith, J., Dimitruk, B., & Roche, R. (2009). Using technology to expedite screening and intervention for domestic abuse and neglect. *Public Health Nursing, 26(1).*	Objective: response to escalation of community violence, the U.S. Department of Commerce funded Home Health VNA (HHVNA), serving the Merrimack River valley communities in Massachusetts and New Hampshire, for a project demonstrating innovative use of technology in screening for abuse and neglect. DESIGN: All health care providers in the HHVNA were trained in screening through tools loaded on their personal digital assistants. SAMPLE: The sample was comprised of patients served by HHVNA during the study period. Intervention: When a patient screened positive, the health care provider mobilized resources, including social workers, the office of elder services, or the local department of social services office for same-day follow-up. OUTCOMES: Screening for abuse and neglect was mainstreamed into routine care. Health care providers noted significant reduction in redundant domestic abuse data collection. The close communication networks created enabled health care providers to mobilize resources, initiating same-day in-depth social work assessment and referrals to appropriate community agencies. Health care providers now transmit selected encrypted health information and mandated reports to official agencies. CONCLUSIONS: Wedding technology with health care professionals' skills and knowledge can move prevention of and early intervention for domestic abuse and neglect to a new level of efficacy.	Does not evaluate the outcome of an intervention

Hill, J.R., & Thies, J. (2010). Programme theory and logic model to address the co-occurrence of domestic violence and child maltreatment. *Evaluation & Programme Planning, 33*(4), 356-364.	Social work and child welfare practitioners have long confronted the reality that child maltreatment and domestic violence often coexist within families. However, services for the victims of these types of family violence have been fragmented, forcing victims to go to multiple agencies for assistance. The purpose of this paper is to describe the programme theory and logic model developed to guide evaluation of the St. Louis County Greenbook Collaboration to Address Domestic Violence & Child Maltreatment, together with an assessment of the use of this approach as applied to a comprehensive community initiative. Both the programme theory guiding the collaboration and the logic model developed from the programme theory are described. Data are drawn from qualitative documents produced in conjunction with collaboration participants. The findings suggest that a programme theory and logic model approach to programme planning is difficult to develop with large collaborations. Such methods may not be useful to programme stakeholders. Further, attempting to use a graphic to portray a programme may do a disservice to the complex ways in which many of the strategies and outcomes overlap in a community-wide collaboration.	Does not evaluate the outcome of an intervention
Hirst, A. (2009). *Multiple and Complex Needs Initiative: Pogramme Evaluation Report.* Edinburgh, UK: Scottish Government Social Research.	Presents an evaluation of Multiple and Complex Needs Initiative (MCN) launched in 2006, drawing out lessons learned around what works and what does not work in improving service access, the service experience and outcomes for clients with multiple and complex needs. Describes the 14 pilot MCN projects: African Health Project, Improving Primary Health Care Services for People with MCN, Inequalities Sensitive Practice Initiative, LGBT young people with MCN, Male Carers Initiative, Partnerships for Access to Health Project, Plan2Change, Positively Sorted, Project Empower, RCA Trust project (formerly Renfrew Council on Alcohol); Routes out of Prison, Securing Care for Ethnic Elders in Scotland, Supporting BME Families of Deaf Children, Tayside Domestic Abuse and Substance Misuse. Includes an assessment of the multiple and complex needs of the target groups, which service gaps the projects are addressing and how they approached the problem. Discusses the lessons learnt regarding: improving access and removing barriers; developing and improving needs assessments; and improving the client service experience or client outcomes. Identifies lessons on mainstreaming and what MCN projects can teach service providers about initiating and managing service or organisational change.	Does not have outcomes relevant to research question
Home Office (2000). *Multi-Agency Guidance for Addressing Domestic Violence*. London, UK: Home Office, Marketing and Communications Group.	No abstract	Does not have outcomes relevant to research question
Hovmand, P.S., Andersen, D.F., Rouwette, E., Richardson, G.P., Rux, K., & Calhoun, A. (2012). Group Model-Building Scripts' as a Collaborative Planning Tool. *Systems Research and Behavioural Science, 29*(2), 179-193.	Group model building (GMB) is a participatory method for involving stakeholders in the process of developing system dynamics models. GMB has historically consisted of undocumented structured small-group exercises. This paper describes an effort to document GMB scripts called Scriptapedia, and how documented GMB scripts can be used to design more effective GMB sessions that address cultural and ideological barriers to collaboration. A case study of a project to develop a coordinated community response to domestic violence is used to illustrate the use of scripts for planning collaboration. The paper concludes with a discussion of potential limitations of scripts and implications for future research.	Does not have outcomes relevant to research question
Hyde, M.M., Lamb, Y., Arteaga, S.S., & Chavis, D. (2008). National evaluation of the Safe Start Demonstration Project: Implications for mental health practice. *Best Practices in Mental Health:*	This article summarizes key findings from the national evaluation of the Safe Start Demonstration Project. As part of Safe Start, local mental health systems and practitioners played essential roles in protecting young children from the impact of exposure to violence. Both crisis circumstances (e.g., a domestic violence incident) and noncrisis circumstances (e.g., ongoing mental health treatment) are opportunities for mental health practitioners to access children exposed to violence and address the negative consequences often associated with exposure. One Safe Start grantee found that family and child functioning improved and violence ended when families participated in a crisis intervention provided by clinicians. Three grantees found evidence that therapeutic and family support services reduced the impact of exposure to violence on children. Community partnerships were a critical component of the Safe	Non-systematic review

An International Journal, 4(1), 108-122.	Start services that demonstrated positive mental health outcomes for children who have been exposed to violence and their families. Furthermore, successful mental health interventions incorporated cross-disciplinary strategies and practices that integrated and sequenced services so that all family members and their multiple needs were supported. In addressing the needs of families experiencing violence, mental health practitioners need to consider the potential value of partnering with other service providers in the community and providing their services within the context of more comprehensive interventions.	
Janczewski, C., Dutch, N., & Wang, K. (2008). Crafting the Greenbook: framers reflect on the vision, process, and lessons learned. *Journal of Interpersonal Violence, 23*(7), 981-1006.	Guided by research and the experiences of judges nationwide, the National Council of Juvenile and Family Court Judges made a commitment in 1998 to improve community response to families experiencing domestic violence and child maltreatment. A year later, the council's work culminated in a set of recommendations commonly called the Greenbook, which summoned child welfare agencies, domestic violence service providers, and dependency courts to implement internal changes and collaborate to address co-occurring domestic violence and child maltreatment. In 2000, the federal government funded six community-based demonstration programs to implement the Greenbook recommendations. As part of the evaluation of the Greenbook initiative, the evaluation team asked the national experts who helped frame the Greenbook to reflect on the processes used and the decisions that shaped the document. In addition, the experts were asked to describe their expectations for the systems and communities that implemented the recommendations, including anticipated challenges.	Does not evaluate the outcome of an intervention
Javdani, S., & Allen, N.E. (2011a). Councils as empowering contexts: mobilizing the front line to foster systems change in the response to intimate partner violence. *American Journal of Community Psychology, 48*(3-4), 208-221.	Collaborative approaches to change are common, and though evidence for their effectiveness is equivocal, there is growing support that councils facilitate desired changes in the systems response to intimate partner violence. Questions remain regarding the specific mechanisms by which this change is facilitated, and recent work has focused on examining the intermediate processes through which councils may produce more distal change. One such mechanism relates to the potential of councils to be empowering contexts for their membership, often comprised of front-line providers and responders. The present study examines what factors are positively related to perceived individual empowerment as an outcome for members, and importantly, considers not only perceived council context, but also the perceived organizational contexts in which each council member is employed. Study findings suggest that both contexts-council and organizational-are important when considering the degree to which members are empowered. Specifically, member participation, council leadership, and supportive council and organizational climates are significantly positively related to the degree to which councils function as empowering contexts. However, the effect of belonging to a council with a supportive climate, characterized in particular by shared power in decision-making, is stronger when members are from high organizational support settings versus low support settings.	Does not evaluate the outcome of an intervention
Javdani, S., & Allen, N.E. (2011b). Proximal outcomes matter: a multilevel examination of the processes by which coordinating councils produce change. *American Journal of Community Psychology, 47*(1-2), 12-27.	Communities are engaged in efforts to create a coordinated response to intimate partner violence. Though coordinating councils are commonly employed vehicles for such efforts, research provides only equivocal support regarding their effectiveness. These mixed findings may reflect methodological and conceptual challenges. Specifically, there is an over-reliance on conceptualizing council effectiveness in terms of distal outcomes (e.g., behaviour change), rather than the intermediary processes by which councils affect change. A direct assessment of councils' proximal outcomes may highlight change mechanisms. To that end, this study investigates the extent to which councils impact proximal outcomes and examines the processes through which proximal outcomes are interrelated and linked to distal community change. Study findings suggest that perceived proximal outcomes do significantly predict variability in perceived distal community change across councils. Specifically, promotion of social capital and institutionalized change predict achievement of distal community change, and promotion of social capital also predicts achievement of institutionalized change.	Does not evaluate the outcome of an intervention
Kok, A.C. (2001). Economic advocacy for survivors of domestic violence. *Affilia: Journal of Women & Social Work, 16*(2), 180-197.	With great uncertainty about the effects of the federal welfare reform law on survivors of domestic violence, researchers and activists have recommended that domestic violence programme staff work closely with welfare workers in implementing new policies. This article describes the collaboration between a Wisconsin domestic violence shelter and a county welfare programme in providing direct services to survivors who need economic assistance.	Does not evaluate the outcome of an intervention
Lalayants, M., Epstein, I., &	This article presents the results of an evaluation of a multidisciplinary consultation programme in child protection by	Does not have

Adamy, D. (2011). Multidisciplinary consultation in child protection: a clinical data-mining evaluation. *International Journal of Social Welfare, 20*, 156-166.	applying a clinical data-mining approach. Using available agency records, data concerning mental health, substance abuse, and domestic violence consultations were extracted retrospectively for evaluative purposes. The results demonstrated that by examining existing records, child-protection practitioners were able to evaluate the existing practices as well as recognize areas for programme improvement. Additionally, differential patterns emerged in consultation types. Lastly, a discussion of the strengths and limitations as well as implications of clinical data-mining studies is presented.	outcomes relevant to research question
Lederman, J.C.S., & Osofsky, J.D. (2008). A judicial-mental health partnership to heal young children in juvenile court. *Juvenile and Family Court Journal, 29(1)*, 15-26.	In this article, we describe the background and issues to be addressed related to dependent children in juvenile court. In an important effort to systematically examine developmental functioning and treatment needs in maltreated and violence-exposed young children, the Prevention and Evaluation of Early Neglect and Trauma (PREVENT) initiative of the Dependency Court Intervention Programme for Family Violence, a national demonstration project in the Miami-Dade juvenile Court, developed a programme to evaluate all infants, toddlers, and preschoolers who are adjudicated dependent by the court. The goal of the intervention is to raise awareness of the needs of infants and toddlers in juvenile court and to work toward healing the child. The PREVENT programme involved the evolution of a judicial-mental health partnership designed to assist the court in making more informed decisions about the best interest of the child by adding scientific knowledge about development, prevention, intervention, evaluation, and treatment. The outcome of the partnership and multidisciplinary approach is illustrated through presenting a case vignette of a mother and baby showing the challenges and strengths of intervention. Finally, we consider overall outcomes of the intervention and directions for the future.	Does not have outcomes relevant to research question
Lessard, G. (2006). Conditions for resolving controversies between social actors in domestic violence and youth protection services: Towards innovative collaborative practices. *Children and Youth Services Review, 28*(5), 511-534.	Presents the results of a qualitative analysis on strategies to encourage innovative collaborative practices, and the difficulties these pose, among various groups of practitioners involved with families experiencing both domestic violence and child abuse. The study was carried out in Canada and uses the sociology of innovation as its theoretical framework. Proposed strategies include: learning how to know the other actors better, identifying effective communication mechanisms, involving family members and ensuring their interests are a priority, focusing on the common interests of all the actors, adopting attitudes allowing for the reduction of inequalities of power, and sensitising practitioners more to this dual problem.	Does not evaluate the outcome of an intervention
Lia-Hoagberg, B., Kragthorpe, C., Schaffer, M., & Hill, D.L. (2001). Community interdisciplinary education to promote partnerships in family violence prevention. *Family & Community Health, 24*(1), 15-27.	Family violence is a major social and health problem in the United States. Educational approaches are needed that help professionals and communities develop more effective skills to work with families and communities. This article describes a statewide, interdisciplinary, community-based educational programme for professionals and paraprofessionals and a 6-month post-evaluation. Participants reported knowledge and skill development in assessment and interventions, improved use of violence prevention data for planning and interventions, and increased community partnerships and collaborations. Recommendations address violence prevention leadership, funding, infrastructure, interdisciplinary professional education, greater community awareness, and policy development.	Does not evaluate the outcome of an intervention
Lindsay, J., & Brady, D. (2002). 'Nurturing fragile relationships': Early reflections on working with victims of domestic violence on the National Probation Service's Duluth Pathfinder research programme. *Issues in Forensic Psychology, 3*,	Discusses experiences as a practitioner working with both victims and male perpetrators on the National Probation Service's Domestic Violence (Duluth) Research Pathfinder programme. An overview of the programme and the measures being used to evaluate its effectiveness are presented. One of the most contentious issues in the implementation of the programme has been the extent to which the programme provides services to victims. The model' for working with victims within the programme is described and discussed. Relationships with external agencies in terms of addressing victims' needs are also addressed. Components of collaborative endeavor are used as a framework to analyse some of the issues that have arisen and to suggest a way forward.	Does not evaluate the outcome of an intervention

59-71		
Local Government Improvement and Development. (2009). *Bolsover's supporting women suffering from domestic violence.* London, UK: Local Government Association.	Bolsover District Council is supporting a coordinated approach to provide specialist support services for women suffering from domestic violence.	Non-systematic review
Luna-Firebaugh, E.M. (2006). Violence against American Indian Women and the Services-Training-Officers-Prosecutors Violence Against Indian Women (STOP VAIW) programme. *Violence Against Women, 12*(2), 125-136	When Congress appropriated funds to develop ways to reduce violence against American Indian women, tribal elders faced a challenging task: find ways to cooperate with various tribal and nontribal criminal justice agencies and navigate the maze of law enforcement authority. An evaluative study was conducted of these programs and the different approaches used to help keep women safe by American Indian tribal governments. This study found that the tribes rose to the challenge; the money was making a difference. The grants to stop violence against Indian women have made a significant impact in the 134 native communities that received awards.	Non-systematic review
Lynch, L. (2009). Domestic abuse -- the role of the practice nurse. *Practice Nurse, 38*(3), 28-31.	Working in partnership with other agencies is the approach most likely to have the most significant impact on preventing or reducing harm for those experiencing domestic abuse.	Does not evaluate the outcome of an intervention
Macdonald, E., & Alexander, H. (2003). Evaluating the partnership process. *Research Policy and Planning, 21(3*), 37-45.	Reports on a study which contributes to the shift in the evaluation of partnership policies beyond operational success factors and auditing the establishment of joint working arrangements. The authors propose a framework derived from Lowndes and Skelcher's partnership cycle and Liddle and Gelsthorpe's partnership hierarchy. The model adopted was tested on an evaluation of the development of a multi-agency domestic abuse partnership (involving health, social services, voluntary organisations and the police). Results from a questionnaire to all members of the partnership (19 replied) and a follow up interview with 11 regular attenders are firstly organised into the four partnership lifecycle stages and then evidence relating to different levels of integration are distilled. Results found the multi-agency partnership was able to move from the communicating to co-operation level due to the dedicated funding it had attracted. Discusses some of the difficulties inherent in encouraging greater integration between different organisations, especially in the light of the confusing policy messages about flexible partnerships and structural changes as levers. The authors stresses that the proposed framework requires to be more extensively tested in other evaluations.	Does not evaluate the outcome of an intervention
Malks, B.F., & Cartan, H. (2010). Creating large systems that work. *Journal of Elder Abuse & Neglect, 22*(3-4), 365-374.	To meet the challenge of underfunding, creative partnerships are being developed to enhance government and nonprofit programs. This article will describe how to build large systems that work to ameliorate elder abuse and neglect. Projects funded through the Archstone Foundation Elder Abuse and Neglect Initiative in California identify key components of system change, the process by which systems have been built to overcome barriers, and lessons learned for replication.	Does not evaluate the outcome of an intervention
Manchester Partnership. (2010). *Multi Agency Domestic Abuse Strategy 2010-2014.* Manchester, UK: Manchester City Council.	No abstract	Does not have outcomes relevant to research question

Manthorpe, J., Hussein, S., Penhale, B., Perkins, N., Pinkney, L., & Reid, D. (2010). Managing relations in adult protection: a qualitative study of the views of social services managers in England and Wales. *Journal of Social Work Practice, 24*(4), 363-376.	Collaboration or partnership between different agencies is seen as an important part of resolving problematic social issues. This article reports on findings from interviews with 32 managers working in 26 local authority social services departments that were undertaken as part of a larger study of interagency working in adult protection in England and Wales (2004-2007). Themes of managing relations, system development and prioritisation emerged from the analysis of the interviews. These findings are set in the context of developments in adult protection or safeguarding in England and Wales. The article concludes that managers perceive relationships as key in implementing aspirations for adult safeguarding, in the context of a lack of statutory obligations and sets this in the context of policy and practice.	Based on same data as Penhale (2007)
Mathew, D., Brown, H., & Kingston, P. (2002). The response to 'No Secrets'. *Journal of Adult Protection, 4*(1).	Survey of local authorities' progress in response to the Department of Health's guidance on multi-agency measure to protect vulnerable adults from abuse.	Does not evaluate the outcome of an intervention
McLellan, A.T., Gutman, M., Lynch, K., McKay, J. R., Ketterlinus, R., Morgenstern, J., & Woolis, D. (2003). One-year outcomes from the CASAWORKS for Families intervention for substance-abusing women on welfare. *Evaluation Review, 27*(6), 656-680.	AIM: To evaluate the effectiveness of a multiservice intervention designed to move substance-abusing women on welfare to sobriety and self-sufficiency by addressing their substance abuse, domestic violence, employment, and basic needs. DESIGN: A field evaluation with repeated measures at 6 and 12 months on an intent-to-treat sample of 529 women conducted in 11 selected sites across the country. There were significant improvements shown in substance use and family and social functioning by the 6-month point, and additional improvements in employment by the 12-month point. By 12 months, more than 46% were abstinent from alcohol and other drugs, and 30% were employed at least part-time. There were only modest improvements shown in the medical and psychiatric status of these women. These preliminary findings suggest that site-level interagency coordination and programme-level case management were associated with improvements in the targeted areas as predicted by the model. Future work will require a more closely specified, manual-guided form of the intervention plus the inclusion of control groups and cost measures to fully evaluate the cost benefits from the final form of the intervention.	Does not have outcomes relevant to research question
Merkes, M. (2004). The Darebin Family Violence Working Group: A partnership approach. *Australian Journal of Primary Health, 10*(2), 104-111.	In 2002, the City of Darebin initiated a partnership involving individuals and organisations that provide services to people in Darebin experiencing family violence. This coincided with the establishment of a Family Violence Coordination Unit for the Darebin Police. Subsequently, the Darebin Family Violence Working Group developed and strengthened the relationship between its members, resulting in improved communication, increased and better informed referrals, and a greater understanding of members' professional roles and limitations. Traditionally, local governments have not considered it their role to address family violence at the policy level, or to improve the local service system for individuals and families experiencing family violence. By taking leadership, and establishing, supporting, and facilitating the Darebin Family Violence Working Group, the City of Darebin has demonstrated that local government can play an important role in this area and achieve positive outcomes for its community. This paper describes the partnership of local services and organisations that came together in the Darebin Family Violence Working Group, the resulting changes to the service system, and the factors that have contributed to the success of the partnership.	Does not evaluate the outcome of an intervention
Mills, L.G. (2000). Child protection and domestic violence: training, practice, and policy issues. *Children and Youth Services Review, 22*(5), 315-332.	Traces the experiences of four of the five Department of Health and Human Services (DHHS) recipients who received funding to provide domestic violence training to child welfare agencies in four areas of the United States. The article begins with the developing research that documents the connection between child abuse and domestic violence and explores the tension between battered women and their advocates and child protective service (CPS) workers. This article also presents findings from the experiences of the DHHS funded programmes, their accomplishments, and the obstacles they faced in integrating domestic violence into child welfare practice with the ultimate goal of protecting the mother-child unit. Finally, it concludes with practice and policy recommendations for researchers and practitioners who are working at the intersection of these abuses.	Non-systematic review

Nancarrow, H., & Viljoen, R. (2011). *Breaking the Cycle: Trial integrated response to domestic and family: violence in Rockhampton. Client experiences and outcomes.* Queensland, AU: Queensland Centre for Domestic and Family Violence Research.	No abstract	Does not evaluate the outcome of an intervention
No Author. (2002). Community-based public health looks to law enforcement as a partner. *Community-Based Public Health Policy & Practice,* 6, 1-4.	No abstract	Does not evaluate the outcome of an intervention
No Author. (2004). Agencies unite to promote working in partnership for adult protection. *Community Practitioner, 77*(12), 446-446.	No abstract	Does not evaluate the outcome of an intervention
No Author. (2005). CPHVA joins alliance against domestic violence. *Community Practitioner, 78*(10), 344-344.	No abstract	Does not evaluate the outcome of an intervention
No Author. (2011). Response team pairs MH specialists with violence victims' advocates. *Mental Health Weekly, 21*(34), 1-7.	No abstract	Does not evaluate the outcome of an intervention
Oetzel, J., & Duran, B. (2004). Intimate partner violence in American Indian and/or Alaska Native communities: a social ecological framework of determinants and interventions. *American Indian & Alaska Native Mental Health Research, 11*(3), 49-68.	This essay synthesizes the research on intimate partner violence (IPV) in American Indian and/or Alaska Native communities using a social ecological framework. The review of literature demonstrates that American Indian and/or Alaska Native women are at an elevated risk for IPV compared to non-American Indian women and thus this essay describes multi-level interventions that are culturally appropriate for American Indian and/or Alaska Native communities. The interventions address a variety of determinants including gender, age, socioeconomic status, alcohol, European colonization, and infrastructure.	Non-systematic review
O'Sullivan, E., & Carlton, A. (2001). Victim services,	To evaluate proposals that independent rape crisis centers (SA) merge or add services. this article compares victim services and community outreach efforts of 16 North Carolina rape crisis centers: 8 SAs and 8 multiservice centers.	Does not have outcomes relevant to

community outreach, and contemporary rape crisis centers - A comparison of independent and multiservice centers. *Journal of Interpersonal Violence, 16*(4), 343-360.	The data raise serious questions about the ability of combined domestic violence/sexual assault (DV/SA) programs to reach sexual assault victims, to educate the community about sexual assault, and to work on rape prevention. DV/SA heard from far fewer sexual assault victims, including teenagers; did not routinely receive requests for hospital advocates; and did not provide systematic community education. SAs inform the community about sexual assault and develop strategies to change its knowledge and behaviours. SAs promoted inclusive definitions of sexual assault incorporated cultural concerns in assessing their services and outreach and initiated community education programs targeted at young people and males.	research question
Otto, J.M. (2008) Twenty Years of a Community Review Team. *Victimization of the Elderly & Disabled, 11(1),* 3-4.	No abstract	Does not evaluate the outcome of an intervention
Otto, M., & Quinn, K. (2007). *Barriers to and Promising Practices for Collaboration between Adult Protective Services and Domestic Violence Programs.* Washington, DC: National Centre on Elder Abuse.	No abstract	Non-systematic review
Patterson, D. (2009). *The Effectiveness of Sexual Assault Services in Multi-Service Agencies.* Harrisburg, PA: National Online Resource Centre on Violence Against Women.	No abstract	Non-systematic review
Pence, E., & McMahon, M. (2003). Working from inside and outside institutions: How safety audits can help courts' decisions making around domestic violence. *Juvenile and Family Court Journal, 54*(4), 133-147.	As systems begin to work collaboratively to address the overlap of domestic violence and child maltreatment, systems-analysis approaches are also being explored to test the effectiveness of collaborative interventions in meeting the needs of victims and their families. The institutional safety audit model is one such approach currently being explored in sites across the country. Under this model, case files of families receiving services are submitted to an analysis that compares the interventions received with the needs that were demonstrated. Though still in a formative stage, the institutional safety audit has the potential-to be used by the courts as an innovative information-gathering tool on the effectiveness of court-ordered interventions. This article will provide a detailed overview of the safety audit model, describe how safety audits are currently being used in the field, and discuss how the courts can incorporate safety audit findings into decision-making around domestic violence and child maltreatment.	Does not evaluate the outcome of an intervention
Pinkney, L., Penhale, B., Manthorpe, J., Perkins, N., Reid, D., & Hussein, S. (2008). Voices from the frontline: social work practitioners' perceptions of multi-agency working in adult protection in England and Wales. *Journal of Adult Protection, 10*(4), 12-24.	This article reports on the views of 92 social workers about their practice in adult protection in England and Wales as part of a wider study of adult protection working and regulation that took place between 2004-2007 in 26 sample local authorities. The article explores social workers' reported experiences of partnership or multiagency working and how this, along with overarching regulatory frameworks, affected their practice within and across agencies. Among findings from the study were that social workers considered that sharing information and responsibilities led to positive outcomes for service users and that the incorporation of different agency perspectives supplemented sharing of best practice.	Based on same data as Penhale (2007)

Poorman, P.B. (2001). Forging community links to address abuse. *Women & Therapy, 23*(3), 7.	This study is a comprehensive review of lesbian domestic abuse in the psychological, sociological, legal, and social work literature. Planning intervention and prevention strategies is discussed in light of what is known and what remains to be known. A strong argument is made to turn attention away from the elusive tasks of documenting prevalence and incidence characteristics, and forge the community links needed to develop effective intervention and prevention strategies.	Non-systematic review
Post, L. A., Klevens, J., Maxwell, C.D., Shelley, G. A., & Ingram, E. (2010). An examination of whether coordinated community responses affect intimate partner violence. *Journal of Interpersonal Violence, 25*(1), 75-93.	This study tests the impact of coordinated community response (CCR) on reducing intimate partner violence (IPV) and on modifying knowledge and attitudes. The authors conduct hierarchical linear modeling of data from a stratified random-digit dial telephone survey (n=12,039) in 10 test and 10 control sites, which include 23 counties from different regions in the United States, to establish the impact of a CCR on community members' attitudes toward IPV, knowledge and use of available IPV services, and prevalence of IPV. Findings indicate that CCRs do not affect knowledge, beliefs, or attitudes of IPV, knowledge and use of available IPV services, nor risk of exposure to IPV after controlling for age, gender, ethnicity, income, and education. Women in communities with 6-year CCRs (as opposed to 3-year CCRs) are less likely to report any aggression against them in the past year. These results are discussed within the context of evaluation challenges of CCRs (e.g., IPV activities in comparison communities, variability across interventions, time lag for expected impact, and appropriateness of outcome indicators) and in light of the evidence of the impact of other community-based collaborations.	Does not have outcomes relevant to research question
Punukollu, M. (2003). Domestic violence: screening made practical. *Journal of Family Practice, 52*(7), 537-543.	Physicians should routinely screen women for domestic violence. Although the US Domestic Task Force considers the evidence for or against specific instruments insufficient, the recommendation to include questions about physical abuse may be made on other grounds, such as the high prevalence of undetected abuse among women patients, the potential value of this information in helping such patients, and the low cost and low risk of screening. Offer abused patients information about community resources and advocates. Advocacy and connections with community agencies have proven helpful (in a randomized controlled trial) in improving quality of life and preventing violence-related injuries.	Does not have outcomes relevant to research question
Reid, D., Penhale, B., & Manthorpe, J. (2009). Form and function: views from members of adult protection committees in England and Wales. *Journal of Adult Protection, 11*(4).	Research into the effectiveness of interagency working in adult protection committees (APCs) in which, in line with government guidance, social services departments play a lead role. APC members' views on factors which contribute to good multi-agency working in APCs, perceived barriers and ways in which these problems can be addressed are discussed.	Based on same data as Penhale (2007)
Roughton, S. (2000). Domestic violence: assessing and improving inter-agency work. *Community Practitioner, 73*(6).	Effective inter-agency care is fundamental in caring for women and children who suffer from domestic violence, but the track record isn't great. The author, who is a health visitor, looks at a study examining some of the services available in York and how they might be improved. Cites eight references.	Does not evaluate the outcome of an intervention
Sadler, P., & Sorensen, G. (2000). Coordination and elder abuse: development of inter-agency protocols in New South Wales. *Australasian Journal on Ageing, 19*(3), 118-124.	Improving coordination is a key concern for aged and community care services. Dealing with abuse, neglect and exploitation of older people requires effective coordination between agencies. This paper reviews the implementation of the NSW Inter-Agency Protocol and the development of local protocols, using existing service provision systems, via a statewide training programme. The protocol development process is an example of moving agencies from informal collaboration toformal coordination processes. The training programme was successful and the local protocols provide flexibility to utilise the full range of providers and professional skills through the appointment of assessment teams including the most appropriate members from local agencies. There are weaknesses to this approach, including difficulties involving all key agencies in the protocol development and its reliance on busy existing providers and an incomplete service infrastructure. The effectiveness of the protocol in addressing individual cases of abuse requires further examination.	Does not evaluate the outcome of an intervention

Sanders, C.K., & Schnabel, M. (2007). Organizing for economic empowerment of battered women: women's savings accounts. *Journal of Community Practice, 14*(3), 47-68.	When describing reasons for remaining with or returning to an abusive partner, many women mention economic dependence on their abuser. Few battered women, especially those who are poor, have the economic resources necessary to live independently. Additionally, battered women are commonly isolated from financial resources lacking ready access to cash, checking accounts, or charge accounts. Creating strategies that address financial well-being is essential to addressing the issue of domestic violence. This article discusses collaboration among domestic violence service providers in the St. Louis, Missouri, region created to promote the economic development of low-income battered women. The collaboration has culminated in formalized economic service provisions including economic education and credit counselling; women's matched savings accounts; and economic advocacy and support services.	Non-systematic review
Scottish Government. (2009). A partnership approach to tackling violence against women in Scotland: guidance for multi-agency partnerships. Edinborough, UK: Scottish Government.	Notes that partnership is essential for providing a comprehensive and coordinated response to violence against women across the four key areas of prevention, protection, provision and participation. Offers guidance on developing an agreed definition of violence against women, terms of reference for the partnership and partners, clear remits for partners singly and jointly, shared understanding and vision, agreed action plans, sharing information and consistent policies. Includes examples of how multi-agency partnerships across the country are tackling these issues.	Does not evaluate the outcome of an intervention
Shaw, S. (2002). The role and involvement of the voluntary sector in the work on domestic violence. *MIDIRS Midwifery Digest, 12*, S22-25.	This article begins by contextualising the practical responses to domestic violence and the historical role played by women's groups and refuges in the delivery of services to women and children. It will outline the range of services provided by Panahgar (an Asian and black women's refuge) and other refuges. It will explain their links and networking capacity including specific services such as those for black and minority women. The article concludes with the integral role played by the voluntary sector in partnership working and the positive results that can be achieved.	Does not evaluate the outcome of an intervention
Shoultz, J., Magnussen, L., & Oneha, M.F. (2005). Building capacity to partner: exemplars of community participatory research: building the capacity to identify intimate partner violence. *Communicating nursing research, 38*, 108-108.	No abstract	Does not evaluate the outcome of an intervention
Shoultz, J., Oneha, M. F., Magnussen, L., Hla, M. M., Brees-Saunders, Z., Cruz, M.D., & Douglas, M. (2006). Finding solutions to challenges faced in community-based participatory research between academic and community organizations. *Journal of Interprofessional Care, 20*(2), 133-144.	Partnerships between communities and academic institutions have been vital in addressing complex health and psychosocial issues faced by culturally diverse and hard-to-reach populations. Community-based participatory research (CBPR) has been suggested as a strategy to develop trust and build on the strengths of partners from various settings to address significant health issues, particularly those persistent health issues that reveal disparities among minority populations. There have been many challenges to developing these partnerships in the United States. The purpose of this paper is to discuss approaches and solutions used by this research team in response to the challenges they have faced in using CBPR. The team uses CBPR to understand and support the process of disclosure of intimate partner violence (IPV) within the context of the community health centers that provide services for multicultural and multi-lingual populations. While CBPR provides a route to develop trust and build on the strengths of partners from various settings, there are multiple challenges that arise when partnering organizations present with different infrastructures, missions, resources and populations served. Examples of common challenges and solutions from the literature and from the team's experience will be discussed. Implications for partners, partnerships, practice and research will be explored.	Does not evaluate the outcome of an intervention
Silverman, J.G., Pratt, C.,	No abstract	Non-systematic review

Reed, E., Nagy, B.J., Whitaker, D.K., Baker, C., Decker, M.R., Koh, H., & Pavlos, C. (2004). The CARE Communities project: an academic, practitioner, and federal public health agency collaboration to improve intimate partner violence services for underserved communities. *Public Health Reports, 119*(6), 590-593.		
Simmel, C., & Price, A. (2002). The shared family care demonstration project: challenges of implementing and evaluating a community-based project. *Children and Youth Services Review, 24*(6), 455.	Shared Family Care (SFC) is a demonstration programme designed to assist families who are involved, or are at risk of involvement, with the child welfare system. Reasons for being at risk of involvement may include homelessness, substance abuse, domestic violence, and being a teen parent. SFC can serve either single-parent or two-parent headed families. The National Abandoned Infants Assistance Resource Centre (AIARC) at The University of California at Berkeley has evaluated several SFC demonstration programmes in California and Colorado since 1997. This paper begins with an overview of SFC and then presents a case study of one county's programme to illustrate the challenges and benefits associated with programme implementation and evaluation. Particular emphasis is given to the challenges and conflicts faced by the AIARC evaluation team, who are in a dual role of providing technical assistance while evaluating the programmes. Also discussed is the issue of multi-agency collaborations. The paper concludes with recommendations for improving the implementation of demonstration projects and evaluating such programmes.	Non-systematic review
Skinner, B. (2000). Learning from experience. *Journal of Adult Protection, 2*(1).	Multi-agency programme of vulnerable adult protection courses for health and social care professionals developed by East Sussex Social Services.	Does not evaluate the outcome of an intervention
Steinman, K.J., & Bambakidis, A. (2008). Faith-health collaboration in the United States: results from a nationally representative study. *American Journal of Health Promotion, 22*(4), 256-263.	PURPOSE: Estimate the prevalence of and identify characteristics associated with religious congregations' collaboration with health agencies. DESIGN: Cross-sectional analyses of self-report data from the National Congregations Study, a random sample of religious congregations generated from the 1998 General Social Survey. SUBJECTS: Key informants from 1236 congregations. Each respondent described a single congregation. MEASURES: Respondents provided open-ended descriptions of congregational programs. Researchers coded programme descriptions by content (e.g., domestic violence) and whether the programme involved collaboration with a secular agency. Other congregational characteristics (e.g, denomination) were measured by validated measures and linked census tract data. RESULTS: Overall, 11.1% of congregations participated in faith-health collaboration (FHC). Logistic regression analyses found that FHC was more common among congregations with more members, with a small proportion of congregants under 35 years, and with a senior pastor with a graduate degree. Other effects were conditional; for instance, denominational differences varied depending on urban/suburban/rural location and the proportion of low-income members. CONCLUSION: This study provides the first national estimates of the prevalence of FHC. Such collaborative efforts may require different approaches in different areas. These results can help practitioners identify congregations that may be more willing to collaborate.	Does not evaluate the outcome of an intervention
Stobart, E. (2009). *Multi-agency practice guidelines: handling cases of forced marriage.* London, UK: Foreign and Commonwealth	These practice guidelines have been developed alongside the statutory guidance "The Right to Choose" issued under s.63 Q(1) Forced Marriage (Civil Protection) Act 2007 to provide supplementary guidance and advice to frontline practitioners. The guidelines are relevant for all frontline practitioners and volunteers within agencies that work to safeguard children and young people from abuse or who protect adults from abuse. The topics covered include: a victim-centred approach; the dangers of family counselling, mediation, arbitration and reconciliation; the importance of	Does not evaluate the outcome of an intervention

Office, Forced Marriage Unit.	sharing information with other agencies; venues for interviews; future contact and meetings; personal safety advice and devising a strategy for leaving home; missing persons and young people who run away; confidentiality and security of information; and record keeping. Specific guidelines for the following groups are also included: health professionals; schools, colleges and universities; police officers; children's social care; adult social care and local housing authorities.	
Strumpel, C., & Hackl, C. (2011). The Breaking the Taboo projects - raising awareness of, and training staff in, community health and care services on violence against older women within families. *Journal of Adult Protection, 13*(6), 323-335.	European partnership projects to raise awareness and provide training for community health and social services staff involved in recognising and acting in cases of familial violence against older women. The research and practical activities of the 2 'Breaking the Taboo' projects carried out within the European Commission's Daphne programme are described, including the development of training materials and workshops.	Study conducted in Slovenia
Sturm, L.A., Shultz, J., Kirby, R., & Stelzner, S.M. (2011). Community partners as co-teachers in resident continuity clinics. *Academic Medicine, 86*(12), 1532-1538.	Standard approaches to teaching the management of psychosocial issues in pediatrics--visits to community-based organizations and stand-alone block rotations in developmental-behavioural pediatrics and community pediatrics--neither expose residents to models of interdisciplinary collaboration between faculty preceptors and community providers nor take advantage of the efficacy of learning in continuity clinics. The authors describe their project, developed from an existing Community Pediatrics Training Initiative with long-standing relationships with a domestic violence shelter, a community centre for Latino families, and a special needs resource organization for parents. They lay out in detail the project's innovative use of partners from community-based organizations, colocated within pediatric continuity clinics, who teach both residents and faculty about community resources and linkages with multidisciplinary providers. The authors present lessons learned by faculty preceptors, residents, the community partners, and project staff that can guide future applications of this model in other residency training programs. Faculty and residents indicated an increased awareness of available community resources and how linkages can be incorporated into pediatric outpatient visits. Community partners identified keys to successful co-teaching, including readiness to adopt an assertive communication style and frequent presence in the clinics. Project staff recognized the challenges of staff turnover at community-based organizations and the need to choose community partners with expertise that fits the sociodemographic issues of the clinic's patients.	Does not evaluate the outcome of an intervention
Sudderth, L.K. (2003). An uphill climb: The challenge of collaboration in response to family violence in a rural area. *Journal of Aggression, Maltreatment and Trauma, 8*(4), 17-39	The Community Partnership Team (CPT) was created to more effectively address the problems of child sexual victimization and domestic violence in the rural, northeast corner of Connecticut. A multi-disciplinary team was formed to improve collaboration between agencies serving victims of violence. Observations of meetings and confidential interviews suggested that most participants felt quite positively about the process; however, serious conflicts emerged between agencies serving different types of victims. Results indicated that it is important to identify barriers to collaboration, to recognize and use differences to build relationships across agencies, and to maintain a formal mechanism for resolving conflict.	Does not evaluate the outcome of an intervention
Sully, P., Greenaway, K., & Reeves, S. (2005). Domestic violence--Policing and health care: Collaboration and practice. *Primary Health Care Research and Development, 6*(1), 31-36.	The need for effective collaboration when working with survivors of domestic violence is an urgent one. This paper outlines an innovative project that will examine the antecedents of homicide by a current or former partner. The early stages of the project including analysis of closed homicide case records and a survey of police officers' experience of collaboration with health and social care providers is presented. Early findings suggest opportunities where intervention could in future situations prevent homicide.	One case study
Taskforce on the Health Aspects of Violence Against	The Taskforce comprised third sector organisations, other government departments, academics, Royal Colleges and healthcare professionals from a range of backgrounds including emergency care, midwifery, paediatrics, general	Does not evaluate the outcome of an

Women and Children. (2010). *Responding to violence against women and children: the role of the NHS.* London, UK: Department of Health.	practice and child and adolescent mental health services. The group looked specifically at the role of the NHS in meeting the challenge of violence and abuse against women and children, including the treatment and support of victims of violence and the role of the NHS - in partnership with other agencies - in preventing violence and abuse. This is the Taskforce's final report. It describes the key issues identified by women and children themselves, and by NHS staff as well as by experts from a wide range of interested bodies. It sets out a number of recommendations to address these issues.	intervention
Templeton, L. (2009). *Getting the Foundations Right – Improving the Response of Alcohol Services with Clients and Families where there is also Domestic Violence/Abuse. Year 1 External Evaluation Report for the Embrace Project.* London, UK: Alcohol Concern.	No abstract	Based on preliminary data presented in Templeton (2011)
Tiamiyu, M.F., Murphy, P.A., & Foxwell, M. (2005). An innovative programme for domestic violence victims: A university - community collaboration. *Gender & Behaviour, 3*, 296-313.	The purpose of this study is to examine an innovative programme for domestic violence (The Domestic Violence and Self-Sufficiency [DV & SS] Programme at the University of Toledo, Toledo, Ohio). More specifically, the study evaluates the importance and appropriateness of the services this programme offers enrolled and prospective student-parent welfare recipients at the university. Quantitative and qualitative analyses were conducted on the data collected by graduate student interns in social work. The study found that programme services were appropriate and valued by a community partner who doubled the funding for staffing and added $25,000 in tuition assistance money. The study also found that women students not eligible for welfare receipt needed programme services and those students using welfare had barriers interconnected with domestic violence issues. Several recommendations are made that will enable caseworkers/counsellors working in universities and in the larger community improve the services they provide domestic violence victims.	Does not evaluate the outcome of an intervention
Uekert, B.K. (2003). The Value of Coordinated Community Responses. *Criminology & Public Policy, 3*(1), 133-135.	Provides information on the coordinated community responses (CCR), established to promote batterer accountability and improve victim safety in the U.S. Impact of the CCR on domestic violence; Implication of the CCR on the Violence Against Women Act; Discussion on the participation and role of prosecutors and stakeholders in CCR on domestic violence.	Non-systematic review
Vinton, L. (2003). A model collaborative project toward making domestic violence centers elder ready. *Violence Against Women, 9*(12), 1504-1513.	An interagency collaboration was formed in a Florida community with a high proportion of older residents to fill the gaps in services that existed for older domestic violence victims. Results of the collaboration included the creation of safe spaces both inside and out-side the domestic violence shelter. Targeted outreach to older victims resulted in the local domestic violence shelter's providing more than 100 hours of crisis hotline counselling, case management for six individuals, and emergency sheltering of one older woman during a 6-month period. A plan for replication of the project was developed and disseminated.	Does not evaluate the outcome of an intervention
Walker, R., Anderson, T., Holmes, C., Stafford, J., & Gottrich, A. (2004). The Domestic: Violence Enhanced Response Team: A Coordinated Response to Domestic Violence, Child Maltreatment, and Animal	Provides information about the Domestic Violence Enhanced Response Team (DVERT), a collaboration of 39 community partners in Colorado aimed at responding and preventing domestic violence, child and animal abuses in the state. Mission of the association; Objectives of the Children's Programme at DVERT; Initiatives undertaken by the association in improving its support services to families in the state.	One case study

Abuse. *Protecting Children, 19*(1), 29-37.		
Warin, R. (2010). Safeguarding adults in Cornwall. *Journal of Adult Protection, 12*(2), 39-42.	This paper reviews the process and progress of safeguarding adults in Cornwall since the murder of Steven Hoskin and the Serious Case Review that was carried out (Flynn, 2007). Interviews were carried out with frontline staff to assess how the processes have been delivered and whether this has had a beneficial impact. Multi-agency working has improved information sharing, but there is still work to be done to deliver consistent and effective responses from everyone involved in safeguarding adults.	Does not evaluate the outcome of an intervention
Warshaw, C., Gugenheim, A.M., & Moroney, G., Barnes, H. (2003). Fragmented services, unmet needs: building collaboration between the mental health and domestic violence communities: an initiative in Chicago is the result of a growing recognition that domestic violence can have serious mental health consequences. *Health Affairs, 22*(5), 230-234.	The Domestic Violence and Mental Health Policy Initiative (DVMHPI) is an innovative project to address the unmet mental health needs of domestic violence survivors and their children and to develop models that integrate clinical and advocacy concerns. Overseeing a network of more than fifty community-based mental health, domestic violence, substance abuse, and social service agencies, as well as city and state officials, the DVMHPI promotes collaboration and provides training and technical assistance to improve the capacity of local service systems to address the traumatic effects of abuse. This report highlights the importance of generating funding streams that promote collaboration.	Does not evaluate the outcome of an intervention
Welsh, K. (2005). The Disassociation Between Domestic Violence Service Provision and Multi-Agency Initiatives on Domestic Violence. *International Review of Victimology, 12*(3), 213-234.	In recent years in England and Wales, the multi-agency approach has come to be increasingly promoted in government circles as a response in domestic violence. In this article, I reflect on doctoral research to question the assumption that the multi-agency approach should be celebrated as a leading response to the problem. Rather, I argue that such approaches increase neither women's protection nor their safety. Focusing on findings from two research areas in Northern England, I argue that there was a separation or disassociation between multi-agency domestic violence initiatives and service provision in these areas. I illustrate the argument using three examples from the research. Other issues are important in founding the argument that such approaches are not increasing women's protection or safety. These issues centre on the interaction between service provision and prevention. I argue that, because appropriate service provision is essential in preventing domestic violence, an approach that is not grounded in service provision but is disassociated from it can do little to prevent domestic violence and protect women.	Does not evaluate the outcome of an intervention
Welsh, K. (2008). Partnership or palming off? Involvement in partnership initiatives on domestic violence. *Howard Journal of Criminal Justice, 47*(2), 170-188.	One of the most striking features of government policy on domestic violence in the last decade has been the promotion of a partnership approach to the problem and, in particular, of partnership initiatives as the means to deliver the approach. Drawing on doctoral research, I suggest that these initiatives are largely attended by voluntary sector organisations and that, although some State agencies show a real commitment to attending, attendance from many State agencies is disappointing at best and is often mediated through the attendance of those with an interest in, and commitment to, the issue. I reflect on what this suggests about who, exactly, carries the burden of partnership responses to domestic violence and, moreover, what this suggests about the effectiveness and efficacy of such responses and their entitlement to such significance in government policy around the problem.	Does not have outcomes relevant to research question
Wendt, S. (2010). Building and sustaining local co-ordination: an Australian rural community responds to domestic and family violence. *British Journal of Social Work, 40*(1), 44-62.	This article describes an action research project in Murray Bridge, rural South Australia, to improve local service responses to domestic violence. The project involved service providers and past clients, and looked at barriers to service co-ordination and Indigenous services.	Does not have outcomes relevant to research question

Widawski, C., & Frydman, S.D. (2007). A Marriage of Jewish Family Services and the Criminal Justice System. *Journal of Jewish Communal Service, 82*(1), 59-67.	In the field of family therapy it is widely accepted that not every relationship is bashert (meant to be). This notion certainly holds true for organizational partnerships as well. Competition for limited funding opportunities, coupled with the unique nuances in mission, expertise, and style of each organization, can often create an environment in which agencies work individually rather than in concert. This article explores Project Eden, an innovative and successful partnership in Brooklyn, New York, which brings multiple Jewish family service agencies together with the criminal justice system to address domestic violence in the Orthodox community. As more than 450 abused women have been served by Project Eden and its partners, many would likely consider this union of multidisciplinary services to be bashert.	One case study
Wiglesworth, A., Mosqueda, L., Burnight, K., Youngiove, T., & Daniel, J. (2006). Findings From an Elder Abuse Forensic Centre. *Gerontologist, 46*(2), 277-283.	Purpose: The first Elder Abuse Forensic Centre (EAFC) in the United States was instituted in 2003. People from a variety of disciplines, including Adult Protective Services social workers, law enforcement, the district attorney's office, a medical response team, public guardian deputies, ombudsmen, mental health services, a victim advocate, and a domestic violence expert work cooperatively on cases of elder and dependent-adult mistreatment. Researchers conducted an assessment of the EAFC's impact on the efficiency and effectiveness of the collaboration. Design and Methods: Mixed quantitative and qualitative methods included statistical analysis of data from outcome surveys of EAFC collaborators and illustrative case studies developed from case files and structured interviews. Results: Mean survey scores evaluating the efficiency and effectiveness of the collaboration were significantly better than neutral responses. Case studies show efficient and effective case management through cooperation of the collaborating agencies. Survey results clearly support perceptions exemplified in case studies. Implications: An EAFC enhances the efficiency and effectiveness of those who address elder abuse in one community, which in turn leads to improved outcomes. Continued analysis to identify strengths, weaknesses, and cost effectiveness of the EAFC model is ongoing.	Does not have outcomes relevant to research question
Williams, S. (2011). Safeguarding adults at risk in the NHS through inter-agency working. *Journal of Adult Protection, 13*(2), 100-113.	Purpose - The paper aims to appraise professional practice in safeguarding vulnerable adults. It will examine the mechanisms in place and discuss how future policy will affect multi-agency working in this field. Design/methodology/approach - The paper examines recent consultations, policy development, inspectorate reports and legal guidance surrounding the issue of safeguarding adults in England and Wales, and suggests ways in which inter-agency working can be strengthened. Findings - Safeguarding systems need to be timely, rigorous and transparent to increase levels of public confidence and to ensure that the people who are at most risk of being abused are safe when accessing public services. The concept of safeguarding adults is increasingly being integrated into government policy and there are many successful examples of safeguarding partnership working in England and Wales. However, there are also substantial barriers that hinder organisations from working together effectively, such as different cultures, practices and ideologies. Originality/value - The paper explores the fact that there needs to be clarification of roles and responsibilities and integration of processes, and acceptance of true multi-agency working. There is a danger that instead of providing extra protection for adults at risk, multiple routes will result in a lack of co-ordination.	Does not evaluate the outcome of an intervention
Wilson, J.S., & Websdale, N. (2006). Domestic violence fatality review teams: an interprofessional model to reduce deaths. *Journal of Interprofessional Care, 20*(5), 535-544.	In an effort to reduce injuries and prevent deaths from violence, interprofessional domestic violence fatality review teams (DVFRT) have developed across the United States and globally to study factors that contribute to intimate partner injury and deaths. Drawing upon knowledge from the disciplines of health, education, criminal justice, social services, and policy, these teams review and analyse domestic violence homicide cases to uncover basic knowledge about causes, factors that increase or decrease the risk for death and injury, and specific ways to prevent further injury and death. Through interprofessional collective recommendations and cooperative actions, these teams are developing promising practices and systems' changes that offer better services, learning, and interventions to reduce injury and death from domestic violence.	One case study

Appendix E. Quality Appraisal Checklists

Table 18. Quality Appraisal Checklist for Quantitative Intervention Studies

Study identification *(include full citation details)*			
Study design:			
Guidance topic:			
Assessed by:			
++=good, +=mixed, - =poor, nr=not reported, na=not applicable			
Evaluation criteria		**Quality ++ + - nr na**	**Notes**
Section 1: Population			
	1.1 Is the source population or source area well described?		
	1.2 Is the eligible population or area representative of the source population or area?		
	1.3 Do the selected participants or areas represent the eligible population or area?		
Section 2: Method of allocation to intervention (or comparison)			
	2.1 Allocation to intervention (or comparison). How was selection bias minimised?		
	2.2 Were interventions (and comparisons) well described and appropriate?		
	2.3 Was the allocation concealed?		
	2.4 Were participants and/or investigators blind to exposure and comparison?		
	2.5 Was the exposure to intervention and comparison adequate?		
	2.6 Was contamination acceptably low?		
	2.7 Were the other interventions similar in both groups?		
	2.8 Were all participants accounted for at study conclusion?		
	2.9 Did the setting reflect usual UK practice?		
	2.10 Did the intervention or control comparison reflect usual practice?		
Section 3: Outcomes			
	3.1 Were outcome measures reliable?		
	3.2 Were all outcome measurement complete?		
	3.3 Were all important outcomes assessed?		
	3.4 Were outcomes relevant?		
	3.5 Were there similar follow-up times in exposure and comparison groups?		
	3.6 Was follow-up time meaningful?		
Section 4: Analyses			
	4.1 Were exposure and comparison groups similar at baseline? If not, were these adjusted?		
	4.2 Was intention to treat (ITT) analysis conducted?		

	4.3 Was the study sufficiently powered to detect an intervention effect (if one exists)?		
	4.4 Were the estimates of effect size given or calculable?		
	4.5 Were the analytical methods appropriate?		
	4.6 Was the precision of intervention effects given or calculable? Were they meaningful?		
Section 5: Summary			
	5.1 Are the study results internally valid (i.e. unbiased)?		
	5.2 Are the findings generalisable to the source population (i.e. externally valid)?		
[1]Appraisal form derived from 'The GATE frame: critical appraisal with pictures' by Jackson, R. et al., Evidence Based Medicine 2006 Apr;11(2):35-8.			

Table 19. Quality Appraisal Checklist for Qualitative Intervention Studies

Study identification *(include full citation details)*			
Study design:			
Guidance topic:			
Assessed by:			
++=good, +=mixed, - =poor, nr=not reported, na=not applicable			
Evaluation criteria		**Quality ++ + - nr na**	**Notes**
Section 1: Theoretical approach			
	1.1 Is a qualitative approach appropriate?		
	1.2 Is the study clear in what it seeks to do?		
Section 2: Study design			
	2.1 How defensible/rigorous is the research design/methodology?		
Section 3: Data collection			
	3.1 How well was the data collection carried out?		
Section 4: Trustworthiness			
	4.1 Is the role of the researcher clearly described?		
	4.2 Is the context clearly described?		
	4.3 Were the methods reliable?		
Section 5: Analysis			
	5.1 Is the data analysis sufficiently rigorous?		
	5.2 Are the data 'rich'?		
	5.3 Is the analysis reliable?		
Section 6: Summary			
	6.1 Are the findings convincing?		
	6.2 Are the findings relevant to the aims of the study?		
	6.3 Conclusions		
Section 7: Ethics			
	7.1 How clear and coherent is the reporting of ethics?		

Section 8: Overall Assessment			
	8.1 As far as can be ascertained from the paper, how well was the study conducted?		

[1]Appraisal form derived from 'The GATE frame: critical appraisal with pictures' by Jackson, R. et al.,Evid Based Med. 2006 Apr;11(2):35-8.

Appendix F. Studies Excluded for Negative Internal Quality Appraisal Rating

The following tables include the abstracts for all studies that were excluded due to a negative quality appraisal rating.

Table 20. Research Question 1 (Prevention) Studies Excluded for Negative Internal Quality Rating

Study Details	Abstract	Reason for Exclusion
Davila, Y. R., Bonilla, E., Gonzalez-Ramirez, D., Grinslade, S., & Villarruel, A. M. (2008). Pilot Testing Hiv and Intimate Partner Violence Prevention Modules among Spanish-Speaking Latinas. *Journal of the Association of Nurses in AIDS Care, 19(3),* 219-224.	The purpose of this study was to test two modules of a theoretically based, gender- and culturally specific HIV intimate partner violence risk reduction intervention for Spanish-speaking Latinas. The themes of the modules were "Estás en una relación sana y segura?" (Are you in a healthy and safe relationship?) and "Mantenerse sana y segura" (Keeping yourself healthy and safe). An evaluative one-group, repeated measure design with measures collected at pre-intervention (N=31), immediate post-intervention (n=26), and 1-month post-intervention follow-up (n=20) design was used to evaluate the intervention. Study results represent a small but significant first step toward an integrative approach to the prevention of two major and interrelated public health issues among an at-risk and underserved population.	[-] internal quality rating
Davis, M. J., & Medina-Ariza, J. (2001). *Results from an Elder Abuse Prevention Experiment in New York City : Research in Brief.* Washington, DC: National Institute of Justice.	A significant amount of research has been conducted on ways to reduce abuse against women and children, but very little research has been done on the domestic abuse of elderly persons. Virtually all State agencies charged with addressing the problem of elder abuse reported increases in their caseloads over the past decade. This Research in Brief addresses the increasing need for elder abuse prevention and highlights a field experiment involving interventions designed to reduce repeat incidents of elder abuse including difficulties and successes.	[-] internal quality rating

Table 21. Research Question 2 (Screening) Studies Excluded for Negative Internal Quality Rating

Study Details	Abstract	Reason for Exclusion
Boursnell, M. & Prosser, S. (2010). Increasing identification of domestic violence in emergency departments: a collaborative contribution to increasing the quality of practice of emergency nurses. *Contemporary Nurse, 35(1),* 35-46.	This project was initiated to improve the quality of identification and response practices of Emergency Department (ED) nursing staff dealing with possible victims of domestic violence (DV). Nursing staff were trained to identify three key actions in the pathway for domestic violence presentations in the ED. A survey of ED staff was taken pre-training to determine a base-line measure of self-reported knowledge regarding domestic violence policies and practices. The survey was re-administered 1 month and 6 months post-training. A file audit was also undertaken prior to and following the training. Results show the training improved the nurses' confidence, practice and skills in the identification of, and response to, domestic violence, particularly in relation to children. ED nurses are well placed to identify and respond to domestic violence as the ED provides a gateway into health services for women and their children. This paper reports on a participatory action research project which aimed to improve quality and practice around DV for ED staff. The dissemination of the results in this paper are considered to be essential to health services due to dearth of information and research about best practice initiatives for responding to and recognizing domestic violence in the ED.	[-] internal and [-] external quality rating*
Edwardsen, E.A. Pless, N.A., Fiscella, K.A., Horwitz, S.H., & Meldrum, S.C.	BACKGROUND: To assess the impact of a multimodal educational outreach on physician screening and documentation of intimate partner violence (IPV) in primary care. METHODS: Pre- and post-intervention	[-] internal and [-]

(2004). Pilot educational outreach project on partner violence. Preventive Medicine, 39(3), 536-542.	assessment of physician screening and chart documentation of IPV. Physician screening was assessed by post-visit survey of patients and documentation was assessed by medical record review. SETTING: Three medical offices in an urban community of approximately 1 million. PARTICIPANTS: Three primary care physicians (one internist, one obstetrician, and one family physician) and 100 patients from each of these practices. INTERVENTIONS: Multimodal educational outreach to physicians and their office staff regarding appropriate screening and management of IPV. A trained IPV educator made periodic office visits in 2002 to educate the physician and office staff regarding appropriate screening and management of IPV. RESULTS: Before the intervention, 36/150 (24%) of sample patients reported having been previously asked about IPV and 24/150 (16%) reported being asked in a written format. After the intervention, 100/149 (67%) and 41/108(28%) reported being asked verbally or in writing, respectively. CONCLUSIONS: This pilot study of three physicians suggests educational outreach represents a promising and feasible means of improving physician screening and documentation of IPV in primary care.	external quality rating*
Sprague, S., Madded, K., Doshanjh, S., Petrisor, B., Schemitsch, E.H., & Bhandair, M. (2012). Screening for Intimate Partner Violence in Orthopedic Patients: A Comparison of Three Screening Tools. *Journal of Interpersonal Violence, 27*, 881-898.	Accurately identifying victims of intimate partner violence (IPV) can be a challenge for clinicians and clinical researchers. Multiple instruments have been developed and validated to identify IPV in patients presenting to health care practitioners, including the Woman Abuse Screening Tool (WAST) and the Partner Violence Screen (PVS). The purpose of the current study is to determine if female patients attending an outpatient orthopaedic fracture clinic who screen positive for IPV using three direct questions (direct questioning) also screen positive on the WAST and PVS. We conducted a prevalence study at two Level I trauma centres to determine the prevalence of IPV in female patients presenting to orthopaedic fracture clinics for treatment of injuries. We used three methods to determine the prevalence of IPV; 1) direct questioning, 2) WAST, and 3) PVS. We compared the prevalence rates across the three screening tools. Ninety-four women screened positive for IPV using any method. The prevalence of IPV was 30.5% when a direct questioning approach was utilized, 12.4% using the WAST, and 9.2% using the PVS. The WAST identified 37.2% (35/94) of the IPV victims detected and the PVS identified 27.7% (53/94) of the IPV victims detected, whereas direct questioning identified 89.4% of the IPV victims. Identification of IPV may be under-estimated by the WAST and PVS screening tools. Our findings suggest direct questioning may increase the frequency of disclosure of IPV among women attending outpatient orthopaedic clinics.	[-] internal and [-] external quality rating*
Svavarsdottir, E.K. (2010). Detecting intimate partner abuse within clinical settings: self-report or an interview. Scandinavian Journal of Caring Sciences, 24(2), 224-232.	BACKGROUND: Routine screening for intimate partner abuse (IPA) has been recommended within health-care settings. However, the instruments and methods that are most effective in detecting abuse continues to be debated in the literature. OBJECTIVES: To evaluate the effectiveness of two screening procedures/methods, a self-reporting questionnaire and an interview, in detecting women abuse within an emergency department (ED) and a high-risk prenatal care clinic (HRPCC). Comparison was made related to missing data based on the frequency of missing data. DESIGN: Cross-sectional design was used in the study. SETTINGS: Data were collected at one time in 2006, over a period of 7 months, from 101 women seeking health-care services at an ED and 107 pregnant women in their first trimester attending a HRPCC. METHODS: Two methods were used, a self-reporting instrument and a face-to-face interview with a nurse or a midwife to compare the frequency of women's disclosure of abuse. RESULTS: A variety of prior and current abuse experiences were disclosed by each method. The women however disclosed physical abuse more often in the face-to-face interview. The women at the ED disclosed emotional and sexual abuse by an intimate partner more often when using the self-reporting instrument; but the women at the HRPCC disclosed the same ratio of emotional and sexual abuse regardless of the method used. The face-to-face interview had fewer missing data regarding disclosure of abuse. Contradictory to what has previously been reported in the literature, there were no clear-cut results found regarding which of the methods were more effective in revealing abuse; rather, for some of the women, disclosure was based on a combination of the two methods used and the type of abuse inquired about. CONCLUSION: Implications might focus on using different methods within different clinical settings, e.g. face-	[-] internal and [-] external quality rating*

	to-face interviews at an ED, but questionnaire(s) at a HRPCC; or by using the mixed methods approach within the same clinical setting. Such a decision should however be based on the purpose of screening for women abuse and on how and in what way clinicians and researchers would intervene with the women.	
Wahl, R.A., Sisk, D.J., & Ball, T.M. (2004). Clinic-based screening for domestic violence: use of a child safety questionnaire. *BMC Medicine, 2(25).*	Domestic violence affects many women during their lifetime. Children living in homes where they are or have been exposed to violence are at increased risk for adverse outcomes. The American Academy of Pediatrics, the American Academy of Family Practice, and the American College of Obstetrics/Gynecology have recently joined in recommending routine screening of all families for the presence of domestic violence. We present our experience with an office-based domestic violence screening questionnaire.	[-] internal and [-] external quality rating*

*Note two studies (Hamberger et al., 2010; Power et al., 2011) were included in Q2 with negative [-] internal quality ratings, but moderate [+] external quality ratings

Table 22. Research Question 3 (Victim Interventions) Studies Excluded for Negative Internal Quality Rating

Study Details	Abstract	Reason for Exclusion
Basu, A., Malone, J.C., Levendosky, A.A., & Dubay, S. (2009). Longitudinal Treatment Effectiveness Outcomes of a Group Intervention for Women and Children Exposed to Domestic Violence. *Journal of Child and Adolescent Trauma, 2(2), 90*-105.	Social support can moderate negative effects of domestic violence for exposed women and children. Also, interventions targeting exposed women and children simultaneously have been shown to be more effective than those focused on children only. Since group interventions can provide such support, our study examined the effectiveness of a 10-week community-based psycho-educational group intervention for women and children. Mothers' (n=36) and children's outcomes (n=20) were assessed pre-intervention and 3- and 6-months post-intervention. High attrition limited significant findings but maternal outcomes were in the expected direction. Methodological implications and barriers to intervention research are discussed.	[-] internal quality rating
Bennett, L., Riger, S., Schewe, P. Howard, A., & Wasco, S. (2004). Effectiveness of Hotline, Advocacy, Counselling, and Shelter Services for Victims of Domestic Violence: A Statewide Evaluation. *Journal of Interpersonal Violence, 19(7),* 815-829	The authors report the results of an evaluation of services provided by 54 Illinois domestic violence agencies. In collaboration with the University of Illinois at Chicago evaluation team, domestic violence advocates identified services to be evaluated, specified desired outcomes of those services, and participated in developing measures of those outcomes in both English and Spanish. Within the limitations of the study, outcomes were positive in all four programme areas: hotline, counselling, advocacy, and shelter. The authors then discuss implications for evaluation of domestic violence programs that maintain victim safety as a guiding principle.	[-] internal quality rating
Cocozza, J.J., Jackson, E.W., Hennigan, K., Morrissey, J. P., Reed, B. G., Fallot, R., & Banks, S. (2005). Outcomes for Women with Co-Occurring Disorders and Trauma: Programme-Level Effects. *Journal of Substance Abuse Treatment, 28(2),* 109-119.	Programme-level effects at 6 months are reported from meta-analysis of a nine-site quasi-experimental study of comprehensive, integrated, trauma-informed, and consumer-involved services for women who have mental health problems, substance use disorders, and who have experienced interpersonal violence. The average weighted effect size is significant for the treatment condition for improved post-traumatic symptoms ($p<0.02$), drug use problem severity ($p<0.02$), and nearly significant for mental health symptoms ($p<0.06$). There is significant heterogeneity in effect sizes across sites. Programme-level variables were examined in an effort to explain this heterogeneity. The findings indicate that sites which provided significantly more integrated counselling produced more favourable results in mental health symptoms ($p<0.01$) and both alcohol ($p<0.001$) and drug use problem severity ($p<0.001$). The same trend is observable for reductions in post-traumatic stress symptoms, although the difference does not attain statistical significance.	[-] internal quality rating

Cogan, R., & Porcerelli, J.H. (2012). Psychoanalytic psychotherapy with people in abusive relationships: Treatment outcome. *Journal of Aggression, Maltreatment and Trauma, 7(1-2)*, 29-46.	Psychoanalytic perspectives on violence between partners is described and forms a foundation for an approach to group and individual psychotherapy of men and women in relationships in which there is physical violence between partners. The empirical results of a study of the outcome of psychoanalytically oriented psychotherapy are described. Nineteen men and 16 women completed research measures before beginning psychotherapy and after completing 16 sessions of group psychotherapy. Twelve people who completed group psychotherapy continued in individual psychotherapy and completed measures again after 16 sessions of individual psychotherapy, and nine people completed measures again after the 16 sessions of group and 32 sessions of individual psychotherapy. Statistical analyses addressed outcomes in terms of verbal and physical aggression and dysphoric affects and anger. Both research and clinical outcomes are discussed.	[-] internal quality rating
Curry, M.A., Durham, L., Bullock, L., Bloom, T., & Davis, J. (2006). Nurse Case Management for Pregnant Women Experiencing or at Risk for Abuse. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 35(2),* 181-192.	Objective: To determine whether individualized nursing case management can decrease stress among pregnant women at risk for or in abusive relationships. Design: A multisite randomized controlled trial. Setting: Two prenatal clinics in the Pacific Northwest and rural Midwest. Participants: 1,000 women who spoke English and were 13 to 23 weeks pregnant at time of recruitment. Intervention: All intervention group women (N=499) were offered an abuse video and had access to a nurse case manager 24/7. Additionally, participants at risk for or in abusive relationships received individualized nursing care management throughout the pregnancy. Results: The most frequent nursing care management activities were providing support (38%) and assessing needs (32%). The nursing care management group received an average of 22 contacts, most (80%) by telephone and had a significant reduction in stress scores as measured by the Prenatal Psychosocial Profi le. Compared to the control group, the differences were in the predicted direction, but not statistically different. A major finding was the choice by abused women to focus on basic needs and their pregnancies rather than the abuse, although all received safety planning. Conclusions: Pregnant women at risk for or in abusive relationships experience very stressful and complex lives. Nurses need to focus on the needs they identify, which may not be the abusive relationship.	[-] internal quality rating
Finn, J., & Atkinson, T. (2009). Promoting the Safe and Strategic Use of Technology for Victims of Intimate Partner Violence: Evaluation of the Technology Safety Project. *Journal of Family Violence, 1(24),* 1402-1414.	The Technology Safety Project of the Washington State Coalition Against Domestic Violence was designed to increase awareness and knowledge of technology safety issues for domestic violence victims, survivors, and advocacy staff. The project used a “train the trainer” model and provided computer and Internet resources to domestic violence service providers in order to (1) increase safe computer and Internet access for domestic violence survivors in Washington; (2) reduce the risk posed by abusers by educating survivors about technology safety and privacy; and (3) increase the ability of survivors to help themselves and their children through information technology. Evaluation of the project suggests that the programme is needed, useful, and effective. Consumer satisfaction was high and there was perceived improvement in computer confidence and knowledge of computer safety. Areas for future programme development and further research are discussed.	[-] internal quality rating
Gennetian, L.A. (2003). Welfare Policies and Domestic Abuse among Single Mothers: Experimental Evidence from Minnesota. *Violence Against Women, 9(10),*1171-1190	This paper examines the effects on domestic abuse of a pilot welfare programme that took place in urban and rural counties of Minnesota from 1994 to 1998. Like many other random assignment evaluations of welfare programs, this pilot programme was not designed to explicitly test the effects of special provisions for victims of domestic abuse. Yet, in urban counties, the Minnesota programme increased employment and reduced domestic abuse among single mother welfare recipients. Similar effects were not found in rural counties. Urban/rural differences were not a result of racial/ethnic composition but likely related to differences in prior marital experiences.	[-] internal quality rating

Gutman, S.A., Diamon, H., Holness-Parchment, S.E., Brandofino, D.N., Pacheco, D.G., Jolly-Edouard, M., & Jean-Charles, S. (2004). Enhancing Independence in Women Experiencing Domestic Violence and Possible Brain Injury: An Assessment of an Occupational Therapy Intervention. *Occupational Therapy in Mental Health, 20(1),* 49-79.	Women experiencing domestic violence and/or homelessness may have undiagnosed brain damage as a result of abuse over time. Traditionally, women experiencing domestic violence have been diagnosed and treated within a psychiatric paradigm in which the women's personality deficits were thought to contribute to repeated patterns of abuse. This paradigm is increasingly challenged as researchers find that brain damage frequently occurs in women experiencing domestic violence. Such cognitive impairment may prevent women from using higher executive skills to leave the abusive environment, obtain employment needed for economic independence, and live independently in the community. The present study is an assessment of an intervention designed to address the cognitive deficits that may contribute to a woman's inability to leave the abusive environment. The intervention addressed (a) safety planning, (b) drug and alcohol awareness, (c) safe sex practices, (d) assertiveness and advocacy skill training, (e) anger management, (f) stress management, (g) boundary establishment and limit setting, (h) vocational and educational skill training, (i) money management, (j) housing application, (k) leisure exploration, and (l) hygiene, medication routine, and nutrition. Goal attainment scaling (GAS) was used to evaluate participant outcomes. The participants' raw GAS scores were converted to standardized T scores to indicate whether the participants achieved their expected outcome or greater. Eighty-one percent of the participants attained T scores above 50, indicating that they achieved their most favourable outcome. Nineteen percent of the participants attained T scores of 50, indicating that they achieved their expected outcome. None of the participants attained T scores less than 50, indicating that all participants achieved their expected outcome or greater.	[-] internal quality rating
Hughes, M.J.,& Rasmussen, L.A. (2010). The Utility of Motivational Interviewing in Domestic Violence Shelters: A Qualitative Exploration. *Journal of Aggression, Maltreatment & Trauma, 19(3),* 300-322.	This pilot study examined the use of motivational interviewing (MI) with 20 women receiving services at a domestic violence shelter, using qualitative and quantitative research methods. The experimental group (n=10) received regular treatment services from shelter counsellors trained in MI, whereas the control group (n=10) received regular treatment services only. The quantitative findings related to readiness for change were published separately (Rasmussen, Hughes, & Murray, 2008). The qualitative findings suggest MI is an effective intervention for enhancing the impact of regular treatment services in survivors of intimate partner violence and increasing their self-efficacy about ending violence and avoiding violent relationships.	[-] internal quality rating
McNamara, J.R., Tamanini, T., & Pelletier-Walker, S. (2008). The Impact of Short-Term Counselling at a Domestic Violence Shelter. *Research on Social Work Practice, 18(2),*132-136.	Objective: Women who received counselling at a domestic violence shelter were evaluated with several measures to determine the impact of the services they received. Method: A pretest and posttest design using clinical measures for life functioning and coping ability along with posttest-only measures of satisfaction and helpfulness of service were used to assess the outcomes of their counselling and other social work services at the agency. Results: Significant improvement on clinical measures of life functioning as well as coping ability along with a sense of being helped and satisfied with the social work services received are noted. Conclusions: Counselling along with a supportive agency milieu prove beneficial to women seeking services for partner abuse. Limitations of this study are also noted.	[-] internal quality rating
Teague, A.K., Hahna, N.D., & McKinney, C.H. (2006). Group Music Therapy with Women Who Have Experienced Intimate Partner Violence. *Music Therapy Perspectives, 24(2),* 80-86.	The purpose of this study was to investigate the effect of group music therapy combined with other creative arts methods on the self-reported levels of anxiety, depression, and self-esteem in women who have experienced intimate partner violence. Assessments of dependent variables were made at entry, following the final session of the intervention, and 3 weeks later. Using a repeated measures design and post hoc analyses, participants (n=7) reported a significant decrease in depression and a marginally significant decrease in anxiety. No significant effect was found for self-esteem. Most participants reported all interventions to be helpful and the series of sessions a positive experience. The findings suggest that active music therapy within a group context may be an effective intervention for ameliorating mood in women recovering from intimate partner violence.	[-] internal quality rating
Van Hightower, N., & Dorsey, A. (2001). Reaching the Hard-to-Reach: Innovative Responses to Domestic Violence. *Texas Journal of Rural Public Health, 29(2),* 30-41.	No abstract	[-] internal quality rating

Women's Resource Centre. (2011). *Ashiana Network: Journey Towards Safety.* London, UK: Women's Resource Centre.	No abstract	[-] internal quality rating

Table 23. Research Question 3 (Perpetrator Interventions) Studies Excluded for Negative Internal Quality Rating

Study Details	Abstract	Reason for Exclusion
Donovan, R.J., Gibbons, L., Francas, M., & Zappelli, R. (2006). Impact on callers to a men's domestic violence helpline. *Australian and New Zealand Journal of Public Health, 30(4),* 384-385.	No abstract	[-] internal quality rating
Gondolf, E. (2008) Programme completion in specialized batterer counselling for African-American Men. *Journal of Interpersonal Violence, 23*, 94-116.	Despite the many recommendations for specialized counselling for African- American men arrested for domestic violence, research has yet to document its effectiveness in improving programme completion. This experimental clinical trial compared the programme completion rates of culturally-focused counselling in all-African-American groups, conventional counselling in all-African-American groups, and conventional counselling in racially-mixed groups. The completion rate for the 16-week programme was approximately 55% across the three counselling options. Completion rates were slightly lower in the specialized counselling groups following stricter enforcement of dismissal policies. For men with high racial identification, the completion rate rose to between 63% and 65% in the culturally focused and conventional all-African-American groups versus only 40% in the racially-mixed groups. Programs might offer the option of culturally-focused counselling to African-American men to efficiently improve programme completion. The influence of the programme's strong link to the criminal justice system and weaker link to the community warrants further consideration.	[-] internal quality rating
Hendricks, B., Wener, T., Shipway, L., & Turinetti, G. (2006). Recidivism among spousal abusers: predictions and programme evaluation. *Journal of Interpersonal Violence, 21(6),* 703-716.	The relative effectiveness of two interventions for dealing with 200 court referred spousal abusers is examined. The overall failure rate is 17.5%, with most recidivism occurring during the first 6 months after treatment. Offenders who completed a 14-week group treatment programme called SAFE manifest significantly lower rates of recidivism (10.6%) than do offenders who did not complete the mandated treatment (38.8%). Some high-risk clients are referred to a cognitive restructuring treatment programme called R&R, and those completing both programs (despite their high-risk status) have a recidivism rate of only 23.5%. Prediction of recidivism is difficult, with the LSI-R scores correctly predicting only 66% of the outcomes, using a cut score of 11.5. The exploration of other predictors is encouraged.	[-] internal quality rating
Stanley, N., Borthwick, R., Graham-Kevan, N., & Chamberlain, R. (2011). *Strength to change: Find the strength to stop domestic violence.* NHS.	No abstract	[-] internal quality rating

Table 24. Research Question 3 (Elder Interventions) Studies Excluded for Negative Internal Quality Rating

Study Details	Abstract	Reason for Exclusion

Cripps, D. (2001). Rights focused advocacy and elder abuse. *Australasian Journal on Ageing, 20(1),* 17-22.	Objective: To study the effectiveness of the Rights Focused Advocacy Model in supporting older people to overcome situations of elder abuse. Method: 100 case records were retrospectively analysed, which represented approximately 20% of total clients over an eighteen-month period, from November 1997 to June 1999. Data recorded included: type of abuse, risk factors (for older person and abuser) and outcome (i.e. whether or not abuse had ended). Results: 100 older people experienced 267 situations of abuse. The Rights Focused Advocacy Model enabled older people to take steps to stop abuse in SO% of those situations, and to take some action in 34% of situations. No change was recorded in 16% of cases. Conclusion: Rights Focused Advocacy is a holistic model that is effective in supporting older people to take steps to overcome the abuse that they experience.	[-] internal quality rating

Table 25. Research Question 3 (Interventions for Couples) Studies Excluded for Negative Internal Quality Rating

Study Details	Abstract	Reason for Exclusion
Coy, M., Thiara, R., Kelly, L., Phillips, R. (2011). *Into the foreground, an evaluation of the Jacana Parenting Programme.* London, UK: Child and Woman Abuse Studies Unit, London Metropolitan University.	No abstract	[-] internal quality rating
Dumaret, A-C., Constantin-Kuntz, M., Titran, M. (2009). Early Intervention in Poor Families Confronted With Alcohol Abuse and Violence: Impact on Families' Social Integration and *Parenting. Families in Society, 90(1),* 11-17.	To help families challenged by transgenerational problems, substance abuse, and violence, support strategies require professionals who understand their specific needs and inspire trust. Such support, provided by a group consisting of professionals, volunteers, and families, was assessed by a follow-up study. The outcome of 22 families was observed an average of 7 years after their participation in the group ended. Results show that most parents recovered a significant degree of social autonomy and developed the capacity to nurture their children. Alcohol abuse, violence, and child neglect decreased significantly. Such an intensive approach enhances individual and professional practices and prevents adverse childhood experiences, thus reducing welfare costs. But such support systems require accessible structures in order to avoid discontinuities in care.	[-] internal quality rating
Lloyd, C., Wollny, I., White, C. Gowland, S., Purdon, S. (2011). *Monitoring and evaluation of family intervention services and projects between February 2007 and March 2011.* London, UK: Department for Education.	No abstract	[-] internal quality rating
Ortega, S., Beachemin, A., Kaniskan, R. (2008). Building Resiliency in Families with Young Children Exposed to Violence: The Safe Start Initiative Pilot Study. *Best Practice in Mental Health, 4(1),* 48-64.	This study investigated the relationship between risk and protective factors among families with young children who have been exposed to violence and Safe Start treatment outcomes as measured by the Parenting Stress Index–Short Form. Three groups of clients receiving different interventions were studied over the course of two years to investigate changes in parental stress and parent-child interaction. The results suggest that the groups differed in number of needs and protective factors and that these differences were strong predictors of variation in Parenting Stress Index–Short Form scores. Based on this finding, we conclude that families with higher levels of stress require immediate attention and support in linking with services that promote resiliency by reducing parental stress.	[-] internal quality rating

Steen-Greaves M., Downe, S., Graham-Kevan, N. (2009). Men and women's perceptions and experiences of attending an abusive behaviour management programme. *Evidence Based Midwifery, 7(4),* 128-135.	Background: Domestic violence is a global and pernicious problem affecting all spheres of society. It has traditionally been seen as a social problem, but is now recognised to be a public health issue and reducing the incidence is a Priority Action 1 within Public Service Agreement 23. Sadly, domestic violence sometimes commences or escalates during pregnancy and during the transition to parenthood. It has been identified as a significant contributor to maternal and fetal morbidity and mortality, through both direct and indirect means. This paper describes the first phase of a study exploring the views of men and women, who had attended Start Treating Others Positively (STOP) a charity based in Leeds, UK. The adapted Appreciative Inquiry model of behavioural change underpins the work of STOP. Aim of the study: To explore the perceptions and experiences of participants attending STOP, to gain an insight of the effect this has had upon their ability to change their abusive behaviour to non-abusive and manage relationship conflict. Method: An exploratory study involving 20 participants (15 men and 5 women) who are parents and attending Start Treating Others Positively (STOP voluntarily. Ethics approval was granted by the university's health ethics committee and guidance cited in the NHS Research Governance Framework was addressed throughout the study. Semi-structured interviews were undertaken during December 2007 and January 2008. An interview schedule of open and closed questions was used to gain an insight into respondents' perceptions and experiences. Data were analysed by using a thematic analysis which entailed the identification of 6 primary emerging themes, 3 secondary core themes, then a final core theme, and the development of a synthesis statement. Findings: This first phase of this study explored the perceptions and experiences of 20 participants who attend STOP on how they have learnt to manage their behaviour to prevent themselves being abusive in their family relationships, and the impact this has had on their lives. Participants agreed that there were no excuses for domestic violence. Initially, six sub-themes emerged from the data: emotional regulation, emotional understanding, developing empathy skills, changed behaviour, developing conflict resolving skills, coping strategies. These were integrated into three overarching themes: emotional stability, cognitive empathy, conflict competency. Following synthesis, these were summarised into one phrase: 'positive life skills'. The interviews demonstrated the participants had developed positive life skills whilst attending STOP to enable them to manage their emotions, behaviour and family relationship conflict. There was also evidence that these positive life skills were being taught to the participant's own children Conclusions: Domestic violence has enormous implications for the health sector in general and within maternity services. Preventing future cases of domestic violence will reduce both maternal and fetal mortality and morbidity rates. The government has recognised the need to reduce the prevalence of domestic violence as a high priority, yet there is limited research to demonstrate effective preventative measures.	[-] internal quality rating
Stith, S., Rosen, K., McCollum, E, Thomsen, C. (2004). Treating intimate partner violence within intact couple relationships: outcomes of multi-couple versus individual couple therapy. *Journal of Marital and Family Therapy, 30(3),* 305-318.	An experimental design was used to determine outcomes of a domestic violence-focused treatment programme for couples that choose to stay together after mild-to-moderate violence has occurred. Forty-two couples were randomly assigned to either individual couple or multi-couple group treatment. Nine couples served as the comparison group. Male violence recidivism rates 6 months after treatment were significantly lower for the multi-couple group (25%) than for the comparison group (66%). In contrast, men in the individual couple condition were not significantly less likely to recidivate (43%) than those in the comparison group. In addition, marital satisfaction increased significantly, and both marital aggression and acceptance of wife battering decreased significantly among individuals who participated in multi-couple group therapy, but not among those who participated in individual couple therapy or the comparison group.	[-] internal quality rating

Table 26. Research Question 5 (Partnerships) Studies Excluded for Negative Internal Quality Rating

Study Details	Abstract	Reason for Exclusion

Nolan, J. (2011). *An evaluation of the Dyn Project's Advocacy and Support Services: Final evaluation report.* Pontypridd, UK: University of Glamorgan and the Welsh Centre for Crime and Justice.	No abstract	[-] internal quality rating
Perkins, N., Penhale, B., Reid, D., Pinkney, L., Hussein, S., & Manthorpe, J. (2007). Partnership Means Protection? Perceptions of the Effectiveness of Multi-Agency Working and the Regulatory Framework within Adult Protection in England and Wales. *Journal of Adult Protection, 9(1),* 9-23.	This article examines the effectiveness of the multi-agency approach in adult protection and draws on findings from research that examined the effectiveness of both partnership working and perceptions of the regulatory framework to protect vulnerable adults. The research findings were collected through the use of a survey of all local councils with social services responsibilities in England and Wales. Examples of good practice in partnership working were found. However, resource pressures, insufficient information sharing and a lack of clarity about roles and responsibilities were reported to hinder a multi-agency approach.	[-] internal quality rating
Slaght, E. & Hamilton, N. (2005). A Coordinated Response to Intimate Partner Violence: Lessons from an Exploratory Study. *Journal of Community Practice, 13(2),* 45-59.	A qualitative study of two Family Violence Coordinating Councils in Illinois confirmed the importance of collaboration between the law enforcement and treatment communities in responding to the needs of families enmeshed in domestic violence. A key finding of the study is that a joint philosophy of intervention is crucial to effective coordination. As key actors change, training is needed to reemphasize the special needs of batterers and victims, so that emphasis on prosecution does not preclude treatment. The judiciary, the State's Attorney's Office, probation, treatment programs, the medical community, the child welfare agency, and the clergy need to be invested in the coordinating process. Multimodal treatment services are needed, and must be supported by law enforcement. Data documenting the impact of intervention on intimate partner violence should be routinely collected to assess the effectiveness of a coordinated response in reducing recidivism.	[-] internal quality rating
Staggs, S.L., White, M.L., Schewe, P.A., Davis, E.B., & Dill, E.M. (2007). Changing Systems by Changing Individuals: The Incubation Approach to Systems Change. *American Journal of Community Psychology, 39(3-4)*, 365-379.	This article describes and evaluates the implementation of an innovative approach to systems change, the incubation approach, which was developed on a systems change project designed to increase the capacity of multiple systems (e.g., law enforcement, child protection, domestic violence, mental health, early education) to respond to children's exposure to violence. The incubation approach encourages change agents to collaborate with project staff to gently nurture, or "incubate," feasible and warranted change in target systems. Project staff gain concrete commitment from motivated and accessible change agents and collaborate with those agents to implement change actions. This approach works well with committed, executive-level change agents in target systems, with stable systems that have low turnover and well-integrated subsystems, and when seed funds are provided to key organizations.	[-] internal quality rating
Teaster, P. B. & Wangmo, T. (2010). Kentucky's Local Elder Abuse Coordinating Councils: A Model for Other States. *Journal of Elder Abuse & Neglect, 22(1-2),* 191-206.	In 1998 Kentucky's Local Coordinating Councils on Elder Abuse (LCCEAs) were established to intervene in cases of elder abuse in local communities. As of 2008 there were 39 LCCEAs in the state, covering 112 of Kentucky's 120 counties. This study was an attempt to understand a concerted statewide multidisciplinary team (MDT) effort related to elder abuse. Survey questions examined the roles, processes, varieties, and accomplishments of these councils. Nearly half of the councils have been in existence for less than 3 years. Councils provided a range of services from expert consultation to service provided for keeping members up to date about services, programs, and legislation. Roles for the councils included identifying service gaps and systemic problems and advocating for change. Half the councils conducted case reviews, and of those, most examined all types of cases. Lack of funding was a major problem for all councils. Funding came from a patchwork of sources, which suggested that it was inadequate and unreliable. The LCCEAs appear to function largely as community educators. To ensure the long-term viability of the LCCEAs and to better integrate and unify their efforts, LCCEAs need committed staffs, constant funding, clear vision and goals, and uniform and consistent outcome measures.	[-] internal quality rating
Teaster, P. B., Nerenberg, L., & Stansbury, K. L. (2003). A National Look at Elder Abuse	Elder abuse multidisciplinary teams (MDTs) include professionals from diverse disciplines who work together to review cases of elder abuse and address systemic problems. Using an e-mail survey format, the authors	[-] internal quality rating

Multidisciplinary Teams. *Journal of Elder Abuse & Neglect, 15(3-4),* 91-107.	received information from 31 MDT coordinators across the country representing fatality review teams, financial abuse specialist teams, medically oriented teams, and "traditional" teams. The coordinators provided information on the functions their teams perform, the importance of specific functions, cases reviewed, composition of teams, policies and procedures, administration, funding, and challenges to effective functioning. Teams expressed only mild concern for breaches in confidentiality. MDTs stressed the importance of input by professionals from the legal community for successful team functioning.	
Templeton, L., & Galvani, S. (2011). *Think Family Safely: Enhancing the response of alcohol services to domestic abuse and families. External Evaluation Final Report.* London, UK: Alcohol Concern.	No abstract	[-] internal quality rating
Twomey, M. S., Jackson, G., Li, H., Marino, T., Melchior, L. A., Randolph, J. F., Retselli-Deits, T., & Wysong, J. (2010). The Successes and Challenges of Seven Multidisciplinary Teams. *Journal of Elder Abuse & Neglect, 22(3-4),* 291-305.	The teams highlighted in this article represent a diversity of Multidisciplinary Teams (MDTs) but share similar challenges and successes. These shared experiences provide an opportunity to explore the key issues germane to MDTs. A hallmark of the elder abuse prevention community from its earliest days, the MDT has proven itself as a helpful and effective tool, one that will continue to add value to the field into the foreseeable future. These teams show that MDTs play a valuable role in helping communities increase collaboration, promoting efficiency in handling complex cases of elder abuse, educating the public, and ultimately safeguarding vulnerable adults from abuse.	[-] internal quality rating
Whitaker, D. J., Baker, C. K., Pratt, C., Reed, E., Suri, S., Pavlos, C., Nagy, B. J., & Silverman, J. (2007). A Network Model for Providing Culturally Competent Services for Intimate Partner Violence and Sexual Violence. *Violence Against Women, 13(2),* 190-209.	The Massachusetts Department of Public Health implemented the Collaborative for Abuse Prevention in Racial and Ethnic Communities (CARE) project in two Latino communities, in the city of Chelsea and in Berkshire County, Massachusetts. One goal of CARE was to build collaborative networks of service providers to provide culturally competent services. Networks of existing community-based agencies that provide a variety of different services regarding violence against women were established in both locales. This article describes the CARE model, network formation, initial attempts to build collaboration and cultural competence, outreach and education activities, and organizational-level changes resulting from the establishment of the networks. The challenges, successes, and lessons learned in implementing this network model are also discussed.	[-] internal quality rating
Zweig, J. M., & Burt, M.R. (2004). Impacts of Agency Coordination on Nonprofit Domestic Violence and Sexual Assault Programs in Communities with Stop Formula Grant Funding. *Violence & Victims, 19(5),* 613-624.	The goals of the current study are (a) to understand the community and state context in which STOP(Services* Training* Officers* Prosecutors)-funded victim service (VS) programs operate, (b) to assess the degree to which receipt of STOP funding for VS programs and the degree of state-level STOP agency support for collaboration among community agencies have led to improved programme services and community interaction, and (c) to assess the degree to which improved interaction between community agencies leads to improvements for VS programs. The results show that community interaction between VS programs and other community agencies can improve VS programme services as reported by service providers. In addition, the higher the pre-STOP levels of activity around violence against women issues in communities, the more agencies can enhance their service system with STOP funding. Also, STOP funding has facilitated greater levels of change for communities whose pre-STOP attention to violence against women was lower.	[-] internal quality rating

Appendix G. Flow of Literature

Figure 1. Summary of Academic Literature Search

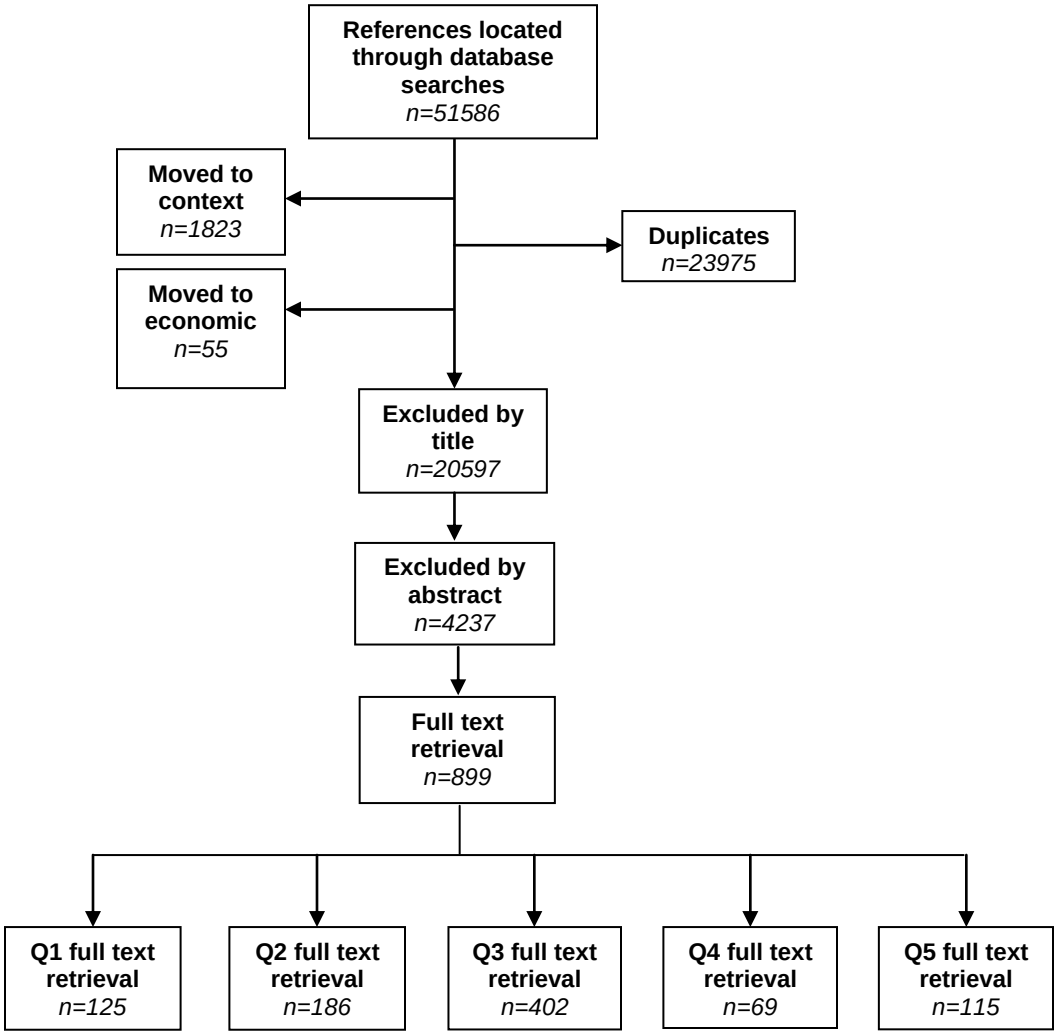


Figure 2. Summary of Grey Literature Search

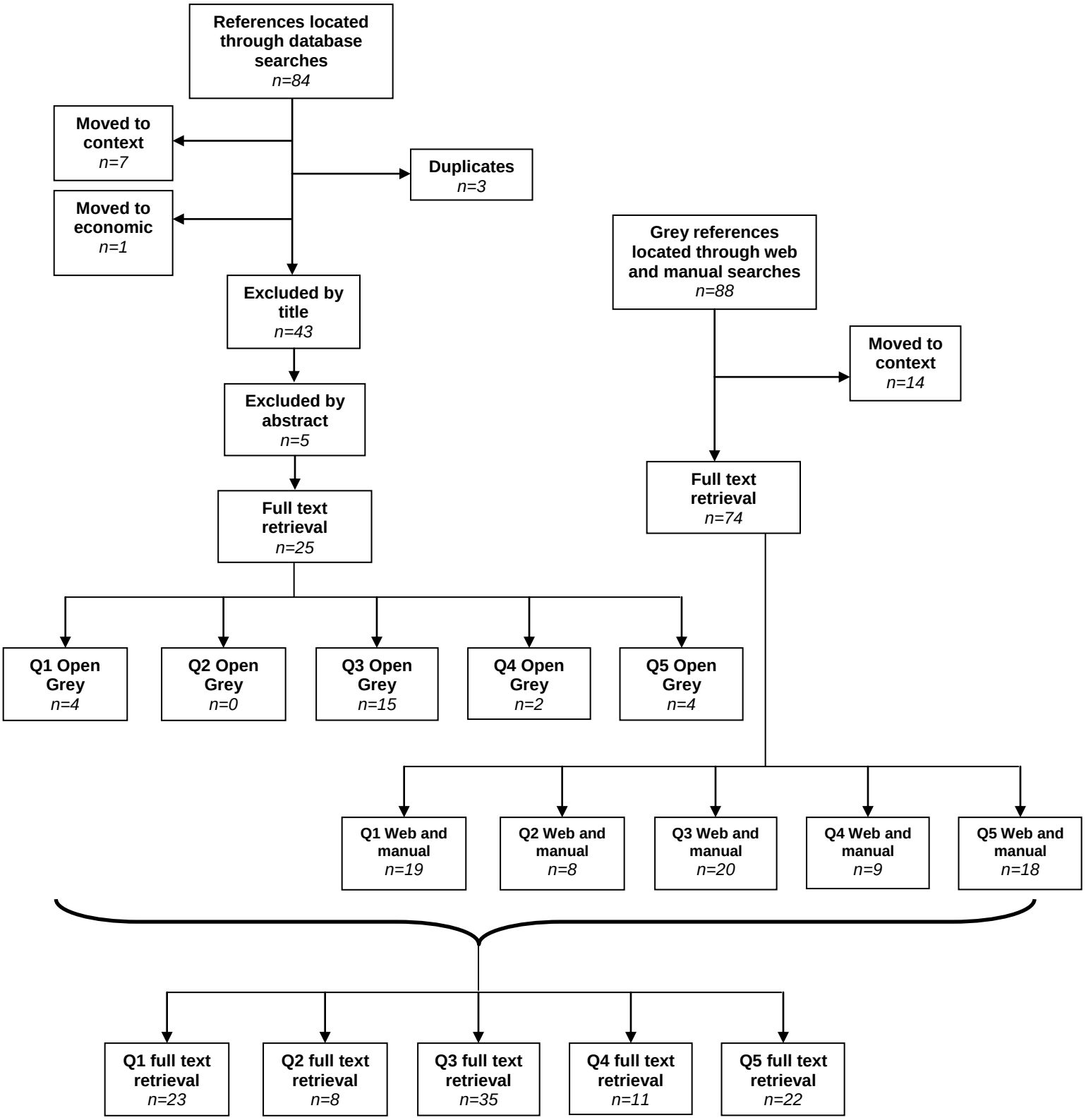


Figure 3. Summary of Research Question 1 (Prevention) Search

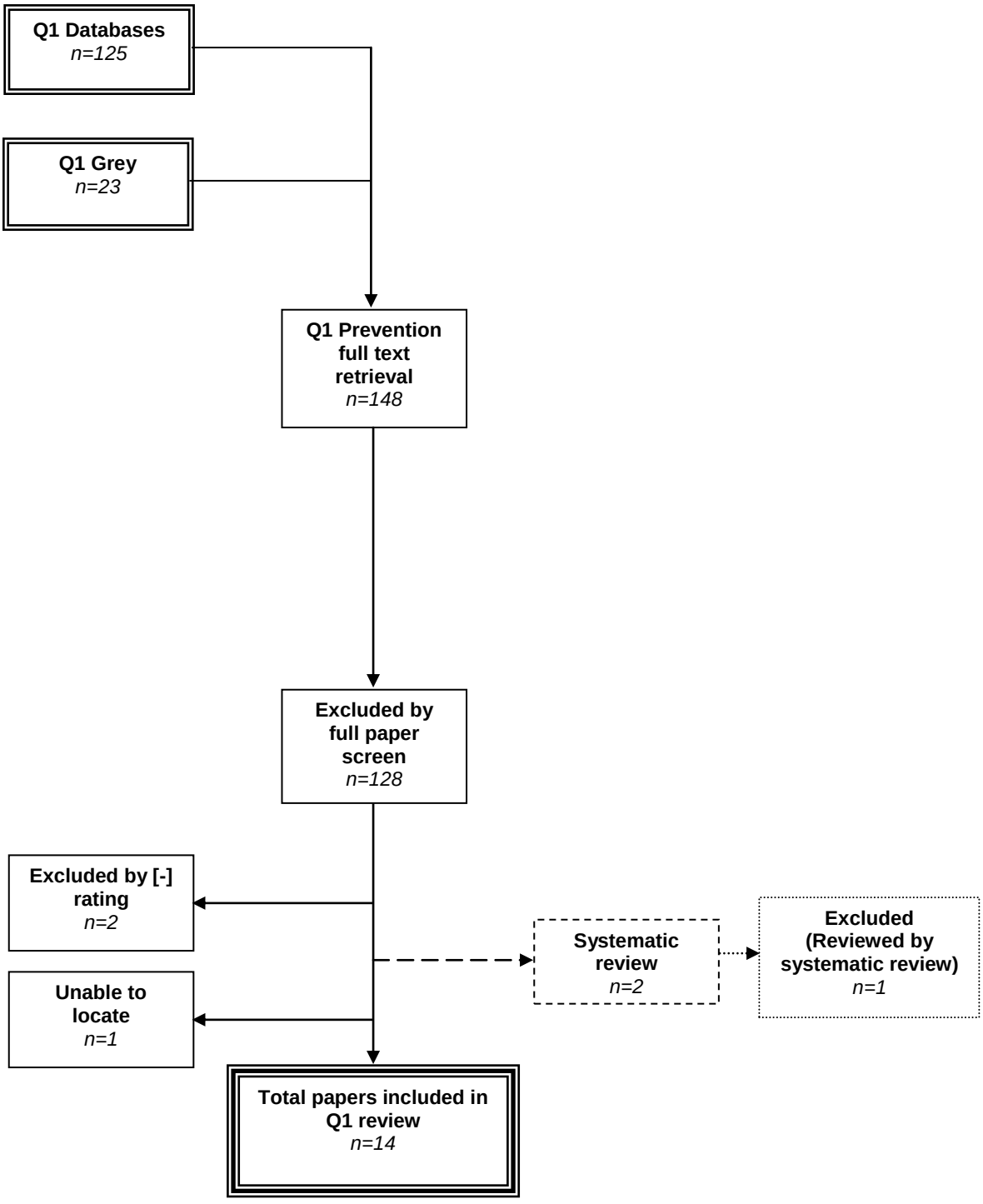


Figure 4. Summary of Research Question 2 (Screening) Search

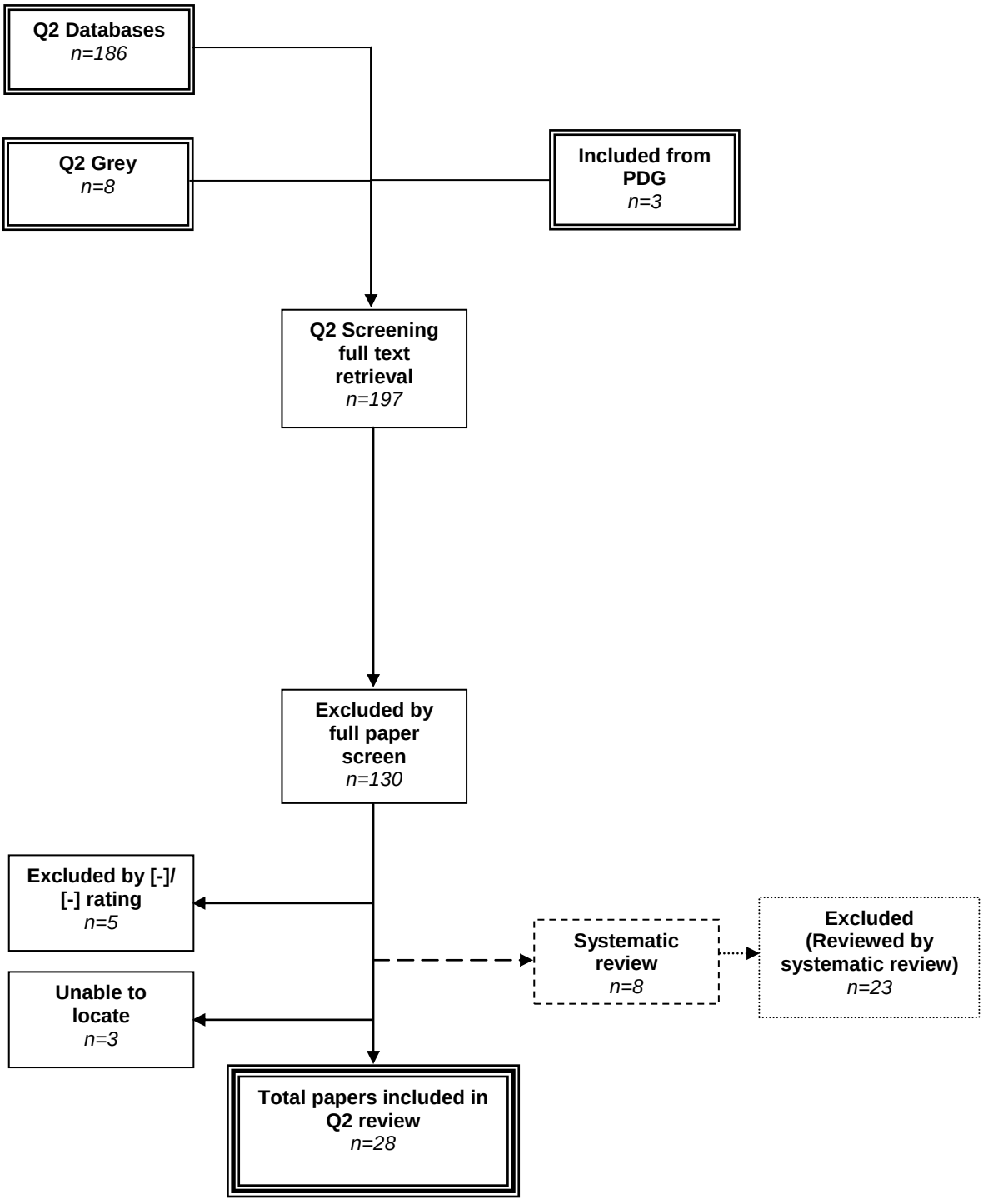


Figure 5. Summary of Research Question 3 (Interventions) Search

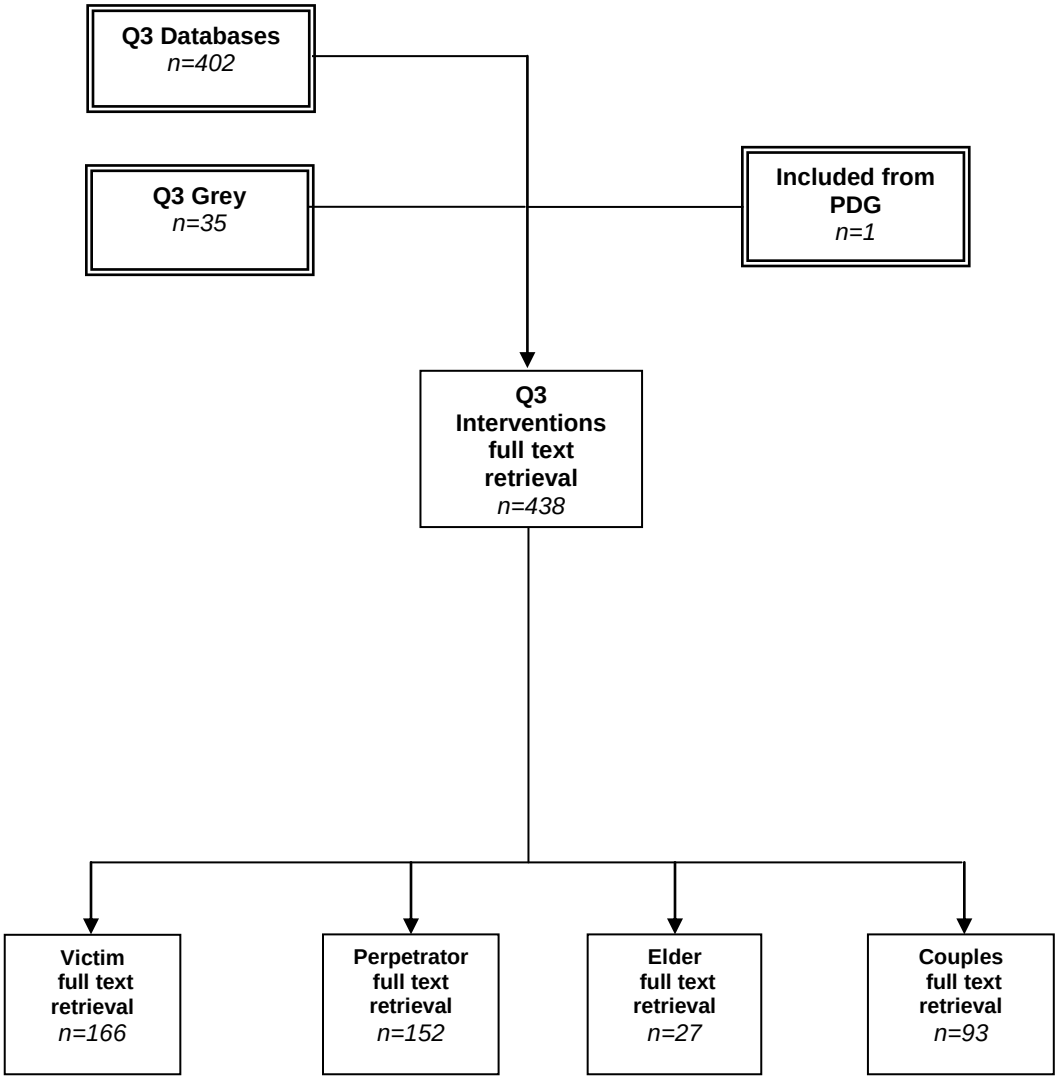


Figure 6. Summary of Research Question 3 (Victim Interventions) Search

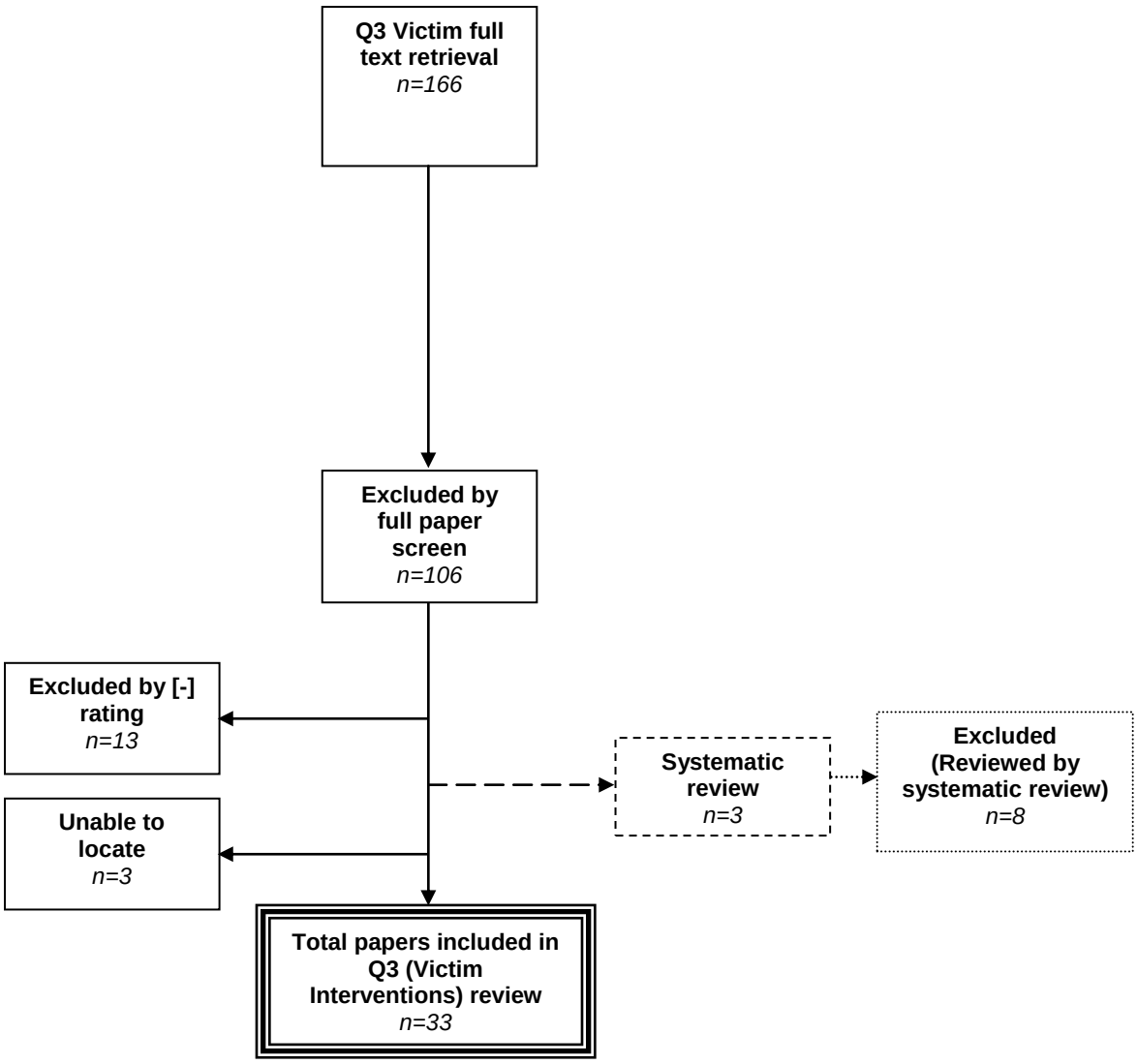


Figure 7. Summary of Research Question 3 (Perpetrator Interventions) Search

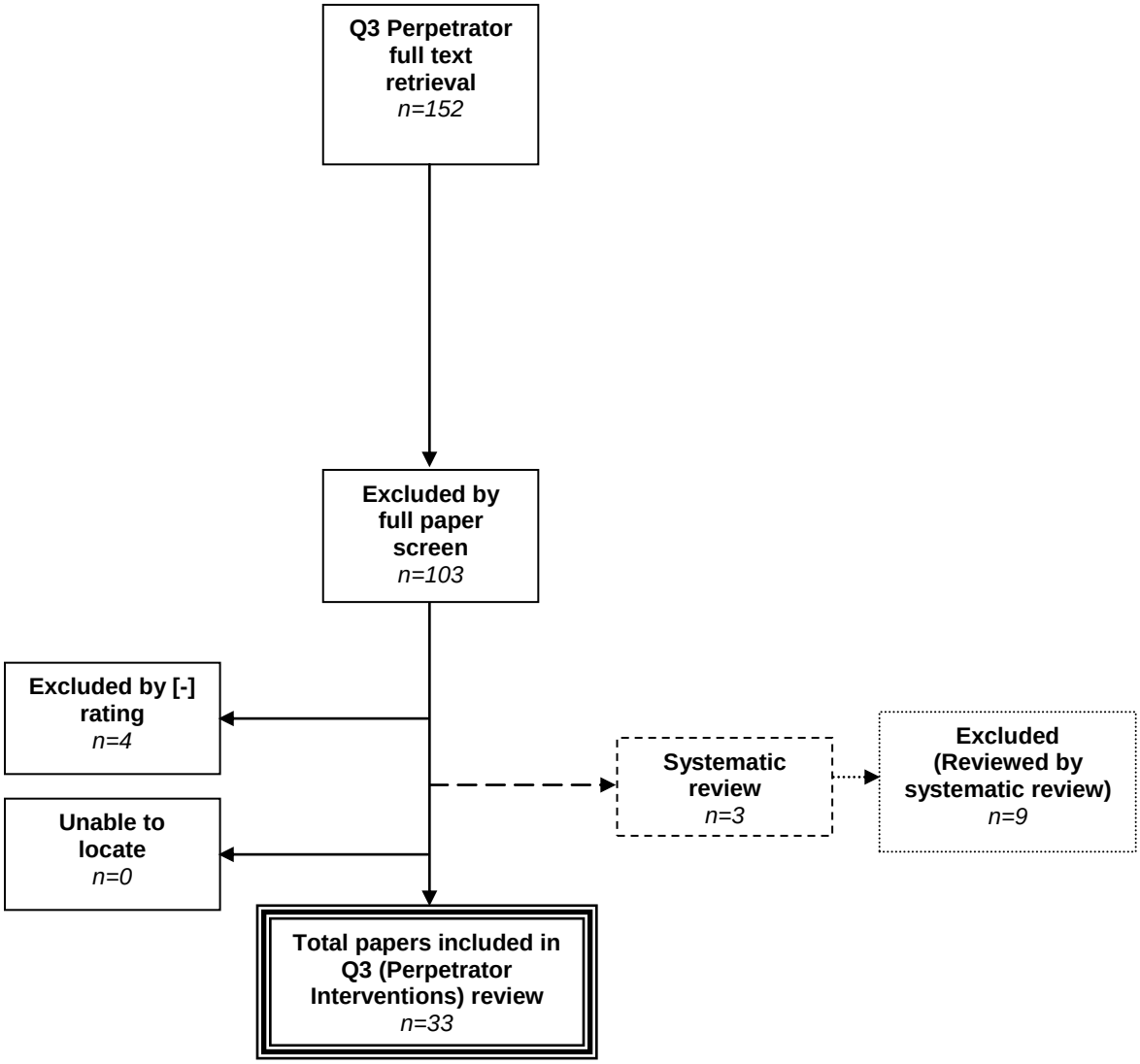


Figure 8. Summary of Research Question 3 (Elder Interventions) Search

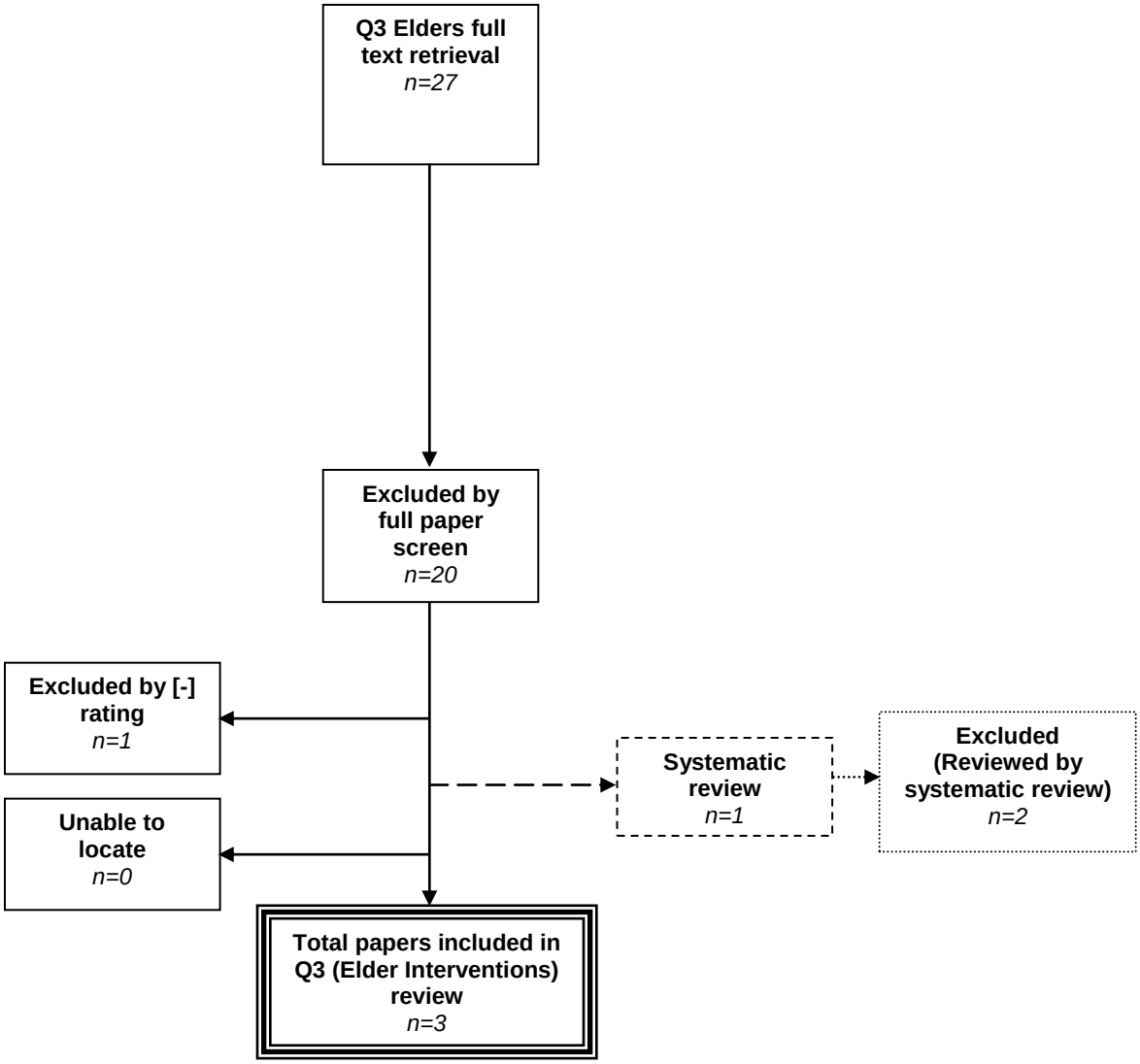


Figure 9. Summary of Research Question 3 (Interventions for Couples) Search

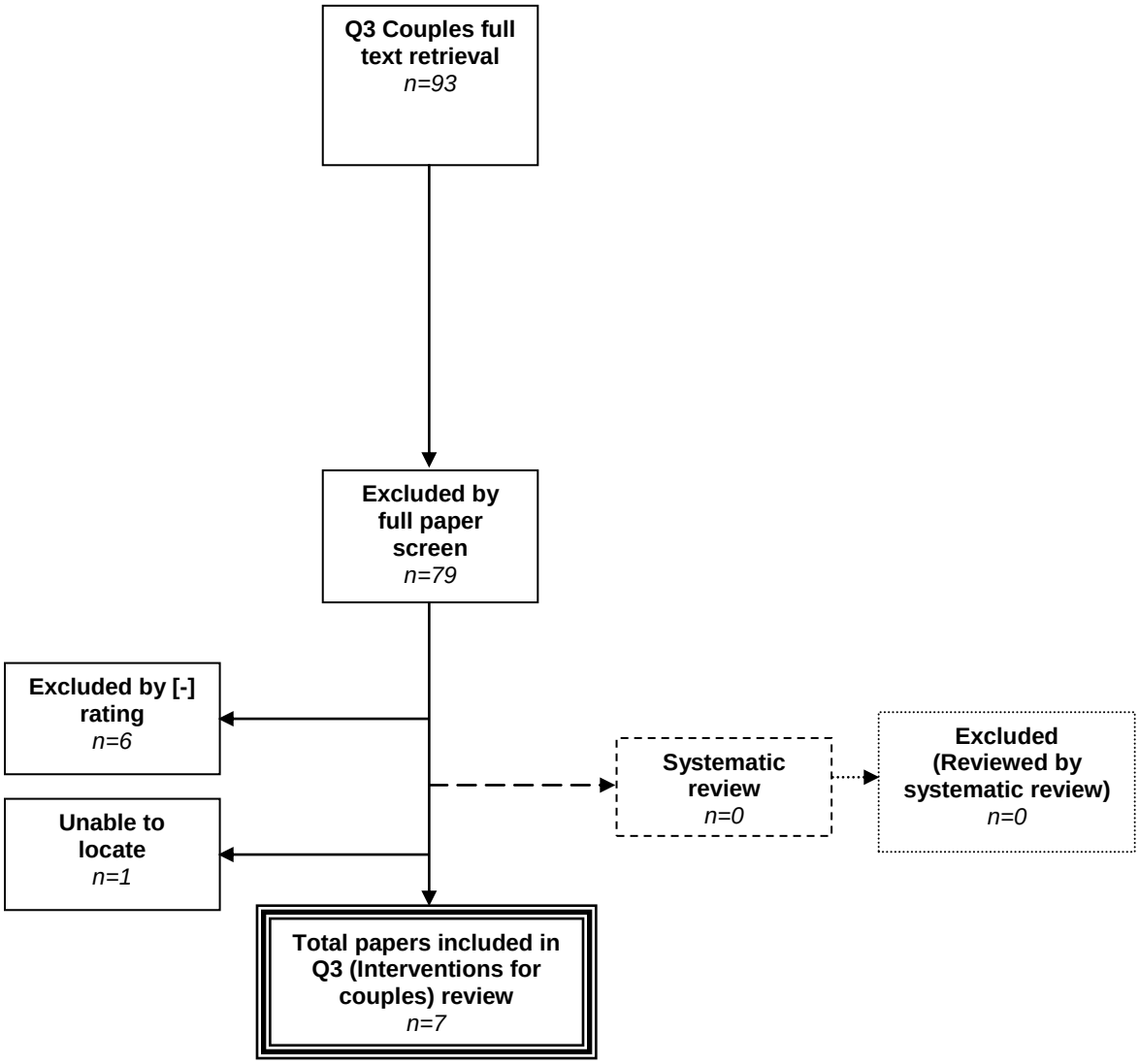


Figure 10. Summary of Research Question 4 (Children Exposed to DV) Search

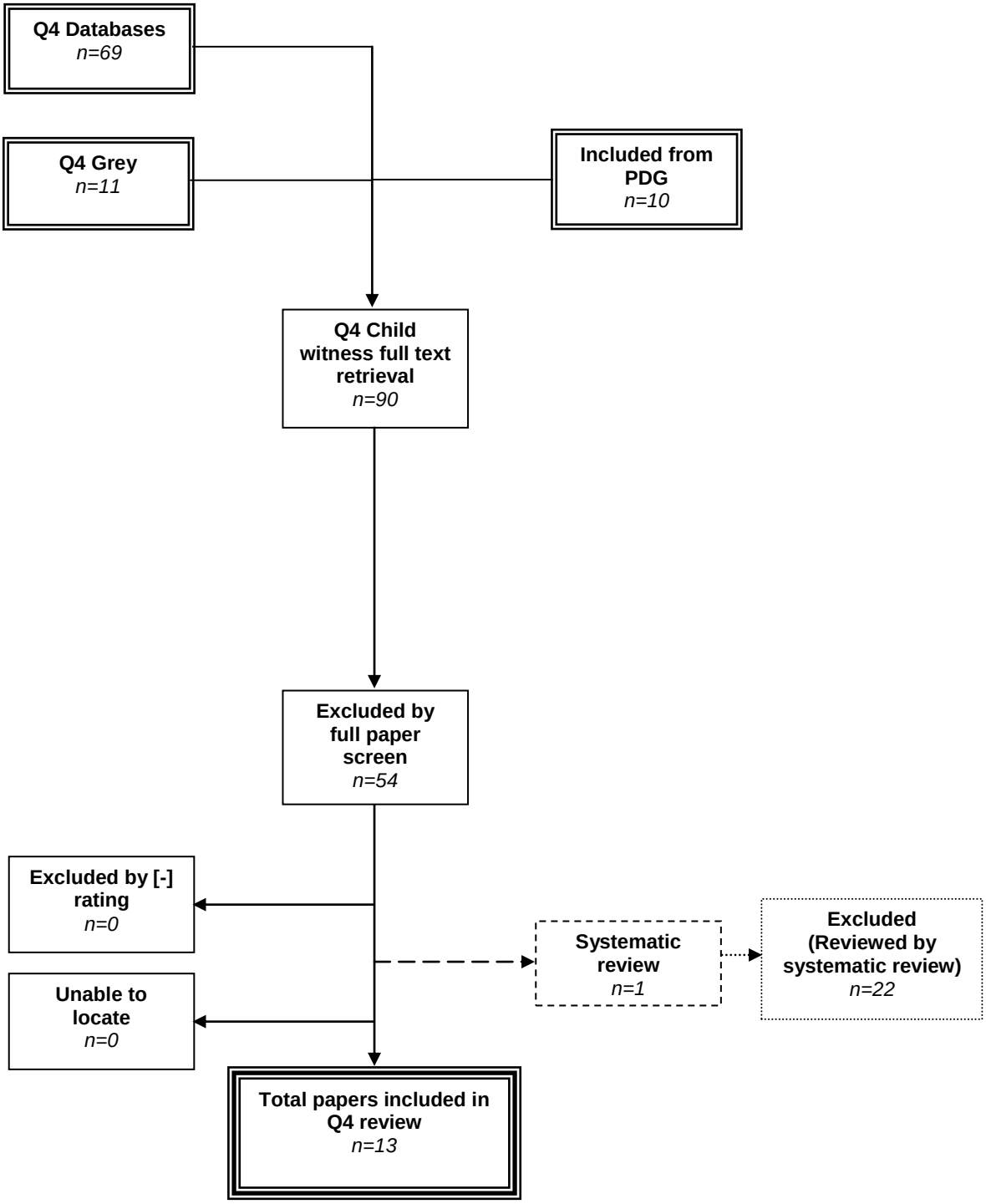
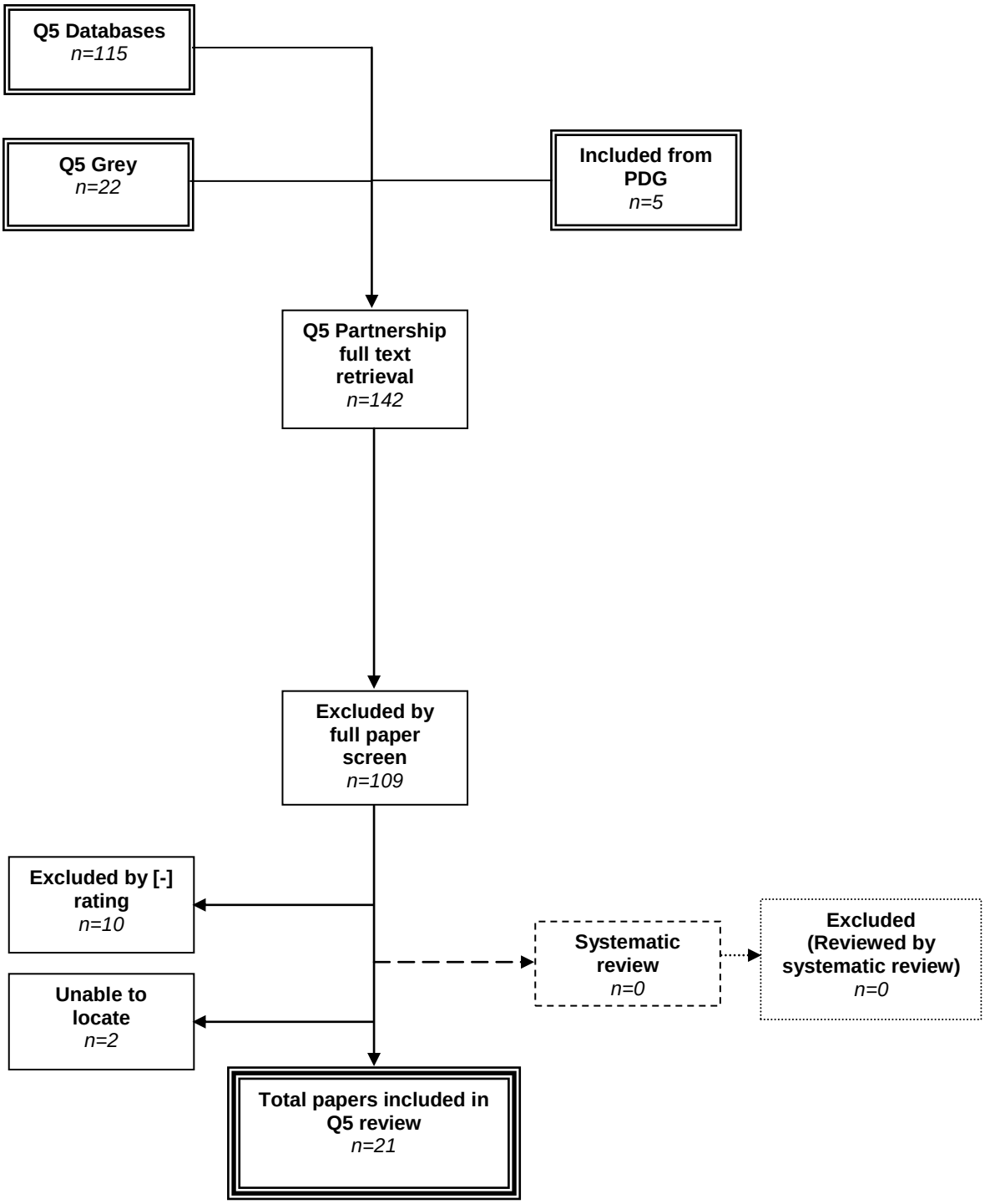


Figure 11. Summary of Research Question 5 (Partnerships) Search



Appendix H. Studies Unretrievable During the Review

Table 27. Research Question 1 (Prevention) Unretrievable Papers

Author	Date	Title	Journal or Publisher	Volume	Number	Page Number	Abstract
.	2007	*The Action Plan on Forced Marriage*	.	.	.	.	Examines the recent strategy developed by the government's Forced Marriage Unit. Covers the main points of the two-year action plan, including: the difference between forced and arranged marriage; the development of outreach programmes the use of existing legislation to its fullest capacity and targeting young people at risk of being forced into; marriage. Sets out some of the indicators that professionals should look out for as warning signs that a forced marriage may be impending. Gives advice on who to contact if a young person is thought to be at risk.

Table 28. Research Question 2 (Screening) Unretrievable Papers

Author	Date	Title	Journal or Publisher	Volume	Number	Page Number	Abstract
.	2004	Leading experts, providers challenge task force recommendation on screening for abuse: as reported by the Family Violence Prevention Fund	*Missouri Nurse*	2	.	11	.
Boursnell, M. & Prosser, S.	2009	Putting children in the picture: improving responses to domestic violence in the emergency department	*Developing Practice*	23	.	56-63	This paper documents a project that improved identification and responses to domestic violence in an Emergency Department within an Area Health Service. This paper outlines the key elements of the project as part of the dissemination of the findings and also in order for other health services to be able to replicate the successful improvements in practice. It is clear from this project that the Emergency Department can act as a critical gateway to services for women and children living with domestic violence.
Senseman,	2002	Screening for	*Clinical*	6	4	27-32	.

R. L.		intimate partner violence among gay and lesbian patients in primary care	*Excellence for Nurse Practitioners*				

Table 29. Research Question 3 (Victim Interventions) Unretrievable Papers

Author	Date	Title	Journal or Publisher	Volume	Number	Page Number	Abstract
Davis, R. E., & Powell, L. R.	2002	Meeting the Health Care Needs of Abused Women in Shelters	*Clinical Excellence for Nurse Practitioners*	6	3	3-9	.
Price, C.	2010	*Modernising Housing Services for Those Experiencing Domestic Abuse: Project Initiation Document*	Newport, South Wales: Newport City Council.	.	.	.	Seeks to formulate actions to drive the objectives in the 10 Year Homelessness Plan and draft Supporting People Strategy, focusing on the provision of appropriate and accessible support and accommodation services for those experiencing domestic and sexual abuse. Identifies the main tasks for each of four phases relating to service planning and selection of pilot areas, implementation, on-going monitoring, and evaluation. Illustrates some of the risks that inherently exist within the project.
Scarlett, C.	2002	*Challenging Domestic Violence: Assessing the Women and Domestic Violence Programme*	.	.	.	.	Considers the Workers Educational Association (WEA) and Women's Aid new national Women and Domestic Violence programme. Describes the programme as being focused on women; survivors of domestic violence. Looks at the mix of people attending the programme, the issue of attracting people currently in an abusive relationship, and the importance of; focusing on their learning needs. Discusses the challenges facing local steering groups, the role of the WEA worker, and the centrality of tutor expertise. Highlights the; use of Women's Aid workers trained as tutors and counsellors, a structured approach to tutor support, and adapting teaching materials for specific cultural groups. Points to; successful course outcomes.

Table 30. Research Question 3 (Interventions for Couples) Unretrievable Papers

Author	Date	Title	Journal or Publisher	Volume	Number	Page Number	Abstract
Stephenson, J.	2010	*Fractured families (Family Intervention*	.	.	.	.	Assesses the long-term work of Family Intervention Projects (FIPs), which offer intensive support to, and co-

		Projects)					ordinate specialist help for, challenging families. Explores the positive results which have resulted from FIPs and provides examples of families who have been assisted. Sets out the FIPs' aims and objectives, their organisation and the various ways in which they assist families. Highlights the lack of funding available to FIPs and the programme's uncertain future.

Table 31. Research Question 5 (Partnership) Unretrievable Papers

Author	Date	Title	Journal or Publisher	Volume	Number	Page Number	Abstract
Blyth, L.	2002	Partnership Work on Domestic Violence: Possibilities and Practicalities	*MIDIRS Midwifery Digest*	.	.	.	Multi-agency work across boundaries of voluntary and statutory organisations.
Stella Project	2003	*The Stella Project Separate Issues Shared Solutions: Exploring Positive Ways of Working with Domestic Violence and Substance Misuse*	London, UK: Greater London Domestic Violence Project		.	.	.

Appendix I. Studies Included In the Review

Table 32. Research Question 1 (Prevention) Included Studies

Study reference	Aim	Method	Population	Country
Antle et al. (2011)	To determine the impact of a brief (two-day) healthy relationship programme on relationship knowledge and attitudes toward violence and conflict resolution skills among high-risk youth.	Before and after study	Youth at high risk for relationship violence and who are economically and socially disadvantaged	USA
Edwardsen & Morse (2006)	To determine the educational impact of placing partner violence resource information in an emergency department washroom.	Cross-sectional	All adults at an emergency department, both patients and visitors. Target population of potential victims, abusers, at-risk individuals, and friends and/or family of at-risk individuals	USA
Enriquez et al. (2010)	To examine the feasibility of an HIV and IPV prevention intervention that enhances self-esteem, social support, and readiness for healthful behaviour change for women, and to determine which of 3 programme lengths were best received by participants.	Mixed methods (Before and after/ Participatory action research)	Low-income single African-American mothers	USA
Enriquez et al. (2012)	To pilot test "Familias En Nuestra Escuela", an intervention based on ethnic pride as a protective factor against violence.	Before and after study	Hispanic teenagers	USA
Ernst et al. (2011)	To compare two brief computer-based education interventions about perpetration of IPV.	Randomized controlled trial	Emergency room patients	USA
Florsheim et al. (2011)	To pilot test the Young Parenthood Programme, a couples-focused preventive intervention designed to facilitate positive communication skills and relational competence, to support communication and prevent IPV.	Randomized controlled trial	Young couples in pregnancy and early parenthood	USA
Gadomski et al. (2001)	To measure change in societal attitudes and behavioural intention in response to a seven-month public health education campaign targeting DV in a rural county.	Randomized controlled trial	Potential victims and bystanders	USA

Keller et al. (2010)	To look at the different effects of the "Open Your Eyes" campaign on men and women.	Cross-sectional study	Men and women in the general population	USA
Khemka et al. (2005)	To examine the effectiveness of an abuse-prevention curriculum for women with mental retardation.	Non-randomized controlled trial	Women with mild or moderate mental retardation at risk for abuse	USA
Salazar et al. (2006)	To evaluate the efficacy of a five-session IPV prevention programme for adjudicated African American male adolescents.	Randomized controlled trial	African-American adolescent males in the state of Georgia adjudicated to an IPV prevention programme	USA
Scottish Executive (2002)	To evaluate the pilot of the "Respect" educational programme.	Qualitative study	Students at secondary schools and primary schools, and youths in youth groups from Edinburgh and Glasgow	Scotland, UK
Soloman & Fraser (2009)	To evaluate the impact of Wave 12 of an annual domestic abuse campaign.	Cross-sectional study	The general public in Scotland	Scotland, UK
Toews et al. (2011)	To examine the research question, how did conflict resolution strategies in participants' dating relationships change after a skill-based relationship education programme?	Qualitative study	Pregnant and parenting adolescents enrolled in Pregnancy, Education, and Parenting programs in six high schools in central Texas	USA
Wray et al. (2004)	To evaluate the impact of "It's Your Business", a dramatic radio serial promoting DV prevention in the African-American community.	Cross-sectional study	African American men and women	USA

Table 33. Research Question 2 (Screening) Included Studies

Study reference	Aim	Method	Population	Country
Ahmed et al. (2009)	To test the effectiveness of a computer-assisted screening for increasing IPV and creating discussion opportunities between patient and physician provider.	Randomized controlled trial	Women patients at a multi-physician family practice clinic	Canada
Bonds et al. (2006)	To test the effectiveness of practice-centered intervention (PAAVE) to increase DV screening in primary care.	Before and after study	Women attending primary care	USA
Calderon et al. (2008)	To assess the impact of provider cueing on patient–provider discussions about IPV.	Cluster randomized controlled trial	Pregnant women attending one of five prenatal clinics in urban San Francisco	USA

Colarossi et al. (2010)	To determine whether a new, empirically developed screening tool elicited more disclosures than an older tool.	Before and after study	Pregnant women attending an urban reproductive health centre	USA
Coonrod et al. (2000)	To test an educational intervention regarding DV.	Randomized controlled trial	Medical residents	USA
Duncan et al. (2006)	To determine if individualized performance feedback provided to obstetrics and gynaecology (OB/GYN) residents would increase screening for DV.	Before and after study	OB/GYN residents at a hospital-based, ambulatory, prenatal clinic	USA
Feder et al. (2011)	To test the effectiveness of a training programme for primary health-care practices for DV identification and referral.	Cluster randomized controlled trial	Clinicians at urban primary care practices	England, UK
Garcia & Parsons (2002)	To determine the effectiveness of an educational and policy initiative to increase screening rates for IPV among pregnant women.	Before and after study	Doctors, nurses and social workers at an inpatient obstetrics clinic	USA
Grafton et al. (2006)	To investigate the relationship between the introduction and implementation of the Routine Universal Comprehensive Screening Protocol and the frequency of abuse screening among postpartum women involved with the Healthy Babies, Healthy Children (HBHC) Programme to determine the effect of professional development strategies and training on documented abuse inquiry.	Before and after study	Low and high risk post-partum women in Ontario	Canada
Halpern et al. (2009)	To compare two protocols to identify women who self-report IPV-related maxillofacial injuries.	Cross-sectional study	Adult women ED patients	USA
Hamberger et al. (2010)	To investigate the effect of adding a chart prompt to a three hour DV training programme on rates of documented screening for IPV in a family practice clinic.	Before and after study	Medical residents at a Midwest family practice clinic	USA

Hamby et al. (2006)	To determine if the standard Revised Conflict Tactics Scales (CTS2) would lead to greater reporting of violence, whether there were differences between computer-assisted self-interview (CASI) and paper-and-pencil administrations questionnaire, and whether gender interacted with the methodological manipulations.	Randomized controlled trial	Male and female university students	USA
Humphries et al. (2011)	To examine the impact of a computer-based prenatal screening intervention and cueing sheet on patient-provider discussions of IPV.	Randomized controlled trial	Pregnant women attending prenatal clinics	USA
Janssen et al. (2002)	To evaluate the implementation of a DV screening protocol based on Roger's innovation-diffusion model in a postpartum clinical setting.	Before and after study	Post-partum women a clinic	Canada
Kapur & Windish (2011)	To determine the optimal method and screening instrument for IPV among men and women in a primary-care resident clinic.	Before and after study	Medical residents at an urban primary care clinic	USA
Klevens et al. (2012)	To explore the utility of different strategies used to screen women for IPV and refer those reporting exposure.	Randomized controlled trial	Women attending a public hospital in Chicago	USA
Lo Fo Wong et al. (2006)	To investigate whether awareness of intimate partner abuse, as well as active questioning, increase after attending focus group and training, or focus group only.	Randomized controlled trial	Doctors in family practices in Rotterdam	The Netherlands
MacMillan et al. (2009)	To examine the effectiveness of IPV screening and communication of a positive screening result to clinicians in health care settings, compared with no screening, in reducing subsequent violence and improving quality of life.	Randomized controlled trial	Women attending community health clinics and family practices in Ontario	Canada
Moody et al. (2000)	To assess the psychometric properties of the Hwalek-Sengstock Elder Abuse Screening Test (HSEAST), a questionnaire to screen for elder abuse.	Cross-sectional study	Elderly residents (age 60+) in public housing	USA

Power et al. (2011)	To evaluate the impact of a new domestic and family violence screening programme, which was based on an ecological model and introduced by a social work team in the Emergency Department of a major metropolitan hospital.	Before and after study	Doctors, nurses and social workers in an urban ED	Australia
Price et al. (2007)	To examine the impact of routine enquiry on the number of domestic abuse during pregnancy.	Before and after study	Midwives	England, UK
Rhodes et al. (2006)	To determine the effect of computer screening (self administered computer-based health risk assessment by women patients with a prompt for the health care provider) on health care provider–patient DV communication in emergency departments.	Randomized controlled trial	Women attending ED	USA
Ricket et al. (2009)	To determine the effectiveness of three different screening approaches using computer-based screening methodology and to assess relationship violence among adolescent and young adult women; and to gain information on patient and provider satisfaction with these approaches.	Randomized controlled trial	Women aged 15 to 24 attending a Manhattan reproductive health centre	USA
Robinson-Whelen et al. (2010)	To test the impact of the Safer and Stronger Programme (SSP) on abuse awareness, safety self-efficacy, and safety promoting behaviours among women with disabilities.	Randomized controlled trial	Women who self-identified as being disabled	USA
Shye et al. (2004)	To compare the effectiveness of two system-level multifaceted quality improvement approaches to enhancing the secondary prevention of DV.	Non-randomized controlled trial	Patients and clinicians of a large, not-for-profit group practice HMO in the northwestern USA	USA
Trautman et al. (2007)	To compare a computer-based method of screening for intimate partner violence with usual care in an emergency department setting.	Before and after study	Women attending the ED of large inner city hospital	USA
Vanderburg et al. (2010)	To investigate changes in public health nurse practices and the incidence of abuse inquiry and disclosure during home visits as part of The Healthy Babies Health Children (HBHC) programme.	Before and after study	Public Health Nurses that conduct Ontario's HBHC home visits	Canada

Wathen et al. (2008)	To compare the results of the Woman Abuse Screening Tool (WATS) with the Composite Abuse Scale (CAS).	Randomized controlled trial	Women attending one of 26 health care sites in Ontario	Canada

Table 34. Research Question 3 (Victim Interventions) Included Studies

Study reference	Aim	Method	Population	Country
Allen et al. (2004)	To examine whether the degree to which advocacy affected access to resources was dependent on the patterns of needs that women presented.	Randomized controlled trial	Women experiencing IPV	USA
Allen et al. (2011)	To determine the effectiveness of a holistic, integrative and alternative healing treatment group that discouraged repetitive disclosure of history of abuse; and to determine if current IPV interventions can be enhanced to produce transformative healing effects by supporting women in making the necessary changes in social and personal identity transitioning from thriving rather than surviving in spite of the abuse.	Mixed methods (Before and after study/ Grounded theory)	Women experiencing IPV (not currently living with partner)	USA
Bair-Merritt et al. (2010)	To estimate whether home visitation beginning after childbirth was associated with changes in average rates of mothers' IPV victimization and perpetration as well as rates of specific IPV types (physical assault, verbal abuse, sexual assault, and injury),	Randomized controlled trial	New mothers experiencing IPV	USA
Cath Gregory Consulting (2008)	To increase understanding of the impact which calling the National Domestic Violence Helpline can have on an individual's life.	Qualitative study	Women experiencing IPV	England, UK
Coker et al. (2012)	To determine if in-clinic advocate vs. usual care reduced depressive symptoms and stress and IPV and increased safety.	Cluster randomized controlled trial	Women experiencing IPV	USA

Crespo et al. (2010)	To assess the efficacy of a psychological intervention programme for women victims of violence by their intimate partner with clinical symptoms but not fulfilling all the diagnostic criteria for PTSD.	Randomized controlled trial	Women experiencing IPV	Spain
Glass et al. (2011)	To develop (Phase 1) and evaluate (Phase 2) a computerized safety decision aid with victims of IPV for impact on their decisional conflict.	Before and after study	Women experiencing IPV seeking shelter	USA
Grip et al. (2011)	To determine if participation in a psychosocial group intervention was associated with self-reported: reduction of mothers' trauma symptoms; symptoms of general psychopathology; improvement in their sense of coherence; perceived parental locus of control.	Before and after study	Women experiencing IPV	Sweden
Hassija et al. (2011)	To determine if telehealth based cognitive behavioural therapy sessions for abused women will reduce PTSD and depression symptoms.	Before and after study	Rural women experiencing IPV	USA
Hernandez-Ruiz et al. (2005)	To explore the effect of a music therapy procedure (music listening paired with progressive muscle relaxation) on the reduction of anxiety and improvement of sleep patterns in abused women in shelters.	Randomized controlled trial	Women living in violence shelters with sleeping problems	USA
Howarth et al. (2009)	To examine the provision and impact of IDVA (Independent Domestic Violence Advisor) services for female victims of domestic abuse deemed to be at high risk of harm or homicide. To examine the effectiveness of these interventions in increasing victims' safety and well-being, and the factors that increased or decreased the likelihood of achieving these positive outcomes. In addition, the research examined the extent to which these outcomes were sustained over time.	Before and after study	Women accessing IDVA services	England and Wales, UK

Iverson et al. (2009)	To determine if women who completed a group intervention would exhibit significant improvements on measures of depressive symptoms, hopelessness, general psychiatric distress, and social adjustment from pre-treatment to post-treatment.	Before and after study	Women experiencing IPV	USA
Iverson et al.(2011)	To examine the effect of CBT for PTSD and depressive symptoms on the risk of future IPV victimization in a sample of women survivors of IPV.	Randomized controlled trial	Women experiencing IPV	USA
Johnson et al. (2006)	To examine the effectiveness of Helping to Overcome PTSD through Empowerment (HOPE), a cognitive behavioural intervention, to: reduce depression, PTSD, and improve women's ability to access resources.	Cross-sectional study	Women experiencing IPV	USA
Kendall et al. (2009)	To assess the impact of ED IPV counselling and resource referrals on patient-perceived safety and safety planning.	Cross-sectional study	Men and women experiencing IPV reporting to an ED	USA
Kiely et al. (2011)	To estimate the efficacy of a psycho-behavioural intervention in reducing intimate partner violence recurrence during pregnancy and postpartum and in improving birth outcomes in African-American women.	Randomized controlled trial	Minority women who are pregnant experiencing IPV or at risk for IPV	USA
Koopman et al. (2005)	To examine the effects of expressive writing on symptoms of depression, PTSD and pain among women who have experienced IPV	Randomized controlled trial	Women experiencing IPV	USA
Laughon et al. (2011)	To test the feasibility and acceptability of a combined brief nursing intervention (BNI) to prevent STIs, including HIV, and reduce IPV.	Before and after study	Rural women experiencing IPV	USA
McWhirter et al. (2006)	To pilot test a group intervention for women in housing transition who are vulnerable to abuse.	Non-randomized controlled trial	Women experiencing IPV	USA

McWhirter et al. (2011)	To assess the clinical effectiveness to two community-based treatments to reduce family violence and increase psychosocial well-being of women and children previously exposed to IPV through addressing posttraumatic coping strategies.	Randomized controlled trial	Women experiencing IPV, with children	USA
Miller et al. (2009)	To determine whether an intervention administered in clinic settings would reduce effects of IPV and reproductive coercion and convince women to leave abusive relationships.	Randomized controlled trial	Women experiencing IPV and reproductive coercion.	USA
Morales-Campos et al. (2009)	To examine the question, "What were participants' experiences of the La Rosa Family Services, a community-based organization support group for immigrant Hispanic women?"	Qualitative study	Women experiencing IPV	USA
Poole et al. (2008)	To explore the relationships between the use of alcohol and other substances, using-to-cope behaviour, and levels of stress in substance-using women who temporarily resided in a DV shelter.	Before and after study	Women entering transition shelters	Canada
Price et al. (2008)	To report on the outcomes of the first 18 months of the Domestic Violence Intervention Project (DVIP).	Before and after study	Male perpetrators of DV	England, UK
Rasmussen et al. (2008)	To evaluate the effectiveness of motivational interviewing to enhance outcomes of regular treatment services.	Non-randomized controlled trial	Women living in violence shelters	USA
Reed & Enright (2006)	To examine if women treated with Forgiveness Therapy would demonstrate less depression, anxiety, and posttraumatic stress symptoms and more self-esteem, environmental mastery, and finding meaning in suffering than those who engaged in the more standard therapeutic procedure which does not directly target the amelioration of this resentment.	Randomized controlled trial	Women experiencing IPV	USA

Resick et al. (2008)	To examine the components of CPT, singly and compared with the full protocol, to determine when change occurs during the course of treatment and to examine the effects of the three therapy conditions on a range of comorbid symptoms of depression, anger, anxiety, and cognitions.	Randomized controlled trial	Women with past IPV and current PTSD	USA
Rychtarik & McGillicuddy (2005)	To test the effectiveness of two interventions on levels of depression in the spouse or partner of men with problem drinking.	Randomized controlled trial	Women living with partners with untreated problem drinking	USA
Sanders et al. (2007)	To increase access to and knowledge of financial resources and women's self-confidence in managing and coping with financial problems independently.	Randomized controlled trial	Women living in violence shelters	USA
Sullivan et al. (2002)	To demonstrate the effectiveness of a advocacy and child education programme for improving the self-esteem of children and the psychological well-being of mothers in families who have experienced DV.	Randomized controlled trial	Women experiencing IPV, with children	USA
Sullivan et al. (2004)	To determine the effectiveness of a 9 week mother-child dyad cognitive behavioural intervention to reduce mental ill-health and self-blame for mothers and children.	Before and after study	Women experiencing IPV, with children	USA
Taft et al. (2011)	To determine the effectiveness of non-professional mentor support in reducing IPV and depression among pregnant and recent mothers experiencing, or at risk of IPV.	Randomized controlled trial	New mothers or pregnant women experiencing IPV or at risk for IPV	USA
Zlotnik et al. (2011)	To examine the initial feasibility, acceptability, and effects of an intervention in reducing PTSD and depressive symptoms from pregnancy until 3 months postpartum in a sample of low-income, pregnant women with IPV within the last year.	Randomized controlled trial	Pregnant women experiencing IPV or at risk for IPV	USA

Table 35. Research Question 3 (Perpetrator Interventions) Included Studies

Study reference	Aim	Method	Population	Country
Alexander et al. (2010)	To compare the efficacy of a stages-of-change motivational interviewing (SOCMI) group intervention vs. a cognitive behavioural therapy gender reeducation (CBTGR) group intervention on IPV, including whether efficacy varied depending on the batterer's readiness to change.	Randomized controlled trial	English or Spanish speaking male perpetrators of IPV	USA
Bowen et al. (2008)	To assess the extent of both statistically and clinically significant psychological change across a variety of measures (pro-domestic-violence attitudes, anger, locus of control, interpersonal dependency).	Before and after study	Male DV offenders	UK
Carney et al. (2006)	To evaluate a batterer intervention programme for women involuntarily placed in treatment and investigate the differential effectiveness of this programme for African American vs. White batterers.	Before and after study	Female perpetrators of IPV mandated to treatment	USA
Connors et al. (2012)	To evaluate the effectiveness of an IPV prevention programme for incarcerated offenders.	Before and after study	Incarcerated male IPV offenders	Canada
Cranwell – Schmidt et al. (2007)	To assess short term changes in attitude and motivating factors to change abusive behaviour after completion of a 27-session programme for male batterers.	Before and after study	Male perpetrators of IPV	USA
DeLeon-Granados et al. (2005)	To test the effect of two batterer interventions based on alternative theoretical models of recidivism, and advance the theoretical debate on effective deterrence.	Non-randomized controlled trial	Arrested DV offenders	USA
Gondolf (2008)	To evaluate the impact of treatment-received; men who actually contacted additional services were compared to those who did not make contact within the case-management sample.	Non-randomized controlled trial	African-American men who batter	USA

Gondolf (2009)	To determine if referral to the supplemental mental health treatment (i.e., the intention-to-treat) in comparison to no referral, partial referral, and mandatory referral would reduce batterer behaviours. To determine if treatment contact would improve outcomes (i.e., treatment received) for men who obtained a clinical evaluation or received mental health treatment with the untreated men under mandated referral.	Cross-sectional study	Male perpetrators of IPV who volunteered to enter treatment	USA
Gondolf & Snow Jones (2001)	To test the programme effect of three established batterer programs.	Before and after study	Male perpetrators of DV	USA
Kistenmacher (2008)	To determine the potential effectiveness of motivational interviewing in changing the way batterers think about their violent behaviour.	Randomized controlled trial	Male perpetrators of IPV	USA
Lawson et al. (2001)	To evaluate the effectiveness of a group programme for men who abuse their intimate partners.	Before and after study	Men on probation for partner violence	USA
Lawson et al. (2006)	To examine attachment pattern change and its relationship to symptom change with partner violent men.	Before and after study	Men on probation for partner violence	USA
Lawson (2010)	To compare the effectiveness of cognitive behavioural therapy (CBT) to integrated CBT and psychodynamic therapy (CBT/ PT) in reducing IPV.	Non-randomized controlled trial	Male perpetrators of IPV	USA
Lee et al. (2004)	To evaluate the effectiveness of a solution-based DV group treatment in terms of: effects on self-esteem, recidivism rates following programme completion, programme completion rates, and relational context change as evaluated by partners.	Before and after study	Men and women DV offenders	USA
Lee et al. (2007)	To evaluate the effectiveness of a solution-based DV group treatment to investigate the role of self-determined goals in predicting recidivism.	Before and after study	Men and women DV offenders	USA

Maxwell et al. (2010)	To better understand the timing and trends in new arrests in order to address the question of whether an intervention temporarily suppressed abusing behaviour or whether the programme produces lasting changes.	Randomized controlled trial	Male criminal court defendants charged with assaulting their intimate female partners	Germany
McGregor et al. (2000)	To evaluate the effectiveness of a group programme for men who are abusive towards their intimate partners.	Before and after study	Male perpetrators of IPV	Canada
Milner & Singleton (2008)	To determine the effectiveness of a solution-focused programme aimed at reducing DV.	Before and after study	Men and women who abused their intimate partner	England, UK
Morgan et al. (2001).	To examine the questions, "What discursive resources do the men bring to the programme? Are there any changes in the men's accounting repertoires over the course of the programme? How do they relate to the organization's discursive structure as identified in the participant observation exercise?"	Qualitative study	Men who had physically assaulted their partners and were attending Men for Non-Violence (MFNV) stopping violence course in a provincial city	New Zealand
Morrell et al. (2003)	To explore the relative effectiveness of cognitive behavioural therapy compared to supportive group therapy,	Quasi-randomized controlled trial	Male perpetrators of IPV	USA
Muftic & Bouffard (2007)	To determine if there are differences in the effectiveness of the intervention for male and female offenders.	Cross-sectional study	Male and female DV offenders in heterosexual relationships	USA
Musser et al. (2008)	To examine motivational interviewing as a pregroup preparatory intervention for partner-violent men.	Non-randomized controlled trial	Male perpetrators of IPV	USA
Price et al. (2008)	To report on the outcomes of the first 18 months of the Domestic Violence Intervention Project (DVIP).	Before and after study	Male perpetrators of DV	England, UK
Rosenberg (2003)	To examine the outcomes of DV intervention programs from the experiences of the probationers.	Qualitative study	Court-mandated batterers, both male and female	USA
Schrock et al. (2007)	To examine the question, "How do men's interactions construct their masculinity which might explain batterer intervention programme ineffectiveness?"	Qualitative study	Male court mandated perpetrators of IPV	USA

Schumacher et al. (2011)	To improve IPV treatment outcomes by increasing motivation to change IPV and IPV-related behaviours.	Randomized controlled trial	Men in treatment for alcohol abuse who report IPV	USA
Schwartz et al. (2003)	To test a group intervention to reduce gender role conflict among men who had committed partner abuse.	Non-randomized controlled trial	Male perpetrators of IPV	USA
Smith (2011)	To discover what perpetrators perceive to have changed following abuser schema therapy.	Qualitative study	Self-referred men with abuse problems that had not been in the justice system	England, UK
Taft et al. (2001)	To examine the effectiveness of straightforward and easily implemented retention procedures during the course of group counselling for male DV perpetrators.	Non-randomized controlled trial	Male perpetrators of IPV with difficulties with attending treatment	USA
Tutty et al. (2001)	To evaluate the effectiveness of an intervention based on family-of-origin treatment.	Before and after study	Male perpetrators of IPV	Canada
Tutty et al. (2006)	To evaluate the "Responsible Choices for Women" programme for effectiveness.	Before and after study	Female perpetrators of IPV	Canada
Tutty et al. (2009)	To assess changes in women after participation in an intervention to assist women who are abusive in intimate relationships to become violence free.	Before and after study	Female perpetrators of IPV	Canada
Waldo et al. (2007)	To explore if using a counselling approach within a guidance based programme will result in the men experiencing different therapeutic factors.	Cluster randomized controlled trial	Male perpetrators of IPV	USA

Table 36. Research Question 3 (Elder Interventions) Included Studies

Study reference	Aim	Method	Population	Country
Nahmiash & Reis (2008)	To rate the success or non-success of various interdisciplinary elder abuse intervention strategies in the community Project Care study.	Qualitative study	Elderly victims of abuse and neglect identified using the Brief Abuse Screen for the Elderly	Canada

Phillips (2008)	To test the effect of a nursing intervention intended to decrease the frequency of physical and verbal/psychological aggression toward older caregiving wives and daughters by care recipients and improve selected abuse related outcomes for older caregivers including anger, depression, anxiety, confusion, and caregiving burden.	Randomized controlled trial	Older caregiving wives and daughters	USA
Reay & Browne (2002)	To investigate education and anger management interventions to address cases of elder maltreatment.	Before and after study	Families experiencing elder abuse	England, UK

Table 37. Research Question 3 (Interventions for Couples) Included Studies

Study reference	Aim	Method	Population	Country
Babock et al. (2011)	To test the immediate impact of two interventions for IPV men in affecting emotional change during arguments with their partners.	Randomized controlled trial	Male perpetrators of IPV	USA
Cleary-Bradley et al. (2011)	To evaluate the efficacy of Couple and Relationship Education (CRE) for low-income parent couples who exhibit situational violence.	Randomized controlled trial	Heterosexual low-income couples experiencing situational violence	USA
Fals-Stewart et al. (2002)	To compare the impact of Behavioural Couples Therapy and Individually-Based substance abuse Treatment on the prevalence of male-to-female partner violence.	Randomized controlled trial	Men in treatment for substance abuse who report IPV	USA
Fals-Stewart et al. (2009)	To examine whether participation in couples therapy, compared with individual therapy, had a differential effect on the day-to-day relationship between substance use and IPV among married or cohabiting substance-abusing men.	Randomized controlled trial	Men and women in relationships with male-to-female IPV and substance use issues	USA
O'Farrell et al. (2004)	To examine the impact of behavioural couples therapy on IPV in couples where the male partner abuses alcohol.	Before and after study	Heterosexual couples with an alcoholic male partner	USA
Schumm et al. (2009)	To examine the impact of women's alcoholism treatment on partner aggression to find out if IPV decreases after women receive alcoholism treatment, as it does for men.	Before and after study	Men and women in relationships with male-to-female IPV and substance use issues	USA

Woodin et al. (2010)	To examine the impact of therapists' motivational interviewing behaviours on changes in partner aggression perpetration for men and women in a college couple's intervention.	Before and after study	Heterosexual couples with IPV	USA

Table 38. Research Question 4 (Children Exposed to DV) Included Studies

Study Reference	Aim	Method	Population	Country
Addressing Family Violence Programs (2011)	To draw conclusions about the effectiveness of the Peek-a-boo Club on mother's attachment (for all children) and social and emotional skills (for toddlers)	Before and after study	Mothers and children exposed to DV in Melbourne, Tasmania, and rural Victoria	Australia
Bunston & Dileo (2005)	To comprehensively evaluate FisT to more fully measure and substantiate its true effectiveness.	Before and after study	Children aged 8-12 years who experience problems in expressing their strong feelings and who have difficulties in their interpersonal relationships	Australia
Finkelstein et al. (2005)	To describe the development and content of a unique intervention for children of mothers with co-occurring disorders and histories of violence as well as the various dose, fidelity and implementation instruments used in the Women, Co-occurring Disorders and Violence--Children's Subset Study.	Before and after study	Children aged 5-10 of mothers with co-occurring disorders participating in *Women, Co-Occurring Disorders and Violence Study*	USA
Gosh Ippen et al. (2011)	To investigate whether child-parent psychotherapy is efficacious with preschoolers exposed to multiple traumatic and stressful life events (TSEs).	Randomized Control Trial	Child–mother dyads where child was 3–5 years old	USA
Grip et al. (2011)	To evaluate the impact of a community based programme for children exposed to intimate partner violence on: children's behavioural problems, degree of social impairment and prosocial ability, and to determine whether the perceived effectiveness of the programme was associated with children ' s exposure to IPV and the mothers trauma symptoms.	Before and after study	Mothers with their children (aged 5-14) reporting for help for IPV	Sweden
Humphreys et	To examine the outcomes of age appropriate	Qualitative	Children and mothers from Refuge Essex	England,

al. (2006)	'activity packs' designed to promote communication between mothers and children.	study		UK
Miller et al. (2012)	To assess baseline knowledge about safety-planning in preschoolers exposed to IPV and whether knowledge of safety-planning improves following participation in the Preschool Kids' Club Programme.	Randomized controlled trial	Children 4-6 years old who were part of a larger RCT	USA
Noether et al. (2007)	To promote resilience by enhancing the emotional and behavioural strengths and competencies of the children enrolled.	Non-Randomized controlled trial	Children aged 5-10 of mothers with co-occurring disorders participating in *Women, Co-Occurring Disorders and Violence Study*	USA
Parker et al. (2006)	To identify characteristics of adolescents exposed to DV and evaluate the efficacy of a group intervention.	Before and after study	Adolescent females who were connected to social services/child welfare agency	USA
Puccia et al. (2012)	To determine if intervention Trauma-Focused Cognitive Behavioural Therapy improves trauma symptoms in child witnesses to DV.	Before and after study	Children exposed to DV	USA
Schultz et al. (2007)	To test the efficacy of equine-assisted psychotherapy (EAP) in al group of children referred to a psychotherapist for various childhood behavioural and mental health issues.	Before and after study	Children 4-16 years old who were seeing a psychotherapist for equine-assisted psychotherapy	USA
Sharp et al. (2011)	To evaluate the outcomes of the group work programme for children/young people and their mothers, assess the impact of the partnership working model, and appraise cost effectiveness.	Qualitative study	Children referred to the Cedar pilot programme in Edinburgh and their mothers	Scotland, UK
Whiteside-Mansell et al. (2009)	To examine if attending Early Head Start centre-based child care during the first 3 years of life protects children from the expected negative impact of witnessing family conflict with respect to maladaptive and aggressive behaviour at the end of the programme (age 3) and before starting school (age 5).	Randomized controlled trial	Children referred to Early Head Start (enrolled in programme at 14 months)	USA

Table 39. Research Question 5 (Partnerships) Included Studies

Study reference	Aim	Method	Population	Country

Allen (2005)	To examine what elements of council climate and structure explained variation in the perceived effectiveness of these settings in meeting their objectives.	Cross-sectional study	Community coordinating councils for DV	USA
Allen et al. (2008)	To investigate the particular activities and proximal outcomes of 41 DV coordinating councils, and to investigate 'what characterized the activities of these councils and what outcomes were these councils well-positioned to achieve?'	Qualitative study	Community coordinating councils for DV	USA
Banks et al. (2008a)	To examine system change activities in child welfare agencies in the Greenbook project.	Mixed methods (Before and after study/ Qualitative study)	Child protection case workers and agencies	USA
Banks et al. (2008b)	To examine the questions: how did the collaborations organize and plan their work?; Did the collaborative bodies reflect the Greenbook guidance?; What facilitators and obstacles were most salient to the work?; How were they addressed?; and what activities did the collaborations plan to implement policy and practice change in the three primary systems?	Mixed methods (Before and after study/ Qualitative study)	Key stakeholders in the Greenbook project, including child welfare systems, dependency courts, and DV service providers	USA
Bennett & O'Brien (2010).	To examine the questions: In dual service DV/ substance misuse settings, are different “doors” to service associated with different outcomes of service?; Do women who are abstinent prior to the onset of DV services show greater improvement in self-efficacy or vulnerability to battering than women who are drinking or using substances prior to programme admission?; How does proximity of violence impact programme outcomes?	Before and after study	Substance use and IPV services	USA

Coll et al. (2010)	To assess the effectiveness of a coordinated, collaborative approach to services for parents involved in the legal system because of DV and child protection issues.	Before and after study	Community resources and social services for court-referred clients and their families	USA
Donovan et al. (2010)	To explore the development and working of multi-agency operations.	Qualitative study	DV services participating in the Domestic Abuse Intervention Project to provide early crisis intervention services	England, UK
Ernst & Smith (2012)	To compare differences in outcomes in adult protective cases between a nurse/social worker team and a lone social worker.	Before and after study	Adult protective services nurse and social worker teams	USA
Giacomazzi & Smithey (2001)	To investigate the collaborative process for a multi-agency project.	Qualitative study	Agencies participating in DV Prevention Commission	USA
Laing et al. (2012)	To examine what factors contribute to enhanced collaboration and what are the benefits of this for women who experience both DV and mental health issues.	Qualitative study (Action research)	Mental health and DV workers	Australia
Penhale et al. (2007)	To examine the prevalence and understand the process of partnership working in adult protection; identify strengths, barriers, an disadvantages of a multi-agency approach; and examine perceptions on regulation in this area.	Mixed methods (Cross-sectional study/ Qualitative study)	People providing services or otherwise engaged in the response to address abuse of vulnerable adults	England, UK
Robinson (2003)	To evaluate the Women's Safety Unit, in part to examine multi-agency working relationships.	Cross-sectional study	The Women's Safety Unit, a central point of access for women and children experiencing DV	Wales, UK
Robinson (2006a)	To examine the functioning and impact of Multi-Agency Risk Assessment Conferences (MARACs), as well as risk factors for experiencing DV.	Mixed methods (Cross-sectional study/ Qualitative study)	Members of 16 agencies, including police, probation, local authority, health, housing, Women's Aid, the NSPCC (the British child protection charity), and the Women's Safety Unit	Wales, UK
Robinson (2006b)	To describe whether the implementation of ASSIST has impacted upon the working practices of key agencies in the multi-agency partnerships, and if so, whether the changes have been positive.	Participatory qualitative study	Partner agencies and institutions	Wales, UK

Robinson & Rowlands (2006)	To identify and understand the services offered, the process of screening referrals, the type of intervention most helpful to specific groups of clients, the impact on clients, benefits and challenges of incorporating services for men and women, and clients' perceptions of the Dyn Project.	Participatory qualitative study	People working in a variety of disciplines relevant to DV	Wales, UK
Robinson & Tregidga (2007)	To determine the levels of revictimization one year after being referred to a MARAC and the victims' perceptions of the intervention.	Before and after study	People working in a variety of disciplines relevant to DV	Wales, UK
Sharp & Jones (2003)	To assess the impact of the partnership working model of delivery among practitioners including effective referral arrangements, co-facilitation of groupwork and the wider impact on inter-agency working and any changes in practice relating to domestic abuse.	Qualitative study (Action research)	People working in a variety of disciplines relevant to children and youth who witness DV	Scotland, UK
Stanley et al. (2011)	To identify some of the tools and approaches currently being developed for screening purposes in the United Kingdom and to identify the challenges of implementing them.	Mixed methods (Cross-sectional study/ Qualitative study)	Social service providers and police	England, UK
Steel et al. (2011)	To improve understanding of how MARACs worked and potential areas of development, including considering the case for putting MARACs on a statutory basis.	Mixed methods (Cross-sectional study/ Qualitative study)	People working in a variety of disciplines relevant to DV	England, UK
Whetstone (2001)	To examine the efficacy of a pilot project which teamed police officers with victim advocates as first responders to 911 calls for DV cases.	Mixed methods (Before and after study/ Qualitative study)	Teams of police officers and victim advocates	USA
Woodford (2010)	To advance understanding of successful community-government collaborative policy making by examining the factors that promoted this outcome in the selected case.	Qualitative study	Collaborative policy makers	Canada

Appendix J. Systematic Literature Reviews Identified During Review

Table 40. Research Question 1 (Prevention) Systematic Literature Reviews Included in Review

Author	Date	Title	Citation	Location
Murray, C.E., & Graybeal, J.	2007	Methodological Review of Intimate Partner Violence Prevention Research	*Journal of Interpersonal Violence, 22(10),* 1250-1269	USA
Whitaker, D.J., Morrison, S., Lindquist, C., Hawkins, S.R., O'Neil, J.A., Nesius, A.M., Mathew, A., & Reese, L.	2006	A Critical Review of Interventions for the Primary Prevention of Perpetration of Partner Violence	*Aggression and Violent Behaviour, 11(2),* 151-166.	USA

Table 41. Research Question 2 (Screening) Systematic Literature Reviews Included in Review

Author	Date	Title	Citation	Location
Coulthard, P., Yong, S., Adamson, L., Warburton, A., Worthington, H.V., & Esposito, M.	2010	Domestic violence screening and intervention programmes for adults with dental or facial injury	*Cochrane Database of Systematic Reviews, 12.*	England, UK
Feder, G., Ramsay, J., Dunne, D., Rose, M., Arsene, C., Norman, R., Kuntze, S., Spencer, A., Bacchus, L., Hague, G., Warburton, A., & Taket, A.	2009	How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening criteria	*Health Technology Assessment, 13(16).*	England, UK
Nelson, H.D., Nygren, P., McInerney, Y., & Klein, J.	2004	Screening women and elderly adults for family and intimate partner violence: A review of the evidence for the U.S. Preventive Service Task Force	*Annals of Internal Medicine, 140(5),* 387-396.	USA
O'Campo, P., Kirst, M., Tsamis, C., Chambers, C., & Ahmad, F.	2011	Implementing successful intimate partner violence screening programs in health care settings: evidence generated from a realist-informed systematic review	*Social Science & Medicine, 72(6),* 855-866.	Canada
O'Reilly, R., Beale, B., & Gilles, D.	2010	Screening and intervention for domestic violence during	*Trauma Violence & Abuse, 11(4),*	USA

		pregnancy care: a systematic review	190-201.	
Rabin, R.F., Jennings, J.M., Campbell, J.C., & Bair-Merritt, M.H.	2009	Intimate partner violence screening tools: a systematic review	*American Journal of Preventive Medicine, 36(5)*, 439-445.	USA
Ramsay, J., Richardson, J., Carter, Y.H., Davidson, L.L., & Feder, G.	2002	Should health professionals screen women for domestic violence? Systematic review	*BMJ, 325(10).*	England, UK
Stayton, C.D., & Duncan, M.M.	2005	Mutable influences on intimate partner abuse screening in health care settings: a synthesis of the literature	*Trauma Violence & Abuse, 6(4),* 271-85.	USA
Trabold, M.	2007	Screening for intimate partner violence within a health care setting: a systematic review of the literature	*Social Work in Health Care, 45(1),* 1-18.	USA

Table 42. Research Question 3 (Victim Interventions) Systematic Literature Reviews Included in Review

Author	Date	Title	Citation	Location
Ramsay, J., Rivas, C., & Feder, G.	2005	*Interventions to Reduce Violence and Promote the Physical and Psychosocial Well-Being of Women Who Experience Partner Violence: A Systematic Review of Controlled Evaluations: Final Report*	London, UK: Barts and The London Queen Mary's School of Medicine and Dentistry.	England, UK
Ramsay, J., Carter, Y., Davidson, L., Dunne, D., Eldridge, S., Feder, G., Hegarty, K., Rivas, C., Taft, A., & Warburton, A.	2009	Advocacy Interventions to Reduce or Eliminate Violence and Promote the Physical and Psychosocial Well-Being of Women Who Experience Intimate Partner Abuse	*Campbell Systematic Reviews, 3.*	England, UK
Wathen, N.C., & MacMillan, H.L.	2003	Scientific Review and Clinical Applications. Interventions for Violence against Women: Scientific Review	*JAMA, 289(5),* 589-600.	USA

Table 43. Research Question 3 (Perpetrator Interventions) Systematic Literature Reviews Included in Review

Author	Date	Title	Citation	Location

Feder, L.	2008	Court-mandated interventions for individuals convicted of DV	*Campbell Systematic Reviews, 12*	USA
Sheehan, K.A., Thakor, S., & Stewart, D.E.	2012	Turning points for perpetrators of intimate partner violence	*Trauma .Violence & Abuse, 13(1),* 30-40.	USA
Smedslund, T.K., Steiro, A.K., Winsvold, A., & Clench-Aas, J.	2007	Cognitive behavioural therapy for men who physically abuse their female partner	*Cochrane Database of Systematic Reviews, 8.*	Norway

Table 44. Research Question 3 (Elder Interventions) Systematic Literature Reviews Included in Review

Author	Date	Title	Citation	Location
Ploeg, J., Fear, J., Hutchison, B., MacMillan, H., & Bolan, G.	2009	A systematic review of interventions for elder abuse	*Journal of Elder Abuse & Neglect, 21(3),* 187-210.	Canada

Table 45. Research Question 4 (Children Exposed to DV) Systematic Literature Reviews Included in Review

Study reference	Date	Title	Citation	Location
Rizo, C.F., Mach, R.J., Ermentrout, D.M., & Johns, N.B.	2011	A review of family interventions for intimate partner violence with a child focus or child component	*Aggression and Violent Behaviour, 16 (2011),* 144-166.	USA

Appendix K. Quality of Included Quantitative and Qualitative Studies

Quantitative studies

Table 46. Research Question 1 (Prevention) Quality of Quantitative Included Studies

	Population			Method of allocation to intervention/comparison								Outcomes						Analysis						Summary	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Antle et al. (2011)	++	+	+	NA	+	NA	NA	++	NA	NA	+	+	+	+	+	+	+	+	NR	NR	+	+	+	+	+
Edwardsen & Morse (2006)	-	+	+	NA	+	+	NA	NA	NA	NA	+	+	++	-	+	NA	+	NA	NR	-	NR	+	+	+	+
Enriquez et al. (2010)	++	+	+	-	++	+	+	NA	+	++	-	++	+	+	+	NA	-	NA	NR	NR	NR	++	+	+	+
Enriquez et al. (2012)	+	+	+	NA	++	NA	NA	NA	NR	NA	++	++	+	++	++	NA	-	NA	NR	NR	+	++	+	+	+
Ernst et al. (2011)	+	+	+	++	+	++	+	++	NA	NA	++	+	++	+	+	++	+	++	NR	++	+	++	+	+	+
Florsheim et al. (2011)	NR	NR	NR	+	+	NR	NR	-	NR	+	++	-	+	+	+	+	++	++	NR	+	-	+	-	+	+
Gadomski et al. (2001)	++	+	+	++	++	NA	NA	NA	-	+	NA	-	NR	+	-	++	+	++	NR	++	+	+	+	+	+
Keller et al. (2010)	NR	NA	++	NA	++	NA	NA	NA	NA	NA	+	+	+	+	+	NA	+	NA	NR	NR	NR	+	+	+	+
Khemka et al. (2005)	+	NR	NR	+	++	NR	++	++	++	+	+	+	+	+	+	++	+	++	++	+	+	+	NR	+	+
Salazar et al. (2006)	++	+	NR	+	++	+	+	+	++	+	+	++	++	+	+	-	+	++	++	+	++	++	+	++	+
Soloman & Fraser (2009)	+	+	+	NA	+	NA	NA	+	NA	NA	NA	-	+	+	+	NA	-	NA	NA	NA	NR	-	NR	+	-
Wray et al. (2004)	+	NR	NR	NA	++	NA	NA	+	NA	NA	NA	-	++	+	+	NA	-	NA	NA	+	++	+	+	+	+

Table 47. Research Question 2 (Screening) Quality of Quantitative Included Studies

	Population			Method of allocation to intervention/comparison								Outcomes						Analysis						Summary	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Ahmed et al. (2009)	++	++	+	++	++	++	++	++	+	NA	++	++	++	++	++	++	++	++	++	++	++	++	+	**++**	**++**
Bonds et al. (2006)	-	+	+	NA	NA	NA	NA	NA	-	NA	NR	NA	NA	+	+	+	++	+	+	+	NR	+	+	+	-
Calderon et al. (2008)	++	+	NA	++	+	++	NA	++	+	++	++	+	++	+	++	NA	NA	++	NR	-	+	+	-	++	+
Colarossi et al. (2010)	-	+	+	NA	NA	NA	NA	NA	NA	NA	NA	+	+	+	+	+	+	+	NR	+	NR	+	-	+	+
Coonrod et al. (2000)	+	+	+	+	+	NR	++	+	+	++	+	-	+	-	+	+	+	NR	NR	NR	NR	+	+	+	**-**

Duncan et al. (2006)	+	+	+	-	+	NR	NR	+	+	+	++	++	++	+	+	-	-	++	NR	+	NR	+	+	+	+
Feder et al. (2011)	+	+	+	++	++	++	++	+	++	-	++	+	+	++	++	++	++	-	NA	++	+	+	+	++	++
Garcia & Parsons (2002)	-	NR	NR	NA	NA	NA	NA	NA	NA	NA	NA	+	+	+	+	NA	+	NR	NR	-	NR	-	+	+	+
Grafton et al. (2006)	+	-	+	NA	NA	NA	NA	NA	NA	NA	NA	++	++	+	+	NA	NA	NA	NR	NR	NR	+	NR	+	+
Halpern et al. (2009)	+	+	+	-	-	NR	NR	+	NA	+	++	+	+	+	+	NA	NA	NR	NR	NR	NR	+	+	+	+
Hamberger et al. (2010)	-	-	NA	+	-	++	-	++	NR	-	NA	++	-	-	+	-	++	-	NR	+	+	-	-	-	+
Hamby et al. (2006)	-	++	-	NR	+	NR	NR	+	+	+	+	+	+	+	+	NA	NA	+	NR	+	+	+	+	+	+
Humphries et al. (2011)	++	NA	+	NR	+	NR	NR	++	++	NA	-	-	-	-	+	++	++	++	++	NR	-	++	++	+	+
Janssen et al. (2002)	+	+	NR	NA	++	NA	++	++	+	+	NA	++	NA	+	++	NA	++	-	NR	NR	-	-	NR	+	+
Kapur & Windish (2011)	+	+	+	NA	++	NA	NA	+	NA	NA	-	++	+	+	+	NA	NA	+	NR	+	++	++	++	+	+
Klevens et al. (2012)	-	+	+	++	+	++	NR	++	++	+	NR	+	+	+	+	++	++	++	NR	+	+	+	+	+	+
Lo Fo Wong et al. (2006)	++	+	+	++	++	++	NA	++	++	+	++	+	++	+	+	++	+	++	+	++	++	++	++	++	++
MacMillan et al. (2009)	+	+	++	++	++	+	++	++	+	++	+	++	+	++	++	++	++	++	++	++	++	++	++	++	++
Moody et al. (2000)	+	NR	+	NA	++	NA	NA	NA	NA	NA	NA	+	++	+	-	NA	NA	NA	NA	NR	+	++	+	+	-
Power et al. (2011)	-	-	-	+	+	+	+	+	+	+	-	+	+	+	+	+	+	+	NR	-	-	+	-	-	+
Price et al. (2007)	+	+	-	NA	-	NA	NA	NA	NA	NR	++	++	+	+	++	+	+	+	NR	+	+	+	+	+	-
Rhodes et al. (2006)	+	+	+	++	++	+	+	+	+	+	-	++	-	+	+	NA	NA	++	++	NR	++	+	++	+	+
Ricket et al. (2009)	-	+	+	+	+	NR	NR	+	+	+	+	+	+	+	+	NA	NA	+	NR	+	NR	+	+	+	+
Robinson-Whelen et al. (2010)	+	+	+	++	++	++	NA	+	++	++	++	+	++	++	+	NA	+	+	+	NR	+	++	+	+	+
Shye et al. (2004)	+	+	+	-	+	NA	NA	+	+	+	-	-	-	+	+	+	+	+	-	NR	-	+	+	+	-
Trautman et al. (2007)	++	++	++	++	++	++	++	NR	++	++	-	++	+	+	++	NA	NA	++	-	++	+	+	++	+	+
Vanderburg et al. (2010)	+	++	+	NA	++	NA	NA	NA	NA	NA	++	+	++	+	+	NA	NA	NA	+	NR	+	+	+	++	+
Wathen et al. (2008)	-	++	+	NR	++	NA	NA	+	++	NA	++	++	+	++	++	++	-	+	-	++	++	+	+	+	+

Table 48. Research Question 3 (Victim Interventions) Quality of Quantitative Included Studies

	Population			Method of allocation to intervention/comparison								Outcomes						Analysis						Summary	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Allen et al. (2004)	-	-	-	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	NR	NR	NR	+	+	+	-
Allen et al. (2011)	-	NA	NA	NA	+	NA	NA	NA	NA	NA	+	+	+	-	+	+	+	NR	NR	+	NR	+	+	+	-
Bair-Merritt et al. (2010)	-	-	-	++	+	+	++	+	-	+	+	+	NR	+	+	+	+	+	+	+	+	+	+	+	+

Coker et al. (2012)	-	-	-	-	+	NR	NR	-	-	+	-	+	+	+	+	+	-	+	+	NR	NR	+	+	+	+
Crespo et al. (2009)	-	-	-	++	++	NR	NR	-	NR	+	-	+	+	+	+	+	-	+	NR	+	+	+	+	+	+
Glass et al. (2011)	+	+	+	NA	+	NA	NA	+	NR	NA	NA	+	+	+	NA	NA	NA	NR	NR	NR	+	+	+	+	+
Grip et al. (2011)	-	-	-	NA	+	NA	NA	+	NA	NA	-	+	+	+	+	NA	+	NR	+	NR	+	+	+	+	+
Hassija et al. (2011)	+	+	-	NA	+	NA	NA	NA	NA	NA	-	+	+	+	+	+	+	NR	NR	NR	+	+	-	+	-
Hernandez-Ruiz et al. (2005)	-	-	-	+	+	+	+	-	+	+	+	+	+	+	+	+	+	NR	NR	-	NR	+	-	+	+
Howarth et al. (2009)	++	++	+	NA	++	NA	NA	++	+	NA	-	+	-	+	+	NA	+	-	NR	+	NR	+	+	+	+
Iverson et al. (2009	-	-	-	NA	+	NA	NA	NA	NA	NA	-	+	+	+	+	NA	+	+	NR	NR	-	+	-	+	+
Iverson et al.(2011)	-	-	-	+	+	NR	NR	+	+	-	+	+	+	+	+	+	-	NR	+	NR	+	+	+	+	+
Johnson et al. (2006)	-	-	-	NA	+	NA	NA	NA	NA	NA	NA	+	+	+	+	+	-	+	+	NR	+	+	-	+	+
Kendall et al. (2009)	+	+	+	NA	+	NA	NA	-	NA	NA	-	+	+	+	+	+	+	NR	NR	-	NR	+	+	+	+
Kiely et al. (2011)	+	+	+	++	+	++	+	+	+	+	-	+	+	-	+	+	+	+	+	+	NR	+	+	+	+
Koopman et al. (2005)	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	+	NR	-	NR	+	+	+	+
Laughon et al. (2011)	+	NR	+	NA	++	NA	NA	++	NA	+	++	++	++	++	++	NA	++	NA	NR	NR	++	++	+	+	+
McWhirter et al. (2006)	+	-	NR	-	+	NA	NA	+	NR	NR	+	+	++	-	-	+	+	+	NR	+	+	++	+	+	+
McWhirter et al. (2011)	++	++	++	++	++	++	++	++	+	+	++	++	++	++	++	++	+	NR	+	++	NR	++	++	+	++
Miller et al. (2011)	-	-	-	+	+	NR	NR	+	+	+	-	+	-	+	+	-	-	+	+	NR	NR	+	+	+	+
Poole et al. (2008)	++	++	+	NA	-	NA	NA	NA	NA	-	+	++	+	++	++	NR	++	NA	NR	NR	++	+	++	+	++
Price et al. (2008)	++	+	NR	NA	+	NA	NA	NA	NA	NA	+	+	+	+	++	-	++	NA	NR	NR	NR	NR	NR	+	+
Rasmussen et al. (2008)	+	+	-	++	+	NA	NA	++	++	+	-	+	++	++	+	++	+	++	NR	-	-	++	-	+	+
Reed & Enright (2006)	-	-	-	++	++	NR	NA	++	NR	++	++	+	NR	++	++	++	++	++	NR	++	++	++	+	+	+
Rychtarik & McGillicuddy (2008)	+	++	NR	++	++	++	++	++	NR	NA	++	++	++	+	++	++	++	+	++	+	+	++	+	++	++
Rychtarik et al. (2005)	-	NR	NR	++	++	+	++	++	NR	NA	++	++	++	-	++	++	++	++	++	NR	++	++	++	++	+
Sanders et al. (2007)	+	++	+	++	+	NA	NA	++	NA	++	-	+	+	-	+	++	-	++	NR	NR	NR	+	+	+	-
Sullivan et al. (2002)	++	++	++	+	+	NR	NA	+	NA	NA	++	+	++	++	++	++	+	++	NR	NR	NR	++	+	++	++
Sullivan et al. (2004)	-	-	-	NA	+	NA	NA	NA	NA	NA	NR	+	-	+	+	+	+	NR	NR	NR	+	+	+	+	-
Taft et al. (2011)	+	+	+	++	++	++	+	+	+	++	-	+	++	++	++	++	+	++	++	+	++	++	+	++	+
Zlotnik et al. (2011)	+	+	-	++	++	++	NA	++	++	++	+	++	+	++	++	++	+	+	++	-	NR	++	+	+	+

Table 49 Research Question 3 (Perpetrator Interventions) Quality of Quantitative Included Studies

	Population	Method of allocation to	Outcomes	Analysis	Summary

Appendix K

				intervention/comparison																					
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Alexander et al. (2010)	+	NR	+	+	+	NR	+	+	+	+	+	++	-	+	+	+	+	+	+	NR	+	+	+	+	+
Bowen et al. (2008)	+	NR	-	NA	+	NA	NA	NR	NA	NA	+	+	++	+	+	++	+	-	NA	-	-	+	NR	+	+
Carney et al. (2006)	+	NR	+	NA	++	NA	NA	+	NA	NA	++	++	++	+	+	NA	-	+	NA	-	++	+	+	+	+
Connors et al. (2011)	+	NR	NR	NA	+	NA	NA	++	NA	NA	+	+	+	+	+	NA	-	+	NA	+	+	+	-	+	+
Cranwell –Schmidt et al. (2007)	+	NR	-	NA	-	NA	NA	NR	NA	NA	-	+	+	-	+	NA	-	NA	NA	+	-	+	-	+	-
DeLeon-Granados et al. (2005)	+	NR	++	+	+	+	+	+	NA	NR	++	+	++	-	+	+	+	+	NA	+	-	+	NA	+	+
Gondolf (2008)	-	-	-	-	+	NR	NR	+	-	+	-	+	+	+	+	+	+	+	NR	NR	+	+	+	+	+
Gondolf (2009)	-	-	-	-	-	NR	+	-	+	+	+	-	++	+	+	+	+	+	+	NR	+	+	+	+	+
Gondolf & Snow Jones (2001)	+	+	+	++	-	NA	NA	NA	NA	NA	-	+	-	+	+	+	+	NR	NR	++	+	+	+	+	+
Kistenmacher (2008)	-	-	-	+	+	NR	NR	+	++	+	-	+	-	+	+	NA	+	++	NR	-	NR	-	-	+	-
Lawson et al. (2001)	-	NR	+	NA	+	NA	NA	+	+	+	+	++	+	++	+	NA	+	NA	-	NR	+	+	+	+	+
Lawson et al. (2006)	-	-	+	NA	-	NA	NA	+	+	NA	+	++	+	++	+	NA	+	NA	-	NR	++	+	+	+	+
Lawson (2010)	-	NR	NR	+	++	+	+	+	+	NR	+	+	+	+	+	NA	-	++	+	-	++	++	+	+	-
Lee et al. (2004)	-	-	+	NA	++	NA	NA	+	NA	+	-	++	+	++	++	NA	++	NA	NR	NR	++	+	++	+	+
Lee et al. (2007)	-	-	+	NA	++	NA	NA	+	NA	+	+	-	+	+	+	NA	+	NA	-	NR	+	++	+	+	+
Maxwell et al. (2010)	+	+	+	++	++	NA	NA	++	+	++	+	++	+	+	++	++	++	+	NR	NR	++	++	++	++	++
McGregor et al. (2000)	+	+	+	NA	++	NA	NA	+	+	+	-	++	-	+	+	NA	++	NA	-	NR	+	++	+	+	+
Milner & Singleton (2008)	-	-	+	NA	++	NA	NA	+	NR	NA	+	+	+	+	+	NA	-	NA	+	NR	-	-	-	+	-
Morrell et al. (2003)	NR	-	NR	+	++	NR	+	++	++	-	-	++	-	++	++	+	+	++	+	NR	NR	+	+	+	+
Muftic & Bouffard (2007)	+	NA	NA	NA	++	NA	NA	NA	NA	NA	+	+	++	+	+	+	+	NA	NA	NR	++	+	NR	+	+
Musser et al. (2008)	+	++	++	+	++	NA	NA	++	++	+	-	++	+	++	++	++	++	++	NR	-	NR	++	++	+	+
Price et al. (2008)	+	NA	-	NA	+	NA	NA	NA	NA	NA	-	++	-	+	++	NA	+	-	NR	NR	NR	+	+	+	+
Schumacher et al. (2011)	-	+	NR	++	-	NR	NR	+	+	-	+	++	+	+	+	++	+	-	+	NR	NR	+	NR	+	+
Schwartz et al. (2003)	-	NR	NR	+	++	NR	NA	++	NR	NA	++	++	+	+	+	++	-	++	NR	-	NR	++	+	+	+
Taft et al. (2001)	+	-	-	NR	+	NR	NR	-	+	+	+	+	+	+	+	+	+	+	NR	NR	+	+	+	+	+
Tutty et al. (2001)	+	+	-	NA	+	NA	NA	NA	NA	NA	++	+	+	+	++	NA	+	NA	NR	++	+	++	+	+	+
Tutty et al. (2006)	+	+	+	NA	+	NA	NA	NA	NA	NA	-	++	-	+	+	NA	-	NA	NR	NR	+	+	+	+	+
Tutty et al. (2009)	+	+	+	NA	++	NA	NA	NA	NA	-	+	++	+	-	+	NA	+	NA	NR	+	NR	+	+	+	+

Waldo et al. (2007)	+	+	++	++	++	NA	++	++	NA	++	-	++	-	+	++	++	+	-	NR	NR	-	-	-	+	+

Table 50. Research Question 3 (Elder Interventions) Quality of Quantitative Included Studies

	Population			Method of allocation to intervention/comparison								Outcomes						Analysis						Summary	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Phillips (2008)	-	-	-	+	+	NA	+	+	+	+	+	++	+	+	+	+	+	+	-	NR	+	+	+	+	+
Reay & Browne (2002)	-	-	-	-	+	NA	NA	+	+	NA	+	+	+	+	++	+	+	+	NR	-	+	+	+	+	-

Table 51. Research Question 3 (Interventions for Couples) Quality of Quantitative Included Studies

	Population			Method of allocation to intervention/comparison								Outcomes						Analysis						Summary	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Babock et al. (2011)	+	-	+	+	+	NR	+	+	++	+	NA	+	++	+	+	++	-	++	++	+	+	+	+	+	-
Cleary-Bradley et al. (2011)	NR	NR	NR	+	-	NR	NR	+	+	+	-	+	+	+	+	-	-	+	+	+	+	+	-	+	+
Fals-Stewart et al. (2002)	++	NR	+	++	++	NR	NR	++	++	++	-	++	-	+	++	++	++	++	-	NR	NR	+	-	+	+
Fals-Stewart et al. (2008)	-	NR	NR	+	++	NR	+	+	NR	++	++	+	+	+	+	++	++	++	NR	+	++	++	+	++	+
O'Farrell et al. (2002)	+	+	+	+	++	NA	NA	++	NA	NA	++	+	++	++	++	NA	++	++	++	+	++	++	+	++	+
Schumm et al. (2009)	-	-	-	NR	-	NA	NA	++	++	-	+	++	+	+	+	+	+	++	NR	NR	NR	+	+	+	+
Woodin et al. (2010)	+	NR	-	NA	++	NA	++	NA	NA	NA	+	++	+	++	++	NA	+	NA	NR	+	++	++	++	+	+

Table 52. Research Question 4 (Children Exposed to DV) Quality of Quantitative Included Studies

	Population			Method of allocation to intervention/comparison								Outcomes						Analysis						Summary	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Addressing Family Violence Programs (2011)	++	+	NR	NA	++	NA	NA	NA	NR	NA	+	+	NR	+	+	NA	+	NA	NR	NR	-	+	NR	+	+
Bunston & Dileo (2005)	+	NR	NR	NA	++	NA	NA	NA	NA	NA	+	++	+	+	++	NA	+	NA	-	NR	NR	++	++	+	+
Finkelstein et al. (2005)	+	+	+	-	+	NA	NA	-	NA	NA	-	-	-	-	+	NA	-	NA	-	-	-	-	-	+	-
Gosh Ippen et al. (2011)	++	++	++	++	++	NR	NR	+	-	+	+	+	++	++	++	++	++	++	++	+	++	++	++	++	+
Grip et al. (2011)	+	+	+	NA	NA	NA	NA	+	NA	Na	-	+	+	++	+	NA	++	NA	+	NR	++	++	++	+	+

Miller et al. (2012)	++	NR	++	++	++	NA	NA	-	+	NA	+	+	++	++	++	++	+	+	NR	NR	+	++	+	+	+
Noether et al. (2007)	+	+	+	+	+	NR	NR	+	NR	+	+	+	++	+	+	-	+	++	+	NR	+	-	+	+	+
Parker et al. (2006)	-	-	-	NR	+	NR	NA	+	+	+	+	++	+	+	++	NA	NA	NR	NR	NR	NR	-	+	-	-
Puccia et al. (2012)	NR	+	-	NA	++	NA	NA	NA	NA	NA	-	++	+	+	+	-	+	-	NR	NR	+	-	-	+	+
Schultz et al. (2007)	-	-	+	-	++	NA	NA	+	NA	NA	+	++	+	-	+	NA	-	NA	NR	NR	NR	+	+	+	-
Whiteside-Mansell et al. (2009)	-	NR	NR	++	+	NR	NR	+	+	+	+	+	+	+	++	++	++	++	++	NR	+	+	++	+	+

Table 53. Research Question 5 (Partnerships) Quality of Quantitative Included Studies

	Population			Method of allocation to intervention/comparison								Outcomes						Analysis						Summary	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Allen (2005)	+	++	NA	NA	NA	NA	NA	NA	NA	NA	++	++	++	+	+	NA	NA	+	NR	+	+	++	+	+	+
Banks et al. (2008a)	+	NR	NR	NA	+	NA	NA	NA	NA	NA	-	+	+	+	+	NA	++	-	NR	+	+	+	+	+	+
Banks et al. (2008b)	NR	NR	NR	+	-	NA	NA	NA	NA	NR	-	+	-	+	+	++	-	NA	NR	+	+	++	+	+	+
Bennett & O'Brien (2010)	-	-	-	NA	NA	+	+	NR	NA	NA	-	+	+	+	+	+	-	+	NR	-	NR	+	+	+	-
Coll et al. (2010)	+	NR	NR	NA	+	NA	-	NA	NA	NA	-	+	+	++	+	NA	+	+	NA	+	+	+	+	+	-
Ernst et al. (2012)	++	NA	-	NA	+	NA	NA	NA	NA	+	NA	+	NA	+	+	NA	NA	-	NR	+	+	+	-	+	-
Robinson (2003)	+	+	NR	NA	++	NA	NA	NA	NA	NA	-	+	+	+	+	NA	NA	NA	NR	NR	-	+	+	+	+
Robinson (2006)	+	NR	NR	NA	+	NA	NA	NA	NA	NA	+	++	NR	+	++	+	+	NA	NA	NA	NA	+	NA	+	+
Robinson & Tregidga (2007)	+	++	++	NA	+	NA	NA	NA	NA	NA	++	+	++	+	+	+	+	NA	NR	+	NR	-	+	+	+
Stanley et al. (2011)	+	+	+	NA	+	NA	++	NA	NA	NA	+	++	++	+	+	NA	+	NA	NR	NR	NR	+	+	+	+
Whetstone (2001)	+	+	+	+	+	NA	NA	NA	++	-	NA	+	++	++	+	++	-	-	NA	++	+	+	NA	+	+

Key to questions:

1. Is the source population or source area well described?
2. Is the eligible population or area representative of the source population or area?
3. Do the selected participants or areas represent the eligible population?
4. Allocation to intervention (or comparison). How was selection bias minimized?
5. Were interventions (and comparisons) well described and appropriate?
6. Was the allocation concealed?
7. Were participants and/or investigators blind to exposure and comparison?
8. Was the exposure to intervention and comparison adequate?
9. Was contamination acceptably low?
10. Were the other interventions similar in both groups?

11. Were all participants accounted for at study conclusion?
12. Were the outcome measures reliable?
13. Were all outcome measurements complete?
14. Were all important outcomes assessed?
15. Were outcomes relevant?
16. Were there similar follow-up times in exposure and comparison groups?
17. Was follow-up time meaningful?
18. Were exposure and comparison groups similar at baseline? If not, were these adjusted?
19. Was Intention to Treat (ITT) analysis conducted?
20. Was the study sufficiently powered to detect an intervention effect (if one exists)?
21. Were the estimates of effect size given or calculable?
22. Were the analytical methods appropriate?
23. Was the precision of intervention effects given or calculable? Were they meaningful?
24. Are the study results internally valid? (i.e. unbiased)
25. Are the study results generalisable to the source population? (i.e. externally valid)

Key to answers 1-23:
++ The study has been designed/conducted in such a way as to minimize the risk of bias
+ Either the answer to the checklist question is not clear from the way the study is reported, or the study may not have addressed all potential sources of bias
- Significant sources of bias may persist
NR The study fails to report this particular question
NA Not applicable given the study design

Key to answers 24-25:
++ All or most of the checklist criteria have been fulfilled; where they have not been, the conclusions are very unlikely to alter
+ Some of the checklist criteria have been fulfilled, where they have not, or not adequately described, the conclusions are unlikely to alter
- Few or no checklist criteria have been fulfilled and the conclusions are likely to alter

Qualitative studies

Table 54. Research Question 1 (Prevention) Quality of Qualitative Included Studies

	Theoretical Approach		Study Design	Data Collection	Trustworthiness			Analysis			Summary			Ethics	Overall Assessment
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Enriquez et al. (2010)	+	+	+	++	++	-	+	+	+	+	-	+	+	+	+
Scottish Executive (2002)	+	+	+	+	NR	+	+	NR	+	NR	+	++	+	NR	+
Toews et al. (2011)	+	++	+	+	-	+	+	+	+	+	+	++	+	+	+

Table 55. Research Question 3 (Victim Interventions) Quality of Qualitative Included Studies

	Theoretical Approach		Study Design	Data Collection	Trustworthiness			Analysis			Summary			Ethics	Overall Assessment
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Allen et al. (2011)	-	-	+	+	+	+	+	+	-	NR	+	-	-	-	+
Cath Gregory Consulting (2008)	+	++	-	+	-	-	+	+	++	+	++	++	+	+	+
Morales-Campos et al. (2009)	+	+	-	+	+	+	+	+	+	+	+	-	+	+	+

Table 56. Research Question 3 (Perpetrator Interventions) Quality of Qualitative Included Studies

	Theoretical Approach		Study Design	Data Collection	Trustworthiness			Analysis			Summary			Ethics	Overall Assessment
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Morgan et al. (2001)	+	++	+	NR	-	+	+	+	+	+	+	++	+	+	+
Rosenberg (2003)	++	+	+	-	+	+	-	-	+	-	+	++	++	+	+
Schrock et al. (2007)	++	+	++	++	++	++	+	++	++	++	+	+	+	-	+
Smith (2011)	++	+	++	+	++	++	+	+	++	++	++	++	-	++	++

Table 57. Research Question 3 (Elder Interventions) Quality of Qualitative Included Studies

	Theoretical Approach	Study Design	Data Collection	Trustworthiness	Analysis	Summary	Ethics	Overall Assessment

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Nahmiash & Reis (2008)	+	-	-	+	+	NR	+	+	-	+	+	+	+	NR	**+**

Table 58. Research Question 4 (Children Exposed to DV) Quality of Qualitative Included Studies

	Theoretical Approach		Study Design	Data Collection	Trustworthiness			Analysis			Summary			Ethics	Overall Assessment
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
Humphreys et al. (2006)	+	-	-	+	-	+	+	-	+	-	+	+	-	NR	**-**
Sharp et al. (2011)	+	+	+	-	NR	+	+	NR	+	NR	+	++	+	+	**+**

Table 59. Research Question 5 (Partnerships) Quality of Qualitative Included Studies

	Theoretical Approach		Study Design	Data Collection	Trustworthiness			Analysis			Summary			Ethics	Overall Assessment
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Allen et al. (2008)	+	+	++	NR	-	-	+	+	+	+	+	++	+	NR	+
Banks et al. (2008a)	-	+	-	+	-	+	+	-	-	-	+	+	+	NR	+
Banks et al. (2008b)	+	+	+	-	-	+	NA	-	-	NR	+	++	+	NR	+
Donovan et al. (2010)	++	+	NR	+	NR	-	+	NR	+	NR	+	+	+	NR	+
Giacomazzi & Smithey (2001)	++	+	NR	+	NR	+	NR	NR	+	NR	+	++	+	NR	+
Liang et al. (2012)	+	+	+	-	+	+	+	+	+	-	+	+	+	+	+
Penhale et al. (2007)	++	++	+	+	NR	+	+	+	++	NR	++	+	+	+	+
Robinson (2006b)	++	+	+	+	-	+	+	NR	++	NR	++	+	+	NR	+
Robinson & Rowlands (2006)	+	++	+	+	NR	+	+	NR	++	NR	+	+	+	+	+
Robinson & Tregidga (2007)	++	++	-	NR	-	+	+	-	++	+	+	++	+	NR	+
Sharp & Jones (2003)	+	-	+	+	++	++	+	NR	+	NR	+	-	+	NR	+
Stanley et al. (2011)	++	+	+	+	NR	-	+	+	+	NR	+	++	+	++	+
Steel et al. (2011)	++	++	+	++	+	+	++	+	++	+	++	++	+	+	+
Whetstone(2001)	+	++	+	NR	NR	+	+	NR	NR	NR	+	+	+	NR	+
Woodford (2010)	+	+	+	+	-	+	++	++	+	-	+	+	+	NR	+

Key to questions:

1. Is a qualitative approach appropriate?
2. Is the study clear in what it seeks to do?
3. How defensible/rigorous is the research design/methodology?
4. How well was the data collection carried out?
5. Is the role of the researcher clearly described?
6. Is the context clearly described?
7. Were the methods reliable?
8. Is the data analysis sufficiently rigorous?
9. Are the data 'rich'?
10. Is the analysis reliable?
11. Are the findings convincing?
12. Are the findings relevant to the aims of the study?
13. Conclusions
14. How clear and coherent is the reporting of ethics?
15. As far as can be ascertained from the paper, how well was the study conducted?

Appendix L. Summary of Papers Reviewed by Rizo (2011) in Q4 (Children Exposed to DV)

Study Citation	Aims or Goals	Study Type/ Country	Analysis	Outcomes
Becker, K. D., Mathis, G., Mueller, C. W., Issari, K., & Atta, S. S. (2008). Community-based treatment outcomes for parents and children exposed to domestic violence. *Journal of Emotional Abuse, 8*(1-2), 187-204.	Provide a safe setting to learn more about family violence; explore beliefs and attitudes about violence; and develop and enhance coping skills.	Before and after study USA (Hawaii Native)	Mothers' reports, 72.3% of pre-intervention children exhibited levels of psychopathology within the clinical range, and 36.2% post - intervention, *p*=0.001. For externalizing, pre-intervention 57.4% and 29.8% post intervention, *p*=0.001. For internalizing 53.2% at pre-intervention and 21.3% at post-intervention, *p*=0.055.	• Child and parent completers were rated as more improved on IPV-related skills than non-completers • Significant improvements in children's IPV related skills; children's internalizing and externalizing behaviours; and children's psychopathology • Significant improvements in parents' IPV-related and parenting skills
Blodgett, C., Behan, K., Erp, M., Harrington, R., & Souers, K. (2008). Crisis intervention for children and caregivers exposed to intimate partner violence. *Best Practices in Mental Health, 4*(1), 74-91.	Establish immediate and ongoing safety; increase physical and emotional comfort; reduce emotional distress; identify needs to guide support and service need assessment; empower to use coping skills; connect to natural and professional resources.	Non-comparative study USA	For children whose families received brief or extended support 42% demonstrated benefit, vs. 4% of children who received crisis intervention only, *p*<0.001. Benefits were greatest among the children whose families had more than five direct contacts, with 77% benefiting, as compared to 4% of crisis intervention families and 15% of brief support families, *p* <0.001.	• 13% of cases evidenced benefit to the child and/or family • Benefits were significantly related to duration of support, with greatest benefits for families with more than five direct contacts • Greater benefit associated with assailant non-arrest, increasing assailant age, and support due to crisis intervention team
Carter, L., Kay, S. J., George, J. L., & King, P. (2003). Treating children exposed to domestic violence. *Journal of Emotional Abuse, 3*(3-4), 183-202.	Safe place; safety skills; self-esteem; social skills; conflict resolution; expression of feelings; improvement in family relationships; and support-building. Parents: learning about child development; parenting skills; effects of IPV on children; and supporting child's healing.	Before and after study USA	The mean scores for intrapersonal distress, somatic symptoms, interpersonal relations, social problems, behavioural dysfunction, and critical items (e.g., suicide, eating disorders, delusions) decreased from pre-treatment to post-treatment from 60.3 (SD 34.2) to 44.8 (SD 30.5) (F value=33.4, *p* <0.001). Parents reported significantly fewer behaviour problems in their children: 111.3 (SD14.3) pretreatment to 102.1 (SD 15.6) t=3.43, p <0.01	• Significant improvements in children's distress, somatic symptoms, interpersonal relations, and social problems • Children experienced improved emotion expression and ability to define abuse, discuss family violence, express anger appropriately, and create a safety plan • Parents reported less stress and fewer behavioural problems with their children after treatment
Crusto, C. A., Lowell, D. I., Paulicin, B., Reynolds,	Decrease incidents of violence; decrease trauma symptoms;	Before and after study	Decrease in overall traumatic events (*t*(81)=8.61, *p* <0.00), and the number of	• Significant improvements in traumatic events, parenting stress, and children's

J., Feinn, R., Friedman, S. R., & Kaufman, J. S. (2008). Evaluation of a wraparound process for children exposed to family violence. *Best Practices in Mental Health, 4*(1), 1-18.	decrease parenting stress; and connect to community-based resources.	USA	family violence events (t(81)=8.12, p <0.00). Significant decreases in post-traumatic stress–intrusive thoughts (t(37)=2.90, p=0.007) and post-traumatic stress-avoidance (t(37)=2.80, p=0.009). Significant decreases parent-child dysfunctional interaction (t(75)=2.73, p=0.008), and difficult child (t(75)=2.10, p=0.04). Statistically significant interaction between hours of service and post-traumatic stress–intrusive thoughts (F(1,36)=11.297, p=0.002) and length of stay (F(1,36)=8.63, p=0.006). Number of hours of service also significantly interacted with the depression (F(1,34)=6.639, p=0.014); composite post-traumatic stress symptoms (F(1,34)=4.869, p=0.034); post-traumatic stress-avoidance (F(1,35)=3.157, p=0.084); composite post-traumatic stress symptoms (F(1,34)=5.903, p=0.021); and post-traumatic stress-avoidance (F(1,35)=4.959, p=0.032). The post-traumatic stress–intrusive thoughts (M=1.53, SD=3.28) and service hours showed a statistically significant positive correlation (r(36)=0.49, p <0.01) as did the post-traumatic stress–intrusive thoughts and length of stay (r(36)=0.44, p <0.01). Change in depression scores (M=1.39, SD=3.49) and hours of service showed a statistically significant positive correlation (r(36)=0.40, p <0.05). Change in composite post-traumatic stress symptoms scores (M=3.38, SD=9.28) had a statistically significant positive correlation with total service hours (r(36)=0.35, p <0.05), and length of time in the programme (r(36)=0.39, p <0.05). There was a statistically significant positive correlation between change in post-traumatic stress-avoidance scores (M=1.16, SD=2.58) and length of time in the programme (r(37)=0.35, p <0.05).	intrusive and avoidance behaviours • Non-statistically significant improvements in children's depressive symptoms, dissociative symptoms, hyperarousal, angry feelings, and overall post-traumatic stress symptoms • Children's improvements were associated with hours of services received and duration in programme

Dodd, L. W. (2009). Therapeutic groupwork with young children and mothers who have experienced domestic abuse. *Educational Psychology in Practice, 25*(1), 21-36.	Promote positive mother–child relationships and enhance the psychological well-being of mothers and children.	Before and after study UK	Qualitative analysis. "All the mothers who attended the Groups felt their children had enjoyed and benefited from the Groups. They felt that the Group had enabled their child to receive some extra attention and that their children were made to "feel special"." Several mothers reported improvements in their children's behaviour and development both at the Group and at home – happier, better eating, talking, more confidence, playing and sharing better with other children, less violent and aggressive behaviours. "It has done Sarah good … She loves mixing with other children and I haven't been getting out much." "Kai is eating and talking better..." Mother's reports of the frequency and intensity of disruptive behaviour declined pre-intervention to post-treatment (averages, no p values). Staff felt that Family and Children's Centres were "ideal places to run the Groups" as they were "cosy and conducive to groupwork – not like an office or classroom". The "party" lunch and party bags worked well, and transport was seen as "vital".	• Mothers and children were satisfied with the programme • Mothers enjoyed both the separated and joint components, and felt group should last longer • Mothers experienced improvements in daily parenting hassles and self-esteem • Group leaders felt positive about the group and attributed the group's success to the staff's efforts to encourage attendance
Ducharme, J. M., Atkinson, L., & Poulton, L. (2000). Success-based, noncoercive treatment of oppositional behaviour in children from violent homes. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(8), 995-1004.	Increase child compliance; decrease child maladaptive behaviour; reduce parent stress; and improve parent–child relationship.	Cluster randomized controlled trial Canada	The Compliance Probability Checklist indicated significant change in maternal perception of child cooperation. The effect size was huge (***r*=**0.91). Errorless compliance training increases maternal perceptions of success from *5%* (with no treatment) to 91% (with treatment). Parents rated their children **as** significantly and substantially (***r*=**0.58, BESD=0.21-0.79) less likely to exhibit a broad range of externalizing behaviours. There was significant and substantial ***(r*=**0.58, BESD=0.21-0.79) improvement on the Internalizing scale. Improvements in externalizing and internalizing significant at $p < 0.05$.	• Improvements in compliance generalized across situations and were maintained at follow-up • Significant improvements in maternal perception of child cooperation and parental stress • Significant improvements in children's externalizing and internalizing behaviour problems • Consumer satisfaction with treatment

Ernst, A. A., Weiss, S. J., Enright-Smith, S., & Hansen, J. P. (2008). Positive outcomes from an immediate and ongoing intervention for child witnesses of intimate partner violence. *American Journal of Emergency Medicine, 26*(4), 389-394.	Teach children family violence is not their fault; teach healthy behaviours and coping skills; improve self-esteem.	Before and after study USA	15 of 16 evaluation questions found a statistically significant improvement from pre-intervention to post intervention p <0.01. Significant improvements include children aware that violence was not their fault (59% pre-intervention vs 84% post-intervention, difference 25%; 95% CI, 9-41) and a significant increase in the number who knew a safety plan (32% pre-intervention vs 93% post-intervention; difference, 61%; 95% CI, 47-75). Other findings: 12% improvement in ability to talk about violence, 56% improvement in understanding dynamics of abuse, 39% improvement in ability to recognize phases of violence, 35% improvement in knowing they did not cause violence, 31% improvement in knowing they cannot control it, and 21% improvement in knowing they cannot change violence that has already occurred, 36% improved in actual ability to use a safety plan, 41% percent improved in knowledge of what to do during violent episodes. Identifying adults as a safe adult was improved in 34%; self-nurturing behaviours to help in the healing process improved in 41%.	• Significant improvement in children's understanding of IPV • Statistically significant improvements in children's awareness that the violence is not their fault and children's understanding of a safety plan
Graham-Bermann, S., Lynch, S., Banyard, V., DeVoe, E. R., & Halabu, H. (2007). Community-Based Intervention for Children Exposed to Intimate Partner Violence: An Efficacy Trial. *Journal of Consulting and Clinical Psychology, 75*(2), 199-209.	Address children's knowledge, attitudes, and beliefs about families and family violence; support emotional and behavioural adjustment. Mothers' goals: empower mothers; provide a safe environment; discuss the impact of IPV on children; address fears about parenting; increase parenting self-efficacy; peer support; improve parenting and disciplinary skills; and improve emotional and social	Cluster randomized controlled trial USA	Only the child-mother (CM) intervention (not child-only, CO) was effective in changing externalizing problems and their attitudes concerning violence. The CM condition change in the slope showed a large effect (ES externalizing -0.65), and a fixed effect -0.22. All three measures (externalizing, internalizing, and attitude) for CM were significant at p <0.001. Small to moderate effects were found for changing externalizing behavioural problems and violence attitudes in the CM intervention, but not in the CO condition relative to those who received no intervention services.	• Child-plus-mother intervention showed improvements in behaviour problems and attitudes about violence at post-test • Both treatment groups showed significant reductions in internalizing problems compared to no treatment • Both treatment groups maintained improvements in externalizing behaviours at follow-up and children in the child-plus-mother intervention showed continued improvements • At follow-up, the child-plus-mother group maintained changes in attitudes about violence

	adjustment.			
Johnston, J. R. (2003). Group interventions for children at-risk from family abuse and exposure to violence: A report of a study. *Journal of Emotional Abuse, 3*(3-4), 203-226.	Increase child awareness of internal scripts, expectations, and rules; teach feelings, empathy, relationships, and problem solving.	Before and after study USA	Pre-intervention 47% of the children scored in the abnormal range on the CBCL (population rate: 16%), and post-intervention, 25% scored in the abnormal range. Pre-intervention to post-intervention change from abnormal to normal: 33%, p <0.001. Teachers' reports gave significant positive changes in behaviour problems (t=3.75, p <0.001) and social competence (t=-4.8, p <0.001).	• Positive outcomes at six months per the clinicians', parents' and teachers' ratings • Significant improvements in children's behavioural problems, social competence, and emotional and behavioural difficulties • Effects were modest to substantial in size
Jouriles, E. N., McDonald, R., Rosenfield, D., Stephens, N., Corbitt-Shindler, D., & Miller, P. C. (2009). Reducing conduct problems among children exposed to intimate partner violence: a randomized clinical trial examining effects of Project Support. *Journal of Consulting and Clinical Psychology, 77*(4), 705-717.	Provide support to children and mothers; teach mothers problem-solving and child management skills.	Individual randomized controlled trial USA	During the intervention period, child conduct problems decreased more rapidly in the intervention group than in the comparison group, p <0.01. At follow-up, conduct problems continued to decrease in the intervention group, p <0.005, but not in the comparison group, p <0.23. Oppositional child behaviour decreased more slowly than the other conduct problems, p <0.001, and decreased more rapidly in the intervention group than the comparison group during the intervention and at follow-up. In the Project Support group, only 15.6% (5 of 32) of the children had CBCL scores in the normative range at pretreatment. Post intervention, 57.1% (16 of 28) were in the normative range; and at follow-up, 74.1% (20 of 27) were in the normative range. For the comparison group, 23.5% (8 of 34) were in the normative range pretreatment; 38.7% (12 of 31) post intervention period; and 48.3% (14 of 29) at follow-up. The proportion of children in the normative range was greater for the Project Support group than the comparison group at follow-up, p <0.05.	• Treatment group showed greater improvements in children's conduct problems and mothers' parenting • Changes in mothers' parenting and psychiatric symptoms accounted for a sizable portion of the treatment's effects on children's conduct problems • Improvements in parenting maintained at follow-up • Children's conduct problems continued to decrease through follow-up • Medium to large effect sizes for children's outcomes; small to medium effect sizes for maternal outcomes • Children in the treatment group showed clinically significant gains
Jouriles, E. N., McDonald, R., Spiller, L., Norwood, W. D., Swank,	Provide support to children and mothers; teach mothers problem-solving and child	Individual randomized controlled trial	No differences between the treatment and comparison groups for CBCL Externalizing problems, but there was a significant	• Externalizing behaviours and management skills improved at a faster rate for participants in the treatment group

P. R., Stephens, N., Buzy, W. M. (2001). Reducing conduct problems among children of battered women. *Journal of Consulting and Clinical Psychology, 69*(5), 774-785.	management skills.	USA	difference in slope across the two conditions, p <0.01, demonstrating improvement at a faster rate in the treatment condition than in the comparison condition. No significant differences for the Internalizing scale.	• Clinically significant reduction of externalizing behaviours for the treatment group • Statistically significant improvements for mothers' management skills for the treatment group • Mothers' distress and children's internalizing behaviours improved over time for both groups at similar rates
Liberman, A. F., Van Horn, P., & Ippen, C. G. (2005). Toward evidence-based treatment: Child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(12), 1241-1248.	Promote affect regulation; change maladaptive behaviours and interactions; support and encourage developmentally appropriate parent–child interactions and activities.	Individual randomized controlled trial USA	The intervention group had a significant reduction in-take/posttest in the number of TSD symptoms, p <0.001, whereas the comparison group did not. Only the intervention group evidenced significant intake-posttest reductions in CBCL score, p <0.01. The intervention group showed significant reductions in behaviour problems. The intervention: intake mean=60.32, SD=9.00; post-test mean=54.16, SD=8.71, p <0.01); comparison: intake mean=58.86, SD=8.82; posttest mean=59.64, SD=13.11). At posttest, there was a statistically significant group difference for attaining TSD criteria, p <0.01, with 6% in the intervention group and 36% in the comparison group.	• Child-Parent Psychotherapy group showed significant improvements children's behaviour problems and traumatic stress symptoms • Mothers in the CPP group showed significant improvements in PTSD avoidance symptoms and global distress. Mothers in both groups showed significantly fewer PTSD symptoms
Lieberman, A. F., Ippen, C. G., & Van Horn, P. (2006). Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 45*(8), 913-918.	Promote affect regulation; change maladaptive behaviours and interactions; support and encourage developmentally appropriate parent–child interactions and activities.	Individual randomized controlled trial USA	Only the intervention children group evidenced significant reductions in CBCL total score 6 months post-treatment, p <0.001.	• Children in the Child Parent Psychotherapy group showed significant reductions in total behaviour problems • Mothers in the CPP group showed significant improvements in the global severity of their symptoms
MacMillan, K. M., & Harpur, L. L. (2003). An examination of children exposed to marital	Create a safe environment where children can express thoughts, feelings, and experiences of family violence.	Before and after study Canada	Using ACTS, 40% of the children rated themselves in the clinical range for posttraumatic stress and associated symptoms. Children's behaviour problems	• Improvements in child knowledge and behaviours • Parents demonstrated a reduction in stress

violence accessing a treatment intervention. *Journal of Emotional Abuse, 3*(3-4), 227-252.	Parenting goals: foster parent–child relationship; promote positive discipline.		were rated by their parents, with improvements in CBCL externalizing scores t=3.52, p <0.05, internalizing score t=4.10, p <0.01, and total problem score t=5.85, p <0.01. PSI child domain scores improvements were significant (p <0.05). Child report measures of knowledge improved significantly, t=-5.32, p <0.01.	• Clinically significant improvements in parental stress and children's total and externalizing behaviour problems
McDonald, R., Jouriles, E. N., & Skopp, N. A. (2006). Reducing conduct problems among children brought to women's shelters: intervention effects 24 months following termination of services. *Journal of Family Psychology, 20*(1), 127-136.	Provide support to children and mothers; teach mothers problem-solving and child management skills.	Individual randomized controlled trial USA	Based on the CBCL, 15% of the intervention children compared to 53% of the comparison children were reported with externalizing problems at clinical levels 2 years post-treatment, p <0.05. In the comparison condition, 35% of the children exhibited clinical levels of internalizing problems, compared with 0% in the treatment group, p <0.05. Children's Happiness/Social Relationships Scale scores for children in the intervention were significantly higher than for control, p <0.05 (one-tailed).	• At follow-up, more children in the comparison group exhibited clinically significant conduct problems • Children in the treatment group were happier, had better social relationships, and lower levels of internalizing problems relative to the comparison group • Mothers in the treatment group were less likely to use aggressive child management strategies and to have returned to their partners during the follow-up period
McFarlane, J. M., Groff, J. Y., O'Brien, J. A., & Watson, K. (2005). Behaviours of children following a randomized controlled treatment programme for their abused mothers. *Issues in Comprehensive Pediatric Nursing, 28*(4), 195-211.	Assess how two interventions for mothers compared for reducing child behaviour problems compared to a normative clinical sample.	Cluster randomized controlled trial USA	Most of the mean internal, external, and total behaviour problem scores for children of abused mothers significantly improved from the study entry to 24 months, regardless of which treatment protocol the mother received. Both interventions showed improvements over a clinical normative sample at 2 year post-treatment. Improvements for CBCL internalizing were significant for 18 months-5 years old (p <0.001), and boys 6-11 years old (p <0.01). Externalizing scores were significantly better for both treatments over the normative in all ages and genders (p <0.01). Total CBCL scores were significantly better for all age groups except boys 12-18 years old (p <0.01).	• All children improved significantly on behaviour problems from intake to 24 months • By 24 months, the majority of children scored significantly lower than referred norms • Children ages 18 months to 5 years showed the most improvement; teenagers showed the least improvement
McFarlane, J. M., Groff, J. Y., O'Brien, J. A., &	Assess how two interventions for mothers compared for	Cluster randomized	Both groups of children improved significantly (p <0.001) on CBCL scores from intake to 1	• Both groups of children improved significantly on behaviour problems at 1

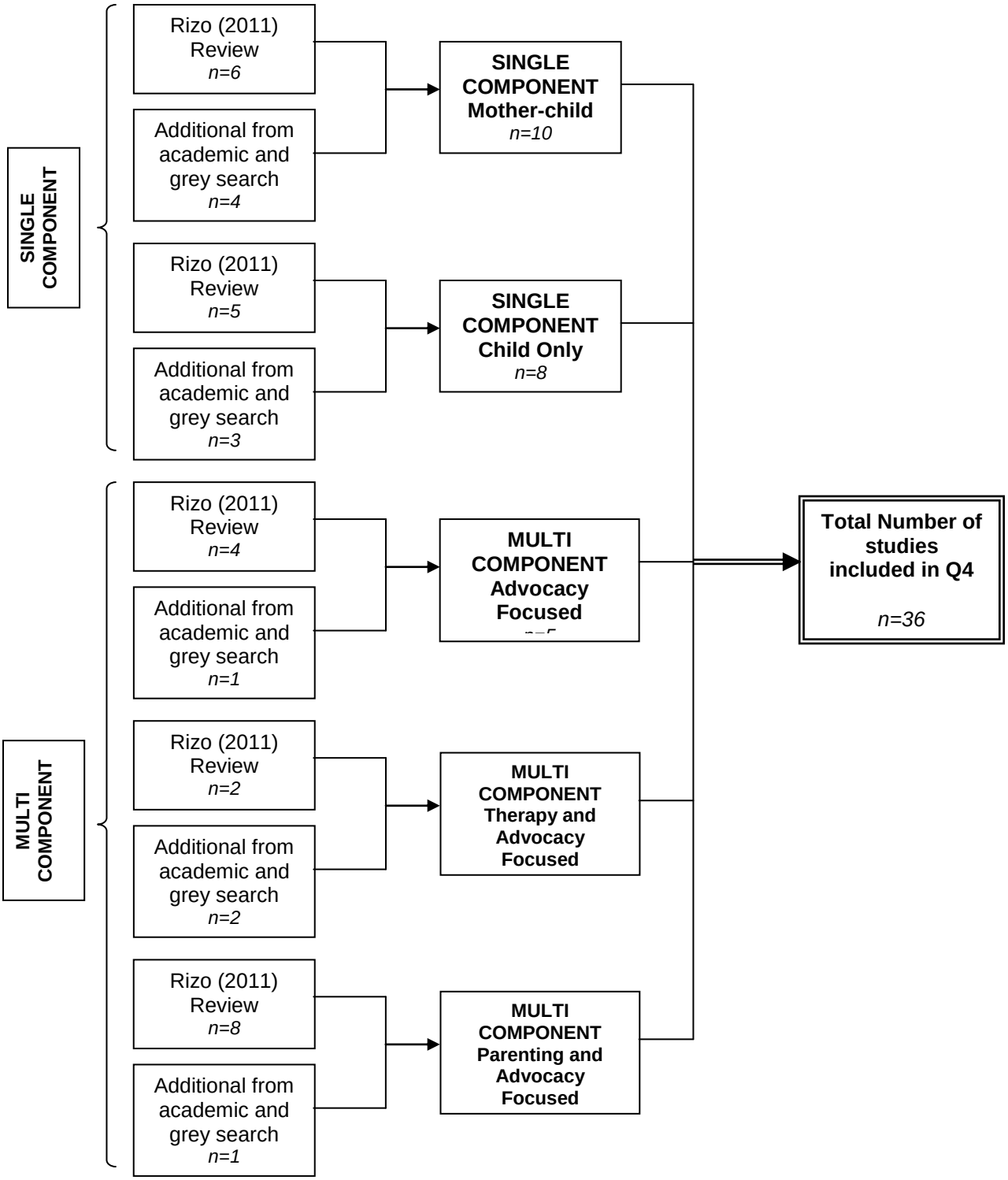
Watson, K. (2005). Behaviours of children exposed to intimate partner violence before and 1 year after a treatment programme for their mother. *Applied Nursing Research, 18*(1), 7-12.	reducing child behaviour problems, compared to a normative clinical sample.	controlled trial USA	year, irrespective of which treatment protocol their mother received. Except for girls aged 12-18 internal behaviour scores, all scores of children from mothers in both interventions were significantly lower from the scores of clinically referred children (p <0.05).	year follow-up • At 1 year, the scores of children with treated mothers were significantly lower than the scores of clinically referred children (as presented in the CBCL manual)
McWhirter, P. T. (2008). An empirical evaluation of a collaborative child and family violence prevention and intervention programme. In G. R. Walz, J. C. Bleuer & R. K. Yep (Eds.), *Compelling Counselling Interventions: Celebrating VISTAS' Fifth Anniversary* (pp. 221-227). Alexandria VA: American Counselling Association.	Provide a safe and caring atmosphere; empower children to cope with stress; dealing with stress and strong emotions; building communication skills; increasing responsible behaviour and self-efficacy; identifying and making friends; handling interpersonal and familial conflict.	Before and after study USA	Results revealed a positive group effect on the general measure of well-being (F=18, p <0.01, no further data provided). Descriptive data generated from the children indicated that the group intervention helped them to "learn something new and important" (80%); they "would want to come back again" (100%); they wanted the session to continue after the group therapy was completed (86%); they "liked the other kids in their group" (66%); and they "felt they talked about things important to them" (93%).	• Statistically significant improvements in children's psychological well-being • A majority of children reported learning something new and important from group, wanting to return to group, liking the other children in their group, and having talked about things important to them in group
Pepler, D. J., Catallo, R., & Moore, T. E. (2000). Consider the children: Research informing interventions for children exposed to domestic violence. *Journal of Aggression, Maltreatment and Trauma, 3*(1), 37-57.	Change maladaptive behaviours; improve child functioning; increase child understanding of partner violence.	Before and after study Canada	There was a significant difference in the pre-group and post-group depression scores: F (1,45)=12.84 (p<0.001). Anxiety scores were significantly lower following peer group counselling, F (1,45)=20.06 (p<0.001). Mother's report children's behavioural adjustment showed significant improvement following the counselling, F (51)=9.54 (p<0.001). The univariate analyses indicated significant improvements in emotional problems, F (1,24)=7.57 (p<0.01), and for hyperactivity, F (1,23)=6.86 (p<0.014). Attitudes towards violence, no significant differences. There was no significant gender by time interaction for the conduct, hyperactivity, or emotional scales.	• Significant improvements in acceptability of violence, depression, anxiety, and behavioural adjustment • Mothers perceived fewer child problems following the programme • Mothers' counselling had no impact on children's behavioural adjustment

Smith, N., & Landreth, G. (2003). Intensive filial therapy with child witnesses of domestic violence: A comparison with individual and sibling group play therapy. *International Journal of Play Therapy, 12*(1), 67-88.	Help parents become therapeutic agent in child's life; teach parents child centered play therapy principles; strengthen and enhance mother–child relationship.	Before and after study USA	Children in the intensive filial therapy experimental group demonstrated significant improvement as compared to children in the non-treatment comparison group on all measures: the JSCS, F (1,19)=4.77, *p*=0.042; the CBCL Total Behaviour Problems, F (1,19)=9.106, *p*=0.007; Internalizing Behaviour Problems F (1,19)=6.28, *p*=0.021; Externalizing Behaviour Problems F (1,19)=14.648, *p*=0.001; Anxious/Depressed, F (1,18)=6.868, *p*=0.017; and Aggressive Behaviours, F (1,18)=13.677, *p*=0.002. Children in the intensive individual play therapy group scored significantly higher in self-concept than children in the filial therapy group on the JSCS, F (1,19)=25.617, *p*=0.000. There were no significant differences between the intensive filial therapy experimental group and the intensive sibling group play therapy comparison group on the JSCS, F (1,18)=0.741, *p*=0.40 and all other measures used.	• Children in experimental group demonstrated significant improvement compared to the no treatment group comparison group on all measures • Children in the intensive individual therapy group scored significantly higher in self-concept than children in experimental group • Mothers in the experimental group showed significant improvements in empathy, communication of acceptance, and allowing child self direction
Sudermann, M., Marshall, L., & Loosely, S. (2000). Evaluation of the London (Ontario) community group treatment programme for children who have witnessed woman abuse. *Journal of Aggression, Maltreatment and Trauma, 3*(1), 127-146.	Increase adaptive functioning; remediate social behavioural problems; prevent violence in child's future relationships; teach safety skills.	Before and after study Canada	Pre-intervention, 55% of children and teens replied ‘‘false’’ to the statement that ‘‘sometimes children are the cause of parents’ abusive behaviour/fights’’ while post-intervention it increased to 84%. Pre- intervention, 59% replied that they would try to stop a fight between their parents, post-intervention this response rate was 10%. For the children’s satisfaction with the groups, 60.7% responded at 5 on a five-point scale, 32% at 4. For children’s learning, 64% rated the groups at 5 and 29% at 4. In both these areas, there were no ratings below 3. 92% of the children said they would recommend the group to a friend who had violence problems in his or her family. No p values or additional analysis.	• Children and adolescents learned intended content and showed positive changes in attitudes and beliefs; knowledge of community resources and persons from whom to get help; and responses to peers in conflict situations • Children rated group high in terms of what they had learned • Mothers/caregivers rated value of groups positively and reported positive changes in their children

Sullivan, C. M., Bybee, D. I., & Allen, N. E. (2002). Findings from a community-based programme for battered women and their children. *Journal of Interpersonal Violence, 17*(9), 915-936.	Educate children about safety, feelings, and respect.	Individual randomized controlled trial USA	Significant Condition X Time linear effects found (all p <0.05): self worth (1.89), physical appearance (2.27), athletic (2.21), depression (2.13), and self-esteem (2.37). Other measures not significant: quality of life, scholastic, social acceptance, and behavioural conduct.	• Decrease in mothers‘ depression • Increase in mothers' self-esteem • Mothers in the intervention group reported a higher quality of life than the comparison group • Children in the intervention showed improvements in self confidence, global self-worth, athletic competence, and physical appearance from pre-intervention to 4-month follow-up
Sullivan, M., Egan, M., & Gooch, M. (2004). Conjoint interventions for adult victims and children of domestic violence: a programme evaluation. *Research on Social Work Practice, 14*(3), 163-170.	Learn about safety planning; work toward trauma resolution; reduce self-blame; and gain conflict resolution skills.	Before and after study USA	Only 3 of the 14 CBCL measures were significantly reduced from pretest to posttest: anxious or depressive behaviours, $t(76)=1.99$, $p=0.05$; internalizing behaviours, $t(76)=2.41$, $p=0.02$; and externalizing behaviours, $t(76)=1.95$, $p=0.05$. All scores had significant reductions in the Trauma Symptom Checklist for Children: Anxiety (t=3.86, p <0.01), Depression (t=3/43, p <0.01), Anger (t=3.67, p <0.05), PTSD (t=6.13, p <0.001), Disassociation (t=6.50, p <0.001), Dissociate/overt (t=5.76, p <0.001), and Dissociate/fantasy (t=3.11, p <0.05). In the child domain of the parent’s test scores, significant improvements in Hyperactivity (t=3.36, p <0.01). Adaptability (t=3.58, p <0.001), mood (t=2.71, p <0.01), and overall child domain (t=3.28, p <0.01).	• Significant improvements in children's mood disorder symptoms, trauma symptoms, self blame, and behaviour problems • All children showed improvements in anger • Significant improvements in child adaptability, mood, reinforcing parent, and distractibility or hyperactivity • Significant improvements in mothers' isolation, life stress, and health • Parents' life stress and health change not clinically significant
Timmer, S. G., Ware, L. M., Urquiza, A. J., & Zebell, N. M. (2010). The effectiveness of parent-child interaction therapy for victims of interparental violence. *Violence & Victims, 25*(4), 486-503.	Improve parent–child relationship; reduce child's behaviour problems; improve child's compliance; improve parent's behaviour management and communication skills.	Non-Randomized controlled trial USA	Analyses of the ECBI intensity and problem scores showed strong treatment effects, overall $F(2, 110)=22.16$, p <0.001, observed power=1.0. Analyses of the three CBCL broadband scales showed significant treatment effects, overall F(3, 114)=10.96, p <0.001, observed power=1.0.	• Neither IPV nor related-risks accounted for attrition variation • Significant improvements in children's behaviour problems; no significant differences between groups • Significant improvements in mothers' psychological distress; no significant differences between groups • Children's behaviours improved after phase one, but completion was associated

				with continued and significant improvements
Tyndall-Lind, A., Landreth, G. L., & Giordano, M. A. (2001). Intensive group play therapy with child witnesses of domestic violence. *International Journal of Play Therapy, 10*(1), 53-83.	Empower children to organize their experiences, gain a sense of self-control, and learn coping skills.	Before and after study USA	Children in the intensive group play therapy experimental group scored significantly higher than children in the control group on the JPPSST, F(l,21)=18.91, *p*=0.000; the CBCL Total Behaviour Problems, F(l,21)=11.67, *p*=0.003; Externalizing Behaviour Problems, F(1,21)=13.73, *p*=0.002; Aggressive Behaviour, F(l,21)=11.06, *p*=0.004 and Anxious/Depressed subscales, F(l,21)=5.04, *p*=0.038. Children in the intensive group play therapy experimental group did not score significantly higher than children in the control group on the CBCL Delinquent Behaviours, Attention Problems, Internalizing Behaviours, Withdrawn Behaviour, and Somatic Complaints subscales. Children in the intensive group play therapy experimental group did not score significantly higher than children in the intensive individual play therapy comparison group, on the JPPSST; the CBCL Total Behaviour Problems, Externalizing Behaviour Problems, Aggressive Behaviour, Delinquent Behaviours or the Attention Problems subscales. Children in the experimental group did not score significantly higher than children in the comparison group on the CBCL Internalizing Behaviours, Withdrawn Behaviour, Somatic Complaints or the Anxious/Depressed Subscales.	• Children in the experimental group a significant improvements in total behaviour problems, externalizing and internalizing behaviour problems, aggression, anxiety, depression, and self-esteem • Intensive sibling group play therapy was equally effective a individual play therapy with child witnesses of IPV

Appendix M. Summary of Q4 Framework for Reporting Evidence



Appendix N. Details of 'No Secrets' Documents

Note that the Penhale (2007) report was included in the main findings of the review, while several individual studies that examined data/ findings already covered by the Penhale (2007) report were excluded. The table below shows the data sources used in each of the documents. The Penhale (2007) final evaluation report actually covers more data sources than all of the other papers combined.

Excluded Study	Questionnaires from 133 Councils with Social Services Responsibility (CSSRs)	Interviews with 32 senior social services managers	Interviews with 92 social service workers	Additional unspecified interviews**	Focus groups with members of multi-agency adult protection committees (n=271)	22 interviews and 19 focus groups with service users, carers and relatives
Manthorpe (2010)		X				
Penhale (2007)	X	X	X	X	X	X
Perkins (2007)*	X					
Pinkney (2008)			X			
Reid (2009)					X	

* Perkins (2007) was also excluded due to a low quality rating.

** Note: The final report (Penhale, 2007) states 260 interviews were conducted, but the individual articles list only the 32 social services managers and the 92 social service workers

Appendix O. Evidence Tables

Table 60. Research Question 1 (Prevention) Evidence Tables

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Antle, B. F., Sullivan, D. J., Dryden, A., Karam, E. A., & Barbee, A. P. **Year:** 2011 **Citation:** Healthy relationship education for dating violence prevention among high-risk youth. *Children and Youth Services Review, 33*(1), 173–179. **Country of study:** USA **Aim of study:** To determine the impact of a brief (two-day) healthy relationship programme on relationship knowledge, attitudes toward violence, and conflict resolution skills among high-risk youth **Study design:** Before and after study **Quality score:** [+]	**Source population(s):** Economically and socially disadvantaged youth **Eligible population(s):** Youth from economically and socially disadvantaged areas of Metro Louisville **Selected population(s):** "Youth at risk" from economically and socially disadvantaged areas of Metro Louisville: Young people whose background places them "at risk" of future offending or victimization due to environmental, social and family conditions that hinder their personal development and	**Method of allocation:** N/A **Intervention(s) description:** The Love U2: Communication Smarts curriculum consists of seven modules that address healthy and unhealthy relationship patterns, communication and conflict resolution skills, and general problem solving. This training teaches youth skills to form and maintain healthy relationships, as well as to avoid or end unhealthy relationships. An eighth module is on dating violence more directly. The eight modules of the Love U2 Communication Smarts curriculum are offered over two consecutive days on-site at the Y.O.U. programme for high-risk youth. Staff members from the Y.O.U. programme have been trained by project personnel to facilitate the curriculum. Youth sign up for the Love U2 class with their career planners two weeks prior to the training. The classes averaged 10 participants. Four hours of curriculum were presented per day with the additional 2 hours each day used for pre and post evaluation, breaks and lunch. Each student received a participant manual the first day of class and a certificate of completion the last day. The pre-test	**Primary outcomes:** Learning was measured using a knowledge test of the training curriculum written by the authors and developed specifically for this research and consisted of 20 multiple-choice questions on material from each of the key content areas of the training. Communication and conflict resolution skills were assessed with the *Communication Patterns Questionnaire* and *Conflict Resolution Styles Inventory-Partner*. Attitudes toward relationship violence were measured using the *Acceptance of Couple Violence* scale which contains 11 items that measure acceptance of male on female violence, female on male violence, and acceptance of general dating violence. The reported internal consistency reliability is greater than 0.70 for all components of the scale. **Secondary outcomes:**	**Who is the target of the intervention?** Youth at high risk for relationship violence and who are economically and socially disadvantaged **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** *Communication Patterns Questionnaire*: A significant decrease in the demand–withdraw pattern of communication ($t(155)=3.59$, $p<0.0001$). The average pre-training score was 25.67 (SD=10.34), and the average post-training score was 22.68 (SD=10.51).There was also a significant decrease in the mutual avoidance pattern of communication ($t(158)=2.85$, $p<0.01$). The average pre-training score was 8.36 (SD=3.95), and the average post-training score was 7.43 (SD=3.98). *Conflict Resolution Inventory*: A significant decrease in the withdraw dynamic for conflict resolution ($t(167)=2.04$, $p<0.05$). The average pre-training score was 10.00 (SD=3.89), and the average post-	**Limitations identified by author:** No control group utilized and no follow-up data post-intervention. There is also a need to link these immediate outcomes to more long-term outcomes such as reductions in relationship violence and improvements in relationship quality and decision-making. Self-report biases **Limitations identified by review team:** Results not generalisable to other marginalized populations **Evidence gaps and/or recommendations for future research**: Conduct a longitudinal, randomized controlled trial of high-risk youth using the Love U2 healthy relationship curriculum, including direct measurement of communication and conflict resolution skills

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]	successful integration into the economy and society **Excluded population(s):** NR **Sample characteristics:** *Sex*: 60% female, 40% male; *Race*: 74% African Americans, 19% White, 7% other racial groups; *Employment status*: 62% unemployed, 38% employed full- or part-time; *Income:* 88% with gross annual family income of $30,000 or less. Author states these demographics are consistent with the general client population at the Youth Opportunities Unlimited (Y.O.U.) Programme **Setting:** Unclear - educational programme. Urban	was administered on the first day of training prior to the initiation of the lecture and the post-test was administered on the last day of training prior to dismissal. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=233 for the pre-training surveys and 202 for the post-training surveys **Baseline comparisons:** No significant differences in demographic variables between those completing the pre-test and those completing the post-test **Study sufficiently powered:** NR	NR **Follow up period(s):** N/A **Methods of analysis:** Authors compared before and after scores on measures using t-tests		training score was 9.46 (SD=3.71). This decrease in the withdraw dynamic represents an improvement in conflict resolution skills. There was also a decrease in conflict engagement ($t(167)=4.35$, $p<0.0001$). The mean pre-training score was 9.64 (SD=4.12), and the mean post-training score was 8.48 (SD=3.51). *Attitudes toward Couple Violence* scale: A significant improvement in attitudes toward couple violence ($t(114)=2.04$, $p<0.05$); mean pre-training score was 17.16 (SD=6.90); mean post-training score was 16.09 (SD=6.99) **Secondary outcomes:** N/A **Attrition details:** Retention rate of participants for all classes across all sites and formats was 93%. 90% response rate to the surveys at the pre-training data collection point, 78% for immediate post-training	through observational research methods. Researchers should examine the relationship between these immediate relationship gains reported in this study (knowledge, skills, attitudes), and long-term relationship quality and safety. These issues should be examined in light of the dosage question addressed by the present study to determine whether a brief educational intervention can produce similar improvements in relationship safety for high-risk youth. Future research should collect relationship violence data and follow these high-risk youth over time. **Source of funding:** U.S. DHHS, Office of Family Assistance

Appendix O

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Edwardsen, E. A., & Morse, D. **Year:** 2006 **Citation:** Intimate partner violence resource materials: Assessment of information distribution. *Journal of Interpersonal Violence, 21*(8), 971-981. **Country of study:** USA **Aim of study:** To determine the educational impact of placing partner violence resource information in an emergency department washroom **Study design:** Cross-sectional study **Quality score:** [+] **External validity:** [+]	**Source population(s):** All adult patients and visitors at an emergency department. 10%-15% of the population were non-English speakers. **Eligible population(s):** 18 years old and older, patient or visitor to the emergency department, ambulatory or requiring little assistance **Selected population(s):** 70% participation rate (122 of 175). 26 declined to participate, 6 were excluded due to language barriers, and for 21 potential participants, an interviewer was not available. **Excluded population(s):** Patients and visitors less than 18 years old, Spanish-speaking with no interpreter available, participants who could not be interviewed privately **Sample characteristics:** *Gender:* 71% female, 29% male; *Status:* 51 patients, 71 visitors. Women: *Mean age:* 35. Men: *Mean age:* 34. **Setting:** Washroom in an urban emergency department in a tertiary care hospital	**Method of allocation:** N/A **Intervention(s) description:** In a single occupancy restroom, mounted on a wall by the sinks, cardholders for 4"x9" pamphlets, 4"x6" pamphlets, and 2"x3.5" business cards were placed. The Alternatives for Battered Women (ABW) pamphlet discussed the agency, hotline, shelter, counselling groups, children's services, court advocacy, and dating violence education. The Men's Education for Non-Violence (MEN's) pamphlet described forms of abusive behaviour, and the counselling programme that addressed consequences of violence, alternatives to abusive behaviour, and self-responsibility for actions. Pamphlets and resource cards displayed a phone number for the individual to contact each service if desired. Women's literature was in Spanish and English, and MEN's in English only. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=122 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** Author created a 10 question survey instrument (included in article). Questions were formatted for a limited response, and were not intended to elicit disclosure of histories of personal exposure to violence. The instrument was subjected to a pilot test with no significant ambiguity found in the questions and no unusual variance among the test participants. Interviewers received 1.5 hours of instruction. Interviews were held in a private area. **Secondary outcomes:** Literature distribution count **Follow up periods:** N/A **Methods of analysis:** Two-tailed Fisher's exact tests	**Who is the target of the intervention?** All adults at an emergency department, both patients and visitors. Target population of potential victims, abusers, at-risk individuals, and friends and/or family of at-risk individuals **Did they conduct any aspect of sex, gender or diversity analysis?** Responses also reported by gender - see results below **Do they report sex, gender or diversity based factors in findings?** Outcomes by gender: Saw information: 34% of men, 61% of women (p=0.009). Other results nonsignificant by gender **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** 65 (53%) noticed cards or literature. 10 (8%) read the materials. 7 (6%) retained a copy. 19 (16%) knew someone who would benefit from the literature. 9 (7%) said the information was new to them. **Secondary outcomes:** Total literature distributed: 15 ABW cards, 12 ABW pamphlets, 13 MEN's cards, 15 MEN's pamphlets **Attrition details:** N/A	**Limitations identified by author:** Count discrepancies. Lack of men's literature in Spanish. Small sample size **Limitations identified by review team:** Questionnaire very limited, and yes/no format could easily skew answers (e.g. "Did you know what the pamphlets were about?") **Evidence gaps and/or recommendations for future research**: Determine experiences of other EDs, health care, or community settings. Study contacts made to agencies **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Enriquez, M., Cheng, A-L., Kelly, P. J., Witt, J., Coker, A. D., & Kashubeck-West, S. **Year:** 2010 **Citation:** Development and feasibility of an HIV and IPV prevention intervention among low-income mothers receiving services in a Missouri day care centre. *Violence Against Women, 16*(5), 560-578. **Country of study:** USA **Aim of study:** To examine the feasibility of an HIV and IPV prevention intervention that enhances self-esteem, social support, and readiness for healthful behaviour change for women, and to determine which of 3 programme lengths were best received by participants **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Population is predominantly African American. This study's district has one of the lowest education levels per household, ranks among the highest in nonviolent and violent crime rates, and has a smaller percentage of owner-occupied single family homes than other districts in the city. **Eligible population(s):** Women whose children attend a day care **Selected population(s):** On site recruitment. Convenience sample of volunteers, recruited through flyers at the centre's reception desk, posted in the centre, and printed in the newsletter **Excluded population(s):**	**Method of allocation:** Participants were asked to choose one of three start dates, unaware that each start date was linked to a different length of intervention (i.e. participants were blinded to programme length). **Intervention(s) description:** Researchers spent 3 months as weekly volunteers at the centre before the intervention to develop a relationship with staff. 5 lay intervention facilitators were trained during six 2-hour sessions. There were three intervention lengths: 4, 8, and 12 sessions. Lay helpers were supported by nurse. Sessions were held once weekly for 90 minutes, in the evening, with childcare provided. The basic session format was: socialization period, small group work, and music based wrap-up activity of either dance or journalling. Participants in the 4- and 8-session lengths received the same content but spent proportionately less time on each activity. The following is an outline of the 12-session plan: Session 1, overview and goalsetting; 2 & 3, sexual health; 4, reproductive health; 5 & 6, relationship negotiation; 7 & 8, violence against women; 9 & 10, IPV strategies; 11, skill demonstration review; and 12, celebration and support materials. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=25 women completers; 12-session n=10; 8-session n=5; 4-session n=10	**Primary outcomes:** The *Medical Outcomes Study (MOS) Social Support Survey (SSS)* measures emotional support, informational support, tangible support, and positive social interaction. It has 19 items with Cronbach's alpha of 0.97 overall. The *Perlow Self-Esteem Scale (PSES)* was used to examine esteem support, Cronbach's alpha=0.81-0.86. The *Index of Readiness Scale* indicates readiness for healthful behaviour change, reliability=0.89. The Acceptance of General Dating Violence subscale from the *Couple Violence Scale (CVS)* was used to examine attitudes about IPV, used for high school students, who have characteritsics similar to this study population. The *Self-Care Index (SCI)* examines preventive and protective health related behaviours. Qualitative data was collected via a focus group conducted by a social worker and researchers not involved in the intervention. **Secondary outcomes:**	**Who is the target of the intervention?** Low-income single African-American mothers **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Only the 12-session group had significant change in social support (p=0.006), self-esteem (p=0.002), readiness for change (p=0.049), IPV attitudes (p=0.054), and protective health behaviours (p=0.004). No significant changes on any measure for the 8- and 4-session groups. Data from the focus group indicate that participants felt Women Empowering Women (WEW) better prepared them to prevent and recognize sexually transmitted diseases, address IPV, and enhance health. There were also reports of improved social support. **Secondary outcomes:** Qualitative data indicate that participants liked the staff and the dancing activity. All participants preferred a 12-session intervention. **Attrition details:** 31 enrolled, 6 dropped out (19%). Dropouts were significantly less educated (p=0.02). More women dropped	**Limitations identified by author:** No long-term follow-up. Lack of control group. Drop-outs in 8-session group. No IPV screening or assessment **Limitations identified by review team:** No IPV assessment in the post-intervention measurement **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** Centre for the City Urban Research Fellowship

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	NR, all volunteers **Sample characteristics:** *Mean age (Range):* 31 (21-51); *Ethnicity:* 23 (74%) African American, 7 White, 1 no response; *Marital status:* 27 (87%) single, 2 married living with partner, 2 no response; *Education:* 7 (23%) incomplete high school, 11 (35%) completed high school, 11 (35%) some college, no college graduates **Setting:** Large urban daycare centre	Fourteen of the 25 programme completers took part in a focus group. **Baseline comparisons:** NR **Study sufficiently powered:** NR	Participants' satisfaction with programme **Follow up periods:** Post-intervention **Methods of analysis:** Comparisons of pre-to-post-intervention mean scores, and one-tailed paired t-tests were used for the quantitative data. For qualitative data, patterns and themes were identified with content analysis by one internal and one external investigator.		out of the 8-session group.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Enriquez, M., Kelly, P. J., Cheng, A.-L., Hunter, J., & Mendez, E. **Year:** 2012 **Citation:** An intervention to address interpersonal violence among low-income Midwestern Hispanic-American teens. *Journal of Immigrant and Minority Health, 14*(2), 292-299. **Country of study:** USA **Aim of study:** To pilot test "Familias En Nuestra Escuela", an intervention based on ethnic pride as a protective factor against violence. The goals of the Familias En Nuestra Escuela intervention were to increase ethnic pride, enhance self-efficacy for self control, and change attitudes about couple violence and gender. **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Hispanic teenagers **Eligible population(s):** Freshmen and sophomore Hispanic students at a high school **Selected population(s):** Voluntary student participants with their parents' permission **Excluded population(s):** NR **Sample characteristics:** *Grade level:* 26 freshman, 25 sophomore; *Ethnicity:* 88% Latino, 8% African American, 4% Caucasian; *Gender:* 58% female; *Average length of time student's families had lived in the community:* 15 years; *Average household size (range):* 4.5 (2-8) **Setting:** School. Urban vs. rural setting not specified	**Method of allocation:** N/A **Intervention(s) description:** The intervention activities were designed to change attitudes toward violence and dating violence as well as improve prevention efficacy by enhancing ethnic pride (i.e. respect for self, the extended family, the community and Hispanic culture). The intervention was a small group format consisting of students of the same gender in the same grade. The intervention lasted the academic year, with weekly sessions of 45 minutes each. There were 14 sessions in total, one per week, except for the mask activity which spanned 3 sessions. Each session was a combination of education and art/creative activity. The sessions covered: introduction, keeping one's word, stereotypes, Hispanic identity, gender roles, mask-making, impact of teen violence on community, self-control, relationships, cultural pride, goal-setting, and closing celebration. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=51 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** Ethnic pride was measured by the *Ethnic Identity Scale* (alpha=0.66). Other measures were from CDC's Compendium of Assessment Tools for Measuring Violence-Related Attitudes, Behaviours and Influences Among Youths. Perception of self-control was measured with the *Self-Efficacy for Self-Control* scale (alpha=0.71). Acceptance of couple violence was measured by *Attitudes About Couple Violence* (alpha=0.87). Gender stereotyping was measured by *Attitudes about Gender* (alpha 0.74). Incidence of physical fighting was measured with the *Physical Fighting Behaviour* scale (alpha=0.70). Incidence of dating violence was measured with the *Victimization in Dating Relationships* scale (alpha=0.91). Acculturation was measured with the *Short Acculturation Scale for Hispanics (SASH)* (alpha=0.88). **Secondary outcomes:** Qualitative data (i.e. field notes) were transcribed and examined for common themes related to feasibility and receptivity. **Follow up periods:** Post-intervention **Methods of analysis:** A linear mixed model was used to estimate and test the significance of the changes.	**Who is the target of the intervention ?** Hispanic teens **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Ethnic pride increased significantly ($p<0.05$). No other change measures were significant, although there were positive changes in attitudes and incidents of violence. In the linear model, 10th grade participants showed a significantly greater decrease in physical fighting compared to 9th grade participants ($p<0.05$). **Secondary outcomes:** The qualitative observations showed high receptivity to the intervention. Student engagement in intervention activities started off slow but grew as the year progressed. **Attrition details:** NR	**Limitations identified by author:** Small sample size. One site for recruiting. No long-term follow-up **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: The next step in the development of the Familias En Nuestra Escuela intervention is a controlled efficacy trial to examine its impact and sustainability among a larger group of Hispanic-American adolescents. **Source of funding:** National Institute of Nursing Research

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Ernst, A. A., Weiss, S. J., Hobley, K., Medoro, I., Baker, J., & Kanter, J. **Year:** 2011 **Citation:** Brief intervention for perpetration of intimate partner violence (IPV): Simulation verses instruction alone. *Southern Medical Journal, 104*(6), 446-455. **Country of study:** USA **Aim of study:** To compare two brief computer-based education interventions about perpetration of IPV **Study design:** Individual randomized controlled trial [note: authors call this a cross-sectional study, but this is not its NICE classification] **Quality score:** [+]	**Source population(s):** Patients presenting to emergency department **Eligible population(s):** 2 months of patients reporting to emergency department **Selected population(s):** 272 eligible, 32 refused (12%) **Excluded population(s):** 159 people were excluded for various reasons: patients too ill, patients with an arm injury, intoxicated patients, "mentally unstable", patients unable to write English, patients taken to acute care or requiring resuscitation **Sample characteristics:** *Gender:* 48% male, 52% female; *Age:* 9% 18-20, 38% 21-30, 18% 31-40, 16% 41-50, 14% >50. *Ethnicity:* 42% White, 32% Hispanic, 8% African American, 10% American Indian; *Income:* 32% <$10,000, 28% $10,000-$20,000, 15% $20,000-$40,000, 7% >$40,000, 19% no answer; *Education:* 17%	**Method of allocation:** Participants were randomly assigned to receive either the PowerPoint presentation with the simulation, or just the PowerPoint presentation. **Intervention(s) description:** Patients were invited to participate by trained research assistants. Consent, intervention and assessments were held in a private room. The intervention was a PowerPoint presentation about IPV prevention on a touch screen computer, followed by a five-minute university media video showing IPV in adults by trained actors. It showed a bystander unable to stop IPV at home, but later successfully intervening with a male friend and girlfriend. The presentation was in English only. Both intervention and control participants were checked for distress after the intervention and offered services of a social worker or their physician if needed. **Control/comparison(s) description:** PowerPoint presentation of IPV statistics and perpetration **Sample size(s):** Total n=239; Intervention n=121; Control n=118 **Baseline comparisons:** NR **Study sufficiently powered:** Power analysis was conducted. Assuming a 20% prevalence of perpetration of IPV, the study was powered at 80% with 186 participants for finding a	**Primary outcomes:** Evaluation of knowledge, attitudes, and practices was assessed with a knowledge, attitude and practices (KAP) survey created by 6 IPV physicians and researchers, consisting of yes/no questions. Used the *Perpetrator Rapid Scale (PERPS)* for prevalence of perpetrators (Cronbach's alpha=0.68), and *Ongoing Violence Assessment Tool (OVAT)*, plus questions on whether the participant had witnessed IPV as a child and whether the participant had children who witnessed IPV. A "no answer" category was provided. **Secondary outcomes:** NR **Follow up periods:** Post-intervention **Methods of analysis:** "No answer" removed for univariate analysis. Wilcoxon Signed Rank Sums for paired data. Chi-square tests	**Who is the target of the intervention?** All emergency room patients **Did they conduct any aspect of sex, gender or diversity analysis?** All measures used gender analysis - see outcomes **Do they report sex, gender or diversity based factors in findings?** There was no significant difference in KAP scores for men and women. Men in the intervention improved significantly more than men in the control ($p<0.05$, 29% vs. 6%). No significant improvement for women between intervention and control. **Did this study examine or discuss links between DV and substance use or issues of trauma?** 39% declined to answer about partner's use of alcohol, 25%	**Primary outcomes:** There was an increase of 13% (CI=4-22) from pre- to post-test in terms of the proportion of people getting a perfect score on the KAP survey. The intervention condition had significantly higher improvement (Diff=15%, CI=6-24). 40 participants were perpetrators (17%, CI=12-21), 52 participants were victims (22%, CI=17-27). No significant differences were found between the intervention and control for either perpetrators or victims. In addition, no significant difference was found in scores for men and women. However, men in the intervention improved significantly more than men in the control (29% vs. 6%, $p<0.05$). There was no significant difference between women in the intervention and women in the control. **Secondary outcomes:** N/A **Attrition details:** 12 refused participation,	**Limitations identified by author:** Exclusion criteria may have introduced bias, especially critical incident patients who were excluded. KAP not validated **Limitations identified by review team:** Did not account for those who had worsened scores **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]	not a high school graduate, 61% high school graduate, 14% college graduate, 5% professional degree; *Marital status:* 24% married, 52% single, 15% divorced; *Violence:* 31% were child IPV witnesses, 15% said their children have witnessed IPV **Setting:** Urban hospital emergency department	20% improvement in the intervention vs. control group.		declined to answer about partner's drug use. Demographic data: 15% alcohol use, 19% spouse alcohol use, 13% drug use, 8% spouse drug use. No analysis was done on drinking or drug use and outcomes.	and 1 failed to complete the survey. There were no significant differences between those who refused to participate and those who participated in the study.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Florsheim, P., McArthur, L., Hudak, C., Heavin, S., & Burrow-Sanchez, J. **Year:** 2011 **Citation:** The Young Parenthood Programme: Preventing intimate partner violence between adolescent mothers and young fathers. *Journal of Couple & Relationship Therapy, 10*(2), 117-134. **Country of study:** USA **Aim of study:** To pilot test the Young Parenthood Programme (YPP). The YPP is a couples-focused preventive intervention designed to facilitate positive communication skills and relational competence; help young women and their partners manage the intense interpersonal challenges of an unplanned pregnancy and early parenthood; and decrease hostility and prevent the occurrence of IPV. **Study design:**	**Source population(s):** Pregnant adolescents and the biological father **Eligible population(s):** First-time mothers, aged 14-18 years old, and no more than 26 weeks pregnant. Fathers had to be between the ages of 14 and 24. **Selected population(s):** Recruited through medical clinics and school programs for pregnant adolescents. Father had to consent for a minimum of an intake interview. Recruitment rate: 64% of eligible participants. **Excluded population(s):** 5 had a miscarriage or gave up their child for adoption, 6 declined intervention, 10 could not be	**Method of allocation:** Random assignment to either the YPP intervention or treatment-as-usual. "High risk" couples were assigned to the programme director. All others were randomly assigned to a counsellor. **Intervention(s) description:** The intervention focused on the development of positive relationship skills to express warm feelings; provide support and reassurance; regulate hostility and deescalate conflict; state personal needs and feelings clearly and tactfully; listen reflectively and empathically; and repair relationship damage. The length of the programme was 10 weeks (+/- 2 weeks). The intervention was couple-focused and manualized. The phases of the intervention were: introduction and engagement; setting personal and relationship goals; communication skills; role negotiation; summary and looking forward. The intervention was delivered by graduate students with previous clinical experience, a marriage and family therapist, and the programme director. **Control/comparison(s) description:** Treatment-as-usual included prenatal services and psychosocial services, but no coparenting counselling or IPV prevention. Control participants with IPV or child maltreatment were given referrals.	**Primary outcomes:** The study used semi-structured interviews on relationship conflict, open-ended with follow-up probes. Interviews were held in a private room. A 1-3 scale was used for IPV: 1=less severe, 2=moderate, 3=serious violence. A score was calculated based on the average of both partner's responses. Single responses were used to represent a couple when there was only one response. 15% of the codes used in the study were checked for interrater reliability and the mean intraclass correlation coefficient was 0.90. **Secondary outcomes:** NR **Follow up periods:** 3 months postpartum and 18 months postpartum **Methods of analysis:** Repeated measures ANOVA was used to evaluate differences between the treatment and control groups on IPV over time. Descriptive statistics for	**Who is the target of the intervention?** Young couples in pregnancy and early parenthood **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Used the *Drug Use Index* to assess lifetime drug use. Men's mean score was at the threshold for regular alcohol or substance use at some time in their history,	**Primary outcomes:** IPV was 48% at baseline, 54% at 2-3 months postpartum, and 56% at 18 months. 13% of couples at 18 months postpartum reported severe violence. The mean score for IPV on the 1-3 scale was 0.57 at baseline, 0.74 at 2-3 months, and 0.84 at 18 months. Prevalence of female-to-male only violence was 36%. Prevalence of male-to-female violence went from 14.5% at baseline to 28% at 18 months. There was a significant treatment effect on IPV scores from baseline to 2-3 months postpartum, $F(1,86)=3.50$, $p=0.065$; partial $\eta 2=0.04$, but this difference became non-significant at 18 months postpartum. **Secondary outcomes:** N/A **Attrition details:** Attrition among fathers was 16% at 2-3 months and 12% at 18 months. For mothers, attrition was 15% at 2-3 months and 9% at 18 months. There was no	**Limitations identified by author:** Needs to address role of other family members. YPP is not appropriate for couples who are already engaging in serious violence and in need of a higher level of intervention. Small sample size. Exclusion of women with uninvolved partners. **Limitations identified by review team:** IPV measure **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** NIMH and OAPP grants

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Randomized controlled trial **Quality score:** [+] **External validity:** [+]	located for follow-up **Sample characteristics:** *Mean age:* 16 (women), 18 (men); *Ethnicity:* 45% Hispanic, 42% White, 13% other **Setting:** Community based clinic or participants' home. Urban vs. rural setting not specified	**Sample size(s):** Total n=105 couples; Intervention n=55 couples; Control n=50 couples **Baseline comparisons:** No significant differences were found between the treatment and control group at baseline. **Study sufficiently powered:** NR	outcome measures	including the recent past. Women's DUI lifetime score was significantly correlated ($p<0.05$) with IPV scores at all three time points. Fathers' DUI scores were significantly correlated with partner's DUI scores ($p<0.01$).	difference in attrition between treatment and control groups at every time point.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Gadomski, A. M., Tripp, M., Wolff, D. A., Lewis, C., & Jenkins, P. **Year:** 2001 **Citation:** Impact of a rural domestic violence prevention campaign. *Journal of Rural Health, 17*(3), 266-277. **Country of study:** USA **Aim of study:** To measure change in societal attitudes and behavioural intention in response to a seven-month public health education campaign targeting DV in a rural county **Study design:** Before and after study (with comparison group) **Quality score:** [+] **External validity:** [+]	**Source population(s):** Rural county population **Eligible population(s):** NR **Selected population(s):** Pre-intervention response rate was 73%, post-intervention response rate was 65%. Ages 18-50 **Excluded population(s):** NR **Sample characteristics:** Intervention county: *Total population:* 62,000; *Population <19 years old:* 18,108; *Population density:* 60.3; *Unemployment per 100 people in the labour force:* 5.0; *Median household income:* $25,099; *Poverty:* 12.8% at 100% rate, 30.0% at 185% rate; *DV crime:* 51 simple assaults male to female, 5 aggravated assaults, 11 violated protection orders, 253 total DV crime events. Comparison county: *Total population:* 64,700; *Population <19 years old:* 19,075; *Population density:* 46.6; *Unemployment per 100 people in the labour force:* 5.7; *Median*	**Method of allocation:** Used two matched counties **Intervention(s) description:** The intervention was a 7 month campaign with 4,000 30-second radio spots in the first and last month, 12 weeks of still image public service announcements on local cable TV, 105 bulletin board posters, mailings to libraries and clergy, 10 newspaper articles, 36 print advertisements, 15 civic group presentations, and health facility modification including 55 restroom posters, education materials posted in public areas in the hospital, and the distribution of palm cards and victim's rights statements in clinical areas. An art display was used for gathering responses to DV. Radio and print ads were tested in focus groups for SES and gender. The main messages were: recognition of DV, the verbal to physical continuum of abuse, the effects of DV on health and on children, promotion of active public disapproval and actions to take about DV. Gender-neutral or reversed messages were used when possible. Radio spots emphasised talking to one's doctor. The campaign used the state health slogan "no one deserves to be abused." **Control/comparison(s) description:** Comparison county was matched for demographics **Sample size(s):** *Total*: Pre-intervention n=378; Post-	**Primary outcomes:** The research involved a random-digit-dialing telephone survey conducted by a survey research firm. The norms targeted for change were: tacit approval of DV, not talking about DV, and the idea that nothing can be done about DV. The survey instrument used questions from prior research. The interview ended with a bystander vignette of neighbor DV. **Secondary outcomes:** NR **Follow up periods:** Post-intervention **Methods of analysis:** 95% CIs for percentages calculated on survey responses. It was assumed that change in the comparison county represented secular changes due to national media exposure, and so to assess intervention effects alone, these secular change estimates were subtracted from the intervention county estimates.	**Who is the target of the intervention?** Target audience was potential victims and bystanders. Batterers were not targeted. **Did they conduct any aspect of sex, gender or diversity analysis?** Yes **Do they report sex, gender or diversity based factors in findings?** Men had a significantly larger increase in reports of hearing the campaign slogan, from 53% to 71% (p=0.01). There was a 13% increase in men who thought most people would talk to the victim in the vignette (p=0.0001) and a 7% increase in men who thought most	**Primary outcomes:** There was a significant increase in the intervention county in hearing the slogan and exposure to materials, 6% (p=0.03). In response to the vignette where a neighbor was hypothetically abusing their partner, the percentage of respondents who thought most people would: talk to the victim increased 8% in the intervention county compared to 3% in the comparison county (p=0.04), talk to friends increased 4% in the intervention county compared to a 7% decrease in the comparison county (p=0.002), and talk to a doctor increased 3% in the intervention county compared to a 2% decrease in the comparison county (p=0.004). A significantly higher proportion of respondents in the intervention county (59%) than in the comparison county (49%) reported finding educational materials on DV in clinics (p=0.02). Calls to the	**Limitations identified by author:** Perinatal network had radio campaign and posters on DV in the comparison county (contamination). It is difficult to disaggregate the impact intervention from other local and national efforts. **Limitations identified by review team:** Commercial marketing data collection. Heavy reliance on vignette for analysis **Evidence gaps and/or recommendations for future research**: A risk-benefit analysis of behaviour change regarding DV might assist in the development of more actionable public health service messages. **Source of funding:** New York State Department

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	household income: $23,075; *Poverty:* 12.8% at 100% rate, 33.4% at 185% rate; *DV crime:* 62 simple assaults male to female, 3 aggravated assaults, 44 violated protection orders, 335 total DV crime events. Post-intervention respondents: *Age:* 10% 18-24, 23% 25-34, 34% 35-44, 31% 45-50; *Gender:* 60% female; *Employment:* 62% full-time, 10% part time, 11% homemaker, 4% retired, 3% student, 6% unemployed; *Education:* 8% less than high school, 30% high school, 25% partial college, 35% college graduate; *Marital status:* 21% never married, 50% married, 19% divorced, 4% widowed, 4% unmarried couple. 54% with children under 18 in the home **Setting:** Rural. Telephone survey, multimedia campaign	intervention n=633. *Baseline*: Intervention n=240; Control n=138. *Post-intervention*: Intervention n=433; Control n=200 **Baseline comparisons:** Comparisons showed no significant differences **Study sufficiently powered:** The sample size required for a significance level of 5% and 80% power to detect 10% change in the proportion of respondents feeling that DV is a very important issue = 173. The study was sufficiently powered to assess this change.		people would call 911 as a response. **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	hotline increased from 520 precampaign to 694 during the campaign, and 1,145 post campaign. **Secondary outcomes:** N/A **Attrition details:** N/A	of Health Bureau of Injury Prevention

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Keller, S. N., Wilkinson, T., & Otjen, A. J. **Year:** 2010 **Citation:** Unintended effects of a domestic violence campaign. *Journal of Advertising, 39*(4), 53-67. **Country of study:** USA **Aim of study:** To look at the different effects of the "Open Your Eyes" campaign on men and women **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** General public in media campaign area **Eligible population(s):** All who received the mail in-survey. The survey was sent to random stratified samples of 2,500 men and women, matched by demographic distribution of the source population **Selected population(s):** 17% baseline survey response rate, and 15% post-test response rate **Excluded population(s):** NR **Sample characteristics:** Matched to source community with stratified sample **Setting:** Rural. Media campaign	**Method of allocation:** N/A **Intervention(s) description:** Based on the health belief model. The campaign ran from April through the "winter" and included three print ads, and four television ads. “Barbecue”: a man hitting his wife with a spatula during a family barbecue and being put in jail. “Brain injury”: a man "freaking out" as an ambulance arrives, his wife on the floor with her head bleeding. “Teddy bear”: a young boy shaking his teddy bear after seeing his parents have a violent argument. “MP3”: a young woman jogging in an upscale neighborhood, with a voice-over echoing her husband’s emotional abuse. Each ad was followed by a fact about the prevalence of DV and a prompt to call a hotline. **Control/comparison(s) description:** N/A **Sample size(s):** Baseline n=430; Post-test n=374 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** The research involved a mail-in questionnaire, with a reminder letter after one month. Survey questions covered: attitudes toward DV, campaign exposure, awareness of services, perceived severity of DV, and response efficacy (i.e. beliefs that DV counselling and support services are good ways to help victims of DV). Cronbach's alpha was reported only for "perceived severity" (alpha=0.61). **Secondary outcomes:** NR **Follow up periods:** Post-test **Methods of analysis:** Descriptive statistics, t-tests for comparison of means, and ANCOVA to examine the variance in the DV's by campaign exposure and gender	**Who is the target of the intervention?** Public awareness, and abusers and victims (to access a helpline) **Did they conduct any aspect of sex, gender or diversity analysis?** Yes, the researchers examined gender differences in responses **Do they report sex, gender or diversity based factors in findings?** See primary outcomes **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** 21% of women and 21% of men saw the ads. When asked where they saw the ads, 15% responded "TV", and 7% responded "billboards". Action after ad: 4 helped others, 2 left a relationship, 5 recommended someone else leave a relationship, 3 intervened, and 2 called police. Awareness of services: Women had greater awareness at post-test than at pre-test ($p<0.01$). In the ANCOVA for awareness of services, campaign exposure was significant at the 0.10 level ($F=3.02$, $p<0.10$) and age was also significant ($F=6.36$, $p<0.05$). Perceived severity: Gender was significant ($F=7.77$, $p<0.00$), as was the gender x campaign exposure interaction: women's mean score increased significantly ($p=0.01$), men's scores decreased significantly ($p=0.000$). Response efficacy: Women perceived greater response efficacy post-campaign compared to pre-campaign, while the men in the study did not change significantly from before to after the campaign. **Secondary outcomes:** N/A **Attrition details:** N/A	**Limitations identified by author:** Limited comparison with cross-sectional sample. Self-selected sample **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Further research on defensive-avoidance attitudes with qualitative methods, and more research on perceived perceptibility to DV **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Khemka, I., Hickson, L., & Reynolds, G. **Year:** 2005 **Citation:** Evaluation of a decision-making curriculum designed to empower women with mental retardation to resist abuse. *American Journal of Mental Retardation, 110*(3), 193-204. **Country of study:** USA **Aim of study:** To examine the effectiveness of an abuse-prevention curriculum for women with learning disabilities **Study design:** Non-randomized controlled trial **Quality score:** [+] **External validity:** [+]	**Source population(s):** Women with mild or moderate learning disabilities at risk for abuse **Eligible population(s):** Women aged 22-55 years, with mild or moderate learning disabilities (IQ 35-75), who lived with their natural/foster family or on their own, from four programme sites of AHRC New York City, an adult services agency **Selected population(s):** Eligible participants who agreed to take part and whose scheduling and location permitted them to take part **Excluded population(s):** NR **Sample characteristics:** *Mean age (SD):* 34.3 (7.9); *Mean*	**Method of allocation:** At pre-test, participants completed the Decision Making Video Scale, a modified version of the Social Interpersonal Decision-Making Video Scale which measures decision-making skills in response to 12 hypothetical social interpersonal decision-making vignettes involving sexual, physical, or verbal abuse. They were ranked according to their scores on this measure and then randomly assigned from matched pairs to either the intervention or the control group. **Intervention(s) description:** The curriculum, An Effective Strategy-Based Curriculum for Abuse Prevention and Empowerment (ESCAPE), was designed to empower women with learning disabilities to become more effective decision-makers, with the tools to protect themselves against violence and abuse. Sessions were 40-50 minutes, once or twice a week, over a 6-12 week period in small group (3 women) sessions at participating sites. Each group was led by a curriculum trainer who had received 15-18 hours of instruction and practice in administering the ESCAPE curriculum. The ESCAPE curriculum has 12 lessons and 6 support group sessions covering three units: Unit I (Knowledge of Abuse and Empowerment) consisted of five lessons designed to teach cognitive concepts of abuse and empowerment. Unit II (Decision-Making Strategy Training) consisted of six lessons focused on teaching participants a self-instructional, four-step decision-making process in simulated situations of abuse: identification and definition, or framing (Is	**Primary outcomes:** Instruments were modified to ensure that items were appropriate for the project participants in terms of comprehension level and cultural content. The *Knowledge of Abuse Concepts Scale* (inter-rater reliability=0.81) assessed understanding of types of abuse (e.g., physical, sexual, verbal, rape) and the meaning of giving consent to a relationship. The *Empowerment Scale* was developed for this project to assess perceptions of control and self-efficacy. Cronbach alpha=0.61. The *Stress Management Survey* measured self-reported stress levels. Cronbach alpha=0.55. The *Self Decision-Making Scale* was included as an overall measure of decision-making in situations of abuse. It measures participants' ability to suggest self-protective decisions in response to simulated interpersonal situations involving different scenarios of sexual, physical, and	**Who is the target of the intervention?** Women with mild or moderate learning disabilities at risk for abuse **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Significant differences between groups were obtained for three of the four measures: *Knowledge of Abuse Concepts Scale* ($t(34)=2.91$, $p<0.01$), *Empowerment Scale* ($t(34)=2.15$, $p<0.05$), and *Self Decision-Making Scale* ($t(34)=3.13$, $p<0.01$). Participants in the intervention group had higher post-test means (indicating higher knowledge, empowerment, and prevention-focused decision-making for self) than did their counterparts in the control group on all three measures. These effects were maintained at post-post-test (after Unit III). Group differences were not significant for post-test scores on the *Stress Management Survey*. **Secondary outcomes:** N/A **Attrition details:** Only 10 of the 18 control group members completed the post-post-test measures	**Limitations identified by author:** NR **Limitations identified by review team:** Short-term follow-up only. Did not assess behavioural outcomes such as the actual presence of DV **Evidence gaps and/or recommendations for future research**: Longitudinal studies to evaluate the long-term effectiveness of a curriculum like ESCAPE **Source of funding:** A grant from the Joseph P. Kennedy, Jr. Foundation

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	IQ (SD): 55.9 (10.6); *Ethnicity:* 50% African American, 33% White, 17% Hispanic **Setting:** Urban. AHRC New York, an adult services agency	there a problem?); alternative choice generation (What are the choices?); consequence evaluation (What will happen if ?); and selection of the best course of action (What is the best decision?). Unit III (Structured Support Groups) consisted of a six-session support group experience designed to allow for review and application of the knowledge and decision-making skills acquired in Units I and II. During the support group sessions, participants were encouraged to talk about their own life experiences and apply the information and strategies learned to their own experiences. Each of the six support group sessions included semi-structured group activities for which materials were provided. The group sessions were co-facilitated by the trainer who delivered instructional Units I and II and a designated social worker on the agency staff. **Control/comparison(s) description:** Participants in the control group received no specific intervention, but had access to the existing abuse prevention services offered by the agency, which typically included counselling with a social worker as well as sex education activities. **Sample size(s):** Total n=36; Intervention n=18; Control n=18 **Baseline comparisons:** No significant differences between groups at pre-test **Study sufficiently powered:** NR	verbal abuse. Interrater reliability between two trained raters was 0.84. Blind post-testing and post-post-testing was conducted by project team members who had not worked with participants during the treatment phase. **Secondary outcomes:** NR **Follow up periods:** Post-testing was conducted from 1 week to almost 3 months after units I and II of ESCAPE (different women had different availabilities). A second post-test was conducted from 1 week to 4 months after unit III of ESCAPE (most women completed this second post-test within 1-3 weeks of finishing unit III). **Methods of analysis:** Independent samples t tests		after Unit III. All intervention group members completed the post-post-test measures.	

Appendix O

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Salazar, L. F. & Cook, S. L. **Year:** 2006 **Citation:** Preliminary findings from an outcome evaluation of an intimate partner violence prevention programme for adjudicated, African American, adolescent males. *Youth Violence and Juvenile Justice, 4*(4), 368. **Country of study:** USA **Aim of study:** To evaluate the efficacy of a five-session IPV prevention programme for adjudicated African American adolescent males **Study design:** Randomized controlled trial **Quality score:** [++] **External validity:** [+]	**Source population(s):** Adolescent males in the state of Georgia adjudicated to an IPV prevention programme **Eligible population(s):** Adjudicated, adolescent males at the Juvenile Justice Courthouse in DeKalb County, Georgia who were mandated by their probation officer to attend the programme during the period June 1999 to May 2000. Probation officers would refer males if they were adjudicated for committing mildly violent and abusive behaviours toward a female, if they experienced violence within their homes either as a victim or a perpetrator, or if they revealed to court personnel that violence influenced their behaviour (e.g., gang member, or made verbal threats). **Selected population(s):** Those in the eligible population who agreed	**Method of allocation:** After informed consent was obtained, the first author administered the pre-test and opened a sealed envelope indicating assignment to either the intervention group (began the programme immediately) or the wait-list control group (told to return in 2 weeks to begin the programme). No further details on how randomization was conducted. **Intervention(s) description:** The intervention was a five-session IPV prevention programme guided by feminist theory and targeted at African-American males. Session 1 (Stage Setting): 2-hour session to enhance adolescents' awareness of their personal location at the courthouse, the nature of their problems regarding their delinquency, and the communal and personal responses to violence toward women and girls. Session 2 (The Court Class): Participants attended a 2-hour court class at an adult courthouse for men who were arrested for battering. This class was an overview of the basic principles taught in the "Men Stopping Violence" 6-month Batterers Intervention Programme. Sessions 3 and 4 (The Batterers Intervention Classes): Participants met with co-instructors for 30 minutes before attending a 2-hour class for men working in the 6-month batterers programme. The purpose of this meeting was to review the respective roles of the participants and the instructors.	**Primary outcomes:** Knowledge of IPV and patriarchal attitudes was assessed with *Violence in relationships: A Seventh Grade Inventory of Knowledge and Attitudes* (18 true/false knowledge statements and 12 Likert-scale-rated attitude statements; adequate reliability for the attitudinal portion) and the Wife Beating Is Justified subscale of the *Inventory of Beliefs About Wife Beating* (acceptable reliability and construct validity). The authors also examined whether outcomes differed depending on whether participants had witnessed parental violence or committed violence themselves. For the prevalence of witnessing parental violence, the authors used a modified form of the *Revised Conflict Tactics Scale (CTS2)* which included 12 items asking participants whether they had ever witnessed their father, male guardian, or male partner of their mother display any of the behaviours (e.g., hit, slap, etc.) while in conflict with their mother	**Who is the target of the intervention?** African-American adolescent males in the state of Georgia adjudicated to an IPV prevention programme **Did they conduct any aspect of sex, gender or diversity analysis?** The authors compared results including and excluding the two White participants (given that the programme was tailored for African-Americans), and also looked at these two individuals' scores compared to the rest of the sample. **Do they report sex, gender or diversity**	**Primary outcomes:** Compared to the control group, the intervention group at post-test had higher levels of knowledge (R^2 =0.12, p<0.05) and less patriarchal attitudes (R^2=0.08, p<0.05 one-tailed on the Wife Beating is Justified subscale only, but not on the Seventh Grade Inventory) and these effects were maintained at 3-month follow-up. Committing violence was not a significant moderator of intervention effectiveness. The witnessing-parental-violence x group interaction approached significance (p=0.08): adolescents in the intervention group had significantly lower patriarchal attitudes post-test compared with adolescents in the control group, but only for those who witnessed high levels of parental male-to-female violence. **Secondary outcomes:** N/A **Attrition details:** 60 males were referred to	**Limitations identified by author:** The use of a wait-list control group versus an attention comparison group does not rule out the potential of demand characteristics or that the participants in the intervention group responded in socially desirable ways. The small sample size obtained in this study suggests that the results may be limited in terms of generalisability. **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Explore why witnessing parental male-to-female violence impacts the effectiveness of the programme. Have a longer follow-up and assess changes in behaviour **Source of funding:** The study was based on the first author's doctoral dissertation and was supported in part by a dissertation award from Georgia State University.

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	to participate **Excluded population(s):** NR **Sample characteristics:** *Currently attending school:* 84%; *Mean grade level in school (SD):* 8.83 (1.41); *Ethnicity:* 92% African American, 5% White, 3% other; *Living situation:* 65% indicated their father did not live in the household, 32% lived with both parents, 3% did not live with either parent; *Committed at least one act of violence against a female at baseline:* 76%; *Witnessed at least one act of male-to-female violence between parents at baseline:* 40% **Setting:** Urban. Juvenile court building and an adult courthouse	Class members (adult batterers) were prepared for the adolescents' participation, and introductions were made. The 2-hour class then followed. Session 5 (The Review Class): Provided the adolescents with a forum to express themselves in respect to their salient memories from the previous interventions. Adolescents were not restricted as to the number of review sessions they could attend. **Control/comparison(s) description:** The control group took part in the intervention, but with a delay of two weeks. I.e. The intervention group did a pre-test, took part in the intervention, did a post-test, and then a 3-month follow-up. The control group did a pre-test, waited for 2 weeks, did the post-test, and then entered the intervention (with no 3-month follow-up). **Sample size(s):** Total n=37; Intervention n=21; Control n=16 **Baseline comparisons:** No significant differences between intervention and control group on sociodemographic variables or the study variables at baseline **Study sufficiently powered:** NR	or another woman (CTS2-witnessing was reliable, Cronbach's alpha=0.91). Prevalence of committing violence was assessed with the Physical Assault (12 items) and Sexual Coercion (7 items) subscales of the CTS2 (good reliability, alpha=0.89). **Secondary outcomes:** N/A **Follow up periods:** Follow-up at 3 months for the intervention group only **Methods of analysis:** ANCOVA using hierarchical multiple regression	**based factors in findings?** Excluding the two White participants' scores did not change the findings. Looking at their scores individually, one of the White participants showed changes in knowledge and attitudes in the desired direction, while the other showed changes in the undesired direction. **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	the study. 47 agreed to participate. 37 completed all measures and were included in the final analyses. There were no significant differences between programme completers and dropouts.	

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Scottish Executive, Reid Howie Associates Ltd **Year:** 2002 **Citation:** Evaluation of the Zero Tolerance "Respect" Pilot Project: Summary Report. **Country of study:** Scotland **Quality score:** [+]	**What was/were the research question(s)?** To evaluate the pilot of the "Respect" educational programme **Theoretical approach:** NR **How were the data collected?** Data used included: project-related materials of the pilot and related work in Scotland; interviews with steering group members before (n=7) and after the project (n=6); interviews with staff at the start (n=37) and end (n=34) of the project; interviews with youth participants at the start (n=81) and end (n=71) of the project; data from self-completion questionnaires to all young people at the start (n=377) and end (n=236) of the project; staff feedback forms after each session; group discussions and debriefing sessions.	**What population was the sample recruited from? How were they recruited?** The project took place in two secondary schools, two primary schools, and seven youth groups from Edinburgh and Glasgow in early 2001. **How many participants were recruited?** See data collection methods for info on numbers of each stakeholder group providing evaluation data **Inclusion and exclusion criteria:** NR **Population demographics:** NR	**Description of intervention(s):** The "Respect" project involved primary prevention work to address violence against women and promote relationships based upon equality and respect. The main content of the educational package comprised teaching materials for 7-8 sessions in each setting, but the project also included the use of a CD (made available to older participants), bus sides, posters and a screensaver. The materials for secondary schools and youth groups involved eight sessions using a variety of activities that covered a number of topics: the meaning of respect, showing respect, power and misuses of power (e.g. bullying, physical violence, racial and sexual harassment), unfair treatment, violence and abuse in relationships, discrimination, and gender stereotypes. The primary programme covered broadly similar issues, using materials considered appropriate to the different age group. Topics included: respect, communication,	**Method and process of analysis:** NR **Key themes relevant to this review:** As an evaluation of a pilot programme, many of the findings related to opinions of delivery and implementation (e.g. whether people the programme was a good idea; whether staff thought the training was good or not; opinions about the learning materials; how much participants enjoyed the programme; feedback on logistics like timing, group composition, and venues; etc.) and so are not summarized here. Findings related to programme outcomes follow: The majority of young people suggested that the project had increased their knowledge of sources of help, and there was an overall perception of improved understanding. 85% of staff believed that this was a successful project and the benefits identified for the staff included increasing their skills, providing them with additional knowledge and providing the opportunity to consider these issues. Young people identified the benefits to them as including raising awareness of the issues, encouraging them to treat each other properly and beginning to work to prevent violence and abuse. Both staff and young people believed that there had been changes in many of the	**Did they conduct any aspect of sex, gender or diversity analysis?** Though some gender-specific findings were noted (e.g. "more than 1 in 7 boys thought it was fun to 'make fun of people'"), the findings related to programme outcomes/impacts were presented as summary statements across both genders. **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** N/A **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Male and female youths in Scotland	**Limitations identified by author:** NR **Limitations identified by review team:** Primarily subjective opinion data using unvalidated tools. Limited information on methodology and how data were analysed. Unable to assess how representative the findings are **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** The Scottish Executive

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
			cooperation, name-calling, group identification, appearances, bullying, power, harassment (racial, sexual, and other), and stereotypes, including gender stereotypes. **Intervention setting:** Primary schools, secondary schools, and youth groups	young people as a result of the work (even though these may not always be measurable). 78% of primary school pupils and almost half of the older participants believed that they had changed personally as a result of their participation in the project. More than 80% of young people believed that they had learned more about respect for each other. Around 3/4 believed that they had learned more about communication, and more than 3/4 that they had learned more about equality and about power. Around 80% of all of the older participants believed that they had learned more about violence and abuse. Despite these positive views of the outcomes, however, the exploration of the views of young people after the project indicated that there were still some issues for which there remained a continuing need for work, particularly in areas such as gender stereotyping, some forms of harassment and perceptions of violence against women.		

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Solomon, S. & Fraser, O. **Year:** 2009 **Citation:** Domestic Abuse 2008/09: Post Campaign Evaluation Report. Scottish Government Social Research. **Country of study:** Scotland **Aim of study:** To evaluate the impact of Wave 12 of an annual domestic abuse campaign **Study design:** Cross-sectional study **Quality score:** [+] **External validity:** [-]	**Source population(s):** General adult population in Scotland **Eligible population(s):** General adult population in 52 constituencies in Scotland **Selected population(s):** A representative sample of the adult population in Scotland in terms of sex, age, employment status, and socioeconomic group, using quota sampling and a random route technique within each sampling point to select addresses. Respondents had to be age 16 or older. **Excluded population(s):** NR **Sample characteristics:** NR **Setting:** The	**Method of allocation:** N/A **Intervention(s) description:** The Scottish Government, working under the Safer Scotland superbrand, has conducted an annual Domestic Abuse campaign for the past 11 years, conducting post-campaign evaluations to track attitudes and perceptions towards domestic abuse and the media executions. The main message of the most recent wave (Wave 12) was that there is help out there for people who find themselves in abusive situations. This was supported by the introduction of a new TV advert, “I Soar”. The campaign ran for four weeks from Dec 26/08 and consisted of TV and online advertising, containing the contact details for both the Scottish Domestic Abuse helpline and the website. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=1,040 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** The researchers used a monthly in-home survey based directly on the previous wave to ensure comparability, with additional questions directly related to the most recent advertising campaign being included. Those parts of the questionnaire thought to be particularly sensitive were completed by the respondents themselves, directly into CAPI machines. The interview protocol is provided in the paper, and includes Likert-scale and multiple-choice questions assessing awareness, opinions, beliefs, and behaviours related to domestic abuse. **Secondary outcomes:** NR **Follow up periods:** None **Methods of analysis:** The final data set was weighted to match the 2001 Census results.	**Who is the target of the intervention?** The general public in Scotland **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The proportion of respondents who had any experience of domestic abuse dropped from Wave 11 from 38% to 21%, with 8% having personally been the victim of domestic abuse. The number of respondents who stated that domestic abuse is something that happens in all age groups dropped from 45% in Wave 11 to 32%, whilst the number of people saying that domestic abuse was most common amongst younger people remained steady at 76%. Respondents were most likely to say that domestic abuse was most common within working classes (87%). Nearly half of all respondents (45%) spontaneously cited "police/ ambulance/ emergency services" as a service available to women who might be experiencing domestic abuse, with Women's Aid a close second (42%). Only 13% mentioned the Scottish Domestic Abuse Helpline, which was featured in the ad campaign. Although the proportion of people spontaneously aware of advertising or publicity about domestic abuse has been consistently high at more than seven in ten over the previous four waves, in Wave 12, this proportion dropped to 30% (39% when prompted). This may be a result of the different softer campaign strategy, the reductions in media spend and the media mix utilised this Wave. Of those who recalled seeing or hearing the ad campaign, 90% could recall at least one element of the TV execution and almost a third recalled either a direction to telephone or visit the website. Only 36% of respondents agreed or agreed strongly with "I believe there are	**Limitations identified by author:** NR **Limitations identified by review team:** Mainly assessing awareness of the campaign and opinions. Single-group, post-test only design **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	campaign was on TV and online. The interviews were conducted in respondents' homes. Urban vs. rural setting not specified				enough services available to help women who may be experiencing domestic abuse". When public attitudes towards domestic abuse were assessed there was little change for the majority of statements; but there was a drop in those agreeing that those subjected to domestic abuse "can escape from domestic abuse and make a new life for themselves", and a correlating upturn in those believing such people "just had to learn to live with it". The majority of respondents thought that pornography and prostitution were exploitative of women (56% and 63% respectively) and that "pressuring a woman to take part in sexual activities if she doesn't want to" was either unacceptable or totally unacceptable (97%), a slight increase on Wave 11. 26% thought that a woman was in part responsible for being raped "if she is drunk", but for all other circumstances figures have dropped. **Secondary outcomes:** N/A **Attrition details:** N/A - respondents in the final analytic sample either did or did not complete the survey	

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Toews, M. L., Yazedjian, A., & Jorgensen, D. **Year:** 2011 **Citation:** "I haven't done nothin' crazy lately:" Conflict resolution strategies in adolescent mothers' dating relationships. *Children and Youth Services Review, 33*(1), 180-186. **Country of study:** USA **Quality score:** [+]	**What was/were the research question(s)?** How did conflict resolution strategies in participants' dating relationships change after a skill-based relationship education programme? **Theoretical approach:** The study was guided by social learning theory **How were the data collected?** 23 focus groups were conducted from Spring 2007 to Fall 2008, with an average of 9 participants per group (range 3-16). The moderator followed a semi-structured interview protocol, asking the following questions: 1. How helpful has the programme been for you? 2. What specific topics were the most helpful? 3. How has the programme affected your conflict resolution skills? 4. Can you provide an example of how you resolved a conflict before you attended the programme? 5. How would you resolve a conflict now that you have attended the	**What population was the sample recruited from? How were they recruited?** Pregnant and parenting adolescents enrolled in Pregnancy, Education, and Parenting (PEP) programs in six high schools in central Texas were invited to participate in sessions focusing on relationship building skills. **How many participants were recruited?** 199 **Inclusion and exclusion criteria:** NR **Population demographics:** *Ethnicity:* 87% Hispanic, 7% Black, 3% White, 3% biracial; *Mean age:* 16.4 (range 14-18); *With children:* 83%	**Description of intervention(s):** The goal of the Strengthening Relationships programme was to assist adolescent parents in building and maintaining healthy relationships by helping them develop their personal and relationship skills. Adolescent parents met in groups of 10–30 each week for 12 weeks. The sessions were both interactive and didactic in nature, and covered topics such as creating realistic expectations about relationships, improving communication and conflict resolution strategies, and learning skills to build and maintain healthy relationships. Specifically, twelve lessons from the Connections: Relationships and Marriage curriculum were used as the basis for the programme.	**Method and process of analysis:** Transcripts were thematically coded by a team of graduate student coders, using a constant comparative method of interpretative analysis. All team members independently read one transcript and developed codes utilizing line-by-line analysis. After individually coding the first transcript, the team met and resolved coding discrepancies by reaching consensus regarding the best representation of the data. Team members followed the same pattern with the other focus groups, individually coding and then meeting as a team. Codes were refined and new codes were developed during these meetings. Once all transcripts were read, the team went through each transcript again and recoded using the final coding sheet. **Key themes relevant to this review:** The authors identified four themes. First, adolescent mothers were both perpetrators and victims of psychological and/or physical abuse. Second, adolescent mothers reported learning positive conflict resolution strategies in the programme (e.g. "I" statements, alternatives to physical violence). “[We learned the importance of] communicating more instead of us always yelling. Actually talk.” "Yeah, I start to say those I statements now. Instead of saying, you you you, I say, I feel like." Many mothers noted they were unaware of these strategies prior to the programme because the role models in their lives didn't use these	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Pregnant and parenting adolescents. The article only reports on data from females, and most of the sample was Hispanic.	**Limitations identified by author:** Potential lack of generalisability. Only used self-report of the female partners **Limitations identified by review team:** Focus groups were the only data source. Subjective measures. Single-group post-test only design **Evidence gaps and/or recommendations for future research:** Recommendations for future research were not provided, but the authors recommend that future programs should more specifically address abusive behaviours in dating relationships, and educate both partners. **Source of funding:** United States Department of Health and Human Services, Administration for Children and Families (Grant: HHS-2006-ACF-OFA-FE-0033)

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
	programme? 6. How has your relationship with your partner changed as a result of the programme? 7. In what ways do you feel you have benefited from being in the programme? The interviews were tape recorded and transcribed verbatim.		**Intervention setting:** Not explicitly stated, but seems like the intervention took place at the high schools	strategies. Third, participants talked about implementing new conflict resolution strategies as a result of participating in the programme. "Every Wednesday we would learn something new and I would try it out and it would work for me. I haven't done nothin' crazy lately." Some adolescent mothers began to realise the impact their own negative behaviours had on their partners. "But, now [after participating in the programme] I see, dang I was mean to him. I was abusing him. But, now I don't." "He was like "I really think it's working," I was like "you think so?" I didn't see it, but I guess he saw it because he was used to me always nagging on him and stuff." Fourth, a small number of adolescent mothers even reported ending abusive relationships. "What I'm looking for, I'm not getting it from him, so that's why I'm not with him no more. I broke up with him."		

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Wray, R. J., Hornik, R. M., Gandy, O. H., Stryker, J., Ghez, M., & Mitchell-Clark, K. **Year:** 2004 **Citation:** Preventing domestic violence in the African American Community: Assessing the impact of a dramatic radio serial. *Journal of Health Communication: International Perspectives, 9*(1), 31-52. **Country of study:** USA **Aim of study:** To evaluate the impact of "It's Your Business", a dramatic radio serial promoting DV prevention in the African-American community **Study design:** The study was designed as a before and after study, but due to inadequate implementation for reasons beyond the authors' control, the final analysis was cross-sectional **Quality score:** [+]	**Source population(s):** African Americans in the US **Eligible population(s):** African Americans who were regular listeners of the radio stations that broadcast the radio serial **Selected population(s):** Only one of the initial four evaluation cities was included since three cities did not give the radio serial sufficient air time to warrant an evaluation. A random digit dial sample was purchased, focusing on specific telephone exchanges where the likelihood was greater than 60% that an answering respondent would be African American. Respondents had to be over 18, African American, able to respond in English, and a	**Method of allocation:** N/A **Intervention(s) description:** The radio serial was a "social drama" consisting of twelve 90-second episodes, which aimed to encourage African Americans to talk and offer support to victims of abuse and become more aware of, and condemn, DV in conversation. The series featured a central character, Ma B, who was the host of a community affairs radio call-in show that began each of the 12 campaign segments. At the beginning of each episode Ma B would provide an ‘‘update’’ about a local DV trial, which served as a framing device that allowed other ‘‘characters’’ in Ma B’s fictional audience to discuss, and thereby reinforce the relevant lesson of that particular episode. Different episodes promoted specific elements of the overall theme. The first episode encouraged listeners to speak out about DV. Other episodes modeled characters offering help to a victim and providing information about where to seek help. Within this fictional audience, a set of recurring characters made up an extended family that struggled over the course of the series to convince a young woman in the family to leave her abusive husband. Each episode concluded with a telephone number listeners could call for information about how to get involved in their communities. The programme was made available to a wide range of radio stations across the country through the African-	**Primary outcomes:** Five waves of telephone surveys were conducted in total. Pre-broadcast telephone interviews were approximately 15 minutes long; and post-broadcast interviews were about three minutes longer. The pre-broadcast instrument included measures of demographics, experience with DV, racial identification, media use, and a series of measures designed to capture beliefs, attitudes, intentions, and behaviours related to the goals of the campaign. Exposure measures included a general item which was asked in the pre-broadcast surveys to assess the level of false positives, the tendency to recall exposure to the programme even before it was broadcast. The analysis assessed general beliefs about DV (e.g. "DV is one of the most important problems in your community") rated on a 1-5 scale ranging from strongly disagree to strongly agree; intentions to talk to a DV victim in hypothetical scenarios (yes/no); and dichotomous self-reports of whether the respondent had recently talked to a victim of DV or engaged in general	**Who is the target of the intervention?** African Americans in the US **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** 66% of respondents were classified as unexposed (i.e. could not recall hearing the radio serial), 9% were moderately exposed (i.e. recalled hearing the radio serial, answered a very simple recall question about the storyline correctly, and claimed to have heard 3+ episodes or any episode 3+ times), and 25% had ambiguous exposure (i.e. reported hearing the series, but either answered the recall question incorrectly or did not report hearing 3+ segments). Moderately exposed respondents scored higher than unexposed respondents on 21 out of 27 anti-DV beliefs and behaviours; 10 differences were statistically significant (p's<0.05). However, the moderate exposure group only displayed stronger outcomes than the ambiguous exposure group in 2 out of the 27 outcomes at a statistically significant level, which is about what would be	**Limitations identified by author:** Even in the one city which was included in the final analysis, the radio serial was broadcast less frequently than originally planned, and there was a shift in the programme schedule from one radio station to another, which likely reduced the level of exposure. Low levels of exposure meant that the authors couldn't validly test their hypothesis that radio serials such as this have an effect on beliefs, attitudes, or behaviours. Potential for biases on self-report measures **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Research how to achieve and reliably measure exposure in public health communication, as well as how to maximize effects

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]	listener of the relevant radio station. **Excluded population(s):** NR **Sample characteristics:** Detailed demographics not reported. All telephone interviewees who were included in the analysis were African American. **Setting:** Radio. Urban vs. rural setting not specified	American-owned network. The recommended schedule included several airings of each episode over the course of a week, with new episodes introduced on a weekly basis, totaling 12 weeks. The Family Violence Prevention Fund also sought to link DV agencies with radio stations in each city to encourage the broadcasts, provide local contact information, and generate press coverage. **Control/comparison(s) description:** N/A **Sample size(s):** Total analytic sample=1,083; Pre-broadcast n=385; Post-broadcast n=698 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	talk condemning DV. **Secondary outcomes:** NR **Follow up periods:** NR **Methods of analysis:** Descriptive statistics for assessing level of exposure to the programme. Cross-sectional dose-response analysis conducted on the post-broadcast data only, in order to examine any relationship between exposure and beliefs, attitudes or behaviours		expected by chance. The authors conclude that the association of moderate exposure and anti-DV outcomes was most likely an artifact of selective perception (i.e. those already concerned about DV would be more likely to remember the radio serial), and not a result of exposure alone. **Secondary outcomes:** N/A **Attrition details:** 84% of eligible respondents participated in the telephone interview	from limited exposure. **Source of funding:** NR

Table 61. Research Question 2 (Screening) Evidence Tables

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Ahmad, F., Hogg-Johnson, S., Stewart, D. E., Skinner, H. A., Glazier, R. H., & Levinson, W. **Year:** 2009 **Citation:** Computer-assisted screening for intimate partner violence and control: A randomized trial. *Annals of Internal Medicine, 151*, 93-102. **Country of study:** Canada **Aim of study:** To test the effectiveness of a computer-assisted screening for increasing detection of intimate partner violence and control (IPVC)	**Source population(s):** "Diverse patients" in a multi-physician clinic described as being "inner city" **Eligible population(s):** Female patients ages 18+ at the clinic who were in a current or recent (in past 12 months) intimate relationship, and were able to read and write English **Selected population(s):** Eligible patients who consented to participate **Excluded population(s):** Patients who declined to participate and those who could not complete informed consent, either because they were called into their medical visit or the research room was busy **Sample characteristics:** Physicians: *Gender:* 64% female; *Ethnicity:* 64% White; *Mean age (SD):* 46.0 (11.3); *Mean years in clinical practice (SD):* 16.1 (9.9); *Mean practice hours per week (SD):* 40.6 (6.6). Intervention patients: *Mean age (SD):* 43.5 (14.8); *Birth country:* 60% Canada, 15% Europe, 12% Asia; *Marital status:* 60% married, 19% living with partner, 17% single; *Percent with children <15 years old at home:* 30%; *Highest education:* 22% some or completed high school, 37% some or completed	**Method of allocation:** Participants were randomly assigned to intervention or control with a 1:1 allocation ratio, using a random-number sampling scheme stratified by participating physicians. The randomization was computer-generated by an off-site biostatistician and patient assignments were sealed in opaque envelopes opened after the patients' written consent. **Intervention(s) description:** The intervention was a computer programme that administered a validated survey to patients. The programme, called "Promote Health", was modified to fit the Canadian family practice context. It included 79 questions on IPVC and alcohol, tobacco, and street drug use; risk for sexually transmitted infection; road and home safety; depression; cardiovascular risks; and sociodemographic factors. Risks assessed were physical or sexual violence, threat of violence, and control by partner. After completing the survey (average completion time=7 minutes), the computer generated 1-page risk reports which were attached to the women's medical charts for physicians to review. Any "yes" response to IPVC-related questions was reported on the risk	**Primary outcomes:** The primary outcomes were whether the patient or physician raised the possibility of the patient being at risk for IPVC (discussion opportunity) and, for cases in which an opportunity occurred, whether the risk was detected when the woman identified that risk as being present and recent (IPVC detection). Outcome measures were derived from audiotapes of the medical visits, which were coded by two researchers blinded to participants' group assignment. IPVC discussion opportunities were coded as "yes" or "no". IPVC was coded as "absent", "present and recent", or "present in the past". After their visit, women completed a pencil-and-paper exit survey which included the same IPVC questions from the computer	**Who is the target of the intervention?** Adult women in a general family practice and family practice physicians **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss**	**Primary outcomes:** Overall prevalence of any type of IPVC according to exit survey data was 22%, with no statistically significant difference between the intervention and control groups (20% and 23%, respectively). The computer-generated risk report improved the frequency of opportunities to discuss IPVC: discussion opportunities were present for 35% of intervention patients and 24% of control patients (adjusted relative risk (RR)=1.4, CI: 1.1-1.9). The intervention also improved detection of IPVC (18% of intervention patients and 9% of control patients; adjusted RR=2.0, CI: 0.9-4.1), indicating that the intervention facilitated conversations in appropriate patients. The researchers conclude that computer screening in the waiting room can screen for partner violence, possibly at an early stage. **Secondary outcomes:** Among detected cases, physicians assessed patient safety more often in the intervention group (9 of 25 participants) than in the control group (1 of 12	**Limitations identified by author:** Only one clinic in the trial. Physician volunteer bias from study participation.Could not tell whether patients with more comorbid conditions experienced the same benefits from screening as those with fewer comorbid conditions, since clinic visit time might be taken up with discussion of these comorbid conditions. Lack of information on types of IPV experienced or the underlying mechanism that improved detection. No assessment of patients' actual utilization of services they were referred to **Limitations identified by review team:** Age of participants

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
and creating discussion opportunities between patient and physician provider **Study design:** Individual randomized controlled trial **Quality score:** [++] **External validity:** [++]	college, 29% some or completed university, 13% some or completed postgraduate; *Current employment status:* 74% full or part time, 13% not employed, 14% retired, on disability, or on maternity leave; *Annual household income:* 29% ≤$40K, 17% $40,001-$60,000, 16% $60,001-$80,000, 16% $80,001-$100,000, 23% >$100,000; *Computer use in past month*: 83% daily to three times per week, 8% once a week or once a month, 9% never. Control patients: *Mean age (SD):* 44.1 (13.8); *Birth country:* 71% Canada, 13% Europe, 7% Asia; *Marital status:* 53% married, 17% living with partner, 24% single; *Percent with children <15 years old at home:* 28%; *Highest education:* 14% some or completed high school, 30% some or completed college, 38% some or completed university, 18% some or completed postgraduate; *Current employment status:* 69% full or part time, 14% not employed, 17% retired, on disability, or on maternity leave; *Annual household income:* 28% ≤$40K, 19% $40,001-$60,000, 12% $60,001-$80,000, 17% $80,001-$100,000, 25% >$100,000; *Computer use in past month*: 79% daily to three times per week, 13% once a week or once a month, 8% never. **Setting:** Urban inner-city multi-physician family practice clinic	report and labeled “Possible Partner Abuse-assess for victimization”. Relevant community referrals were listed at the end of the risk report. The patients also received a computer-generated recommendation sheet about their reported health risks with the contact numbers of appropriate community agencies. **Control/comparison(s) description:** Usual care consisted of no screening before the doctor visit. **Sample size(s):** Initial allocation: Total n=314; Intervention n=156; Control n=158. Final analysis: Total n=293; Intervention n=144; Control n=149 **Baseline comparisons:** No significant differences for age, country of birth, marital status, % with children aged <15 at home, education, employment status, computer use patterns, household income, depression, self-perceived health, purpose of visit, or mean number of visits in the past year. **Study sufficiently powered:** Calculated sample size of 272 for 80% power (alpha=0.05) to detect an absolute increase of 9% in the IPVC detection, assuming a baseline of 3%. Achieved sample size with n=293 in the analysis	survey, as well as questions on demographics, health status, and acceptance of computer-assisted screening. **Secondary outcomes:** Provider assessment of patient safety and provision of appropriate referrals and advice for follow-up were also coded from the audiotapes. Patient acceptance of the computerized screening was based on the exit survey. **Follow up periods:** Immediately after visit **Methods of analysis:** Both completer and ITT analysis were presented. Comparisons between intervention and control groups was done using chi-square and t-tests. Binomial regression models were used to estimate relative risk, controlling for place of birth, education, employment status, and self-rated health.	**links between DV and substance use or issues of trauma?** No	participants). Three patients in the intervention group and 1 in the control group received referrals. Physicians requested patients to set up a follow-up appointment more often in the intervention group (20 of 25 participants) than in the control group (8 of 12 participants). Computer screening provided significantly more opportunities for discussing (adjusted RR=1.5, CI: 1.1-2.0) and detecting (adjusted RR=1.5, CI: 1.0-2.2) mental health disorders. Opportunities for discussing and detecting other risks were not significantly different between groups. On average, participants agreed that screening was beneficial but had some concerns about privacy and about interference with physician interactions. **Attrition details:** Attrition after randomization was n=12 for the intervention group and n=9 for the control group. Reasons for attrition included incomplete surveys, canceled visits, recording failures, patients withdrawing from the study, a participant with mental health issues, and audiotape recordings where the physician and patient conversed in a language not understood by coders.	including SD appears to be biased to middle age women. Excluding patients who couldn’t read or write English may limit generalisability since the patient population was 40% foreign-born **Evidence gaps and/or recommendations for future research:** Future longitudinal research should evaluate the long-term health outcomes subsequent to screening and detection. Computer screening should be tested in multiple primary care settings and in other countries. **Source of funding:** The Canadian Institutes of Health Research and Ontario Women’s Health Council

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Bonds, D. E., Ellis, S. D., Weeks, E., Palla, S. L., & Lichstein, P. **Year:** 2006 **Citation:** A practice-centered intervention to increase screening for domestic violence in primary care practices. *BMC Family Practice, 7*(63). **Country of study:** USA **Aim of study:** To test the effectiveness of a practice-centered intervention to increase DV screening in primary care **Study design:** Before and after study **Quality score:** [-] **External validity:** [-]	**Source population(s):** Women in North Carolina **Eligible population(s):** Female visitors to 15 primary care clinics located within 50 miles of Wake Forest University School of Medicine **Selected population(s):** Female, >18 years old, spoke English, attended clinic 12 months prior to interview **Excluded population(s):** NR **Sample characteristics:** Pre-intervention: *Mean age (SD):* 49 (17.7); *Ethnicity:* 62% White; *Marital status:* 46% married or marriage-like relationship; *Employment:* 46% working full or part-time. Post-intervention: *Mean age (SD):* 48 (16.9); *Ethnicity:* 66% White; *Marital status:* 54% married or marriage-like relationship; *Employment*: 50% working full or part-time **Setting:** 15 primary care practices in North Carolina with at least 2 providers (internal medicine, family medicine, obstetrics and gynaecology)	**Method of allocation:** N/A **Intervention(s) description:** Project PAAVE (Providers Asking About ViolencE) included standardized educational sessions and components customized to the needs of participating practices. The intervention was multi-focal, and included training of two local DV resource persons, provider and staff education, audit of baseline rates and feedback of those rates back to the clinic, and ongoing educational visits. Practices were asked to screen all women over the age of 18 at least once per year. Practices selected patient education material (posters and handouts) that targeted their patient population. Following the central training, the two resource persons conducted either a single 90 minute or two 45 minute training sessions at their own clinic. The clinics also selected a preferred screening method, oral or paper, and a preferred screening tool from among 5 options. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=3009; Pre-intervention n=1482; Post-intervention n=1527 **Baseline comparisons:** Post-intervention sample had a higher percentage of women who were married (p <0.0001) **Study sufficiently powered:** NR	**Primary outcomes:** The percentage of patients reporting being screened by their health care provider in the past 12 months for violence in the home was assessed by telephone survey. Each clinic provided a list of female patients that had been seen in the clinic in the previous 12 months, and the research team randomly selected patients from these lists to interview. The outcome question was embedded in a survey on general healthcare. **Secondary outcomes:** NR **Follow up periods:** Baseline survey was conducted between July and September 2002. The follow-up survey was conducted between August and October 2004. **Methods of analysis:** The odds ratio of being screened after the intervention was determined. To account for the effect of clustering by clinic site on screening rates, generalized estimating equations were used.	**Who is the target of the intervention?** Staff at primary care practices **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** There was an increase in patient-reported screening for DV. Pre-intervention, 16% (n=236) of women surveyed reported being screened, and post-intervention, 26% (n=398) of women surveyed reported being screened. When patient characteristics, health care provider characteristics and clustering by practice were accounted for, patients were 79% more likely to have been screened after the intervention than at baseline (OR=1.79, 95% CI: 1.43–2.23). **Secondary outcomes:** N/A **Attrition details:** N/A	**Limitations identified by author:** No control group. Unable to determine cause of increased screening rates. The outcome question about 'concerns about safety or violence in the home' may be misinterpreted as general safety vs. DV in home. Increase in screening may have resulted from compensation provided to practices for their participation. Small number of practices **Limitations identified by review team:** Variable screening methods implemented by different practices introduces numerous confounds and lowers internal and external validity of study **Evidence gaps and/or recommendations for future research**: The technique of customizing aspects of the intervention to fit the specific needs of the practice (as was done in this study) should be tried with other health care outcomes and assessed with rigorous study designs. **Source of funding:** Duke Endowment 3 year grant

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Calderon, S. H., Gilbert, P., Jackson, R., Kohn, M. A., & Gerbert, B. **Year:** 2008 **Citation:** Cueing prenatal providers: Effects on discussions of intimate partner violence. *American Journal of Preventive Medicine, 34(2),* 134-137. **Country of study:** USA **Aim of study:** To assess the impact of provider cueing on patient–provider discussions about IPV **Study design:** Individual randomized controlled trial **Quality score:** [++] **External validity:** [+]	**Source population(s):** Women attending a prenatal clinic in San Francisco **Eligible population(s):** 18 years or older, less than 26 weeks pregnant, reporting at least one health risk (tobacco, alcohol, drug use, IPV) **Selected population(s):** Convenience sample, 286 women competed risk assessment, 78% did not report any risks and 22% reported at least one risk **Excluded population(s):** Pregnant women at risk for drug use only, or alcohol use only **Sample characteristics:** Intervention: *Mean age (SD)*: 27.4 (6.4); *Ethnicity:* 31% Latina, 35% African American, 16% White, 19% other; *Education:* 22% <high school, 72% high school, 6% college; *Previously pregnant:* 88% **Setting:** Five prenatal clinics in urban San Francisco	**Method of allocation:** Women reporting risks were stratified by risk combination (one of 15 possible combinations of the four risky behaviours) and assigned by computer to intervention or control groups in blocks of one, ensuring equivalent numbers of intervention and control participants for each risk combination. **Intervention(s) description:** Using a laptop computer in a private examination room, participants completed a risk assessment immediately prior to a regularly scheduled prenatal appointment. The computer programme, called Health in Pregnancy (HIP), collected demographics and screened for tobacco, alcohol and drug use, and IPV. A summary "cueing sheet" for the provider was attached to the medical record that summarized the participant's risk profile, and suggested possible counselling statements. All providers received a brief orientation to the use of the cueing sheets. **Control/comparison(s) description:** Control group did not post cueing sheet **Sample size(s):** Total analytic sample n=59; Intervention n=32; Control n=27 **Baseline comparisons:** No significant differences reported **Study sufficiently powered:** NR	**Primary outcomes:** Participants completed a brief interview after their appointment to assess discussion of risks, how helpful they felt the discussion was and acceptability of the HIP programme. **Secondary outcomes:** Women's satisfaction with provider discussion and computer screening instrument. **Follow up periods:** N/A **Methods of analysis:** Discussions of risks were compared by group assignment among participants reporting IPV or smoking, with p-values obtained by Fisher's exact tests.	**Who is the target of the intervention?** Pregnant women **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Of 63 reporting a risk, 34 reported smoking. Six reported drug use, and three reported alcohol use. Twelve participants reported both IPV and smoking (the study examined screening for smoking as well as IPV)	**Primary outcomes:** Seventeen of 20 reporting IPV in the intervention reported having a discussion of IPV with their provider (85%, 95% CI: 62%-97%). Four of the 17 participants reporting IPV in the control group reported discussions with the provider (24%, 95% CI: 7%-50%). **Secondary outcomes:** Of the 21 participants who discussed IPV with their provider, 19 rated the discussion as helpful; only two rated the discussion as not helpful. All 37 participants who reported IPV responded that they liked using the computer programme. All 37 also responded that they found the programme easy. Thirty-three participants responded that they had enough privacy, and four responded that they would like more. **Attrition details:** N/A	**Limitations identified by author:** Reliance on self-report **Limitations identified by review team:** No verification of discussion or treatment fidelity. No report of insurance status **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** U.S. DHHS National Institute on Drug Abuse

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Colarossi, L. G., Breitbart, V., & Betancourt, G.S. **Year:** 2010 **Citation:** Screening for intimate partner violence in reproductive health centres: An evaluation study. *Women and Health, 50*(4), 313-326. **Country of study:** USA **Aim of study:** To determine whether a new, empirically developed screening tool elicited more disclosures than an older tool **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Women living in the New York City limits **Eligible population(s):** Female patients at three reproductive health centres located in the Bronx, Brooklyn and Manhattan, New York **Selected population(s):** Data were collected from medical charts selected using a computer generated random list of patient ID numbers and appointment dates during: January–December 2006 and January–December 2007. If an ID was duplicated in the list, it was removed and another ID and appointment date was randomly selected to replace it until no individuals occurred more than once for chart review. **Excluded population(s):** Because a patient could have received services at a centre more than once over the two-year period, computer generated patient ID numbers were selected for a single appointment date. Data were collected only from the screening form completed on the specified appointment date. **Sample characteristics:**	**Method of allocation:** N/A **Intervention(s) description:** All patients completed a written medical history form prior to their medical appointment. The older screening tool used prior to 2007 was comprised of 2 questions, with yes or no response options. The new screening tool used in 2007 was comprised of 6 questions, 4 of which asked about experience of violence in the past year, with a 5 point scale of frequency. The new tool also incorporated 2 questions about lifetime experience of violence. **Control/comparison(s) description:** There were no significant differences between groups on any measured demographic variable. **Sample size(s):** Total n=805; Old screen n=420; New screen n=385 **Baseline comparisons:** No significant differences between the two screening groups **Study sufficiently powered:** NR	**Primary outcomes:** Levels of disclosure were captured from a chart review. Medical charts contained information based on client self-report and health care staff notes. Reports of violence history were coded into four categories: no violence ever, current violence only, past violence only, and both past and current violence. **Secondary outcomes:** N/A **Follow up periods:** N/A **Methods of analysis:** Demographic variables associated with differences in IPV reporting or screening group were included in multivariate models, singularly and as interaction terms with the screening group. Chi-square analysis determined whether IPV reports were associated with the type of screening form used. Next, multiple logistic regression models with maximum likelihood estimation were used to compare odds of any IPV disclosure (yes/no) by screening form.	**Who is the target of the intervention ?** All adolescent and adult female patients of three reproductive health centres in New York city **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or**	**Primary outcomes:** More women (24%) reported IPV with the new tool compared with the old (11%, p=0.000). The new tool also resulted in over twice as many affirmative reports in all IPV categories than the old form - OR's from logistic regression models adjusting for age and centre site were: any violence (OR=2.66, p<0.001), current violence (OR=2.56, p = 0.07), past violence (OR=2.61, p<0.001), and both current and past (OR=4.18, p<0.05). An additional multinomial regression revealed that women completing the new screen were 2.5 times as likely to report current and past violence, and 4.2 times as likely to report both current and past violence histories. **Secondary outcomes:** N/A **Attrition details:** N/A	**Limitations identified by author:** The tools were not tested simultaneously, which limits the ability to interpret temporal factors related to disclosure rates. Low literacy/ non-English speaking patients had the tests performed verbally rather than by written self-report (not noted in medical records). The new screening questions are also prefaced by an introductory question asking, ''Have things been going well in your relationship?'' This new tool may provoke less socially desirable responses than the older tool. **Limitations identified by review team:** The use of Spanish screening materials may have introduced culturally-mediated confounds such as attitudes towards disclosure. **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** Robert Wood Johnson Foundation

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Old screen: *Mean age (SD):* 24.7 (6.1); *Ethnicity:* 14% Caucasian, 41% African American, 27% Latina; *Payment type:* 49% self pay/full fee, 15% private insurance; 22% Medicaid, 14% sliding scale fee; *Primary language:* 93% English, 5% Spanish; *Marital status:* 95% single, 5% married/domestic partner. New screen: *Mean age (SD):* 25.1 (6.1); *Ethnicity:* 16% Caucasian, 39.5% African American, 26% Latina; *Payment type:* 45% self pay/full fee, 14.5% private insurance; 26% Medicaid, 14% sliding scale fee; *Primary language:* 95.5% English, 4% Spanish; *Marital status:* 95.5% single, 4.5% married/domestic partner **Setting:** Urban reproductive health centre			**issues of trauma?** No		

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Coonrod, D. V., Bay, R. C., Rowley, B. D., Del Mar, N. B., Gabriele, L., Tessman, T. D., & Chambliss, L. R. **Year:** 2000 **Citation:** A randomized controlled study of brief interventions to teach residents about domestic violence. *Academic Medicine, 75*(1): 55-57. **Country of study:** USA **Aim of study:** To test an educational intervention regarding DV **Study design:** Individual randomized controlled trial **Quality score:** [+] **External validity:** [-]	**Source population(s):** Incoming medical residents in the academic years 1995-96 and 1996-97 at Maricopa Medical Centre (a 500-bed county hospital in Phoenix) **Eligible population(s):** All medical residents at the Maricopa Medical Centre in 1995 and 1996 **Selected population(s):** Residents that attended orientation **Excluded population(s):** Residents that did not attend orientation **Sample characteristics:** NR **Setting:** Urban medical clinic	**Method of allocation:** A computer randomized the residents before orientation, stratified by sex and specialty. To blind the participants to the purpose of the study, it was presented as a test of different educational interventions; the specific interest in DV education was not revealed. **Intervention(s) description:** In 1995, the experimental group viewed a videotape, ''Domestic Violence: More Prevalent Than You Think,'' which had been edited down from 30 to 20 minutes. In 1996, the experimental group participated in a 20-minute programme comprising a nine-minute videotape, ''Domestic Violence: The Bottom Line,'' and a role-play that demonstrated interview techniques for detecting DV. This group also received selected readings. **Control/comparison(s) description:** Control groups attended education sessions on topics unrelated to DV **Sample size(s):** Total n= 102; 1995 n=53; 1996 n=49 **Baseline comparisons:** NR **Study sufficiently powered:** NR	**Primary outcomes:** Self-reported diagnosis of a case of DV sometime between the intervention and the follow-up conducted by telephone **Secondary outcomes:** In 1996 only, change in knowledge with five true/false questions, administered both before and after the intervention **Follow up periods:** 9 to 12 months after the intervention **Methods of analysis:** The primary outcome variable was compared via a chi-square test and by calculating relative risks and 95% confidence intervals. No ITT	**Who is the target of the intervention?** Medical residents, both genders **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Across both years, 71% of the residents in the experimental group diagnosed DV; 52% in the control did (RR=1.35, 95% CI: 0.96-1.90, p =0.07) in the nine to 12 months following the intervention. In 1995, the percentages were 75% intervention vs. 60% control (p=0.29). In 1996, the percentages were 67% intervention vs. 46% control (p=0.15). There was a significant difference (p<0.01) in diagnosis reported by specialty: 100% of family practice and medicine-pediatrics residents, 90% of emergency medicine, 80% of obstetrics-gynaecology, 67% of psychiatry, 63% of pediatrics, 47% of internal medicine and 0% of surgery residents diagnosed cases of DV. **Secondary outcomes:** Change in knowledge was assessed in 1996, and a significant improvement was noted. Mean percentage of correct answers was 73% for the intervention vs. 56% for the control (p=0.002). **Attrition details:** In 1995, 83% (n=44) were followed up. In 1996, 86% (n=44) were followed up.	**Limitations identified by author:** Outcome relied on self-report. The interventions varied between the two years of the study. Small sample size **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Duncan, M. M., McIntosh, P. A., Stayton, C. D., & Hall, C. B. **Year:** 2006 **Citation:** Individualized performance feedback to increase prenatal domestic violence screening. *Maternal and Child Health, 10*(5), 443-449. **Country of study:** USA **Aim of study:** To determine if individualized performance feedback provided to obstetrics and gynaecology (ob/gyn) residents would increase screening for DV **Study design:** Interrupted time series **Quality score:** [+] **External validity:** [+]	**Source population(s):** 1st and 2nd year ob/gyn residents in urban hospitals **Eligible population(s):** Ob/gyn residents in the clinic in this study **Selected population(s):** A convenience sample of residents. Teams A and C were composed of female first-year residents. Team B included two male and four female second-year residents. **Excluded population(s):** Ob/gyn residents assigned to other hospitals but occasionally practicing in this clinic, residents in other programs occasionally practicing in the clinic, physicians, and advanced practice nurses **Sample characteristics:** Residents: *Gender:* 83% female; *Race:* 100% White; *Language:* 100% English speaking with no significant second language skills. Screened population:	**Method of allocation:** N/A **Intervention(s) description:** Following baseline measurements, ob/gyn residents attended a two-hour training on DV, DV screening, and documentation of screening findings. Residents were instructed to use the following screening questions: 1) Are you in a relationship with a spouse, partner, or family member who makes you feel afraid? 2) Have you been emotionally, physically, or sexually harmed by your spouse, partner, or other family member (a. ever, b. within the last year, c. during this pregnancy)? 3) Have you been hit, slapped, kicked, or otherwise physically harmed by your spouse, partner, or other family member (a. ever, b. within the last year, c. during this pregnancy)? Two months after the training, researchers began giving residents individualized reports comparing their screening performance with that of other residents at four times. The researchers called this process individualized performance feedback (IPF). Each patient's medical record was examined for evidence of screening at the first medical visit, at week 16 and then again at week 28. Using these three dates, patient records were selected for each of five data collection periods: pre-IPF, after	**Primary outcomes:** Occurrence of screening (yes or no) **Secondary outcomes:** Resident screening performance by gender of resident and year (level of education) **Follow up periods:** Approximately 7 months: IPF was given four times at roughly 7-week intervals **Methods of analysis:** Chi-square analysis and standard logistic regression analysis to examine the data on IPF effectiveness. The model estimated the odds of screening after each IPF report, compared to the period before IPF. Regression was adjusted for resident variables, the patient care team to which each resident was assigned, pregnancy variables (trimester of pregnancy, first medical visit versus subsequent visit),	**Who is the target of the intervention?** 1st and 2nd year ob/gyn residents **Did they conduct any aspect of sex, gender or diversity analysis?** Yes, they compared female and male residents. **Do they report sex, gender or diversity based factors in findings?** Two of the 12 residents were male. Male residents screened at 33% of appropriate visits before feedback and 67% of visits following the fourth feedback report (p=0.032). Female residents started at 65% of visits and finished at 94% of visits (p<0.001). The odds of screening by male residents compared to female residents was 0.46 (95% CI: 0.21-0.98).	**Primary outcomes:** Residents screened at 60% of appropriate visits before IPF. Following the fourth report, the same residents screened at 91% of appropriate visits (chi square=28.4, p<0.001). Team A residents screened at 89% of appropriate visits before feedback and 100% of appropriate visits following the fourth report (not significant). Team B residents started at 45% of appropriate visits and finished at 77% (p=0.036). Team C residents started at 41% and finished at 92% (p<0.001). Overall, residents screened at 70% of first medical visits prior to feedback; this increased to 95% following the fourth report (p=0.001). Residents screened at 46.5% of follow-up visits prior to feedback and 82% following the fourth report (p=0.007). The odds of screening after the last IPF report was significantly greater than the odds of screening before IPF	**Limitations identified by author:** Cannot generalize findings to 3rd and 4th year residents. Study could not address if screening increases endure or deteriorate over time. Results are not generalisable to ob/gyn residency programs nationwide, other prenatal providers or to women in other income groups or women of other racial and ethnic identities. **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Explore whether IPF helps address the physician gender gap in DV screening, whether each new class of residents requires IPF to ensure adequate screening, and whether IPF works as well for 3rd and 4th year residents who may be more resistant to change than new residents. **Source of funding:** Patrick and Catherine

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	low income; *Race:* ~75% Latina (78% of which were Puerto Rican), 11% Black, 9% White; *Language:* ~21% spoke a language other than English, 33% were bilingual; *Stage of pregnancy:* 8.5% first trimester of pregnancy, 69% second trimester, 22% third trimester **Setting:** Hospital-based, ambulatory, prenatal clinic located in an urban Northeastern city in the United States	the first IPF report, after the second report, after the third report, and after the fourth report. A medical record review was conducted before and after the distribution of each set of IPF reports. Record review halted with the first evidence of screening. Residents were grouped into Teams A, B, and C. **Control/comparison(s) description:** N/A **Sample size(s):** Residents: Total n=12. Screened population: Total n=518 **Baseline comparisons:** NR **Study sufficiently powered:** NR	and a methodological variable (data collector).	**Did this study examine or discuss links between DV and substance use or issues of trauma?** No	(OR=7.6, 95% CI: 3.0-18.9). The odds of screening after the second and third reports compared to the pre-IPF period were OR=2.8 (95% CI: 1.3-6.1) and OR=2.9 (95% CI: 1.5-5.8) respectively. Adjusting for visit type (first medical versus subsequent visit), the odds of screening were greatest during the second trimester of pregnancy. **Secondary outcomes:** Six of 12 residents were first year residents. Their performance improved from 71% of visits before feedback to 95% of visits following the fourth report (p=0.003). Second year residents improved from 45.5% to 79% (p=0.02). Both male residents were second year. **Attrition details:** NR	Weldon Donaghue Medical Research Foundation

Appendix O

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Feder, G., Davies, R. A., Baird, K., Dunne, D., Eldridge, S., Griffiths, C., Gregory, A., Howell, A., Johnson, M., Ramsay, J., Rutterford, C., & Sharp, D. **Year:** 2011 **Citation:** Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: A cluster randomized controlled trial. *The Lancet, 378*, 1788-1795. **Country of study:** UK **Aim of study:** To test the effectiveness of a training programme for	**Source population(s):** Primary care teams in two urban primary care trusts, including clinicians and administrators **Eligible population(s):** All practices in the specified geographic areas. For patients, all women aged 16 and older **Selected population(s):** 61% of eligible practices agreed to participate. Practices that participated were larger, had more low income patients, and had a higher percentage of clinicians with postgraduate training than practices that declined to participate. **Excluded population(s):** Patients of investigators in a practice, and practices without electronic records	**Method of allocation:** The practices were stratified by proportion of full time equivalent female physicians, postgraduate training status, number of patients, and percentage of low income patients, and then randomized within the strata using a computer minimization programme for every practice. **Intervention(s) description:** Clinicians received two 2-hour sessions on identification of DV, support for victims, and referral to advocacy services. A handbook and "additional materials" were distributed to each practice site. Ongoing clinical meetings provided feedback on practice data about disclosure and referral to the advocacy service and reinforced training. Administrative staff received a one-hour training on confidentiality and safety for patients experiencing abuse, as well as information about IRIS. Each practice nominated a champion who received an additional 8 hours of training about DV and was asked to integrate this into their practice. Medical records had a prompt to ask about abuse and a simple referral pathway to a named advocate in a specialist DV agency. Cards and posters about DV were present in the intervention practices. **Control/comparison(s) description:** Waitlist **Sample size(s):** Practices: Total n=48; Intervention n=24; Control n=24. Eligible women: Intervention n=70,521; Control	**Primary outcomes:** The number of referrals to the DV advocacy services in the electronic medical records of the practices, measured for the 12 months before the 1st training and for the 12 months after the 2nd training **Secondary outcomes:** The number of identifications of DV in electronic medical records measured from the 12 months before the 1st training and for the 12 months after the 2nd training. The number of referrals received by the DV agencies (including referrals from clinicians, other agencies, and self-referrals) **Follow up periods:** 12 months **Methods of analysis:** Poisson regression, intervention incidence rate ratios	**Who is the target of the intervention?** All clinicians, administrators, and receptionists at primary care practices **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The total number of referrals in the intervention group was 223, and only 12 in the control group. The adjusted intervention group incident rate ratio (IRR) was 22.1 (11.5-42.4), indicating that after adjusting for area and the variables which were used for stratification, referrals were 22 times more likely in the intervention group than in the control. **Secondary outcomes:** Three times more women experiencing DV were identified in intervention practices (641) than in the control practices (236) (adjusted IRR=3.1, CI: 2.2-4.3). The number of referrals received by the DV agencies was 238 in the intervention group and 40 in the control group (adjusted IRR=6.4, CI: 4.2-10.0). **Attrition details:** Three practices dropped out before providing baseline data.	**Limitations identified by author:** Referral as a measure of actual patient benefit was not fully valid because 30% of referrals were not contacted. **Limitations identified by review team:** CIs are wide. Possible volunteer bias in site selection. No check on training fidelity. **Evidence gaps and/or recommendations for future research**: Need alternative methods not dependent on electronic records. More research on the provision of external advocacy services is important. **Source of funding:** Health Foundation, National Institute of Health Research

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
primary health-care practices for DV identification and referral **Study design:** Cluster randomized controlled trial **Quality score:** [++] **External validity:** [++]	**Sample characteristics:** Intervention: *Median % of full-time equivalent female physicians:* 45%; *Physicians with postgraduate training:* 67%; *Median % of registered patients on low income:* 32% of practice. Control: *Median % of full-time equivalent female physicians:* 45%; *Physicians with postgraduate training:* 54%; *Median % of registered patients on low income:* 32% of practice **Setting:** Urban primary care practices. Location of training NR	n=73,347 **Baseline comparisons:** Baseline demographics were "well balanced" between the intervention and control (inferential statistics NR). **Study sufficiently powered:** Yes. With 24 intervention practices and 24 control practices, the study had 80% power to detect a difference of 5.2% in the identification rate of women experiencing DV at a significance level of 0.05. This calculation is based on the assumption of an identification rate of 1% among control practices (a conservative estimate based on previous research), an average of 1600 women in the relevant age group in each practice, and an intracluster correlation coefficient of 0.03.				

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Garcia, F. A. R. & Parsons, M. L. **Year:** 2002 **Citation:** Effective screening for domestic violence in the inpatient obstetric setting. *Primary Care Update for Obstetrics and Gynecology, 9*(3): 94-97. **Country of study:** USA **Aim of study:** To determine the effectiveness of an educational and policy initiative to increase screening rates for IPV among pregnant women **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Social workers, doctors and nurses **Eligible population(s):** All social workers, doctors and nurses at the University of Arizona Health Sciences Centre **Selected population(s):** NR. Out of 97 staff members trained, 80 provided both pre- and post-intervention data. **Excluded population(s):** NR **Sample characteristics:** *Gender:* 97% women; *Age:* range 20-64 years; *Profession:* 74% Nursing **Setting:** Urban inpatient obstetrics clinics in an academic centre	**Method of allocation:** N/A **Intervention(s) description:** The intervention involved: a policy change requiring universal DV screening of obstetric patients in the clinic, at each trimester, and on admission to hospital; the development of a DV screening kit to assist health professionals in intervening with patients who self identify as victims of violence; medical records modifications to cue providers to screen during routine episodes of care; and training (3 hours duration) to orient staff to the policy change, the medical records modifications, and the use of the screening kit. The kit included a simplified screening response algorithm, DV documentation forms for the medical record, a safety planning tool, and a packet of patient education materials that included local resource and referral information. The 3 hour educational programme included: a review of the background and dynamics of DV; a clinical model for screening and intervention; a description of a team approach to DV prevention and intervention; and an orientation to the new policies, protocols, and materials developed to support this effort. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=80 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** Staff knowledge on IPV was assessed using multiple choice and true/false items from a subscale of the *Massachusetts Medical Society Survey* before and after the intervention. These included questions about prevalence, sequential risk factors, and documentation. No information on properties of the survey was reported. Random medical record audits of all obstetric admissions were completed 3 months before implementation of the policy change and 3 and 9 months post-intervention. Information regarding the documentation of DV screening, the staff category of the person performing the screen, and the intervention after positive screens was abstracted from the medical record by a reviewer blinded to the intervention. **Secondary outcomes:** Random medical record audits, as described above **Follow up periods:** 3 and 9 months **Methods of analysis:** Descriptive statistics. Student's t test was used to test differences in means.	**Who is the target of the intervention?** Health care professionals **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Compared with baseline (26%), 75% of respondents at post-intervention were able to identify the existence of an institutional protocol on DV ($p<0.01$). The majority (79%) could identify available patient education resources and materials (compared with 26% pre-intervention, $p<0.01$). 75% of respondents reported knowledge of community resources available for referral and follow-up (compared with 17.5% pre-intervention, $p<0.01$). At baseline, only 9% of the patient charts indicated that DV was addressed and documented. Three months after the intervention, the percentage of patient records that indicated that DV was addressed and documented increased to 47% ($p<0.01$). At 9 months after implementation, a further increase to 90% ($p<0.01$) was noted. **Secondary outcomes:** 3 months post- implementation, 90% of the screening and documentation regarding DV was performed by the nursing staff, compared with 70% pre-implementation ($p<0.05$). **Attrition details:** From a pool of 97 staff members trained, 80 staff members provided enough data for the analyses.	**Limitations identified by author:** NR **Limitations identified by review team:** Unsure if increased rates of documentation of IPV equates to increased ability to detect IPV, since no comparison data was given on baseline rates of IPV prior to intervention. The survey was self report and may have response biases. **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** The Governor's Office for Domestic Violence Prevention grant, Arizona Department of Administration

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Grafton, D., Wright, B. L., Gutmanis, I., & Ralyea, S. **Year:** 2006 **Citation:** Successful implementation of universal woman abuse inquiry. *Public Health Nursing, 23*(6), 535-540. **Country of study:** Canada **Aim of study:** To investigate the relationship between the introduction and implementation of the Routine Universal Comprehensive Screening (RUCS) Protocol and the frequency of abuse screening among postpartum women involved with the Healthy Babies Healthy Children (HBHC) Programme **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Postpartum women in Ontario **Eligible population(s):** All postpartum women who lived in one Ontario county and participated in HBHC **Selected population(s):** Postpartum women who consented to the study, lived in the county in this study, and participated in the HBHC programme **Excluded population(s):** Women were excluded when their privacy could not be assured due to children older than 2 years of age, a partner, or other family member being in the home during the visit. **Sample characteristics:** NR **Setting:** Home visits by public health nurses (PHNs) in an urban area in a Canadian province	**Method of allocation:** N/A **Intervention(s) description:** Before the implementation of RUCS in 2001, PHNs making home visits were not expected to ask low-risk postpartum women about abuse unless there was indication of abuse. Following the introduction of the RUCS Protocol, PHNs making home visits were expected to ask all women about abuse regardless of risk, providing privacy could be assured. In order to meet these expectations, changes in organizational structure, including a dedicated budget and policy changes, were implemented. The strategy, implemented between May 2002 and 2003, included large and small group workshops, meetings with experts in the field, and use of posters, videos, and handouts at regular intervals. Assessment forms were changed to include a question about abuse, reminding PHNs to ask about abuse. **Control/comparison(s) description:** The charts of all postpartum women who received a HBHC home visit pre-RUCS were compared to those of women receiving a HBHC home visit post-RUCS **Sample size(s):** Pre-RUCS n=1,151; Post-RUCS n=1,193 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** A retrospective chart audit of cross-sectional data collected during HBHC postpartum home visits was completed to determine the proportion of women for whom there was documented abuse inquiry both before and after the implementation of the RUCS Protocol. **Secondary outcomes:** The researchers examined documented abuse inquiry based on selected demographic variables. **Follow up periods:** N/A **Methods of analysis:** Pearson's chi-square tests	**Who is the target of the intervention?** Public health nurses in Ontario **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Documented abuse inquiry increased significantly (chi-square=1889.09, df=2, p<0.001) among low-risk postpartum women who received a home visit (0.8% pre-RUCS to 20.5% post-RUCS). **Secondary outcomes:** Before the implementation of RUCS, low-risk women <20 years of age were significantly more likely to be asked about abuse than women in their 20s, 30s or 40s (chi-square=39.92, df=3, p<0.001). Pre-RUCS, 38.5% of all women who were asked were less than 20 years of age whereas post-RUCS, this figure fell to 2.8%. Pre-RUCS, single mothers were significantly more likely to be asked than women who had a partner at home (chi-square=24.97, df=1, p<0.001; 46% versus 6.5%). Post-RUCS, women who were asked about abuse were not significantly different in the measured demographic characteristics from all low-risk women, suggesting more universal screening. **Attrition details:** N/A	**Limitations identified by author:** Based on retrospective chart audit. Some women did not consent to either the in-hospital assessment or the home visit. Some women were not asked about abuse due to lack of privacy in the home. **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Future studies should consider a proactive data collection strategy that would ensure the quality of data through standardized collection procedures. **Source of funding:** Middlesex-London Health Unit

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Halpern, L., R., Parry, B. A., Peak, D., & Dodson, T. B. **Year:** 2009 **Citation:** A comparison of 2 protocols to detect intimate partner violence. *Journal of Oral Maxillofacial Surgery, 67*(7), 1453-1459. **Country of study:** USA **Aim of study:** To compare two protocols to identify women who self-report IPV-related maxillofacial injuries **Study design:** Cross-sectional study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Women living within Boston city limits **Eligible population(s):** Women attending Massachusetts General Hospital Emergency Department (ED) **Selected population(s):** Convenience sample of women aged 18+ who presented to the Massachusetts General Hospital ED for the evaluation and management of non-verifiable injuries (e.g. falls or assaults) **Excluded population(s):** Subjects who presented with verifiable injuries (e.g. motor vehicle accidents), subjects incapable of communication (e.g. intubated patients), subjects who were unavailable to interview in the ED (e.g. those who were in the radiology department at the time of the interview), and subjects who did not consent to participate (n=19) **Sample characteristics:** *Mean age:* 45.8	**Method of allocation:** N/A **Intervention(s) description:** The intervention was a new diagnostic protocol (DP) which classified women into low or high risk for IPV based on location of the injury and results of the Partner Violence Screen (PVS) questionnaire. The PVS is composed of 3 brief questions to identify women at risk for IPV-related injuries. It consists of 1 question that addresses physical violence (Have you ever been hit, kicked, or punched in a relationship?) and 2 questions that address a woman's perception of her safety (Have you ever felt unsafe in a relationship? Do you feel safe now?). A positive response (i.e., yes) to any of the 3 questions on the PVS constitutes a positive screen for IPV. Data were collected from subjects enrolled in the DP group by interview and recorded on standard data collection forms. All participants in the DP group were first screened by the triage nurse using the SOP, described below, before going through the DP. **Control/comparison(s) description:** Data for subjects enrolled in the standard operating procedure (SOP) group (i.e. the comparison group) were abstracted from the triage sheet. The ED's SOP was to have a triage nurse question the patient at intake regarding injury etiology	**Primary outcomes:** The primary outcome was self-reported injury etiology (IPV vs. other). IPV-related injury was defined as subject self-report of an injury due to an assault by an intimate sexual partner. Other injury etiologies included assault by a non-partner, sports and occupational injuries, and falls. **Secondary outcomes:** The researchers examined the association between injury etiology and various demographic variables. **Follow up periods:** N/A **Methods of analysis:** Odds ratios, sensitivity, specificity, positive predictive value, and negative predictive value	**Who is the target of the intervention?** Women in an urban ED **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Yes. IPV-related injuries were significantly associated with substance use (p=0.04).	**Primary outcomes:** The self-reported prevalence of IPV-related injuries was 11.5% for the DP group and 5% for the SOP group. In the final model which adjusted for age, race, and screening protocol, subjects coded as being at high risk using the DP were 38 times more likely to report an IPV-related injury etiology than SOP subjects (OR=38, 95% CI: 4.5-327, p=0.01). The sensitivity of the DP compared to SOP was 94% vs. 50%, specificity was 76% vs. 95%, positive predictive value was 34% vs. 50%, and negative predictive value was 98% vs. 95%. **Secondary outcomes:** IPV-related injuries were significantly associated with age, race, injury location, and substance abuse (p's<0.05). In the final model which adjusted for age, race, and screening protocol, reported injury etiology	**Limitations identified by author:** Because injury etiology was based on subjects' self reports, it is possible that some subjects with IPV-related injuries reported that the injury had another etiology, such as a fall. One consequence of misclassification is a significant increase in false-negative findings. The net effect of having predominantly one type of misclassification error is an underestimation of the true sensitivity of the DP. **Limitations identified by review team:** Description of source population was absent from the article making it difficult to determine external validity **Evidence gaps and/or recommendations for future research**: Future directions include the ability to incorporate the DP into electronic medical records, applying this survey in other clinical settings to test the generalisability of the protocol, and examining how the DP can increase understanding of the relationship between IPV and specific injury types and their impact on subjects' health-related quality of life. **Source of funding:** Department of Oral and Maxillofacial Surgery's Education and Research Fund,

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Setting: Urban hospital ED in Boston, Massachusetts	and record the injury etiology on the triage sheet. Injury etiologies included DV, child abuse/neglect, and elder abuse/neglect. **Sample size(s):** Total n=286; DP n=145; SOP n=141 **Baseline comparisons:** There were significant differences between the DP and SOP samples with respect to age, race, injury location, substance abuse, and ED visits per year. **Study sufficiently powered:** NR			was statistically associated with race (OR=7.5 with White as the reference category, 95% CI: 1.8-30.1, p=0.01) and age (OR=0.95, 95% CI: 0.9-1.1, p<0.05). **Attrition details:** N/A	Centre for Applied Clinical Investigation, Massachusetts General Physicians Organization

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Hamberger, L. K., Guse, C. E., Patel, D., & Griffin, E. **Year:** 2010 **Citation:** Increasing physician inquiry for intimate partner violence in a family medicine setting: Placing a screening prompt on the patient record. *Journal of Aggression, Maltreatment & Trauma, 19*(8), 839-852. **Country of study:** USA **Aim of study:** To investigate the effect of adding a chart prompt to a three-hour DV training programme on rates of documented screening for IPV in a family practice clinic **Study design:** Before and after study **Quality score:** [-]	**Source population(s):** Residents in a family practice clinic **Eligible population(s):** All residents at the clinic **Selected population(s):** NR **Excluded population(s):** NR **Sample characteristics:** NR **Setting:** Urban (Midwest) family practice clinic affiliated with a medical school	**Method of allocation:** N/A **Intervention(s) description:** For phase 1 (establishing baseline measures), all first-year family practice residents received three hours of IPV training which included definitions and dynamics of IPV, medical and psychological impact of IPV, and the health care provider role in caring for patients dealing with IPV. Residents learned and practiced specific skills for asking about and responding to patient reports of DV victimization. For phase 2, the intervention was the addition of a chart prompt on the history and physical examination forms for the clinic stating "Because of the prevalence of violence within our community, I ask all my patients the following question: Are you in a relationship where you have been shoved, hit, kicked, controlled, or made to feel afraid within the last year?" The intervention phase lasted 7 months. Screening was done for both genders. **Control/comparison(s) description:** Outcome measures from phase 2 (intervention) were compared to phase 1 (baseline) and phase 3, which involved removing the DV chart prompt 18 months after the end of phase 2 and	**Primary outcomes:** The primary outcome variable was whether or not the physician documented IPV screening and patient response in the patient record, as determined by a chart audit conducted by a resident physician research assistant. In phase 3, a nurse followed up with patients after their physician encounter to determine whether the physician asked about DV. **Secondary outcomes:** NR **Follow up periods:** 18 months **Methods of analysis:** Chi-square,Wilcoxon rank-sum tests, and two sample tests of proportions	**Who is the target of the intervention?** Medical residents **Did they conduct any aspect of sex, gender or diversity analysis?** Yes, the authors examined resident screening rates by gender **Do they report sex, gender or diversity based factors in findings?** Resident sex was significantly associated with screening documentation (males 39% vs. females 29%, p=0.03). **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The baseline screening rate in phase 1 was 2%. In the intervention period (phase 2), 92% of patient visits had documentation of IPV inquiry (z=-18.6, p<0.0005). The chart prompt removal phase showed a significant decrease in documented screening at 36% (z=7.0, p<0.00005). This decrease remained significant even when a follow-up query revealed nine additional patients who reported being asked about IPV by their physician even though it was not documented in the record (72% of patients asked about IPV, but this was still significantly lower than phase 2, z=3.0, p=0.003). **Secondary outcomes:** N/A **Attrition details:** Two participants were dropped from the analyses in phase 3 since they were patients of one of the authors	**Limitations identified by author:** Family medicine residency training programme may not be generalisable to other settings. In phase 3, when patients were asked whether they had been asked about DV by their physician, some patients may have misinterpreted the question. There was no collection of undocumented screening at baseline or in phase 2. **Limitations identified by review team:** No record of training fidelity. No analysis of improved screening rate from baseline after prompt removed. Pre-screening by the nurse in phase 3 prior to the patient seeing the physician likely to have biased results **Evidence gaps and/or**

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]		replacing it with a pain screening question to mask the change. **Sample size(s):** Phase 1 (baseline) n=274; Phase 2 (intervention) n=137; Phase 3 n=25 **Baseline comparisons:** N/A **Study sufficiently powered:** For phase 3, a sample size of 25 provided the power to detect a 35% or larger reduction in screening.				**recommendations for future research:** More research is needed to determine the relative contributions of education and chart prompts in facilitating health care provider IPV screening, ideally with experimental designs. Another area of research is the application of chart prompts to electronic medical records and computerized IPV screening. **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Hamby, S., Sugarman, D. B., & Boney-McCoy, S. **Year:** 2006 **Citation:** Does questionnaire format impact reported partner violence rates? An experimental study. *Violence and Victims, 21*(4), 507-518. **Country of study:** USA **Aim of study:** To determine if the standard Revised Conflict Tactics Scales (CTS2) would lead to greater reporting of violence than dichotomous yes/no questions, whether there were differences between computer-assisted self-interview (CASI) and paper-and-pencil administrations of the questionnaire, and whether gender interacted with the methodological manipulations	**Source population(s):** Young adults **Eligible population(s):** Undergraduates enrolled in an introductory psychology course **Selected population(s):** Undergraduates at a Northeastern state university who were currently involved in a dating, engaged, or marital relationship of at least 2 months duration **Excluded population(s):** NR **Sample characteristics:** *Mean age (SD)*: 19.16 (2.95); *Year:* 70% freshmen; *Gender:* 82.5% women; *Ethnicity:* 97.5% European American; *Relationship status:* 89% “dating”, all relationships were heterosexual; *Median relationship length:* "more than one year but less than two years”; *Cohabiting:* 11%; *Sexually active with partner:* 82.5%	**Method of allocation:** Random assignment **Intervention(s) description:** The study design included two experimental manipulations of the partner violence measure, the CTS2. In the Administration Method manipulation, half of the students completed the CTS2 in a paper-and-pencil format by reading items from a printed questionnaire and filling in their responses on a computer-scannable response sheet. In the second Administration Method condition, half of the students read the CTS2 items on the monitor of a personal computer and entered their responses on a standard keyboard. In the Response Category manipulation, participants received either the standard CTS2 categories or the dichotomous condition. The standard CTS2 response categories are: once, twice, 3 to 5 times, 6 to 10 times, 11 to 20 times, more than 20 times, and never. The dichotomous condition asked participants to report whether each CTS2 item had occurred ("yes" or "no"), but not how many times. **Control/comparison(s) description:** See intervention descriptions above **Sample size(s):** Total n=160.	**Primary outcomes:** Psychological aggression, physical assault, sexual coercion and injury as indicated by the CTS2 and modified test **Secondary outcomes:** Sex-based findings on disclosure of abuse **Follow up periods:** N/A **Methods of analysis:** Analyses were performed on three different scoring alternatives for the CTS2: yearly incident rates, mode scores (a sum of all the different types of tactics reported for each subscale of the CTS2), and frequency scores for those who received the standard CTS2. Chi-square and logistic regression were used to examine the categorical rate variables. Multivariate analysis of variance was used to examine	**Who is the target of the intervention?** Young adults **Did they conduct any aspect of sex, gender or diversity analysis?** Yes **Do they report sex, gender or diversity based factors in findings?** Yes, the authors examined whether gender interacted with questionnaire formats. See results **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** From the bivariate analyses, more perpetrated physical assault (i.e. respondent was perpetrator rather than victim) was reported in the computer administration than in the paper-and-pencil administration ($p<0.05$), but more perpetrated sexual coercion was reported in the paper-and-pencil administration than in the computer administration ($p<0.01$). Perpetrated and sustained sexual coercion were more frequently reported in the standard CTS2 than the dichotomous categories ($p<0.01$ and $p<0.05$, respectively). Inflicted injury was reported more often in the standard CTS2 condition than the dichotomous condition ($p<0.05$). In the logistic regression analyses, there were no significant administration method or response category effects on perpetration of psychological aggression, physical assault, or injury (all p’s>0.20). For sexual coercion, there was a significant response category effect, with 22.5% of participants receiving the standard CTS2 reporting perpetration of sexual coercion compared to 7.5% of participants in the dichotomous condition (OR=3.37, $p<0.05$).For victimization scales, there were no methodological effects for psychological aggression or sexual coercion (all $p>0.15$).	**Limitations identified by author:** Lack of diversity in this sample, especially regarding age, social class, and race. Relatively small sample size. Lack of stability of some findings across scales and scoring approaches **Limitations identified by review team:** Description of participant recruitment method not provided **Evidence gaps and/or recommendations for future research:** Having larger samples that are more diverse regarding age, social class and race. Increase research efforts to understand the comparability of various forms of partner violence measurement: self-administered questionnaires to other methods such

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Study design: Individual randomized controlled trial **Quality score:** [+] **External validity:** [+]	**Setting:** Urban university	There were 40 participants in each condition (paper-and-pencil/standard CTS2, paper-and-pencil/dichotomous, CASI/standard CTS2, CASI/dichotomous) **Baseline comparisons:** NR **Study sufficiently powered:** NR	continuous scores (modes and frequency).		There was a significant Administration Method by Response Category interaction for physical assault (B=1.36, SE=0.68, p<0.05). The dichotomous categories produced rates that were higher for paper-and-pencil (37.5%) than computer (32.5%) administrations, but the standard CTS2 categories produced a higher rate on the computer (47.5%) than with paper-and-pencil (22.5%). For analysis of mode scores, the multivariate effects for response category, administration method, and the interaction term were not significant (p's>0.05). **Secondary outcomes:** There was a significant Response Category by Gender interaction for the sexual coercion scale (B=2.82, p<0.05). More males than females reported committing sexual coercion using the standard categories (26% vs. 22%) and this difference was much greater using the dichotomous categories (47% vs. 3%). There was a single main effect for gender, also on the sexual coercion scale (B=-3.21, p<0.01). **Attrition details:** NR	as interviews, audio-CASI, and telephone surveys **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Humphreys, J., Tsoh, J. Y., Kohn, M. A., & Gerbert, B. **Year:** 2011 **Citation:** Increasing discussions of intimate partner violence in prenatal care using Video Doctor plus Provider Cueing: A randomized, controlled trial. *Women's Health Issues, 21*(2), 136-144. **Country of study:** USA **Aim of study:** To examine the impact of a computer-based prenatal screening intervention and cueing sheet on patient-provider discussions of IPV **Study design:** Individual randomized controlled trial **Quality score:** [+]	**Source population(s):** Subset of the Health in Pregnancy Study of multiple health risks **Eligible population(s):** Study population subset, women who reported ever experiencing physical or sexual IPV **Selected population(s):** English-speaking eligible participants 18 years or older who were fewer than 26 weeks pregnant, receiving prenatal care at one of the participating clinics **Excluded population(s):** Women attending their first clinic visit **Sample characteristics:** *Race:* 34% Latino, 22% Black, 30% White, 14% other; *Mean age (SD):* 27.7 (7.1), range 18-43; *Marital status:* 46% never married, 38% married, 16% formerly married; *Education:* 22% <high school, 36% high school, 28% some college, 12% college degree; *Had previous pregnancy:* 76%; *Reported physical violence in year before pregnancy:* 86% (50% with 4 or more incidents); *Reported physical violence since pregnancy:* 38% (14% with 4 or more incidents); *Reported ever sexual violence:* 38%; *Reported sexual violence in year before*	**Method of allocation:** Before their clinic appointment, participants completed a computerized risk assessment assessing for tobacco, alcohol, drug use, and IPV. Women reporting risks were stratified by risk combination and randomly assigned to intervention or usual care. **Intervention(s) description:** The intervention was the Video Doctor, a multimedia programme that delivered interactive risk reduction messages using Motivational Interviewing principles. Programme messages were tailored by the participant's responses. The programme closed with the direct suggestion to discuss IPV with the patient's provider. The programme generated a cueing sheet for the medical record with the patient's risk profile and suggested counselling statements. Participants received an educational worksheet for self-reflection, harm reduction tips, and local resources. All providers received a brief orientation to the use of the cueing sheets, but received no training in IPV assessment or counselling. **Control/comparison(s) description:** Care as usual **Sample size(s):** Total n=50; Intervention n=25; Control n=25 **Baseline comparisons:** The intervention and control groups were similar in demographics, pregnancy history, and risk profile.	**Primary outcomes:** Self-report of participants of whether they had a discussion about DV with their provider (yes/no), via a post-visit interview with a research assistant **Secondary outcomes:** Participants' opinions of the helpfulness of the programme **Follow up periods:** 1 month **Methods of analysis:** T-test, Pearson's chi-square, Fisher's exact test, and Wilcoxon rank-sum test. Missing data was treated as "no discussion" for sensitivity analyses.	**Who is the target of the intervention?** Pregnant women **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The intervention group was significantly more likely to report provider-patient discussions of IPV compared to usual care at baseline (82% vs. 17%, p<0.001) and at the 1-month follow-up (70% vs. 23.5%, p=0.008). Summing the baseline and 1 month follow-ups, intervention participants were significantly more likely to have IPV risk discussions at one or both visits compared to usual care (90% vs. 24%, p<0.001). **Secondary outcomes:** 20 out of 22 (91%) participants rated the discussion as helpful or very helpful at baseline and all 18 (100%) participants rated the discussion as helpful or very helpful at the 1-month follow-up. **Attrition details:** 46 (92%) provided baseline data, and 37 (74%) for follow-up. There was no difference in data completion rates at 1-month follow-up between the intervention and control groups.	**Limitations identified by author:** Patient self-report data. No data on changes in IPV exposure or follow-up care. No randomization within providers **Limitations identified by review team:** No data on use of cue sheets or education sheets **Evidence gaps and/or recommendations for future research**: Explore whether outcomes vary by provider characteristics. Determine the relative effectiveness of different IPV content and means of delivery in patient-provider discussions of IPV. Have a longer follow-up **Source of funding: US** DHHS National Institute on Drug

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]	*pregnancy:* 20%; *Reported sexual violence since pregnancy:* 8% **Setting:** Urban prenatal clinics	**Study sufficiently powered:** NR				Abuse and NIDA Centre grant

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Janssen, P. A., Holt, V. L., & Sugg, N. K. **Year:** 2002 **Citation:** Introducing domestic violence assessment in a postpartum clinical setting. *Maternal and Child Health Journal, 6*(3), 195-203. **Country of study:** Canada **Aim of study:** To evaluate the implementation of a DV screening protocol based on Roger's innovation-diffusion model in a postpartum clinical setting **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Hospital employees on obstetrics units **Eligible population(s):** All employees in two hospitals with obstetrics units **Selected population(s):** NR **Excluded population(s):** NR **Sample characteristics:** Providers: NR. Patients: *Ethnicity:* 35% Chinese descent **Setting:** Two large urban hospitals	**Method of allocation:** N/A **Intervention(s) description:** A DV assessment form was included in patient charts, based on the Abuse Assessment Screen. Posters and resource cards with the theme "Let's Talk" were distributed. Roger's five stage innovation-diffusion model was used to design the intervention. For knowledge (stage 1) they circulated information on DV, identified and coached key administrators to lobby for resources for DV, and held one-hour inservice training sessions for all staff covering: prevalence of DV, dynamics of abuse, myths related to abuse, impact of violence on health, principles of assessment, and documentation. For persuasion (stage 2) they personalized the education by recalling real life situations, sometimes the staff's own, and through dialogue with survivors or clinical storytelling. For the decision stage (stage 3), a preceptor either did a screening herself or observed one and gave support and feedback. The implementation (stage 4) was expected to occur over time according to Roger's model. For confirmation (stage 5), the authors attempted to integrate assessment for DV into every facet of programme management: assessment for DV was included in competency checklists for new hires, policies and procedures were written to provide standards for documentation, performance appraisals included assessment for DV, reference binders in every clinical unit were updated with DV info, and a bi-monthly newsletter was sent to staff. Support (including an employee assistance programme) was provided to staff who disclosed personal issues with violence. The programme was tailored for various ethnicities. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=300 nurses. Number of cases used for baseline assessment NR. Actual number of cases screened NR **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** Number of DV assessment forms completed, as measured in the perinatal database. DV assessment form data were inputted into the database by health records personnel. **Secondary outcomes:** NR **Follow up periods:** 18 months **Methods of analysis:** Comparison of screening rates over time	**Who is the target of the intervention?** Postpartum clinicians **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Initial screening rate of 42% increased to 54% at 4 months and 61% at 6 months. At 18 months the screening rate was stable at 62%. **Secondary outcomes:** N/A **Attrition details:** NR	**Limitations identified by author**: NR **Limitations identified by review team:** Lack of data on number of actual participants and non-participants. No report of use of follow-up training materials (binders, etc.). No test of significance for changes in screening rates **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Kapur, N. A. & Windish, D. M. **Year:** 2011 **Citation:** Optimal methods to screen men and women for intimate partner violence: Results from an internal medicine residency continuity clinic. *Journal of Interpersonal Violence, 26*(12), 2335-2352. **Country of study:** USA **Aim of study:** To determine the optimal method and screening instrument for IPV among men and women in a primary-care resident clinic **Study design:** Before and after study	**Source population(s):** Patients at an urban primary care clinic in Waterbury, Connecticut. Waterbury has a population of 107,000 and a per-capita income $4,000 less than the national average. 10% of the clinic's patients are uninsured and 56% have Medicaid as their primary insurance. **Eligible population(s):** Patients attending the clinic for a nonurgent clinical encounter with their primary care doctor **Selected population(s):** English and Spanish speaking literate individuals over the age of 18, who were able to separate themselves from individuals who accompanied them, and not too ill to participate	**Method of allocation:** See intervention description **Intervention(s) description:** The study occurred in two phases. In the first phase, lasting three months, the screening tools were administered as self-administered questionnaires (SAQs). The second phase, lasting 17 weeks, involved residents administering the screening tools in face-to-face (F2F) clinical encounters. Before the second phase, all medical residents were introduced to IPV and screening during two training modules. In the first training module residents viewed and critiqued clips from an IPV prevention training video for healthcare providers. Residents were also introduced to the Partner Violence Screen (PVS) and the Hurt, Insulted, Threatened or Screamed at Questionnaire (HITS) and how to counsel victims of IPV. A second component involved a novel case-based learning module on IPV screening from the Yale Office-Based Medicine Curriculum. This component occurred during a 30-min conference immediately prior to the residents' continuity clinic and introduced residents to IPV screening controversies, tools, national and clinic prevalence estimates, and how to counsel IPV victims. Laminated cards	**Primary outcomes:** In the first phase, SAQs were distributed to patients using questions from the PVS and HITS. In the second phase the same questions were asked F2F by a resident. The *PVS* has three questions about past-year physical violence and perceptions of safety with current or past partners, with a sensitivity of 71% and specificity of 84% compared to the Conflict Tactics Scale. The *HITS* is a four-item instrument including questions about psychological and verbal abuse in the past year with a current partner, with Cronbach's alpha= 0.80 and correlation with the Conflict Tactics Scale=0.85. **Secondary outcomes:** Residents completed an IPV Knowledge, Attitude and Behaviour (KAB) survey after the F2F screening portion of the study.	**Who is the target of the intervention?** Internal medicine residents **Did they conduct any aspect of sex, gender or diversity analysis?** Yes, conducted separate analysis for men and women **Do they report sex, gender or diversity based factors in findings?** Yes. Primary outcomes were reported by gender. **Did this study examine or discuss links between DV and substance use or issues of trauma?**	**Primary outcomes:** By Screening Instrument: In women, the written screening prevalence of IPV was lower on HITS (9%) than on PVS (18%, p=0.008). On the SAQ for men, prevalence of IPV was lower on HITS (4%) than on PVS (9%), but this difference was not statistically significant (p=0.25). No significant differences were seen in IPV prevalence for the FTF versions of the PVS and HITS in either women or men. By Screening Method: Overall IPV prevalence was 17% using the SAQ, whereas the prevalence was 9% using a FTF screening approach. Patients receiving the SAQ were more likely to report IPV than those who were screened FTF, even after multivariate adjustment for socio-demographic effects (adjusted odds ratio [AOR]=2.6, 95% CI: 1.2-5.6). When results were stratified by gender, the effect persisted for women, who were more likely to report IPV when screened through the SAQ approach than a FTF approach (AOR=3.5, 95% CI: 1.4-8.6). Although men were more likely to report IPV through a written screen (11%) versus a FTF screen (9%), these differences were not statistically significant after multivariate adjustment (AOR=1.4, 95% CI: 0.3-5.8).	**Limitations identified by author:** Both screening instruments assess for abuse in the past year and as such do not capture all patients who have been affected by IPV. Providers screened only 28.5% of eligible patients, which may have been due to a physical move of the resident continuity clinic from one office space to another midway through the FTF phase of the study. Thus, lower screening rates may have been observed as residents found insufficient time to screen for IPV in light of adjustment to a new physical setting. Providers screened 7% fewer men than in the written survey. Roughly 25% of the residents reported preferentially screening only men and women who had abuse indices on history or physical exam. This screening pattern, however, would have biased the results toward the null hypothesis. The possibility of a type II error may have also

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Quality score: [+] **External validity:** [+]	**Excluded population(s):** Patients that had completed a written questionnaire in phase one were excluded from phase two. **Sample characteristics:** *Mean age:* 43.9; *Gender:* 32% male; *Race:* 45% White, non-Hispanic **Setting:** Urban primary care clinic	with screening questions and community resources were also distributed. **Control/comparison(s) description:** See intervention description **Sample size(s):** Total n=466; Self-administered n=340; Face-to-face n=126 **Baseline comparisons:** A smaller percentage of men were screened FTF (25%) compared with the SAQ group (35%) (p=0.05). **Study sufficiently powered:** Sample size was calculated on the null hypothesis of no differences in 12-month IPV prevalence across methods, with an alpha set at 0.05 (two tailed test) and power of 80%. Based on the literature, overall IPV prevalence of 12% was expected, with expected differences in methods ranging from 6% for the FTF screening and 18% for the SAQ screening. This required a sample size of 131 patients for each method of administration. However, phase 2 only had 126 participants.	**Follow up periods:** N/A **Methods of analysis:** Chi-square tests were used to assess differences by screening tool and mode of administration. Student's t-tests were also used to assess differences by mode of administration. Multivariable logistic regression models were constructed to determine the association between screening method (main independent variable) and IPV prevalence (main dependent variable) while adjusting for sociodemographic covariates.	No	**Secondary outcomes:** Residents felt prepared to ask their patients about IPV (72.5%), knew a moderate to a great deal regarding screening questions to detect IPV (82.5%), felt as though routine screening for IPV should be part of the annual physical exam (92.5%), and were comfortable asking their patients IPV-related questions (87.5%). However, screening rates remained low: on average, residents only screened 12% of their male patients and 38% of their female patients. Some residents reported preferential screening: 27.5% reported screening male patients only if there was evidence of abuse indicators on patient history or physical exam and 25% of residents screened female patients only if they had abuse indicators. Half of the residents stated that they did not have time to routinely ask their patients about IPV. **Attrition details:** NR	been increased given that the expected sample size to reach a power of 80% for each group was 131 and only 126 patients were screened during the FTF component of the study. The gender and age of the resident may have affected disclosure of IPV during FTF screening but this was not a dimension that was assessed during this study. **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: More studies are needed to examine the manner in which IPV screening tools and methods which have been developed, validated, and used exclusively on a female population, may be used among men. **Source of funding:** No financial support for the research or authorship

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Klevens, J., Sadowski, L., Kee, R., Trick, W., & Garcia, D. **Year:** 2012 **Citation:** Comparison of screening and referral strategies for exposure to partner violence. *Women's Health Issues, 22*(1), e45-e52. **Country of study:** USA **Aim of study:** To explore the utility of different screening and referral strategies for women exposed to IPV **Study design:** Individual randomized controlled trial **Quality score:** [+] **External validity:** [+]	**Source population(s):** Women living in Chicago city limits **Eligible population(s):** Women attending a public hospital in Chicago **Selected population(s):** Women attending the hospital over 18 years old **Excluded population(s):** Women who did not speak English; were accompanied by their partner or a child over 3 years of age without alternative adequate provision for child care; were visually, hearing, or mentally impaired; had no access to a phone; or were over 36 weeks pregnant **Sample characteristics:** *Mean age (SD):*	**Method of allocation:** The audio-computer assisted self-interviews (A-CASI) programme applied simple randomization to consenting participants and assigned them to one of three study groups. IPV advocacy staff were blinded to the study group assignment. **Intervention(s) description:** Research assistants (RAs) accompanied participants to an unoccupied examination room equipped with a touch screen computer and headphones. The computer randomized participants into one of three groups: *Group 1*- Screened by health care provider (HCP) and, if positively screened, support and encouragement to seek IPV services from a printed list of locally available IPV resources; *Group 2*- Screened by A-CASI and, if positive, a computer printout of locally available resources was generated and A-CASI encouraged the patient to show the HCP her results; the HCP provided encouragement to contact IPV services if the patient shared the results; *Group 3*- Screened by A-CASI and, if positive, a short video clip provided support and encouraged help seeking, and the computer printed a list of resources. All participants responded to a short A-CASI health interview and were seen by their HCP but not in the same order. Participants randomized to groups 2 and 3 (A-CASI screened) completed the A-CASI health interview and IPV screen before their HCP visit. Participants randomized to the HCP screening group saw their HCP first and then answered the A-CASI health questions. Providers in each of the clinics were informed of the study and oriented in asking the screening questions, and on how to provide support and	**Primary outcomes:** Rates of disclosure of IPV (using the Partner Violence Screen), preference of screening mode (by provider or computer), and impact of screening (positive or negative reaction for participant) at one-week follow up. Referral outcomes were: recollection of receiving a directory of services, sharing of services list with others, contact of services on the list, and interaction with an in-house IPV advocacy programme within 3-months of screening. **Secondary outcomes:** NR **Follow up periods:** 1 week for the telephone interview, and 3 months for the review of any contact with the in-house advocacy staff **Methods of analysis:** Disclosure rates were calculated using an intent-to-treat analysis. Chi-square tests (or Fisher's exact test as appropriate for small cell size) were used to test for significance for	**Who is the target of the intervention?** Women over the age of 18 years attending public hospitals **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** A-CASI (groups 2 and 3) disclosed IPV more often (21%) than those screened by a HCP (9%, p=0.07). Most women (41%) had no preference for mode of screening. Among those who expressed a preference, women tended to prefer the type of screening they received; 33% of those women screened by HCP preferred this format, while 40% of those women screened by A-CASI preferred the computer format (p<0.05). No differences were found between the provider-delivered and A-CASI delivered screening groups for impact of screening (positive or negative reactions). Nearly all women (94%) remembered being asked about IPV. Among those who recalled being asked, 28% reported positive reactions. Less than 10% in the A-CASI screened group and none of the HCP-screened group reported negative reactions to screening, although these differences were not statistically significant. No women reported problems due to being screened. Women referred by their provider were more likely both to share the list and to	**Limitations identified by author:** A small sample size which limited the researchers' ability to examine significant differences for variables with low prevalence. Reliance on providers' self-reports for measuring their compliance with the screening and referral protocols. Lack of measurement or analysis based on the gender of the perpetrator **Limitations identified by review team:** Insufficient information on acceptability of computer screening for higher SES groups **Evidence gaps and/or recommendations for future research**: Further research should examine the use of

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	35.8 (14.4); *Race:* 79% African American; *Education:* 42% high school or less, 42% some college or vocational training; *Insurance:* 57% uninsured, 37% public insurance **Setting:** Women's health clinics at a public hospital in Chicago	encourage the use of referral resources should the trial participant disclose exposure to IPV. Starting on the sixth day after the initial assessment, the same RA attempted to contact participants by phone. During this phone interview, women were asked about their reactions to the IPV screening questions, whether they had experienced any problems as a result of being asked about IPV, and their use of the referral resources list. **Control/comparison(s) description:** See above for description of the three groups **Sample size(s):** Total n=126; Group 1 n=46; Group 2 n=37; Group 3 n=43 **Baseline comparisons:** No demographic differences between groups were observed. **Study sufficiently powered:** NR	all comparisons between groups except for age differences, which was tested with a t-test. Partitioned chi square was used to compare the preference of screening modes.		contact services, but these differences were not statistically significant (p=0.17 and p=0.36 respectively). No women were found to have interacted with the in-house advocacy staff within 3 months after screening. **Secondary outcomes:** N/A **Attrition details:** 24 were lost to follow-up. Participants lost to follow-up were similar to those who completed participation in level of education and insurance status, but those lost to follow-up were significantly younger (p=0.001).	this screening and referral approach for other settings and sub-populations **Source of funding:** Centers for Disease Control and Prevention

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): MacMillan, H. L., Wathen, C. N., Jamieson, E., Boyle, M. H., Shannon, H. S., Ford-Gilboe, M., Worster, A., Lent, B., Coben, J. H., Campbell, J. C., & McNutt, L. **Year:** 2009 **Citation:** Screening for intimate partner violence in health care settings: A randomized trial. *Journal of the American Medical Association, 302*(5), 493-501. **Country of study:** Canada **Aim of study:** To examine the effectiveness of IPV screening and communication of a positive screening result to clinicians in health care settings, compared with	**Source population(s):** Women at 12 primary care sites (family practices and community health centers), 11 acute care sites (emergency departments), and 3 specialty care sites (obstetrics/ gynecology clinics) in Ontario, Canada **Eligible population(s):** Women presenting for care from July 2005 to December 2006, aged 18 to 64 years, had a male partner in the last 12 months, presented for their own health care visit, were able to separate themselves from those accompanying them, were living within 120 km of the site, were able to speak and read English, were not too ill to participate, and were able to provide informed consent. **Selected population(s):** Only 7% (8,293/121,997) of women presenting	**Method of allocation:** Randomization was by day or shift (for sites with shifts). A table for each day of the week was created for an 8-week period, and a random number table was used to determine the order of weeks 1 through 8 in the cells. **Intervention(s) description:** On a screening day, before seeing the clinician, participants completed the Woman Abuse Screening Tool (WAST), answered questions on their socioeconomic circumstances and provided contact information. For women who screened positive, the completed WAST questionnaire was placed in the chart for the clinician. Any discussion of positive findings and any further referrals or treatment were left to the discretion of the treating clinician according to his/her usual practice. After their visit, all screened women, regardless of screening results, completed the Composite Abuse Scale (CAS). **Control/comparison(s) description:** On a no-screening (control) day, before seeing the clinician, participants answered questions on their	**Primary outcomes:** IPV was defined as a score of 4 or more on the *WAST*, an 8-item instrument that measures physical, sexual, and emotional abuse in the last 12 months. It correctly classified 100% of nonabused women and 92% of abused women in a known-group analysis and is highly correlated (r=0.96) with the Abuse Risk Inventory. The *CAS,* a 30-item validated research instrument, was used as the criterion standard for recurrence of IPV. Its 4 subscales correlate highly with corresponding subscales of the Conflict Tactics Scales. Quality of life was measured with the *World Health Organization Quality of Life (WHOQOL)-Brief* instrument. An a priori decision was made to use the psychological quality-of-life scale, hypothesizing that it would be most amenable to change. Internal consistency of this scale has ranged from alpha=0.86 to 0.91. **Secondary outcomes:** Health outcomes for abused women to determine whether screening was associated with harmful consequences. Depression was measured by the *Centre for Epidemiologic Studies Depression scale*; PTSD by the *SPAN (Startle, Physiological Arousal, Anger, and Numbness)*; alcohol abuse/dependency by the *TWEAK* screening tool; global mental and physical health and well-being by the *Short Form 12 health survey, version 2*; effect of being asked IPV screening questions by the *Consequences of Screening Tool (COST)* (developed for this study); and violence-specific	**Who is the target of the intervention?** Women aged 18 to 64 in Ontario **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The trajectory of IPV recurrence risk was downward, with a small, nonsignificant reduction in risk (at 18 months, OR=0.82, 95% CI: 0.32-2.12) for screened vs. nonscreened women. Women in the screened vs. non-screened groups exhibited more rapid improvement in quality of life (at 18 months, 3.74 points higher, 95% CI: 0.47-7.00). The positive effects associated with quality of life and depressive symptoms (see secondary outcomes) are not robust: Estimates derived from multiple imputation were lower for both of these outcomes (2.29 for quality of life and -1.97 for depressive symptoms) and no longer statistically significant. The comparison of harm using the COST subscale with the sample that included women exposed and not exposed to IPV (data available from the authors) did not reveal any differences based on exposure status, nor	**Limitations identified by author:** Both screened and nonscreened participants received an information card with details about where to seek help in her community and were interviewed using the same methods at the same intervals. This would have reduced the likelihood of detecting differences between groups. High loss to follow-up; lost participants had higher WAST and CAS scores and, therefore, may have been at higher risk of subsequent violence compared with those retained. All outcomes were self-reported. The study was conducted under carefully controlled conditions that may not reflect the reality of most clinical settings. **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations**

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
no screening, in reducing subsequent violence and improving quality of life **Study design:** Cluster randomized controlled trial **Quality score:** [++] **External validity:** [++]	at the health care site were eligible for the study. 81% of eligible participants were randomized. **Excluded population(s):** Not able to speak and read English, too ill to participate, did not have a male partner some time in past 12 months **Sample characteristics:** Screened: *Mean age (SD):* 33.8 (10.8); *Mean years of education (SD):* 13.7 (2.8); *Marital status:* 35% single, never married; *Pregnant:* 4%; Nonscreened: *Mean age (SD)*: 33.9 (10.7); *Mean years of education (SD)*: 13.5 (2.8); *Marital status:* 39% single, never married; *Pregnant:* 9% **Setting:** Medical sites in Ontario, Canada. Urban vs. rural setting not specified	socioeconomic circumstances and provided contact information. After their clinical encounter, they completed the WAST and the CAS. **Sample size(s):** Total n=411; Screened n=199; Nonscreened n=212 **Baseline comparisons:** Groups were not significantly different on measured demographic variables **Study sufficiently powered:** Yes. Based on a 2-sided test at the alpha=0.05 level and 80% power to detect a reduction from 60% to 45% IPV recurrence over 18 months, 186 women per group were required.	service use by a modified version of the *Health and Social Service Utilization questionnaire*. **Follow up periods:** Each individual was followed for 18 months. Interviewers blinded to group assignment met with women within 14 days of the index visit to conduct a baseline interview and again at 6, 12, and 18 months. **Methods of analysis:** Software was used to model growth trajectories for abuse recurrence (logistic model) and quality of life (linear model). Because loss to follow-up was high, average growth measures were estimated from 5 complete files generated through multiple imputation to test the robustness of the observed findings for all enrolled women. Analyses of all outcomes except harm were run on the randomized sample of 411 women (199 screened and 212 non-screened) who screened positive on both the WAST and the CAS at the index visit and who had a baseline interview plus at least 1 follow-up interview. The analysis of harm was conducted using baseline data obtained from all women in the screened group who had positive screening results on at least 1 IPV measure and a random selection of those who screened negative on both. This larger sample was used to assess harm because we were interested in the effects of screening on all women regardless of IPV status.		was there any indication of harm associated with screening for either group. **Secondary outcomes:** Among the secondary measures, only depressive symptoms showed a statistically significant reduction (at 18 months, -2.32, 95% CI: -4.61 to -0.03) **Attrition details:** 43% (148/347) in screened women and 41% (148/360) in non-screened women were lost to follow-up. Women retained in the study had more education, had lower scores on the WAST and CAS, and were less likely to be single.	**for future research:** Further research is essential to determine whether these findings are replicated in other settings and samples. It is important to first determine whether screening and follow-up are acceptable or feasible for women reporting exposure to more severe IPV in the past year. Future research will determine which interventions are effective in improving health outcomes for abused women, regardless of how they are identified. **Source of funding:** Ontario Women's Health Council (Ontario Ministry of Health and Long-Term Care)

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Moody, L. E., Voss, A., & Lengacher, C. A. **Year:** 2000 **Citation:** Assessing abuse among the elderly living in public housing. *Journal of Nursing Measurement, 8*(1), 61-70. **Country of study:** USA **Aim of study:** To assess the psychometric properties of the Hwalek-Sengstock Elder Abuse Screening Test (HSEAST), a questionnaire to screen for elder abuse **Study design:** Cross-sectional study **Quality score:** [+] **External validity:** [-]	**Source population(s):** Elderly people living in public housing **Eligible population(s):** Elderly people (age 60 or older) living in public housing in a 480-unit, high-rise apartment complex in a large southwest Florida city. All residents in the complex were invited by letter to participate in the study. **Selected population(s):** Eligible participants who returned the consent form, thus indicating their willingness to participate. The authors called this a "convenience sample" but provide no further details, so it is unclear whether additional selection criteria were used.	**Method of allocation:** N/A **Intervention(s) description:** This paper assessed the psychometric properties of a screening questionnaire for elder abuse, the HSEAST. The HSEAST is a 15-item questionnaire completed by self-report or administered by interview and requiring on average 5-10 minutes to complete. Scoring of the instrument is summative and based on responses to the 15 items which require a "yes" or "no" response. Each "yes" response to an "abuse" item counts as one point. A response of "no" to items 1, 6,12, and 14 and a response of "yes" to all other items are scored in the abused direction. Scores range from 0 to 15. Previous factor analysis of the 15 HSEAST items delineated three conceptual categories: violation of personal rights or direct abuse, characteristics of vulnerability, and a potentially abusive situation. Results from previous analyses published in 1991 noted that a mean score of 3 or higher on the HSEAST appears to be a reasonable or probable indication of abuse. **Control/comparison(s)**	**Primary outcomes:** The status of "past abuse" vs. "no abuse" was based on self-report of being a previous victim of abuse or crime, and verified using records by the social worker at the housing authority. Additional demographic data collected were: age, ethnicity, sex, number of years lived at the public housing site, and a one-item scale denoting subjects' perceived fear of being abused. **Secondary outcomes:** NR **Follow up periods:** N/A **Methods of analysis:** Descriptive analyses were run on all study variables. Chi-square analysis and independent t-tests were used to compare "past abuse" vs. "no abuse" participants' scores to assess construct validity. Cronbach's alpha was used to assess reliability (internal consistency). Factor analysis, discriminant analyses,	**Who is the target of the intervention?** Elderly people (age 60+) living in public housing **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The abused vs. non-abused groups were significantly different (p's<0.05) on 9 of the 15 items on the HSEAST. Mean total scores on the 15-item instrument were significantly different for the abused group (4.01) vs. the non-abused group (3.01) (t=1.98, p=0.049). A factor analysis supported the 3-factor structure proposed for the HSEAST and explained 38% of the total variance. Factor 1 (Violation of Personal Rights) explained 19% of the variance and included 5 items, Factor 2 (Characteristics of Vulnerability) included 2 items, and Factor 3 (Potentially Abusive Situation) included 3 items. Reliability (internal consistency) on the 15-item scale was weak, alpha=0.46. Reliability on the 10-item scale (i.e. only including items from the factor analysis) was 0.59. Internal consistency results for the three subscales based on the factor analysis were as follows: Factor 1 (5 items)=0.66, Factor 2 (2 items)=0.52, and Factor 3 (3 items)=0.38. A stepwise discriminant function analysis showed that a 6-item model was as effective as a 9-item model in correctly classifying cases as abused vs. non-abused (71% correct). The items which were the most	**Limitations identified by author:** NR **Limitations identified by review team:** Convenience sample and study conducted in a high-crime area, which may limit generalisability to a broader population. It appears that the "abused" vs. "non-abused" classification was based on past abuse, and the time frame was not specified (e.g. ever abuse, past year, past month), so it is unclear how useful the tool is in predicting current or future abuse. **Evidence gaps and/or recommendations for future research:** A prospective cohort study would make it possible to assess the predictive validity of the HSEAST. With a large, diverse sample of elderly, a logistic regression could be used to predict group membership (abused vs. not). Further testing is needed to assess additional psychometric properties of the HSEAST and whether

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Excluded population(s): NR **Sample characteristics:** *Gender:* 55% female, 45% male; *Mean age:* 66.6; *Mean time living at the public housing site:* 6.5 years; *Ethnicity:* 49% White, 34% Hispanic, 32% African Americans [note: these are the percentages reported, though they add to more than 100%]; *First language:* 78% English, 22% Spanish **Setting:** Urban public housing	**description:** N/A **Sample size(s):** Total n=100 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	and principal component analyses were used to assess the factor-structure of the tool.		powerful discriminators among the groups were: “Has anyone taken things that belong to you without your OK?”, “Has anyone close to you tried to hurt or harm you recently?” and “Do you have enough privacy at home?” The 6-item model had a lower rate of false positives (5%) and a higher rate of false negatives (20%) than the 9-item model. Taken together, the authors state that the results provide additional evidence for the construct validity of the HSEAST. **Secondary outcomes:** N/A **Attrition details:** N/A	the number of items in it can be reduced. **Source of funding:** NR

Appendix O

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Power, C., Bahnisch, L., & McCarthy, D. **Year:** 2011 **Citation:** Social work in the emergency department - implementation of a domestic and family violence screening programme. *Australian Social Work, 64*(4), 537-554. **Country of study:** Australia **Aim of study:** To evaluate the impact of a new domestic and family violence screening programme, which was based on an ecological model and introduced by a social work team in the Emergency Department of a major metropolitan hospital	**Source population(s):** Health care providers in Australia **Eligible population(s):** Staff recruited from Flinders Medical Centre (FMC), a hospital located in the southern suburbs of Adelaide providing tertiary level acute care in the State of South Australia **Selected population(s):** NR **Excluded population(s):** NR **Sample characteristics:** *Age:* 30% 21-29 years, 35% 30-39 years, 20% 40-49 years, 15% 50+; *Profession:* 12.5% Enrolled Nurse, 62.5% Registered Nurse, 22.5% Doctor, 2.5% Emergency Department (ED)	**Method of allocation:** N/A **Intervention(s) description:** A screening tool was developed based on these validated questions: Has a partner or significant other person ever done any of the following: Made you feel afraid? Hurt you physically or thrown objects? Constantly humiliated or put you down? These three questions, an ABCDE response protocol (with easy to remember prompts: "Ask alone, Be supportive, Call on resources, Document, Ensure Safety"), and phone numbers for relevant services were recorded on a card, carried by staff at all times. Posters were displayed throughout the ED that included information about what domestic and family violence is, how to respond, what actions to take and key service providers and their contact numbers. A small foldout pamphlet containing DV information and resource contact numbers was offered to all women. ED registrars, interns, and nurses were given a single one hour training session, conducted by the ED senior social worker and offered on a continuing basis. All women aged 16 and up were screened. If a woman answered ''yes'' to any of the screening questions, the staff provided her with three alternatives: information only; information and referrals to community support services; or counselling by an ED social worker, who would arrange	**Primary outcomes:** Rates of referral to the ED social work team were determined for the three month period prior to implementation of the screening programme, and for the three months immediately following training and implementation. **Secondary outcomes:** The acceptability and impact of the screening tool and programme by staff, based on an anonymous survey **Follow up periods:** 3 months **Methods of analysis:** Descriptive analyses of quantitative data. Written comments were reviewed and themed.	**Who is the target of the intervention?** Health care providers in EDs **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Yes. See primary outcomes	**Primary outcomes:** In the 3-month period following the introduction of the programme, the rate of referral to social work increased by 213% (from 15 referrals in the three months preceding the intervention to 47 referrals in the three months after; an extra 32 referrals). From the 47 domestic and family violence clients in the audit period: 12 women suffered from mental health issues, 14 with drug or alcohol dependency issues, and 2 with intellectual or physical disabilities. There were four notations (7%) of domestic and family violence, in which the patient self identified this to the nurse. Another 21 women (37%) had possible assault-related injuries, while 5 had physical injuries or conditions (9%), and 27 women (47%) had mental health issues. **Secondary outcomes:** Staff indicated that they considered the screening questions were effective in identifying domestic and family violence (M=3.8 on a five-point Likert scale, SD=0.68). The impact of the tool in identification was considered mildly effective (M=3.2, SD=0.9). The tool was not part of usual work practice for most (M=2.8, SD=1.1) and the tool had not added significantly to workload (M=2.3, SD=1.0). There was support for the	**Limitations identified by author:** Increase in referrals post-intervention may have been due to seasonal influences (this time period was around Christmas and New Year) or the heightened presence of the social work team. Small sample size. Not generalisable to other settings. Survey was supposed to be anonymous but was completed collaboratively with social work team **Limitations identified by review team:** Self report bias. Poor description of source population **Evidence gaps and/or recommendations for future research:** Evaluate the sustainability of screening programs beyond the first three months implementation **Source of funding:** Southern Adelaide Health Service

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Study design: Mixed methods (before and after study/qualitative study) **Quality score:** [-] **External validity:** [+]	Consultant; *Gender:* 30% male, 70% female **Setting:** Urban emergency department	sheltered accommodation when appropriate. Women were not screened in the presence of their partners or other family members or if they were in acute distress. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=40 for the staff surveys **Baseline comparisons:** N/A **Study sufficiently powered:** NR			appropriateness of using the tool within the ED (M=3.9, SD=0.9) though open-ended comments showed concern about ensuring privacy and whether universal screening was appropriate. The training was rated as effective as a preparation for the use of the tool (M=3.5, SD=1.0). When asked if training was sufficient to understand the reasons for the screening programme, most rated it as satisfactory or very satisfactory (M=3.6, SD=1.4), while most staff were satisfied with their knowledge of referral services (M=3.2, SD=1.0). **Attrition details:** Survey response rate was 53%	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Price, S., Baird, K., & Salmon, D. **Year:** 2007 **Citation:** Does routine antenatal enquiry lead to an increased rate of disclosure of domestic abuse? Findings from the Bristol Pregnancy and Domestic Violence Programme. *Evidence Based Midwifery, 5*(3), 100-106. **Country of study:** UK **Aim of study:** To evaluate the effect of routine antenatal enquiry about domestic abuse, on disclosures of DV in pregnancy **Study design:** Before and after study **Quality score:** [-] **External validity:** [-]	**Source population(s):** Practicing midwives from the North Bristol NHS Trust **Eligible population(s):** NR **Selected population(s):** NR **Excluded population(s):** All midwives from the North Bristol NHS Trust were invited to participate, but four refused. **Sample characteristics:** *Education:* 43% diploma, 39% certificate, 12% degree, 5% Masters **Setting:** Urban	**Method of allocation:** N/A **Intervention(s) description:** "Educational programme" (no details) given to 83 midwives **Control/comparison(s) description:** N/A **Sample size(s):** Total n=83 **Baseline comparisons:** NR **Study sufficiently powered:** NR	**Primary outcomes:** A record audit tallied the number of women disclosing DV to midwives on "cause for concern" forms (completed by any midwife who had anxieties related to the welfare of clients in her care) for 17 months pre-intervention, and for 9 months during implemented screening. **Secondary outcomes:** N/A **Follow up periods:** 9 months **Methods of analysis:** Frequency analysis	**Who is the target of the intervention?** Midwives **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The record audit found 8 cases (out of 6764 women) in 17 months pre-intervention, and 25 cases (out of 3779 women) in the 9 months of routine inquiry - an almost six-fold increase. Since not all disclosures of DV would have automatically resulted in a "cause for concern" form, midwives were also asked at 6-month follow-up to identify the number of clients who had disclosed old or new episodes of violence since the introduction of routine enquiry. There was a total of 100 disclosures of DV reported by midwives. The majority of midwives (59%, n=38) self-reported screening 41-60% of women, 16 midwives reported screening 61-80% of women, and 3 midwives 81-100%. **Secondary outcomes:** N/A **Attrition details:** N/A	**Limitations identified by author:** No comparison group. Small sample size **Limitations identified by review team:** No information on educational programme. No data on number of midwives who did not receive training. No fidelity audit. Self-report of screening rate **Evidence gaps and/or recommendations for future research**: More formal experiments with comparison group and other locations, and use of different modes of questioning **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Rhodes, K. V., Drum, M., Anliker, E., Frankel, R. M., Howes, D. S., & Levinson, W. **Year:** 2006 **Citation:** Lowering the threshold for discussions of domestic violence: A randomized controlled trial of computer screening. *Archives of Internal Medicine, 166*(10): 1107-1114. **Country of study:** USA **Aim of study:** To determine the effect of computer screening on health care provider-patient DV communication **Study design:** Individual randomized controlled trial **Quality score:** [+]	**Source population(s):** Women at two socioeconomically diverse emergency departments (ED's): an urban academic medical centre that serves a predominately publicly insured inner-city African American population, and a suburban community hospital serving a privately-insured suburban white population **Eligible population(s):** Women aged 18 to 65 years and triaged as medically nonemergent **Selected population(s):** All non-emergency women aged 18 to 65 years were invited to participate. Of 2,169 eligible patients, 1,281 consented. **Excluded population(s):** Emergency patients **Sample characteristics:** Overall sample: *Mean age (SD):* 33.3 (12.0); *Race:* 60% African American; *Marital status:* 45% single; *Education:* 48% >high school. Patients at the urban ED: *Mean age (SD):* 32.1	**Method of allocation:** Treatment assignment was ascertained by the research assistant by opening sealed randomization envelopes in sequential order. The envelopes were prepared from a randomization list generated by computer in blocks of size 10 to ensure balance between groups over short time spans, such as shifts and days of the week, as well as over the entire course of the study. **Intervention(s) description:** Self-administered computer based health risk assessment tool (Promote Health Survey) which generated health recommendations for patients and alerted physicians to a variety of potential health risks, including DV. Patients completed the survey on a touch-screen computer in a private room. If the patient answered "Yes" to any of the DV risk questions, the computer-generated report said "Possible partner violence: Assess for current abuse." The DV screen (also completed by both groups on the exit questionnaire) was derived from the previously validated Abuse Assessment Screen and Partner Violence Screen. **Control/comparison(s)**	**Primary outcomes:** Outcomes were assessed by audiotape analysis, and included rates of discussion of DV, patient disclosure of DV to the health care provider, and evidence of DV services provided during the visit, defined as a safety assessment, counselling by the health care provider or social worker, or referrals to DV resources. **Secondary outcomes:** Medical chart documentation of DV screening (positive or negative), DV "case finding" (chart documentation of current or past DV), and overall patient satisfaction assessed by an exit questionnaire **Follow up periods:** N/A **Methods of analysis:** The primary analysis evaluated the effect of the Promote Health Survey, within each site, on audio-coded rates of DV discussion, disclosure, and services, using mixed logistic regression models with intervention as the fixed effect of interest and primary provider as a random effect, entered to adjust standard errors of the intervention effect for correlation due to clustering of patients within providers. All tests of	**Who is the target of the intervention?** Female ED patients **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Rates of current DV risk on the exit questionnaire were 26% in the urban ED and 21% in the suburban ED. In the urban ED, the computer prompt increased rates of DV discussion (56% vs 45%; OR=1.99, 95% CI: 1.25-3.18, p=0.004), any DV disclosure (14% vs 8%; OR=1.71, 95% CI: 0.96-3.05, p=0.07), and any DV services provided (8% vs 4%; OR=2.29, 95% CI: 1.04-5.02, p=0.04). In the suburban ED no significant increases were seen as a result of the intervention. Women at the suburban site and those with private insurance or higher education were much less likely to be asked about experiences with abuse. Only 48% of encounters where a patient disclosed DV risk to the computer led to a DV discussion with the health care provider. **Secondary outcomes:** Chart documentation of DV was not significantly impacted by the	**Limitations identified by author:** Study design does not allow for identification of the specific reasons why health care providers, particularly suburban health care providers, failed to address DV when prompted to do so. Audiotaping had the advantage of providing direct evidence, as opposed to indirect evidence available from chart review, but it may have created a participation bias; participants who were uncomfortable discussing sensitive issues might have declined to have their visit audiotaped. Audiotaping also may have caused a Hawthorne effect owing to the non-blinding of the intervention and, along with the potential for treatment diffusion, may have decreased the authors' ability to detect differences between groups. DV conversations may have occurred that were not captured from inaudible recordings. There may have been important system issues at each site that

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]	(11.6); *Race:* 86% African American; *Education:* 38% >high school; *Marital status:* 11% married, 64% unmarried, 25% unknown; *Income:* 53% <$20,000. Patients at the suburban site: *Mean age (SD):* 36.2 (12.4); *Race:* 80% White; *Education:* 71% >high school; *Marital status:* 43% married, 45% unmarried, 13% unknown; *Income:* 18% <$20,000 **Setting:** Urban and suburban ED's	**description:** Usual care, with no alerts **Sample size(s):** Total n=1281, of which 867 were successfully audiotaped and analysed, 903 completed the exit questionnaire, and 1178 charts were reviewed. Of the audiotapes: Intervention n=421 (suburban n=159, urban n=262); Control n=446 (suburban n=171, urban n=275) **Baseline comparisons:** No significant demographic differences by group assignment **Study sufficiently powered:** NR	intervention effect were conducted as intent-to-treat analyses. Multivariate logistic regression models were used to evaluate simultaneous effects of the Promote Health Survey intervention, ED site, and patient characteristics on the DV audio outcomes and on chart documentation of DV screening. Two-sample t tests and chi-square tests were used to compare patient characteristics and rates of patient disclosure of DV on exit questionnaires between sites, as well as associations between patient satisfaction (dichotomized as "very satisfied" vs lower ratings) and DV discussion and disclosure.		intervention. Both inquiries about and disclosures of abuse were associated with higher patient satisfaction with care. **Attrition details:** Of 1,281 participants who were randomized, 871 (68%) of these were successfully audiotaped, 903 (70%) completed an exit questionnaire, and 1,178 charts were reviewed (92%).	were not captured in the study but influenced the effect of the intervention. **Limitations identified by review team:** No power calculations presented **Evidence gaps and/or recommendations for future research**: More research focused on understanding and reducing the gap between information and health care provider action will be necessary to address the patient-identified need for DV risk assessment and counselling. **Source of funding:** Agency for Healthcare Research and Quality, National Institute of Mental Health

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Rickert, V. I., Davison, L. L., Breitbart, V., Jones, K., Palmetto, N. P., Rottenberg, L., Tanenhaus, J., & Stevens, L. **Year:** 2009 **Citation:** A randomized trial of screening for relationship violence in young women. *Journal of Adolescent Health, 45,* 163-170. **Country of study:** USA **Aim of study:** To determine the effectiveness of three different screening approaches using computer-based screening methodology and to assess relationship violence among adolescent and young adult women. To gain information on patient and provider satisfaction with these approaches **Study design:**	**Source population(s):** Women aged 15 to 24 living in Manhattan **Eligible population(s):** Women aged 15 to 24 attending a reproductive health centre in Manhattan between April 2005 and October 2006 **Selected population(s):** Eligible participants who consented to take part in the study. There were no demographic (age, race/ethnicity, employment status) differences between those who refused and those who participated. **Excluded population(s):** NR **Sample characteristics:** *Sexually active in last 6 months:* 95%; *History of hormonal birth control:* 80%; *One or more previous pregnancies:* 32%; *Victim of any violence, lifetime:* 30%; *Victim of sexual violence, lifetime:* 17%; *Victim of physical violence, lifetime:* 19%	**Method of allocation:** An audio-assisted computer interview (ACASI) performed random assignment **Intervention(s) description:** Prior to seeing a provider, each participant completed the routine clinic health history with the ACASI and then one of three different screening approaches to which they were randomized. Descriptions of the three screening approaches are listed in the primary outcome measures in this table. Each subject listened to the screening questions on headphones, read them on the computer screen protected with a privacy hood, and entered her responses on a laptop. The patient's entire medical history, including responses to the violence screening questions, was printed and attached to the patient's chart. Printed responses were reviewed by the provider, trained in both partner abuse and the study protocol, who did an additional face-to-face assessment subsequent to reviewing the screening responses. At the conclusion of the medical exam, the research assistant gave the young woman a brief evaluation form to evaluate her satisfaction and comfort with the screening process. Following the clinical visit, the provider documented on a structured form an assessment	**Primary outcomes:** The outcome of experiencing violence was measured by women's self-report of "any violence" (lifetime prevalence) and "any recent violence" (within the past year) on the screening tools, as well as the healthcare provider's assessment of violence in a patient's recent or past relationship. The three different ACASI screening approaches were as follows: "Basic" screening patients were asked five questions: three inquiring about violence by a partner within the last 12 months, and two questions about the lifetime receipt of physical or sexual violence. "Healthy relationships" patients were asked seven questions: the five questions in the basic screen and two additional questions inquiring about the degree to which her partner respected and treated her well. "Bidirectional" patients were asked eight questions: the five questions in the basic screen and three additional questions regarding the frequency with which she was the perpetrator (was suspicious of her partner's fidelity; hit, slapped, or physically hurt him; and/or	**Who is the target of the intervention?** Young women living in Manhattan **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** No significant differences emerged between the screening approaches with regard to reports of lifetime occurrence of any violence, or when examining past physical and/or sexual violence. When violence type was segregated into sexual and physical components, a significant difference was found by screening approach for physical violence: 12% of those in the bidirectional screening group reported recent physical violence versus 6% in the basic and 6% in the healthy relationship screen ($p<0.04$). Only one significant difference was detected for the provider's assessment of violence: those in the bidirectional screening were more likely to be assessed by the provider to have perpetrated violence towards their partner. Overall, providers identified fewer women as experiencing violence than the women themselves indicated on the screening; 31% of	**Limitations identified by author:** Since there is no gold standard for the identification of partner violence among adult women, it is possible the questions used in this study may have resulted in a lower rate of disclosure. Results not generalisable to other women and settings. Unclear as to what, if any, effect a different screening method (e.g. paper/pencil) may have on confidential disclosure of dating violence **Limitations identified by review team**: Self-report. No information on participants' comfort using computer **Evidence gaps and/or recommendations for future research**: Future research should compare and contrast different screening tools and approaches (e.g. anonymous tool vs confidential but not anonymous tool) to determine the efficacy of relationship violence screening among young women.

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Individual randomized controlled trial **Quality score:** [+] **External validity:** [+]	**Setting**: Urban reproductive health centre	of whether relationship violence was present, and evaluated the screening process. **Control/comparison(s) description:** See primary outcome measures **Sample size(s):** Total n=699; Basic screening n=232; Health relationship screening n=243; Bidirectional screening n=224 **Baseline comparisons:** There were no significant differences between the screening groups on common demographic or reproductive health characteristics. **Study sufficiently powered:** NR	forced him to have sex). **Secondary outcomes:** NR **Follow-up periods:** N/A **Methods of analysis:** Violence outcomes (physical, sexual, or any) reported by the subject were analysed to determine if differences existed between screening condition using chi-square tests. Patient and provider satisfaction and comfort with the screening by condition were examined using Kruskal-Wallis tests.		women noted a lifetime occurrence of violence, yet only 18% were identified by providers as victims of violence. Overall, 29% of women noted that their provider did not discuss relationship violence. There were no significant differences in women's experiences of screening approach, with most reporting being comfortable with screening. There were also no significant differences regarding provider experiences of screening approaches, with providers on average reporting high rates of comfort with talking to their patients about violence. **Secondary outcomes:** N/A **Attrition details:** NR	**Source of funding:** CDC through the Columbia Youth Violence Centre

Appendix O

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Robinson-Whelen, S. Hughes, R. B., Powers, L. E., Oschwald, M., Renker, P., Swank, P. R., & Curry, M. A. **Year:** 2010 **Citation:** Efficacy of a computerized abuse and safety assessment intervention for women with disabilities: A randomized controlled trial. *Rehabilitation Psychology, 55*(2), 97-107. **Country of study:** USA **Aim of study:** To test the impact of the Safer and Stronger Programme (SSP) on abuse awareness, safety self-efficacy, and safety promoting behaviours among women with disabilities **Study design:**	**Source population(s):** Women who self-identified as disabled **Eligible population(s):** Women who self-identified as having a disability consistent with the Americans with Disabilities Act (i.e. a physical or mental impairment that substantially limits one or more major life activities) from Texas, Washington, and Oregon. Prior experience with abuse not required to participate **Selected population(s):** Convenience sample recruited through flyers at various social service, DV, and disability NGOs; agency referrals; announcements at community-based health and disability events; the researchers' networks of disability community members; and word of mouth **Excluded population(s):** NR **Sample characteristics:** *Mean age (SD):* 50.75 (12.88); *Marital status:* 32% married or partnered; *Education:* 27% high	**Method of allocation:** Computer generated randomization at intake **Intervention(s) description:** The SSP is a computer-based assessment tool for women with disabilities to self-screen for IPV by disclosing their exposure to abuse, describing the characteristics of their primary perpetrator, and reporting their use of safety promoting behaviours. The SSP integrates audio-video vignettes of four IPV survivors (of varying race, age, disability, and type of perpetrator) who describe their abuse and survival experiences, offer affirming messages, identify warning signs, and discuss safety promoting strategies. The researcher sat in an adjoining room during the session, and participants were given a cell phone preprogrammed to contact 911 or a local crisis line if they wanted to speak to someone other than the research assistant. Most completed the programme in 1 to 1.5 hours, after which all were offered local abuse and safety resources. Accessibility was offered with captioning, audio track, text-to-speech, trackballs, headphones, and enhanced visibility keyboards. The intervention group completed the SSP at Time 1 (T1) while control participants received a health awareness programme at T1. At Time 2 (T2), which was roughly three months later, both groups completed the SSP. Intervention participants were also offered the	**Primary outcomes:** Abuse awareness was measured with a 5-item Abuse Awareness Scale. Safety self-efficacy was measured with a 9-item scale. Safety promoting behaviours were measured using 50 questions; from these questions, the authors calculated one score based on 7 selected items and another score based on 3 selected items. Prior year abuse was stratified into 5 classes: class 1=sexual abuse (afraid of and/or had experienced sexual abuse), class 2=physical abuse (afraid of and/or had experienced physical abuse but not sexual abuse), class 3=multiple abuses, class 4=low level (primarily emotional abuse, but did not feel unsafe and did not fear physical or sexual abuse), class 5=no past-year abuse. **Secondary outcomes:** NR **Follow up periods:** 3 months **Methods of analysis:** Two sets of analyses	**Who is the target of the intervention?** Women with disabilities **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** At T2, women in the intervention group had significantly greater abuse awareness scores than women in the control group ($p=0.015$), and women in the low and no past year abuse classes had lower abuse awareness scores than women in the other abuse classes ($p<0.0001$). In the intervention group, a significant time by abuse class interaction ($p=0.0008$) indicated that abuse awareness increased significantly more in the low to no past year abuse classes than in the other three classes. For safety self-efficacy, there was no significant difference between the intervention and control. However, there was a difference by class: women in the low or no past year abuse class had higher safety self-efficacy than the other women	**Limitations identified by author:** Lack of established measures. No data were collected on frequency or severity of abuse or whether participants were currently living with their perpetrators. Not a long enough follow-up time **Limitations identified by review team:** Self-selected sample from researchers' network, heavily weighted towards middle age women **Evidence gaps and/or recommendations for future research**: A larger population-based, randomized design is needed for generalisability of the findings and exploration of group differences on abuse classes.

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Individual randomized controlled trial **Quality score:** [+] **External validity:** [+]	school or less, 41% some college, 13% 4-year college, 15% graduate school; *Employment:* 21% employed; *Mean income (SD):* $11,813 (10,567); *Ethnicity:* 57% White, 30.5% African American, 7.5% Latina; *Disability:* 36% mental illness, 19% vision, 17% cognitive, 15% hearing, 12% learning, 8% speech; *Reported abuse in past year:* 68%. Of those not reporting past year abuse, 70% reported having experienced some abuse in their lifetime. **Setting:** Participants chose location: researcher's offices, local churches, or public facility offering services to people with disabilities	Health Awareness Programme after completing the SSP at T2. **Control/comparison(s) description:** The control group participated in a Health Awareness Programme at T1 and the SSP in T2. **Sample size(s):** T1: Total n=329; Intervention n=172; Control n=157. T2: Total n=259; Intervention n=126; Control n=133. The final analysis included 305 women: the 172 intervention group women who completed the SSP at T1 and the 133 control group women who completed the SSP at Time 2. **Baseline comparisons:** No significant differences at baseline for age, level of education, racial status, marital status, live alone versus live with others, income, the number of disabilities, the number of assistive devices used, or the self-rated severity of their primary disability. A higher percentage of women in the intervention group used personal assistants (60% vs. 48%, p=0.049) and low vision/blindness in the control group (24% vs. 13%, p=0.019). No adjustments were made to control for these differences. **Study sufficiently powered:** NR	were conducted. First, the intervention and control groups were compared at T2, to examine differences between those who had previously participated in the SSP and those completing it for the first time. Second, using the within-group sample, T1 and T2 data from intervention participants were examined for change over time.		(p<0.0001). For safety promoting behaviours, there was no significant difference between intervention and control on either the 7-item or 3-item scale. The only significant effect was that on the 3-item scale, women in the low/no abuse class reported fewer safety behaviours than the other women (p<0.0001). Abuse awareness and safety self-efficacy were significantly correlated with safety behaviours. **Secondary outcomes:** N/A **Attrition details:** Attrition=70. Computer problems accounted for 38 of the dropouts.	Further evaluation of the SSP is warranted. **Source of funding:** National Institute on Disability and Rehabilitation Research

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Shye, D., Feldman, V., Hokanson, C. S., & Mullooly, J. P. **Year:** 2004 **Citation:** Secondary prevention of domestic violence in HMO primary care: Evaluation of alternative implementation strategies. *American Journal of Managed Care, 10*(10), 706-716. **Country of study:** USA **Aim of study:** To compare the effectiveness of two system-level multifaceted quality improvement approaches to enhancing the secondary prevention of DV	**Source population(s):** Patients and clinicians of a large, not-for-profit group practice HMO in the northwestern US **Eligible population(s):** Clinicians: All internal medicine (IM), family practice (FP), health appraisal (HAP), paediatric, and obstetrics/gynaecology (OB/gyn) physicians, physician assistants, and nurse practitioners in the HMO's main metropolitan area. Patients: IM, FP, and OB/gyn female patients were identified from "health maintenance visits" by women aged 18 to 45 years to clinicians in these specialties during the pre- or post-intervention evaluation period. The pediatric sample was drawn from the mothers (aged 18-45) in "well-baby" visits involving infants aged 0 to 24 months during the same time period as the IM, FP, and OB/gyn sample. **Selected population(s):** Clinicians: Eligible clinicians who remained in their original study arm during the 10-month implementation period and worked at least 6 months in a single medical office. Personal and professional traits were similar among survey respondents and non-respondents, except the response rates of female clinicians were significantly higher than those of the male	**Method of allocation:** The 11 HMO medical offices with departments of IM, FP, OB/gyn, or paediatrics were purposively divided into 2 study arms with approximately equal total numbers of clinicians and relatively balanced numbers from each specialty. Clinicians' exposure to the basic or augmented strategy was determined by the study arm of their medical office. Female patients' exposure status was determined by that of their clinicians. **Intervention(s) description:** The intervention was an augmentation of the basic implementation strategy (ABIS) by providing medical office social workers paid time to act as social change agents for DV. The role involved: providing information to clinicians about prevalence of DV, risk markers and abuse dynamics; advocating for secondary prevention with primary care clinicians; clarifying the appropriate goals of screening and intervention activities; and modeling secondary prevention skills (including: asking about DV, conducting risk assessment, documenting violence, etc). These activities were carried out in department meetings and individual contact with clinicians. **Control/comparison(s) description:** The basic HMO implementation strategy (BIS) included dissemination of DV guidelines, continuing medical education and clinical and environmental supports and prompts to increase clinician assessment of and patient disclosure of DV exposure. The guidelines were a "routine inquiry" rather than universal screening approach which recommended primary care physicians to inquire about exposure to DV of female patients and mothers of pediatric patients at "health	**Primary outcomes:** Clinicians: Clinicians completed structured mailed questionnaires at pre- and post-intervention eliciting data on DV-related knowledge, attitudes, and reported practices (KAP). Frequency of inquiry for "red-flag" symptoms was assessed using a 6-item scale measuring the likelihood that clinicians would ask about DV exposure of patients presenting with injuries, chronic pelvic pain, irritable bowel syndrome, headaches, depression/anxiety, and fibromyalgia. Alphas were 0.90 and 0.87 for the pre- and post-intervention surveys, respectively. Patients: Proportion of women asked about DV exposure at their recent health maintenance visit. After providing a definition of DV, interviewers asked each respondent whether, at her recent appointment with a specific clinician,	**Who is the target of the intervention?** Clinicians in HMO medical offices, and female patients **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** At baseline, 3% of the respondents reported being asked about DV exposure at their recent health maintenance visit; this figure rose to 9.5% at follow-up (p=0.001). The proportion of women who reported discussing a DV problem with a clinician during the medical visit increased from 0.7% (n=12) at baseline to 1.2% (n=19) at follow-up, but this was not statistically significant. Logistic regression analyses showed a statistically significant increase in inquiry rates during the study period (OR=3.75, 95% CI: 2.41-5.84, p=0.0001). However, the ABIS was not significantly different from the	**Limitations identified by author:** Study focused on process measures of clinician attitude change and rates of routine inquiry about DV exposure rather than on the ultimate goal of detection and effective intervention with abused women. This limitation stemmed from budget and time frame limitations imposed by funding availability, as well as from the small absolute number of women who reported disclosing DV exposure to a clinician. **Limitations identified by review team:** Non-randomized **Evidence gaps and/or recommendations for future research**: Future

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Study design: Non-randomized controlled trial **Quality score:** [+] **External validity:** [-]	clinicians. Clinicians who responded to both surveys were similar to those who responded to only one. Patients: Sampling frames of visits were converted to sampling frames of unique women and women were randomly sampled according to their most recent visit (1/3 from IM, FP, and HAP; 1/3 from OB/gyn; and 1/3 from paediatrics). Respondents to the pre- and post-intervention surveys were significantly older than non-respondents (p=0.004). **Excluded population(s):** NR **Sample characteristics:** Clinicians (pre-intervention): *Mean age:* 43.9; *Sex:* 50% female; *Profession:* 72% physician. Clinicians (post-intervention): *Mean age:* 45.0; *Sex:* 48% female; *Profession:* 69.5% physician. Patients (pre-intervention): *Age:* 45% 26-35 years; *Marital status:* 74% married or living with partner; *Employment:* 52% full time; *Race:* 87% White; Patients post-intervention): *Age*: 45% 26-35 years; *Marital status*: 73% married or living with partner; *Employment:* 51% full time; *Race:* 87% White **Setting:** Urban group practice	maintenance visits" (routine visits for non-acute care) and for patients who present symptoms suggesting abuse. A task force coordinated the training (through a half-day conference, circulation of educational articles, print materials and cards with referral services) of a DV response team (including nurses, social workers, medical assistants, and sometimes a female physician) to intervene with those patients exposed to DV. The HMO also provided a pediatrician co-chair to the task force to oversee administration, and provided funds and materials to support staff training and secondary prevention. However, no HMO funds were provided to support staff time for these implementation activities. **Sample size(s):** Clinicians: Pre-intervention n=273; Post-intervention n=238. Patients: Pre-intervention n=1925 ; Post-intervention n=1979. **Baseline comparisons:** Clinicians: At baseline, clinicians in the two study arms had similar personal and professional characteristics and DV-related KAP. Patients: In both samples, women in the ABIS arm were significantly older and more educated than women in the BIS arm and had slightly higher income levels. In the pre-intervention sample, ABIS female patients were more likely to be pregnant and of minority race/ethnicity. At baseline, patient-reported levels of clinician inquiry about DV were similar in the BIS and ABIS study arms. **Study sufficiently powered:** NR	anyone had asked her about current or past DV exposure. **Secondary outcomes:** NR **Follow up periods:** 1 year **Methods of analysis:** Clinicians: Multivariate linear regression models to examine, among clinicians who responded to both the pre- and post-intervention surveys, the effect of study arm on post-intervention KAP scores, while controlling for pre-intervention scores and relevant covariates. Patients: Logistic regression to model post-intervention rates of clinician inquiry while controlling for relevant covariates.		BIS in affecting inquiry rates (p=0.61 for main effect of ABIS, p=0.38 for interaction effect of ABIS x time). **Secondary outcomes:** N/A **Attrition details:** Clinicians: Pre- and post-intervention survey response rates were 74% and 69%, respectively. 50% of the pre-intervention sample responded to both surveys. Patients: Response rates for the pre- and post-intervention female patient surveys were 86% (n=1652) and 81% (n=1598), respectively.	evaluations of implementation approaches should use outcome measures in addition to process measures. Future research should address the issue of possible harm to women as a result of increased DV detection and intervention efforts. **Source of funding:** Kaiser Permanente Garfield Memorial Fund grant #101-9062

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Trautman, D. E., McCarthy, M. L. Miller, N., Campbell, J. C., & Kelen, G. D. **Year:** 2007 **Citation:** Intimate partner violence and emergency department screening: Computerized screening versus usual care. *Annals of Emergency Medicine, 49*(4), 526-534. **Country of study:** USA **Aim of study:** To compare a computer-based method of screening for IPV with usual care in an emergency department (ED) setting **Study design:** Before and after study **Quality score:** [+]	**Source population(s):** Inner city women **Eligible population(s):** All women aged 18 or older who presented to the ED **Selected population(s):** Eligible participants who consented to participate and were not excluded based on the criteria listed below in "Excluded population(s)". Women who declined were more likely to be 55 or older compared to women who participated. **Excluded population(s):** Acute or critically ill presentation; illiterate; impaired mental status, disorientation, or apparent intoxication at the time of recruitment; would not separate from their partner; or already enrolled from a previous study period **Sample characteristics:** *Age:* 23%18-24, 23% 25-34, 41% 35-54, 12% ≥55; *Race:* 16% White; *Children in household:* 51%; *Marital status:* 54% never married, 20% married/living with partner, 21% separated/divorced; *Education:* 30.5% not a high school graduate, 42% high school graduate, 27% some college; *Employment:* 45%	**Method of allocation:** There were three consecutive 2-week enrolment periods. Women presenting at the ED during the first and third periods were the control/comparison groups, while women in the second period were the intervention group. **Intervention(s) description:** Patient service coordinators recruited women into the study. Women in the intervention group (period 2) completed a web-based health survey with four questions on IPV (three of them from the Partner Violence Screen), delivered via computer in a private area within the ED completed while they were waiting for care. Those screening positive in the intervention group were supposed to have one copy of the IPV results printed out for their medical record and another copy for a social services referral. **Control/comparison(s) description:** Women in the control/comparison groups (periods 1 and 3) also completed the web-based health survey, but without the four questions on IPV. All women in all three study periods received usual care related to IPV in addition to completing the computer survey. Usual care consisted of current ED policy that recommends, but does not enforce, routine IPV screening by nursing personnel.	**Primary outcomes:** Screening, detection, referral, and receipt of services for IPV were determined by medical record review, with 5% of records subject to 2nd review, with 100% interrater reliability for screening and 96% interrater reliability for detection of IPV. Screening was defined as either documentation in the medical record that the provider asked about IPV, or the patient completing the IPV questions in the computer survey. Detection of IPV was defined as either documented disclosure of current IPV or IPV in the past 12 months by a patient during the ED visit, or indicating IPV in the computer survey. Referral was defined as any offer to social work by the ED staff. Receipts of service were any actions by social workers to respond to a positive IPV screen (e.g. safety assessment, offering advice or community resources, etc.) **Secondary outcomes:** NR	**Who is the target of the intervention?** Women, hospital population predominantly African American and low SES **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** 99.8% of the intervention group were screened compared with 33% in the control group (67% difference, 95% CI: 63%-71%). Detection of IPV was 19% in the intervention group vs. 1% in the control group (18% difference, 95% CI: 14%-22%). Of the 87 participants with a positive screening, only 46 (53%) were referred to social work, with those in the intervention group being more likely to be referred (10.5% vs. 0.5%, 10% difference, 95% CI: 7%-13%). Similarly, participants were more likely to receive IPV services by a social worker if they were in the intervention group (4% vs. 0.3%, 4% difference, 95% CI: 2%-6%). Although referral and receipt of IPV services by a social worker was higher among the intervention group, the social workers still did not receive a referral on 41%, and did not provide services on 77%, of the	**Limitations identified by author:** No measure of emotional abuse. Disadvantaged population may impact generalisability. Receipt of IPV services by social work was lower than anticipated because of logistical issues and limited social work resources. No follow-up on impact of screening. **Limitations identified by review team:** Large population excluded as too ill to perform assessment **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** Authors reported that they received no external funding for this study

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]	employed, 28% unemployed, 8.5% homemaker/student, 18% retired/disabled; *Household Income:* 42% <$10,000, 21% $10,000-15,999, 12% 16,000-20,999, 15% 21,000-35,999, 10% ≥$36,000 **Setting:** ED of large inner city hospital	**Sample size(s):** Total n=1,005; Intervention n=411; Control n=594 **Baseline comparisons:** There were no significant differences between control and intervention in patient characteristics. **Study sufficiently powered:** To detect a 10% difference in screening rates and a 5% difference in detection, referral, and receipt of services between any two of the three study periods, a sample size of 400 in each group would yield adequate power (80%). This was based on the following assumptions: an average of 150 ED patients per day and 53% of them being women, ineligibility and refusal rate of 25%, prevalence of IPV in the ED of 14%, and 2% detection rate of IPV through usual care.	**Follow up periods:** N/A **Methods of analysis:** The authors compared differences in proportions for the outcomes between groups. Since the outcomes of the first and third study periods were similar, they were combined into one control group.		participants who were screened positive by the computer survey. **Secondary outcomes:** N/A **Attrition details:** N/A	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Vanderburg, S., Wright, L., Boston, S., & Zimmerman, G. **Year:** 2010 **Citation:** Maternal child home visiting programme improves nursing practice for screening of woman abuse. *Public Health Nursing, 27*(4), 347-352. **Country of study:** Canada **Aim of study:** To investigate changes in public health nurse practices in home visits with women in the postpartum period and the incidence of abuse inquiry and disclosure after implementation of a screening protocol **Study design:** Before and after study	**Source population(s):** Women receiving home visits by public health nurses (PHNs) through a northern Ontario public health unit. The Healthy Babies Health Children (HBHC) programme in the province of Ontario consists of two types of voluntary visits: the universal 48-hr postpartum home visit, which usually provides one postpartum home visit, and the long-term home visit for families that have been assessed to be ‘‘at high risk’. **Eligible population(s):** A retrospective chart audit of cross-sectional data was compiled from all HBHC home visits completed during 2001 and 2005. **Selected population(s):** All charts in 2001 and in 2005 were assessed. **Excluded population(s):** Rural public health records were not included. **Sample**	**Method of allocation:** N/A **Intervention(s) description:** Routine Universal Comprehensive Screening (RUCS) is a protocol to help practitioners identify and appropriately respond to abuse among women receiving home visits in the postpartum period by public health nurses. RUCS was introduced within the HBHC programme between July 2002 and December 2004. The implementation required a number of organizational changes and new strategies such as: a dedicated budget, commitment from the health unit’s programme director, a research assistant to review records and input data, and a project lead to champion development of policy and procedures and staff training. Staff training consisted of small-group and large-group educational activities, regular presentations by community experts, and orientation for new staff. **Control/comparison(s) description:** N/A **Sample size(s):** Pre-RUCS (2001): Total n=538; 48 hour home visits n=459; Long-term home visits n=79. Post-RUCS (2005): Total n=551; 48 hour home visits n=485; Long-term	**Primary outcomes:** The variables analysed for this study consisted of abuse inquiry, abuse disclosure, and the alone status (indicating if the woman was alone at the time of the abuse inquiry). Each record was reviewed for the first three visits if the woman was not alone or not asked at the initial visit, to allow for three opportunities for the PHN to ask about abuse. **Secondary outcomes:** NR **Follow up periods:** N/A **Methods of analysis:** The proportion of clients for whom there were disclosures and the documentation of the alone status were calculated for both time periods. Pearson’s chi- square tests were used to identify statistically significant ($p<0.05$) differences.	**Who is the target of the intervention?** Public Health Nurses that conduct Ontario's HBHC home visits **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The number of women asked about abuse declined in the 48-hr home visits, from 388 in 2011 to 76 in 2005. For the long-term visits, the number of women asked declined from 77 in 2001 to 52 in 2005. The authors stated that this showed the PHNs recognized the importance of alone status and changed their practice to directly inquire about abuse only when privacy could be ensured. Disclosures of abuse as a percentage of women asked significantly increased in both types of home visits. For 48-hour visits, disclosure increased from 3% in 2001 to 11% in 2005 ($p<0.01$), and for long-term visits it increased from 48% to 75% ($p<0.01$) Documentation of the alone status for the 48-hr home visit was recorded on 32% of the records in 2001, which increased to 86% in 2005. Documentation of the alone status for the long-term home visiting was 75% in 2001 and 92% in 2005. Documentation of the alone status significantly increased from 2001 to 2005 for women who received a 48-hr home visit (chi square=287.5, $p<0.001$), and for women who received long-term home visiting (chi square= 7.9, $p<0.01$). Ensuring privacy, by not asking abuse questions if	**Limitations identified by author:** NR **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Future research that examines practical outcomes for universal screening such as providing an opportunity for abuse disclosure, community referrals, staff education, and changes in health care provider’s practices may be more realistic than examining outcomes such as reduction in family violence, improved health, or quality-of-life indicators. The issue of how current versus past abuse effects both assessment and inquiry could benefit from further study. **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Quality score: [++] **External validity:** [+]	**characteristics:** NR **Setting:** Urban community	home visits n=66 **Baseline comparisons:** NR **Study sufficiently powered:** NR			women were not alone during a visit, significantly improved. For 48-hour visits, 19% of women who were not alone were not asked about abuse in 2001 and this increased to 98% in 2005 (chi square=357.4, p<0.001), and for long-term visits, this percentage increased from 2% in 2001 to 38% in 2005 (chi square=191.2, p<0.001). **Secondary outcomes:** N/A **Attrition details:** N/A	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Wathen, C. N., Jamieson, E., MacMillan, H. L., & The McMaster Violence Against Women Research Group **Year:** 2008 **Citation:** Who is identified by screening for intimate partner violence? *Women's Health Issues, 18*(6), 423-432. **Country of study:** Canada **Aim of study:** To compare the Woman Abuse Screening Tool (WAST) with the Composite Abuse Scale (CAS) **Study design:** Individual randomized controlled trial **Quality score:** [+]	**Source population(s):** All women presenting for care at 26 health care sites **Eligible population(s):** Women aged 18-64, able to separate themselves from individuals who accompanied them, had a male partner in past 12 months, lived within 120km of healthcare site, able to speak and read English, well enough to participate, able to provide informed consent **Selected population(s):** Women presenting for their own health care between Aug 2005-Dec 2006 **Excluded population(s):** 19% refused to participate, 5% withdrew **Sample characteristics:** Intervention group participants who completed the follow-up interview: *Age:* 39% <30 years; *Education*: 21% <12 years; *Marriage:* 30.5% never married, 13.5% married; *Pregnancy:* 8% pregnant **Setting:** 12 primary, 11 acute, and 3 specialty (women's health and	**Method of allocation:** Randomized, but method not reported **Intervention(s) description:** Intervention participants completed the WAST (8 items) prior to the clinical visit and CAS (30 items) following clinical visit, screening for past year IPV. Providers received training sessions in identification of and response to IPV from clinical experts from the research team. For women who were positive on the WAST, the completed WAST was attached to the patient chart to notify the health care provider. **Control/comparison(s) description:** Control participants completed both the WAST and CAS after their clinical visit. **Sample size(s):** Total n for measure of agreement between WAST and CAS=5607. Total n for covariate analyses=399 **Baseline comparisons:** NR	**Primary outcomes:** WAST and CAS screening scores, and post-visit interview (form not reported) within 14 days of visit. The WAST is an 8-item tool measuring physical, sexual, and emotional abuse in the last 12 months (internal consistency alpha=0.75). The CAS was considered the criterion standard. It is a 30-item scale that includes partner behaviours in the last 12 months and its 4 subscales show good internal reliability (Cronbach's alpha>0.75) and good sensitivity and specificity (<17% misclassified in a known group analysis). **Secondary outcomes:** Demographic information and data on depression, somatization, anxiety, PTSD, and alcohol and drug use were also collected. **Follow up periods:** A maximum of 14 days post-visit for interview **Methods of analysis:** Agreement (k) between the WAST and CAS. Multiple regression with covariates: mental health, alcohol, and drug problems. For missing data participants, any positive score counted as positive; missing data participants scoring negative were classified as missing. The 53	**Who is the target of the intervention?** Women **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** NR	**Primary outcomes:** The WAST identified 22% of women as experiencing past year abuse, in contrast with the CAS, which identified 14% (overall k=0.63, SE=0.01). Agreement showed no significant difference by group. The study demonstrates that a commonly used brief screen over identified women as abused. **Secondary outcomes:** Women were significantly more likely to have the following characteristics when identified as IPV positive on both the WAST and CAS than on the WAST alone: being married (OR=2.7, 95% CI: 1.3-5.5, p=0.009), having a mental health issue (OR=2.3, 95% CI: 1.3-4.0, p=0.002), having a drug problem (OR=1.7, 95% CI: 1.1–2.9, p=0.036), and having a partner with a substance problem (OR=2.0, 95% CI: 1.2-3.2, p=0.006). **Attrition details:** 11% lost for failure to complete follow-up questionnaire, and 33% lost to follow-up after intervention. Women lost to the study after the initial health visit were not significantly different from those retained in their age, marital status, pregnancy status, employment, education, source of income, or income level. Similar proportions of women positive on both instruments and WAST-positive only were lost to follow-up. WAST scores were similar among women lost and retained. However, interview drop-outs were significantly more likely to have a higher score on CAS than those who	**Limitations identified by author:** High dropout rates at intervention and follow-up. No validation of CAS results via in-depth clinical interviews **Limitations identified by review team:** No information on follow-up interview procedures **Evidence gaps and/or recommendations for future research**: Authors recommend that future studies should examine the implications of inquiring about exposure to violence among women presenting with mental health concerns as a more effective means of screening **Source of funding:** Ontario Women's Health Council, and Ontario Ministry of Health and

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]	obstetrics/gynaecology) health care sites across Ontario, Canada	**Study sufficiently powered:** NR	(1.8%) women in the intervention group who were negative on the WAST and positive on the CAS were excluded from analysis of the covariates.		completed interviews (22.4 +/- 29.4 vs. 17.8 +/- 23.7, t=-2.1, p=0.040).	Long-term Care

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Wong, S. L. F., Wester, F., Mol, S. S. L., & Lagro-Janssen, T. L. M. **Year:** 2006 **Citation:** Increased awareness of intimate partner abuse after training: A randomised controlled trial. *British Journal of General Practice, 56*(525), 249-257. **Country of study:** Netherlands **Aim of study:** To investigate whether awareness of intimate partner abuse, as well as active questioning, increase after attending focus group and training, or focus group only **Study design:** Cluster randomized controlled trial **Quality score:** [++] **External validity:** [++]	**Source population(s):** All family doctors in Rotterdam and surrounding areas (n=412). Demographics: *Sex:* 74% male; *Full time:* 77%; *Age:* 43% 40-50 years; *Years in residence:* 68% ≥15 years **Eligible population(s):** All doctors practicing at family practices in Rotterdam and the surrounding areas in October 2002 **Selected population(s):** Fifty-four family doctors agreed to join the study (26 male, 28 female) and were included. **Excluded population(s):** NR **Sample characteristics:** Full-training: *Sex:* 43% male; *Full time:* 35%; *Age:* 35% 40-50 years; *Years in residence:* 52% ≥15 years. Focus group only: *Sex:* 50% male; *Full time:*	**Method of allocation:** Participants were numbered at first and then grouped into strata, according to sex, district type (wealthy-mixed-deprived), and finally to practice type (solo-working in group practice or health centre). Members of a team, (group practice or health centre), were linked to each other and marked with a team letter. The research assistant, blinded against the participants' name and that of the group practice or health centre, executed the randomisation by sequential assignment of a number to a group. Participants working in the same practice were allocated to the same group to avoid contamination of the intervention. **Intervention(s) description:** Focus group only: The focus group discussion that preceded the training was considered a low-grade intervention. Six group discussions, led by a qualified social scientist, explored, in a focused way, views, experiences, barriers, and practices regarding partner abuse. In these structured group discussions, which took 1.5 hours each, participants were encouraged to question one another and discuss the subject. The topics that emerged from the focus groups were applied in the training. Full training: In addition to participating in the focus group, the full training group also completed a 1.5 day training. The training was developed to deal with all the negative associations towards abused patients and provide tools to overcome these barriers. The aim was to enhance awareness of non-obvious signs, to increase active questioning, and to improve professional attitude in	**Primary outcomes:** The number of reported cases wherein partner abuse was discussed or suspected. The participants registered and reported cases during 6 months when: the doctor suspected and asked about abuse, whether the abuse was confirmed or not, taking into account that denial is common in abused women who are asked for the first time; the doctor suspected but did not ask, mostly for safety reasons; the patient initiated disclosure of abuse. Cases were registered on numbered forms, anonymously, with a patient's study number and electronic medical file number alone. **Secondary outcomes:** Number of cases with non-obvious signs to suspect/discuss partner abuse **Follow up periods:** 6 months **Methods of analysis:** Number of reported cases followed a Poisson distribution in all three arms. First, the full-training group was	**Who is the target of the intervention?** Male and female doctors practicing in family practice **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** Yes, however, statistical analysis did not support a significant difference between male and female doctors. **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Comparison of the full-training group (n=87 identified cases) versus the control group (n=14 identified cases) resulted in an identification rate ratio of 4.54 (95% CI: 2.55-8.09, p<0.001); the focus group only group (n=30 cases) versus control group: rate ratio of 2.2 (95% CI: 1.14-4.26, p=0.019); full-training versus the focus group only group: rate ratio of 2.19 (95% CI: 1.36-3.52, p=0.001). **Secondary outcomes:** Comparison of the full training group with the untrained groups for awareness of partner abuse in case of non-obvious signs resulted in an OR of 5.92 (95% CI: 2.25-15.62, p<0.01) all corrected for sex, district, practice setting, working part-/full-time, experience, and age of the doctor. **Attrition details:** No	**Limitations identified by author:** It is likely that family doctors with more interest in partner abuse than the norm signed up. Half of the participants were female, which may have influenced the outcomes, as some studies claim that female doctors detect more abuse in women. Did not take clustering into account in recruiting the final sample, mainly because of the cluster size (1.2), resulting in a somewhat underpowered study. Only sampled 13% of doctors in sample population. Short follow-up period of 6 months, and generally the effect of training tends to diminish in time. **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	36%; *Age:* 29% 40-50 years; *Years in residence*: 36% ≥15 years. Control: *Sex*: 53% male*; Full time*: 24%; *Age:* 47% 40-50 years; *Years in residence:* 47% ≥15 years **Setting:** Family practices in Rotterdam	responding to abused women. Training included information on: *Attitudes* - aversions, prejudices and barriers; small group discussion; plenary clarification; *Theory* - background and coping strategies in intimate partner abuse; profiles of perpetrators; effects on children; *Epidemiology* - prevalence; clinical presentation and key features; patient's views; *Consultation skills* - role play with diagnostic tool and clinic with simulation patient; *Information* - Police Domestic Violence Programme; Abused Women's Agency; *Legal aspects* - lawyer specialised in abuse; *Vignettes* - pre- and post-testing of written cases **Control/comparison(s) description:** The control group started with the registration and reporting of cases after personal instruction by the research assistant. They did not take part in either the focus groups or the training. **Sample size(s):** Total n=54; Full-training n=23; Focus-group alone n=14; Control n=17 **Baseline comparisons:** NR **Study sufficiently powered:** Power calculations for 80% power are presented. Sample size of 50	compared with the control group, next the focus group only group was compared with the control group and, finally, the full-training group with the focus group only group. All groups were compared using a multivariate Poisson regression analysis. Comparison between the focus group only group and the full-training and control groups was done to assess the effect of just talking in a focused way about the subject. Regarding cases with non-obvious signs, the trained group (full-training) and the untrained groups (focus group only group and control group) were compared by a multivariate logistic regression analysis. To overcome possible imbalances, all computations were corrected for sex, age, experience, working hours, type of practice setting, and residential district.		participants lost to follow-up	**Source of funding:** Theia Foundation, Zilveren Kruis Achmea Health Insurance

Table 62. Research Question 3 (Victim Interventions) Evidence Tables

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Allen, N. E., Bybee, D. I., & Sullivan, C. M. **Year:** 2004 **Citation:** Battered women's multitude of needs: Evidence supporting the need for comprehensive advocacy. *Violence Against Women, 10*, 1015-1035. **Country of study:** USA **Aim of study:** To examine whether the degree to which advocacy affected access to resources was dependent on the patterns of needs that women presented **Study design:** Randomized controlled trial **Quality score:** [+] **External validity:** [+]	**Source population(s):** Battered women in the US **Eligible population(s):** Battered women leaving a US Midwestern shelter programme **Selected population(s):** Women who spent at least one night in the shelter and planned on staying in the general vicinity for the first 3 months post-shelter **Excluded population(s):** NR **Sample characteristics:** *Race:* 45% African American, 42% White; *Mean age*: 29, range=17-61; *Children:* 74% at least one child living with them; *Education:* ~65% completed high school or obtained GEDs; *Employment:* 59%	**Method of allocation:** On completion of an exit interview conducted within one week of leaving the shelter programme, respondents opened a sealed envelope that informed them if they would or would not be working with an advocate. Group selection was random, stratifying for order and for whether a woman was involved in an ongoing, intimate relationship with her assailant. **Intervention(s) description:** The intervention consisted of providing free community-based advocacy services to women and helping them devise safety plans as needed. This model required that families guide the services they receive and that clients' natural support networks are involved in the advocacy process. Advocacy consisted of five distinct phases: assessment, implementation, monitoring, secondary implementation, and termination. All research participants were interviewed within the first week after exiting the shelter programme by trained research assistants. Women were informed that half the women being interviewed would be	**Primary outcomes:** As part of their first interview, women were asked to identify which of these needs they planned to work on in the coming 10 weeks: housing, education, employment, transportation, legal assistance, health care, social support, financial assistance, material goods and services (e.g., furniture), child care, and issues for their children. At the second interview, conducted 10 weeks later, women were asked which of the 11 needs they had worked on since their first interview, and what actions they took specifically (e.g. making phone calls, obtaining written materials). Effectiveness in obtaining resources was assessed, post-intervention only, by asking women how effective they had been in obtaining the desired resource in each of the areas they had identified working on, using a four-point Likert scale. Scores were created by calculating the mean of self-report effectiveness scores across all areas in which a woman worked. Internal consistency of the Effectiveness in Obtaining Resources (EOR) Scale was 0.64. **Secondary outcomes:** NR	**Who is the target of the intervention?** Battered women in Midwestern US **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Women indicated they wanted to work on obtaining material goods and services (86%), health-related issues (77%), increasing their level of social support (77%), school-related issues (e.g., obtaining a GED, attending college or trade school; 72%), addressing financial needs (68%), transportation needs (66%), obtaining employment (60%), and legal issues (59%). For women who had children, 67% indicated they needed to address child care issues, and 68% indicated they wanted to address other issues related to their children. 6 months following their stay, many survivors engaged in at least one activity to access community resources for housing (61%), education (61%), employment (62%), transportation (49%), legal assistance (59%) health care (62%), social support (37%), financial assistance (48%), material goods and services (69%), child care (40%), and issues for their children (50%). In the model for effectiveness at obtaining resources, there was a main effect of condition: women who worked with advocates were more effective overall at accessing needed community resources	**Limitations identified by author:** Only survivors who had accessed shelter services were included in this sample. Those who seek shelter services may not be representative of women who do not seek shelter-based assistance. **Limitations identified by review team:** Addressing certain needs may require more time and effort (due to limited services) and do not necessarily reflect the woman's motivation level or efficacy of the advocate. Did not control for attributes of advocates **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** Grant from National Centre for Injury

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	unemployed before entering shelter; *Government assistance:* 76%; *Mean length of shelter stay (SD):* 19 days (16.5), range=1-76 **Setting:** Urban	randomly selected to receive free advocacy services for the first 10 weeks post-shelter exit, 4 to 6 hours per week and then were informed if they would be working with an advocate. Women selected to work with advocates began working with their advocates immediately. **Control/comparison(s) description:** Women in the control group were not contacted again after the initial interview, until their next interview 10 weeks later. **Sample size(s):** Total n=278; Intervention n=143; Control n=135 **Baseline comparisons:** No statistical differences between the randomized groups **Study sufficiently powered:** NR	**Follow up periods:** 10 weeks **Methods of analysis:** Cluster analysis was used to group women by their pattern of activity to access community resources. Two general linear models (GLM) were performed. In the first GLM, the degree to which women were effective overall was included as the dependent variable. The second GLM examined differences across groups regarding the extent of activity in which survivors engaged to meet their needs.		(F(1,261)=42.90, p<0.001.) Across clusters, women in the control group reported a mean level of effectiveness of 2.71 (SD=0.71), while women in the advocacy group reported a mean level of 3.26 (SD=0.57). Survivors who worked with advocates engaged in a greater number of activities to address education needs (F(1,254)=19.41, p<0.001), legal issues (F(1,254)=5.72, p<0.05), and acquiring material goods and services (F(1,254)=47.07, p<0.001). There was a significant cluster by condition interaction (F(44,988)=2.71, p<0.001). This indicated that survivors' levels of activity to acquire resources within each cluster were dependent on condition. **Secondary outcomes:** N/A **Attrition details:** NR	Prevention and Control of the Centres for Disease Control and Prevention

Appendix O

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Allen, K. N. & Wozniak, D. F. **Year:** 2010 **Citation:** The language of healing: Women's voices in healing and recovering from domestic violence. *Social Work in Mental Health, 9*(1), 37-55. **Country of study:** USA **Aim of study:** To determine the effectiveness of a holistic, integrative and alternative healing treatment group that discouraged repetitive disclosure of history of abuse **Study design:** Mixed methods (before and after study/ grounded theory) **Quality score:** [+] **External validity:** [+]	**Source population(s):** Battered women in Montana and Michigan **Eligible population(s):** NR **Selected population(s):** 11 women recruited from DV agencies who were not in a state of crisis, were physically safe and removed from the abuser, and who demonstrated an appropriate level of insight and reflective capacity for group participation **Excluded population(s):** NR **Sample characteristics:** *Mean age*: 35; *Education:* 8 some college, 5 associate's degree or baccalaureate degree; *Employment:* 6 employed, 5 receiving state assistance **Setting:** NR	**Method of allocation:** N/A **Intervention(s) description:** "Rites of Passage" was a ten week group intervention model and refers to the activity of creating rituals that support women on the healing journey. It conceptualized healing from trauma as a transitional period that involves passing through three stages: separation (letting go of one's old life ways), liminality (a time of ambiguity, uncertainty, and rolelessness), and incorporation (re-emerging in a new identity or role and reintegrating into society). The group used a semi-structured curriculum that focused on helping women develop alternative ways of thinking about themselves and their futures through cultural myths, projective stories, meditation, active day dreaming, and personal metaphors. Each week women were consulted about group activities as well as the overall pacing for the group. Community partners were often enlisted to facilitate a session. A typical session involved a presentation by the group leaders and community partners, followed by experiential activities and exercises, with guided discussion occurring throughout. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=11 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** The *PTSD Checklist (Civilian Version)* asks participants to rate the severity of their PTSD symptoms with a 5-point Likert scale. The symptoms include: repeated, disturbing memories; the sense of reliving the stressful experience; psychosomatic symptoms; avoidant behaviour; anhedonia and numbness; sleep disturbance; and hyperarousal. *States of change* were qualitatively coded from structured interviews conducted at intake and a focus group conducted in week six. **Secondary outcomes:** Degree of healing **Follow up periods:** Post-programme (for the PTSD Checklist) **Methods of analysis:** Paired samples t-tests for the PTSD Checklist. Coding of qualitative data	**Who is the target of the intervention?** Battered women **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** There were statistically significant t-tests ($p<0.05$) for: repeated disturbing memories or thoughts, reliving stressful experience, avoid thoughts/feelings related to stressful experience, feeling emotionally numb, feeling as if the future will be cut short, trouble sleeping, being 'super alert', and feeling easily startled. Qualitative themes were: creating a safe place, establishing autonomy, taking pride in appearance, reclaiming self, developing inner peace and serenity, and re-joining the community. **Secondary outcomes:** Throughout the groups, the authors observed a series of cognitive shifts that they believed represented healing through transitioning from a self-constructed identity of "survivor," to "thriver" as identity was reconstructed absent a focus on victimhood. **Attrition details:** N/A	**Limitations identified by author:** Small sample size. Lack of comparison or control group. Some women had received therapy prior to this intervention. **Limitations identified by review team:** Women had already been somewhat psychologically stable prior to beginning group therapy -results from therapy might be minimal **Evidence gaps and/or recommendations for future research**: Compare this programme with a more traditional DV treatment group. Explore the optimal point in treatment when this kind of intervention should be introduced **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Bair-Merritt, M. H., Jennings, J. M., Chen, R., Burrell, L., McFarlane, E. Fuddy, L., & Duggan, A. K. **Year:** 2010 **Citation:** Reducing maternal intimate partner violence after the birth of a child. *Archives of Paediatric and Adolescent Medicine, 164*(1), 16-23. **Country of study:** USA **Aim of study:** To estimate whether home visitation beginning after childbirth was associated with changes in average rates of mothers' IPV victimization and perpetration as well as rates of specific IPV types (physical assault, verbal abuse, sexual assault, and injury) during the 3 years of	**Source population(s):** New mothers experiencing IPV **Eligible population(s):** Women enrolled in the Hawaiian home visitation programme. Families were eligible if they: gave birth between November 1994 and December 1995 on Oahu, had an English-speaking mother, were not involved with Child Protective Services, and had an infant who was at high risk of maltreatment. **Selected population(s):** NR **Excluded population(s):** Interviews conducted with individuals other than the mother of child. All participants in testing condition **Sample**	**Method of allocation:** Families were randomly assigned to the HSP home visiting intervention group, control group, or testing control group (although note that for these analyses, the testing control group was excluded). Group assignments were randomly allocated to study ID numbers at a central office using a table of random numbers. By design, more families were randomized to the intervention group than the control groups. **Intervention(s) description:** Intervention families received early childhood home visits by paraprofessionals to promote child health and decrease child maltreatment by improving family functioning and reducing malleable risk factors such as IPV. The paraprofessional linked families to appropriate community services such as IPV shelters/advocacy groups and mental health treatment, and taught about child development; role modeled positive parenting and problem-solving strategies; and offered emotional support. The initial home visit was expected to occur within 1 week of the infant's birth and occur weekly. Visits were to taper as families achieved greater competency. Home visits were designed to be carried out for at least 3	**Primary outcomes:** Interviews with the infant's primary caregiver were conducted by trained research staff blinded to participants' group status. The baseline interview occurred following the child's birth, and follow-up interviews occurred in 2 periods, annually when the child was 1 to 3 years of age and then annually when the child was 7 to 9 years of age. The *Conflict Tactics Scale (CTS)* measured IPV victimization and perpetration over the past year. At baseline, the 38-item CTS1 was used but all subsequent interviews used the 78-item revised CTS (CTS2), which contains the following categories of questions: verbal aggression/abuse, physical assault, sexual coercion/abuse, and injury. Initial validation of the CTS2 estimated that the internal reliability coefficients for each category of questions were 0.79, 0.86, 0.87, and 0.95, respectively. Four sexual coercion questions were purposefully omitted during the interviews. The *Mental Health Index 5-item short form* measured anxiety and depressive symptoms. Responses were s standardized to a scale of 0 to 100. A cut-off of less than 67 defined poor mental health. Maternal drug use was measured as self-report of any current drug use. Problem alcohol use was defined as self-	**Who is the target of the intervention?** New mothers with infants at home experiencing IPV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Yes, see results	**Primary outcomes:** For the first three years of programme implementation, the intervention group reported lower rates of maternal IPV victimization (IRR=0.86, 95% CI: 0.73-1.01) and significantly lower rates of maternal IPV perpetration (IRR=0.83, 95% CI: 0.72-0.96) compared with control women. For specific types of IPV, intervention group women showed significantly lower rates of physical assault victimization (IRR=0.85, 95% CI: 0.71-1.00) and perpetration (IRR=0.82, 95% CI: 0.70-0.96). Over long-term follow-up, the intervention effect was no longer significant, as shown by the adjusted IRRs of maternal IPV victimization (IRR=0.95, 95% CI: 0.77-1.17) and perpetration (IRR=0.98, 95% CI: 0.79-1.22).The adjusted IRRs were lower for the intervention vs. control group for physical abuse, sexual abuse, and injury but were higher for verbal victimization and perpetration, although none of these differences was significant.	**Limitations identified by author:** Low prevalence of sexual abuse and injury may have impacted the ability to detect an association for these IPV types. Two issues complicate interpretation of how home visiting might have influenced IPV: programme IPV content was minimal and few families participated in the expected number of home visits. Women self-reported their own and their partner's IPV over the past 12 months; this duration of recall may be prone to error. Although the CTS2 has been widely validated, there is no "gold standard" from which to determine the accuracy of self-reported IPV. Intervention group women may have felt compelled to portray themselves positively and may have underreported IPV. Despite randomization, baseline differences existed between the groups and while accounted for, unmeasured confounders may remain. **Limitations identified by review team:** Authors performed an intention-

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
programme implementation and during 3 years of long-term follow-up **Study design:** Randomized controlled trial **Quality score:** [+] **External validity:** [+]	**characteristics:** Control group: *Age*: 45% 19-25 years; *Race*: 33% Native Hawaiian/ Pacific Islander; *Education*: 64% high school; *Problem alcohol use:* 48%; *Drug abuse*: 15%; *Poor mental health*: 50%; *Past year employment:* 44%. Intervention group: *Age*: 48% 19-25 years; *Race*: 34% Native Hawaiian/ Pacific Islander; *Education*: 69% high school; *Problem alcohol use:* 40%; *Drug abuse*: 13%; *Poor mental health*: 43%; *Past year employment:* 52% **Setting:** Urban	years. **Control/comparison(s) description:** NR **Sample size(s):** Total n=643; Intervention n=373; Control n=270 **Baseline comparisons:** At baseline, the mean (SD) past-year rates of IPV by group were: intervention group: victimization 4.2 (12.0), acts and perpetration 10.5 (22.0), and control group: victimization 5.7 (16.1), and perpetration 10.4 (21.6). At baseline, a lower proportion of intervention women vs. control women had problem alcohol use (40% vs. 48%) and poor mental health (43% vs. 50%), and a higher proportion were employed in the past year (52% vs. 44%) (all p's≤0.05). **Study sufficiently powered:** NR	report of current alcohol use together with two or more positive responses to the 4CAGE questions, a validated screen for problem alcohol use. **Secondary outcomes:** NR **Follow up periods:** Two periods: when child was 1-3 years of age and again when child was 7-9 years of age **Methods of analysis:** ITT analysis conducted. Primary analyses compared total rates of IPV victimization and perpetration (in separate models) between intervention and control group women when children were 1-3 years of age and separately when they were 7-9 years of age. Additional analyses compared the rates of specific IPV types between intervention and control women during the same 2 periods. Child age (continuous) was included to model time. Because of concern that study site might be a confounder, adjustments for site (categorical) were done in all analyses. Models examining total IPV victimization and perpetration controlled for baseline IPV (continuous). For all analyses, women with no partner were coded as no IPV.		**Secondary outcomes:** N/A **Attrition details:** Women lost to follow-up were more likely to be Asian (44% vs. 26%) and less likely to be Native Hawaiian (20% vs. 35%). Intervention group: 90% of families participated in visitation when the child was 3 months of age; 70% participated at 6 months of age; 49% at 12 months of age; and 25% at 36 months of age.	to-treat analysis whereby women were analysed using their initial group assignment, irrespective of their actual participation in the intervention; results from each group may not reflect the actual outcomes measured. **Evidence gaps and/or recommendations for future research**: Determine whether similar decreases occur in other early-childhood home visiting programs and discover which elements of the programme may lead to reductions in IPV **Source of funding:** Federal Maternal and Child Health Bureau; Robert Wood Johnson Foundation; Annie E. Casey Foundation; David and Lucile Packard Foundation; Hawaii State Dept of Health; National Institutes of Health

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Cath Gregory Consulting **Year:** 2008 **Citation:** *National Domestic Violence Helpline Impact Study* **Country of study:** UK **Quality score:** [+]	**What was/were the research question(s)?** To increase understanding of the impact which calling the National Domestic Violence Helpline can have on an individual's life **Theoretical approach:** NR **How were the data collected?** Data provided by on-line questionnaire and telephone interviews	**What population was the sample recruited from? How were they recruited?** The researchers contacted 109 organizations in the UK supporting women suffering from DV for referrals for participants. Women were mainly recruited through refuge workers, and a minority from advertising on refuge websites or email newsletter **How many participants were recruited?** Total n=47 for online questionnaire, subset of 14 interviewed by telephone **Inclusion and exclusion criteria:** NR **Population demographics:** 12 respondents cited severe violence, 8 cited mental health concerns, 5 cited violence to or in front of children, 4 cited having left the home or being at risk of	**Description of intervention(s):** The helpline was a 24-hour, 365-days per year service that worked to: meet the caller's immediate safety needs; provide risk awareness and help them plan to avoid risk for them and their children; help the caller think through the options available to them; refer the caller to a refuge, or other place of safety; provide other immediate practical help; and refer the caller to other services, information, or support. The line primarily provided a "gateway" helping to clarify the problem, build confidence and provide information to enable the caller to take safe, practical action and find local sources of support. The helpline could provide ongoing support, even over a period of years, or it could be a limited contact for information. 70% of calls were from female DV victims and 30% were from family, friends, and professionals helping victims. Half the callers made only one call, 25% made 2 calls, and the remaining 25% made 3 or more calls. Reasons for accessing the helpline were: panicking and need to escape (18), looking for information (12), just been assaulted (7), planning to leave relationship (6).	**Method and process of analysis:** Used on-line questionnaire and then had telephone interviews (30-60 minutes) with a subset of respondents. Detailed notes were taken, transcribed, and emailed to the authors. **Key themes relevant to this review:** 83% agreed they were able to change their situation. 70% moved to a refuge or ended their relationship. Themes: making real change "The Helpline is vital and it was a life and death situation at the time for me and my daughter. It's essential and vital and it all goes on behind closed doors." "I often think that making that phone call was the first step to me making a new life." Changing thinking: "It sounds really stupid but I still didn't realise I was in an abusive relationship." "What helped was that she [helpline worker] named it. She named it as `domestic abuse'. That really helped me. I surprised myself that I was never able to label it beforehand." Making a decision to act: "As a result of phoning the Helpline and getting in touch with my Support Worker, in less than one week I was not living with my partner anymore." Being believed: "Initially I talked to this woman and explained the situation and she knew exactly what was going on and she believed me. It makes me feel quite choked to say that. That was so important to me, to be believed. Being listened to and having the time to tell her what was going on and feeling that she understood me was so important." Linking the caller to services: "They told me about where I could go and about how I could have a refuge support worker, and they told me that maybe I could get housing support, but that this was something that I could sort out with my key worker. They also told me about how I could get help to get back into education and	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Women experiencing DV	**Limitations identified by author:** Difficulties in contacting referrals for recruitment **Limitations identified by review team:** No description of how transcripts were coded into themes. Self-selected sample. Lack of demographic data **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** Comic Relief Organization

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
		homelessness, 3 cited a planned move or that the partner had gone out, giving an opportunity to call	**Intervention setting:** Telephone hotline for domestic abuse	studying again, get support with working and help, if I needed it, with the legal situation." 24 hour access: "With the Helpline I was able to ring at 3 am in the morning when I most needed to speak to someone and they were there...You can't phone your family at 3 am when they have to get up for work the next day and you're in a state of fear or panic. Immediately after the call I calmed down enough to sleep again." "I didn't have credit on my phone and the good thing was I could ring it from my mobile free of charge. He controlled the phones and he didn't want me communicating with anyone." Negative experiences: two women reported speaking to helpers who were didactic, unfriendly and who did not help them and several reported a sense of confusion about the sheer range of different services available. First change made as a result of calling the helpline: 39% moved to refuge or other safe place, 19.5% took risk reduction measures, 19.5% contacted other services, 12% made decision on their own or made important decisions about their situation. Changes made: 70% moved to refuge, 70% ended the relationship, 50%+ improved children's safety, 22% started legal proceedings, 22% cited living independently		

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Coker, A. L., Smith, P. H., Whitaker, D. J., Le, B., Crawford, T. N., & Flerx, V. C. **Year:** 2012 **Citation:** Effect of an in-clinic IPV advocate intervention to increase help seeking, reduce violence and improve well-being. *Violence Against Women, 18*(118), 118-131. **Country of study:** USA **Aim of study:** To determine if an in-clinic advocate vs. usual care had an effect on depressive symptoms, IPV, victim safety, help-seeking behaviours, and self-rated physical and mental health **Study design:** Cluster randomized controlled trial **Quality score:** [+]	**Source population(s):** Women experiencing IPV who live in rural Southern US **Eligible population(s):** Women experiencing IPV who attend rural health clinics in the Southern US **Selected population(s):** Women: Female, age 18 or older, in an intimate relationship in the past 5 years, and mentally competent to provide consent. Clinics: Six clinics were located in the referral range of the coalition; provided primary care to lower-income women and had a patient volume of at least 1,000 women per year **Excluded population(s):** Women who were accompanied by others **Sample characteristics:** Intervention: *Mean age (SD):* 42.62 (0.90); *Race:* 69% African American; *Education:* 31% <high school	**Method of allocation:** Randomization of clinics **Intervention(s) description:** Women were screened for current or recent psychological and physical abuse using a modified version of the Women's Experience With Battering Scale and a questions from CDC's Behavioural Risk Factor Surveillance System (BRFSS). In the intervention clinics, women who were assessed as positive for any form of IPV were encouraged by the nurse to meet with the advocate immediately after their appointment. The advocate provided needs assessment, safety planning, education, support, and referral/facilitated linkage to coalition services and other community services the woman may need. **Control/comparison(s) description:** In the usual care arm, women who were assessed as IPV+ were given the business card of their health care provider with the coalition hotline number. **Sample size(s):** Total n=231; Intervention n=138; Control n=93 **Baseline comparisons:** Women attending clinics in	**Primary outcomes:** Help-seeking was measured with modified questions from the *National Violence Against Women Survey* (current sample Cronbach's alpha=0.73, range 0-44) on disclosure of partner violence and specific forms of help seeking by the following domains: law enforcement/legal assistance, community services for abused women, mental health counselling, talking with a health care provider about partner violence in a clinic or health department, and disclosure to family and friends. IPV and victim safety were measured with the *Danger Assessment Score (DAS)* (Cronbach's alpha=0.91) and a modified *Women's Experience With Battering Scale (WEB)* (Cronbach's alpha=0.93). Five items from the *Medical Outcomes Study* were used to measure a woman's perception of her own physical and mental health relative to others of her own age. Two items adapted from the CDC BRFSS were used to measure current (past 6 months) symptoms of depression and suicidal ideation as dichotomous variables.	**Who is the target of the intervention?** Rural women experiencing IPV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** 33% of women spoke with advocate in intervention compared to 4% of women in the usual care arm (chi-square=26.00, p<0.0001); there were no differences in the proportion of women in the intervention or usual care arms who called the coalition hotline. Women in the intervention arm were more likely to use services provided by the advocate (p=0.003). Women attending clinics with the advocate intervention were more likely to report involving the police, lawyer, or court systems to receive protective orders (legal/law enforcement help seeking), relative to the control group. In general, IPV scores (DAS, WEB) were highest during the first interview and declined over time. DAS scores in the advocate intervention clinics trended toward greater decline over time relative to usual care (i.e. Intervention × Time interaction F=2.02, p=0.07). A reduction in DAS scores associated with the advocate intervention was more likely to occur within the first 6 months of the intervention and among those women experiencing current IPV at baseline. A similar pattern was observed for WEB Scale scores over time. No differences were observed	**Limitations identified by author:** A smaller sample for comparison in the later months of follow-up. Potential for a selection bias since the response rate for participation in the cohort study was less than 50%. Not able to randomize the individual to receive the IPV advocate intervention relative to the usual care arm **Limitations identified by review team:** Self-report biases **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** Centers for Disease Control and Prevention

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]	graduate; *Marital status:* 22.5% currently divorced or separated; *Mean number of children (SD):* 2.09 (0.15). Control: *Mean age (SD):* 38.08 (1.10); *Race:* 56% African American; *Education:* 34% <high school graduate; *Marital status:* 23% currently divorced or separated; *Mean number of children (SD):* 2.19 (0.18) **Setting:** Rural clinics	the intervention arm were significantly older. The two groups did not differ significantly on other demographics (all p's>0.05). **Study sufficiently powered:** NR	**Secondary outcomes:** NR **Follow up periods:** 6, 12, 18, and 24 months **Methods of analysis:** ITT analysis. Analyses were restricted to those with at least two visits/interviews over time for up to 24 months of follow-up. Models were adjusted at baseline by whether the IPV was "current" or "recent" since the timing of IPV influences help seeking by domain as well as self-perceived mental and physical health.		in either self-perceived current mental health or interference of mental health on daily activities between the intervention and the usual care arms. However, scores for depressive symptoms and suicidal ideation were significantly lower over time for women in the intervention clinics relative to usual care. **Secondary outcomes:** N/A **Attrition details:** Among the screened women who had experienced IPV in the past 5 years, 429 (46%) agreed to follow-up contact. Within this group, 76% or 327 completed the baseline interview and 231 (71%) completed at least one follow-up interview.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Crespo, M. & Arinero, M. **Year:** 2010 **Citation:** Assessment of the efficacy of a psychological treatment for women victims of violence by their intimate male partner. *The Spanish Journal of Psychology, 13*(2), 849-863. **Country of study:** Spain **Aim of study:** To assess the efficacy of a psychological intervention programme for women victims of violence by their intimate partner with clinical symptoms but not fulfilling all the diagnostic criteria for PTSD **Study design:** Randomized controlled trial **Quality score:** [+] **External validity:** [+]	**Source population(s):** Women in Spain experiencing IPV **Eligible population(s):** Women attending several organizations in Madrid that offered programs for battered women **Selected population(s):** Women, 18 years of age or older, suffered violence by a male intimate partner, presenting posttraumatic symptoms in the Severity of Posttraumatic Stress Disorder Symptoms Scale without meeting all the diagnostic criteria for PTSD, receiving no other current treatment **Excluded population(s):** NR **Sample Characteristics:** *Mean age (SD):* 41 (9.26); *Social*	**Method of allocation:** Participants were randomly assigned using the randomization.com computer programme. Each time a group was assigned to a specific treatment programme, the next therapeutic group that was formed was assigned to the other experimental modality. **Intervention(s) description:** The programs consisted of several techniques, mainly exposure therapy and cognitive restructuring, complemented with self-esteem improvement and arousal controlling procedures. The authors designed the treatment to consist of a multicomponent cognitive-behavioural programme that included the following modules: exercises to control arousal by diaphragmatic breathing; planning to increase pleasant activities as a way to improve mood; specific techniques to improve self-esteem; restructuring of biased cognitions; increase of skills for an independent life (by training in problem-solving); additionally the programme included psycho-education, providing the participants information about the violence in intimate relationship and its consequences for the victim. Two versions of the programme were designed: one including the exposure therapy, and another one without it. Each version of the programme made up of a total of seven modules (six common ones and one specific one: exposure or communication skills), to which was	**Primary outcomes:** Overall posttraumatic symptoms (re-experiencing, avoidance and hyper-alertness, and depressive and anxiety symptoms). The *Severity of Posttraumatic Stress Disorder Symptoms Scale* was used to assess posttraumatic symptoms. The *Beck Depression Inventory (BDI-II)* identified the global level of depression and the changes occurring over time. The *Beck Anxiety Inventory* assessed anxiety. **Secondary outcomes:** *Rosenberg's Self-Esteem Scale* assesses women's levels of self-esteem. The *Anger Expression Subscale* from the *State-Trait Anger Expression* reflects angry feelings or actions carried out by a person when angry. All measures had acceptable reliability and validity. **Follow up periods:** 1, 3, 6 and 12 months	**Who is the target of the intervention?** Spanish women experiencing IPV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Yes. Regarding their history of maltreatment: with a mean of more than 12 years, and of daily frequency in the past month for 45% of the sample, with almost 40% classifying the current	**Primary outcomes:** *PTSD:* Controlling for baseline symptomatology, the intervention group had lower PTSD symptoms: Overall at 1-month ($F(1,36)=4.41$, $p<0.05$); Re-experiencing at 1-month ($F(1,37)=8.84$, $p<0.01$); Avoidance at 1-, 3-, and 6-months ($F(1,36)=4.62$, $p<0.05$; $F(1,36)=11.54$, $p<0.01$; and $F(1,36)=9.39$, $p<0.01$); and hyper-alertness at post-treatment ($F(1,37)=3.37$, $p<0.05$). For hyper-alertness, the Time × Programme interaction was significant, ($F(1,34)=6.92$, $p<0.05$). The means show an important post-treatment decrease in PTSD symptoms. *Depression:* Intervention group showed significantly lower scores at 1-month follow-up ($F(1,36)=7.81$, $p<0.01$). *Anxiety:* Intervention group showed significantly lower scores at 1-month follow-up ($F(1,37)=4.52$, $p<0.05$) **Secondary outcomes:** Intervention had lower values of anger expression at the five measurement times ($F(1,37)=4.08$, $p<0.05$; $F(1,36)=5.30$, $p<0.05$; $F(1,36)=3.85$,	**Limitations identified by author:** All the treatments were applied by the same therapist. No untreated control group. It was questionable to treat the women who still lived with their abuser, and who were therefore still exposed to the situation of maltreatment together with those others who had already left the abuser or were in the process of leaving him. **Limitations identified by review team:** Self report bias. Treatment conditions may be similar **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** Spanish Ministerio de Educación

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	class: 38% middle; *Education:* 34% primary school, 36% secondary studies; *Currently on medication:* 45% **Setting:** NR	added a final relapse prevention module. In order to ensure the homogeneity of the interventions, the authors produced the materials for the therapist and a workbook for the women. The programme comprised eight 90-minute weekly sessions (which implies a total programme duration of two months), in groups of 3-5 women led by one female therapist. Between sessions, the women received written material that outlined the topics from the session, as well as exercises to be done as homework. **Control/comparison(s) description:** See description of intervention **Sample size(s):** Total n=53; Intervention n=28; Control n=25 **Baseline comparisons:** The exposure group was more likely to finish university (chi-square=13.78, p<0.01), and higher psychological or psychiatric attention because of violence was significantly higher (chi-square=9.61, p<0.01). Mean level of depression was higher in the communication skills treatment group (F(1,51)=4.90, p<0.05). **Study sufficiently powered:** NR	**Methods of analysis:** No ITT. ANOVAs and ANCOVAs	status of their problem as "the worst moment".	p<0.05; F(1,36)=5.08, p<0.05; and F(1,36)=5.49, p<0.01). **Attrition details:** Out of the 53, 17 women dropped out of treatment, 14 during the sessions and 3 at follow-up. Among the women that dropped out, there was more frequent report of maltreatment (76.5% vs. 47.2%, chi-square=4.02, p<0.05), the reception of medical attention (47.1% vs. 16.7%, chi-square=5.49, p<0.05), and the availability of legal support (76.5% vs. 36.1%, chi-square=7.53, p<0.01).	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Glass, N., Eden, K. B., Bloom, T., & Perrin, N. **Year:** 2010 **Citation:** Computerized aid improves safety decision process for survivors of intimate partner violence. *Journal of Interpersonal Violence, 25*(11)*,* 1947-1964. **Country of study:** USA **Aim of study:** To evaluate the first computerized safety decision aid with victims of IPV for impact on their decisional conflict **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Women in the Pacific Northwest area experiencing DV **Eligible population(s):** Women who attended DV shelters or DV support groups in a three-county metropolitan Pacific Northwest area **Selected population(s):** Women who spoke English or Spanish, were 18 years of age or older, and reported physical and/or sexual violence within a relationship in the previous year **Excluded population(s):** NR **Sample characteristics:** *Mean age (SD):* 34 (11.5), range=17-63; *Race:* 33% Latina, 64% White, 17%	**Method of allocation:** N/A **Intervention(s) description:** The safety decision aid was designed based on the decisional conflict model. The research team developed the content of the safety decision aid using validated measures of safety behaviours, decisional conflict, and risk factors for lethal violence. The computerized safety decision aid began by asking women basic demographic questions. Participants were then asked to report on the safety seeking behaviours and resources they had already accessed. The participants also completed a low-literacy version of the Decisional Conflict Scale (DCS) to assess their decision making process before and after using the safety decision aid. The computerized safety decision aid included an activity that helped the women set priorities for safety as it related to their abusive relationship. These factors were determined through discussions with survivors, advocates, and experts. Each participant received a summary of her priorities. If the woman had children, she was triaged in the programme to include wellbeing of children in the priority-setting activity. Once participants set their safety priorities, they completed the Danger Assessment (DA). After completing the demographics, safety-seeking behaviours, DCS, priorities for safety, and the DA, the woman received detailed and personalized messages about her priorities and level of	**Primary outcomes:** Danger assessment, safety-seeking behaviours, decisional conflict as measured by the *Decisional Conflict Scale* and *Danger Assessment (DA)* (both self-report questionnaires have acceptable validity) **Secondary outcomes:** NR **Follow up periods:** Post-intervention **Methods of analysis:** Descriptive statistics based on scores on self-report, and pairwise comparisons	**Who is the target of the intervention?** Abused women seeking safety and shelter **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** 8% of the women had scores suggesting “variable danger”, 23% were at “increased danger”, 11% were in “severe danger”, and 58% had DA scores that suggested “extreme danger” in the past year. For safety-seeking behaviours, women reported doing an average of 5.0 behaviours (SD=1.56, range=0-9). 91% of the women reported discussing their abuse with someone. Of the 32 women reporting that their abusers threatened or used a weapon against them, 13 (40%) had removed the weapon (e.g., knife, iron bar) from the home. Of the 13 women reporting that their abuser threatened them with a gun, 10 (77%) had removed the gun from the home. Three quarters (76%) of the women kept important papers hidden (most often with a different family member) from their abuser. 60% had made a safety plan, and 76% included a plan to leave the relationship. 60% discussed the plan with someone (primarily with an informal source such as a friend or family member).	**Limitations identified by author:** The safety decision aid was conceived and designed for abused women who were much earlier in their safety decision process, whereas this sample of abused women had already sought services related to the abuse; therefore, they were likely to have been further along in their safety decision process than those who had not yet sought resources to address the IPV. The sample did not include women who were abused by a female partner. **Limitations identified by review team:** Self-report biases **Evidence gaps and/or recommendations for future research**: To take the decision aid to the target audience (women still in

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	African American, 13% American Indian, 2% Asian American; *Children:* 89% had children under age of 18 years, and 46% currently lived with them; *Education:* 28% completed high school or received a GED, 28% attended some college, 19% had a college degree; *Employment:* 37% full-time or part-time **Setting:** Urban. Women completed the decision aid in any place that was safe and convenient (e.g. DV shelter, community agency, their home, a coffee shop, the research office).	dangerousness. Finally, the safety decision aid provided contact information for local advocates as well as the option to print out and keep a summary of her results and personalized safety plan if she determined it was safe to have a written record. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=90 **Baseline comparisons:** NR **Study sufficiently powered:** NR			Regarding the DCS, after using the safety decision aid, the women felt more supported in their decision (baseline score 39.44 improved to 31.3, p=0.012). The women reported less total decisional conflict (baseline score 39.35 improved to 33.01, p=0.014). For safety priorities, most women placed the highest priority on protecting their children, improving their own safety, and locating sufficient resources to provide for their families. **Secondary outcomes:** N/A **Attrition details:** NR	unsafe relationships) and to prospectively compare the use of the decision aid against standard safety planning practice for improvements in the safety decision-making process, increased safety steps, and ultimately, reduction of violence **Source of funding:** Oregon Health & Science University Centre for Women's Health and Johns Hopkins University School of Nursing, Centre for Collaborative Intervention Research

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Grip, K., Almqvist, K., & Broberg, A. G. **Year:** 2011 **Citation:** Effects of a group-based intervention on psychological health and perceived parenting capacity among mothers exposed to intimate partner violence (IPV): A preliminary study. *Smith College Studies in Social Work, 81*(1), 81-100. **Country of study:** Sweden **Aim of study:** To determine if participation in a psychosocial group intervention was associated with self-reported reduction of mothers' trauma symptoms, symptoms of general psychopathology, improvement in their sense of coherence, and	**Source population(s):** Women in Sweden who experience abuse and who have children **Eligible population(s):** Women in Sweden who experience abuse and who have children **Selected population(s):** Women who experienced IPV and wanted help for self and her child, were not living with the perpetrator any longer, and did not have ongoing drug or alcohol abuse **Excluded population(s):** NR **Sample characteristics:** *Mean age (SD):* 38.8 (5.90); *Single parents:* 93%; *Born in Sweden:* 54%; *Education:* all the mothers had a minimum of 11 years of education, and 40% had studied at least one year at university level; *Mean time living in abusive relationship:* 7 years; *Battered >25 times:* 60%; *Stayed at a shelter:* 30% at least once, 48% more than once; *Had sought other*	**Method of allocation:** N/A **Intervention(s) description:** Mothers and children met in separate groups for 15 weeks. The groups for mothers consisted of six to eight participants and were led by two female social workers. The first sessions focused on information about violence and common reactions to IPV. Thereafter the sessions were centred on violence and its effect on personality and family life, family roles, and communication. The programme has taken key concepts from the parent version of the Children Are People Too treatment programme, which was developed in Minnesota for children with parents who abuse alcohol and/or drugs. They were interviewed about their current life situation and background at the start of treatment (pre-test). They also filled in questionnaires regarding their own trauma symptoms, psychological symptoms, sense of coherence, and parental locus of control. All 42 mothers who gave	**Primary outcomes:** Data were collected with semi-structured interviews. Violence exposure was measured by the question "How many times have you been beaten up by your intimate partner?" (0, 1-3, 4-6, 7-24, and ≥25 times). The severity of violence was measured by the question: "Which of 11 different kinds of violence were ever directed toward you by your former partner?" (e.g. stranglehold, sexual assault, and pushes). The *Impact of Event Scale (IES)* is a 15-item self-report trauma symptoms inventory with two subscales: Avoidance and Intrusion. The *Brief Symptom Inventory (BSI),* used to measure psychological problems and physical symptoms, is a 53-item self-report symptom inventory. *Sense of Coherence (SOC)* is a 29-item version measuring comprehensibility, meaningfulness, and manageability using 7-point scales, from 1 (weak) to 7 (strong). The *Parental Locus of Control (PLOC)* was used to measure the mothers' experiences of ability to direct, influence, and have an impact on her child; it is a self-rated 5-point scale instrument. All self-report instruments had acceptable	**Who is the target of the intervention?** Abused women in Sweden **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** Yes, but there was no relationship between symptoms in the dysfunctional range and demographic variables (ethnicity, SES, age, occupational status). **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** For the completer group, trauma symptoms were reduced significantly after treatment and at 1-year follow-up ($F(2,36)=17.27$, $p<0.001$). Effect sizes (Cohen's d) were 0.75 from pre-treatment to post and 1.04 from pre-treatment to 1-year follow-up. ITT analysis also showed a significant effect ($F(2,82)=12.58$, $p<0.001$), with effect sizes (Cohen's d) being 0.52 and 0.63, respectively. On the BSI, 80% of the mothers had psychological symptoms in the clinical range at the start of treatment. Completer analysis showed significantly reduced psychological symptoms after treatment and at 1-year follow-up ($F(2,36)=9.97$, $p<0.001$). Effect sizes after treatment were 0.76 and between pre-treatment and 1-year follow-up 0.91. ITT analysis also showed a significantly reduced symptom level ($F(2,82)=12.82$, $p<0.001$). Effect sizes were 0.62 and 0.71, respectively. For sense of coherence, 47% had a SOC total score at or below 120. The completer group had a higher sense of coherence after treatment and at 1-year follow-up ($F(2,36)=6.88$, $p>0.01$ [sic]). Effect sizes were 0.38 from pre-treatment to post and 0.60 from pre-treatment to 1-year follow-up. ITT analysis showed similar development ($F(2,80)=6.17$, $p>0.05$ [sic]). Effect sizes were 0.31 and 0.46. For parental locus of control, more than half the mothers (63%) scored above the cut-off for dysfunctional (low) parental locus of	**Limitations identified by author:** No comparison group and dropout rates were high. Small sample size. Self-report. Results may be due to spontaneous remission **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Examine mother's quality of attachment as attachment anxiety has been found to partly mediate the relationship between IPV and post-traumatic stress **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
perceived parental locus of control **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	*kinds of help before coming in contact with the treatment unit under study:* 90%; *Mother's perpetrator was the biological father of the child:* 81%; *Child had been abused by perpetrator too:* 71%; *In dispute with abuser regarding custody:* 22%; *Had former partner prosecuted for wife assault and battery:* 44% **Setting:** Urban	consent took part in the first assessment, 28 of these mothers also participated in the post-assessment, and 20 in the 1-year-follow-up. They constitute the completer sample **Control/comparison(s) description:** N/A **Sample size(s):** Total n=42 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	reliability and validity. **Secondary outcomes:** NR **Follow up periods:** 1 year **Methods of analysis:** Intent-to-treat and completer analyses were performed. The method of Reliable Change Index was used to calculate if individual change scores from pre- to post- and from post- to 1-year follow-up were statistically and clinically significant. Treatment effects were calculated using one-way ANOVA for dependent groups. Effect sizes (Cohen's d) were calculated. Between-group t-tests were used to compare the study group with reference groups.		control. There was no change at 1-year follow-up for parental locus of control, neither for the completer nor for the ITT sample. Effect sizes were very small (0.06) for the completer group pre-treatment to post-treatment and 0.05 pre-treatment to 1-year follow-up, and for the ITT group 0.33 and 0.02, respectively. Although the mean differences show significant improvement, on an individual level (from the Reliable Change analyses), most of the mothers starting in the dysfunctional range on the various measures remained in the dysfunctional range at post-treatment and 1-year follow-up. **Secondary outcomes:** N/A **Attrition details:** 28 of the original sample of 42 mothers completed the post-assessment. 20 completed the 1-year follow-up assessment, and these participants constitute the completer sample. There were no significant differences between completers and non- completers	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Hassija, C. & Gray, M. J. **Year:** 2011 **Citation:** The effectiveness and feasibility of videoconferencing technology to provide evidence-based treatment to rural domestic violence and sexual assault populations. *Telemedicine and e-Health, 17*(4), 309-315. **Country of study:** USA **Aim of study:** To determine if telehealth based cognitive behavioural therapy sessions for abused women will reduce PTSD and depression symptoms **Study design:** Before and after study **Quality score:** [+] **External validity:** [-]	**Source population(s):** Abused women living in Wyoming **Eligible population(s):** Rural women attending distal DV and rape crisis centres located in Wyoming **Selected population(s):** All clients who began formal treatment and had received at least four sessions of trauma-focused individual therapy **Excluded population(s):** Women who had <4 sessions of trauma-focused individual therapy **Sample characteristics:** *Race:* 87% White; *Mean age (SD):* 30.20 (9.25); *Marital status:* 47% single, 47% married **Setting:** Rural	**Method of allocation:** N/A **Intervention(s) description:** Psychological services were provided by master's level therapists working toward a doctoral degree in clinical psychology. Videoconferencing-based psychological services provided through the Wyoming Trauma Telehealth Treatment Clinic (WTTTC, an established partnership between a university-based mental healthcare clinic and three rural DV/rape crisis centres several hours away) were delivered at the DV/rape crisis centres using secure, encrypted videoconferencing technology. Participants were provided with free, trauma-focused psychotherapy services. Typically, sessions 1–2 were devoted to information gathering and rapport building. Then, participants received individual sessions of trauma-focused, evidence-based therapy. Treatment for all participants was based on the treatment manuals for prolonged exposure (PE) or cognitive processing therapy (CPT). Treatment components were applied flexibly, depending on the needs of the client. For instance, in cases of psychological distress emanating from DV, treatment may have included PE techniques to combat PTSD symptoms and motivational interviewing procedures to address ambivalence regarding the client's decision to stay or leave their current relationship. Typically,	**Primary outcomes:** The *Post-traumatic Stress Disorder Checklist (PCL),* a brief, self-report questionnaire, was administered to assess the presence and severity of PTSD symptoms. The PCL has demonstrated good psychometric properties and has been found to correlate well with other well-established measures of PTSD. Symptoms of depression were measured by the *Centre for Epidemiological Studies Depression Scale (CES-D)* which has excellent validity and reliability. The *Wyoming Telehealth Trauma Clinic Client Satisfaction Scale (WTTCCSS)* was created by the second author to assess client opinions and reactions regarding video-conferencing based treatment delivery. The measure consists of 11 items and asks respondents to rate on a 5-point scale (1=poor, 5=excellent) their telehealth-based treatment experience.	**Who is the target of the intervention?** Abused women living in rural areas **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** At post-treatment, participants' mean PCL score was 32.20 (SD=12.68), a reduction from 50.07 (SD=17.77) at baseline (Cohen's d=1.17). On the CES-D, participants' mean post-treatment score was 13.07 (SD=9.07), compared to 27.47 (SD=14.12) at baseline (d=1.24). Further, when separated by trauma type, effect sizes were large for each group on PTSD and depression outcomes (DV d=1.00, d=1.33; sexual assault d=2.18, d=1.05, respectively). Additionally, clients' reports of satisfaction with the provision of psychological services via videoconferencing on the WTTCCSS revealed very high levels satisfaction (M= 52.93, SD=2.43). **Secondary outcomes:** N/A **Attrition details:** N/A. The study only included those with baseline and follow-up data.	**Limitations identified by author:** No comparison group hence unable to rule out a number of potential confounds, such as spontaneous remission. No follow-up data on participants, which limits ability to make conclusions regarding the maintenance of treatment gains. Small sample of females who were willing to receive psychological services, hence generalisability of results may be limited to other assaultive violence or trauma populations. Selection bias as authors chose to analyse data only from women who had completed 4 or more sessions **Limitations identified by review team:** Self-report biases **Evidence gaps and/or recommendations for future research**: Continue to evaluate the efficacy of psychological interventions delivered via videoconferencing

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
		sessions took place weekly and lasted 60-90 min depending on the specific treatment being implemented. Assessment measures were administered every four sessions. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=15 **Baseline comparisons:** NR **Study sufficiently powered:** NR	Total scores can range from 55 (indicating a high satisfaction) to 11 (indicating poor satisfaction). **Secondary outcomes:** NR **Follow up periods:** Every 4 sessions **Methods of analysis:** Descriptive statistics			using controlled investigations with diverse trauma populations. Explore variables that may impact the efficacy of videoconferencing technology or contribute to client attrition **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Hernandez-Ruiz, E. **Year:** 2005 **Citation:** Effect of music therapy on the anxiety levels and sleep patterns of abused women in shelters. *Journal of Music Therapy*, *42*(2), 140-158. **Country of study:** USA **Aim of study:** To explore the effect of a music therapy procedure (music listening paired with progressive muscle relaxation (PMR)) on the reduction of anxiety and improvement of sleep patterns in abused women in shelters **Study design:** Randomized controlled trial **Quality score:** [+] **External validity:** [+]	**Source population(s):** Women experiencing DV in upper Midwestern city **Eligible population(s):** Women experiencing DV in upper Midwestern city attending DV shelters **Selected population(s):** Referred to the study by the shelter staff if they had been in the shelter for at least 2 days and no more than 1 week **Excluded population(s):** Women in shelter for more than 1 week **Sample characteristics:** *Mean age:* 35.36; *Mean number of children:* 2, range=0-5. Two women were pregnant. Most were caring for at least one child in	**Method of allocation:** Participants were matched according to their initial score on the Pittsburgh Sleep Quality Index (PSQI) differentiating between good and bad sleepers. After receiving a code number, each woman was assigned to a group in the following way: bad sleepers with odd numbers were assigned to the experimental group; even numbers, to the control group. Good sleepers with odd numbers were assigned to the control group; even numbers, to the experimental group. In this way, an even number of participants for both conditions was ensured in all cases. **Intervention(s) description:** A 15-minute recording of the PMR script was added to the music. Music clips or complete songs were copied to ensure a continuous 20-minute stream of music. Each participant met with the researcher for 5 consecutive days for approximately half an hour each day, in individual sessions. During the first visit, participants: answered a questionnaire to determine demographic information and music preference, answered the PSQI to assess the quality of their sleep during the 2 previous days (time in shelter), and were instructed on how to use the Fatigue Scale immediately upon awakening. On the second day, the researcher collected the Fatigue Scale (first pre-test) and clarified instructions if needed. During the third visit, the researcher again collected the Fatigue scale (second pre-test). Then all participants answered the State part of the State-Trait Anxiety Inventory (pre-test). Participants in both groups lay down on a couch, in a dimly-lit room for 20 minutes. Participants in the experimental group received the 20-minute session of music stimulus. Participants in the	**Primary outcomes:** To assess anxiety levels, the *State Trait Anxiety Inventory (STAI)* was used in sessions 3 and 4, immediately before and after the music stimulus (pre-test and post-test). Sleep quality was measured twice, as pre-test on the first day and as post-test on the fifth day, and fatigue was measured as a post-sleep inventory (using the Fatigue Scale) on mornings 2-5. **Secondary outcomes:** NR **Follow up periods:** Post-intervention **Methods of analysis:** Factorial repeated measures ANOVAs were used to compare STAI scores between the two conditions. To answer the question "Do state anxiety levels have an effect on sleep quality?" the mean difference of the STAI test (pre-test and post-test) and the difference between PSQI scores (pre-test	**Who is the target of the intervention?** Abused women in shelters **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** A statistically significant reduction of anxiety was found in the experimental group. Both a main effect change of anxiety level and an interaction by condition were found for STAI scores (i.e. intervention participants had a greater decrease in mean anxiety than control participants, all p's≤0.001). Surprisingly, no significant relationship was found between state anxiety and sleep quality in this study, even though both constructs significantly improved. Significant improvement of sleep quality was found for the experimental group (t(13)=3.20, p=0.007) but not for the control group (t(13)=1.74, p=0.105). In this sample, 78% of the participants (22/28) qualified as "bad sleepers" on the pre-test assessment (PSQI score >5). On the post-test, 4 women (29%) originally considered "bad sleepers" in the experimental group became "good	**Limitations identified by author:** Women were undergoing considerable amounts of stress, which affected their ability to keep appointments, and impacted their time management skills. Short shelter stays (less than one week), or sudden changes in their decision to stay for the full term, limited the amount of available participants. **Limitations identified by review team:** No analysis of content of music (lyrics). Self-report biases. Small sample size **Evidence gaps and/or recommendations for future research**: Research that specifically measures and compares the stay/leave decisions of abused women in shelters with and without music therapy interventions **Source of funding:**

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	the shelter; *Mean length of time in the last abusive relationship:* 7.94 years, and the abuse had lasted an average of 4.23 years (range from one day to 34 years); *Number of women reporting verbal abuse:* 26; *Number of women reporting physical abuse:* 23 **Setting:** Urban DV shelter	control group were instructed to "lie down quietly for 20 minutes," but they did not listen to the music/PMR intervention. After the 20-minute intervention or silence, participants in both groups answered the State Anxiety Inventory (post-test). Experimental group participants received the CD with the music/PMR script, and the portable CD player, and they were instructed to repeat the procedure at bedtime. Both groups received a Fatigue Scale (first post-test) for the following morning. During the fourth visit, the procedure for Day 3 was repeated. In the fifth visit, the researcher collected the last Fatigue scale (second post-test) and the CD players, and all participants answered the PSQI (post-test). **Control/comparison(s) description:** Control participants were told to lie down quietly for 20 minutes during the intervention **Sample size(s):** Total n=28; Intervention n=14; Control n=14 **Baseline comparisons:** NR **Study sufficiently powered:** NR	and post-test) were analysed using a Pearson correlation.		sleepers". Better sleep quality was not found to be associated with less fatigue at wake-up time. **Secondary outcomes:** N/A **Attrition details:** NR	NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Howarth, E., Stimpson, L., Barran, D., & Robinson, A. **Year:** 2009 **Citation:** *Safety in Numbers: A multi-site evaluation of independent domestic violence advisor services.* The Hestia Fund. **Country of study:** England and Wales **Aim of study:** To examine the provision and impact of IDVA (Independent Domestic Violence Advisor) services for female victims of domestic abuse deemed to be at high risk of harm or homicide. To examine the effectiveness of these interventions in increasing victims' safety and well-being, and the factors that increased or decreased the likelihood of achieving these positive outcomes. In addition, the research examined the extent to which of these outcomes were sustained over time.	**Source population(s):** Women accessing IDVA services in England and Wales **Eligible population(s):** All women who engaged with IDVA services over a 27 month period starting in January 2007 **Selected population(s):** Referral (time one): All clients were included. Closure of case (time two): All clients when the case closed, or at the end of criminal court proceedings. Exit interview: Nine months into the evaluation clients were asked to consent to an exit interview. Six month follow up: Nine months into the evaluation clients were asked to provide their contact information for longer term follow-up. **Excluded population(s):** Cases that did not meet the criteria for high risk, as set out for the purposes of this study were excluded. Cases with predominantly missing data at Time 1 were removed. Time one: Any client that did not agree to share their information. Time two: Any client that lost contact with the service. Exit interview and	**Method of allocation:** N/A **Intervention(s) description:** Core aspects of this approach to intervention include: safety as the overriding goal, independent of any other outcome such as those achieved in the criminal justice system; intervention targeted at victims of domestic abuse at high risk of harm or homicide as a result of domestic abuse; intervention from the point of crisis; a risk based approach to intervention; the proactive provision of practical help to address the immediate risks to victims' safety and help put victims on the path to long term safety. **Control/comparison(s) description:** N/A **Sample size(s):** IDVA Services n=7; Time one n=2567; Time two n=1247; Exit interview n=411; Six-month follow-up n=34 **Baseline comparisons:** There was no statistical difference in the frequency of physical abuse, sexual abuse or jealous behaviour at Time 1 between those who were and were not	**Primary outcomes:** The *Risk Indicator Checklist (RIC)* was initially developed in Cardiff for the use of police officers in attendance at incidents of domestic abuse and gives a basic indication of the risk of significant harm that further abuse poses to victims. The severity of abuse grid was developed for the purposes of this project in order to provide IDVAs with a simple tool with which to gather standardised data relating to the type, severity and frequency of four types of abuse (physical abuse, sexual abuse, perpetrators' jealous and controlling behaviour, and harassment and stalking). For well-being (time two) IDVAs were asked to endorse whether victims had made any significant changes to their coping mechanisms and access to social networks, and checked a box to indicate whether any changes had been made. **Secondary outcomes:**	**Who is the target of the intervention?** women accessing IDVA services in England and Wales **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No, they excluded men from the analysis **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** After the intervention of the IDVA, 57% of all victims experienced a cessation in the abuse they were suffering. The most significant changes were in relation to physical abuse, with stalking and harassment showing a smaller relative decline. There were also important reductions in the levels of severe abuse across each individual abuse type. The relative reductions in abuse ranged from over 75% in relation to physical, sexual abuse and jealous and controlling behaviour, to around 66% for severe cases of stalking. 76% of victims reported improved feelings of safety, confirmed in turn by IDVAs reporting reduced risk in 79% of cases. Importantly, less than 1% of victims who were asked about their feelings of safety reported that they felt less safe following support from an IDVA. The likelihood of a positive outcome increased progressively with the number of interventions received. For example, the odds of feeling safer and of abuse ceasing were doubled when 2-5 interventions were offered and increased by four times where there were	**Limitations identified by author:** Study lacked a control group with which to compare the outcomes for victims receiving no, or a different type of intervention. The 6 month follow-up results are far from conclusive given the small number of victims who were re-contacted and the fact that this sample was not representative of the larger sample of victims referred to IDVA services. The type and amount of data gathered for the purposes of this evaluation was constrained by what was practical for IDVAs to undertake as part of their everyday work. IDVAs were asked to indicate the support they provided to victims, however, questions relating to support were not consistently phrased and little guidance was offered at the outset of this project pertaining to the exact definition of 'support'. The number of contacts with a victim was a

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Study design: Before and after study **Quality score:** [+] **External validity:** [+]	six-month follow up: Any client that did not consent to an exit interview or for more follow up **Sample characteristics:** Time one: *Ethnicity*: 74% White; *Employment*: 51% employed; *Age*: 37% 21-30, 31% 31-40. Time two: *Ethnicity*: 72% White; *Employment*: 50% employed; *Age*: 26% 21-30, 33% 31-40 **Setting:** The seven sites were urban, suburban and rural. They ranged in size from 1 full time IDVA as part of a wider community-based domestic abuse service, up to 12 IDVAs. Some were relatively newly established, with others having been in operation for over 30 years. Some worked in communities with high Black and minority ethnic populations and others in areas where these groups were under-represented. Some were part of a dedicated IDVA service; others included wider services such as community outreach and refuge.	interviewed, although a higher proportion of those who completed exit interviews were experiencing harassment (chi-square(1,1247)=7.67, p<0.01), and severe abuse (chi-square(1,1247)=7.08, p<0.01) at the point of referral. **Study sufficiently powered:** NR	Interviews were conducted with consenting participants 6 months after the closure of their file. **Follow up periods:** At closure of case file, and 6 months after closure **Methods of analysis:** Descriptive statistics. No ITT.		more than 6 different interventions. In absolute terms, 37% of victims felt safer on access to 0-1 forms of support in comparison to 77% of those receiving access to 2-5 forms and 88% of those helped to access 6-10 forms. **Secondary outcomes:** 6 months after the closure of a case showed that a majority of victims surveyed (82%) reported that they had experienced no further abuse since the closure of their case **Attrition details:** 49% had available data gathered at time two. 33% of the sample with T2 data completed the follow-up interview. 10% of all victims with T2 data consented to being re-contacted; IDVAs were able to contact 34 victims, approximately 27% of all those providing consent.	proxy for the intensity of support that victims received. The frequency and intensity of intervention delivery are not exactly synonymous constructs and it is possible that a victim could receive very intensive support during a smaller number of contacts. **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Future work might determine whether the frequency and intensity of support have differential effects on outcomes achieved for victims. **Source of funding:** Sigrid Rausing Trust and The Henry Smith Charity

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Iverson, K. M., Shenk, C., & Fruzzetti, A. E. **Year:** 2009 **Citation:** Dialectical behaviour therapy for women victims of domestic abuse: A pilot study. *Professional Psychology: Research and Practice, 40*(3), 242-248. **Country of study:** USA **Aim of study:** To determine if women who completed the dialectical behaviour therapy (DBT) group intervention would exhibit significant improvements on measures of depressive symptoms, hopelessness, general psychiatric distress, and social adjustment from pre-treatment to post-treatment **Study design:**	**Source population(s):** Women who experienced IPV **Eligible population(s):** NR **Selected population(s):** Women that reported being a victim of domestic abuse by an intimate relationship partner at any time in their life **Excluded population(s):** Women who reported a history of childhood abuse but not domestic abuse from an intimate partner, women who were suicidal **Sample characteristics:** *Mean age:* 40.7, range=22-56; *Ethnicity:* 97% Caucasian; *Income:* 81% earned <$30,000; *Education:* 72% some high school or some college	**Method of allocation:** N/A **Intervention(s) description:** Groups included 6 to 8 women and followed a structured, 12-week, closed group format. Each 2-hour session included the following: new skills were taught and practiced, the use of previously learned skills was reviewed and encouraged, problems in applying skills to daily life were analysed and practiced again (targeting, chain analysis, problem solving, commitment), opportunities for engaging in more effective and skillful behaviours in the coming week were planned, and support, encouragement, and validation were provided both by the therapists and by other group members. Eight master's-level therapists provided treatment, with two therapists per group. Each had taken part in extensive DBT training. DBT is a cognitive-behavioural treatment, originally developed to treat multi-problem clients with severe and chronic emotion dysregulation, and adapted for this study to treat female victims of DV. Ordinary procedures that are central to DBT were woven throughout the programme, including: clear treatment targets in a hierarchy, with safety at the top; detailed chain analyses of	**Primary outcomes:** The *Beck Depression Inventory–II* is a self-report instrument consisting of 21 items designed to measure the presence and severity of depressive symptoms. The *Beck Hopelessness Scale* is a 20-item instrument that measures the severity of negative attitudes about the future and is also used to assess the extent of hopelessness and has been shown to be predictive of suicide risk. The *Social Adjustment Scale–Self-Report* measures an individual's overall social functioning across several domains, such as employment, family, social and leisure, marital, and parenting relationships. The *Symptom Checklist-90-R* is an instrument widely used to assess both domain-specific (e.g. anxiety, psychosis) and broad levels of individual distress. The Global Severity Index of the Symptom Checklist-90-R was selected for analyses so that changes in general levels of distress could	**Who is the target of the intervention?** Women experiencing IPV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The group that completed treatment showed significant improvements on all of the outcome measures; participants reported reduced depressive symptoms, hopelessness, and psychiatric distress and reported increased social adjustment from pre- to post-treatment, as follows (M=mean, SD=standard deviation): *Beck Depression Inventory-II:* pre (M=18.3, SD=15.0), post (M=10.2, SD=11.4), F(1,30)=12.97, p<0.001, d=0.54. *Beck Hopelessness Scale:* pre (M=5.1, SD=6.0), post (M=2.6, SD=3.0), F(1,30)=5.88, p<0.05, d=0.42. *Symptom Checklist-90-R:* pre (M=44.7, SD=11.8), post (M=35.5, SD=13.3), F(1,30)=14.82, p<0.001, d=0.78. *Social Adjustment Scale–Self-Report:* pre (M=2.2, SD=0.57), post (M=1.9, SD=0.50), F(1,30)=7.67, p<0.01, d=0.53. **Secondary outcomes:** N/A **Attrition details:** Attrition rate: 33%. The average number of sessions attended for the 33% of participants who left the treatment programme early was three	**Limitations identified by author:** No control group. Unknown if the gains at post-test were maintained. Low generalisability beyond Caucasian, low-income samples. The outcome variables examined were not exhaustive. **Limitations identified by review team:** Small sample size. Self-report **Evidence gaps and/or recommendations for future research**: Compare the current intervention to other interventions for this population to isolate the effective treatment components (e.g., a support group) and include the collection of follow-up data with a more diverse and representative sample. Evaluate shorter vs. longer programs to determine optimum duration as well as the utility of booster or follow-up sessions. Focus on identifying factors that predict which women might benefit from this treatment. Investigations should

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Before and after study **Quality score:** [+] **External validity:** [+]	education; *Abuse history:* 54% reported being in an abusive relationship for 1-5 years, 77% reported being abused by a current or former husband, 26% still lived in the same home as their abuser **Setting:** Therapy sessions	targets; the use of daily diary/self-monitoring cards; validation; skill building and generalization; balancing acceptance and change; an emphasis on practicing new skills and activities in daily life; and ongoing therapist consultation. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=31 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	be assessed at pre-treatment and post-treatment phases. **Secondary outcomes:** NR **Follow up periods:** N/A **Methods of analysis:** ANOVAs		sessions (range 1-7 sessions). There were no significant differences between completers and non-completers at pre-test on any of the clinical outcome measures of interest (all p's>0.05). Non-completers had fewer years of education ($t(40)=2.94$, $p<0.01$) than completers. Level of income and whether there were children in the home did not significantly differ between completers and non-completers.	include a broader range of mental health measures, such as measures of PTSD, self-esteem, and safety in future relationships (and quality of those relationships), to capture more fully the range of difficulties that women victims of domestic abuse experience. Examine whether DBT commitment strategies or other interventions, such as motivational interviewing techniques, may enhance programme engagement and reduce attrition **Source of funding:** U.S. Department of Justice and the State of Nevada Office of the Attorney General

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Iverson, K. M., Gradus, J. L., Resick, P. A., Suvak, M. K., Smith, K. F., & Monson, C. M. **Year:** 2011 **Citation:** Cognitive behavioural therapy for PTSD and depression symptoms reduces risk for future intimate partner violence among interpersonal trauma survivors. *Journal of Consulting and Clinical Psychology*, *79*(2), 193-202. **Country of study:** USA **Aim of study:** To examine the effect of CBT for PTSD and depressive symptoms on the risk of future IPV victimization	**Source population(s):** Women who experienced IPV in the past **Eligible population(s):** Women who experienced IPV in the past and were seeking psychosocial therapy **Selected population(s):** Women with PTSD secondary to an index event of sexual or physical assault in childhood and/or adulthood aged 18 and over and who met the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition criteria for PTSD as measured by the Clinician-Administered PTSD Scale **Excluded population(s):** NR **Sample characteristics:** *Mean Age (SD):* 35.4 (12.4); *Ethnicity:* 62% Caucasian, 34% African American, 4% other; *Mean years of completed education (SD):* 13.8 (2.8);	**Method of allocation:** Women were randomized to one of three groups **Intervention(s) description:** The three treatment groups all lasted 6 weeks and involved 12 hours of therapy with a female therapist with at least a master's degree. *Cognitive processing therapy (CPT)* was a structured protocol in which the primary goal of treatment was to help the client learn skills to recognize and challenge cognitive distortions, first focusing on those related to their worst traumatic event and then the meaning of the event(s) in terms of their self, others, and the world. Therapy included education about PTSD, identification of relationships between events, thoughts, and emotions and the development of alternative, more balanced thinking. The full CPT package included detailed written accounts (WA) of the index traumatic event and daily readings of these written accounts during the early and middle sessions of therapy. Cognitive therapy was used during sessions and via worksheets completed between sessions to help clients identify cognitive distortions that interfere with recovery from PTSD and from balanced thinking. *CPT-C* was identical to	**Primary outcomes:** The *Standardized Trauma Interview* assesses demographic characteristics as well as physical and sexual victimizations occurring in childhood and adulthood. On a modified version of the *Conflict Tactics Scale-Physical Assault Subscale,* respondents reported on the frequency of abusive behaviours perpetrated by their current partner and most recent previous partner. Respondents were asked about IPV perpetrated by their current partner within the past year (i.e., violence from a current partner within the past year) and IPV by a previous partner during the last year they were together. The *Beck Depression Inventory-II* was used to assess depressive symptoms. The *Posttraumatic Diagnostic Scale (PDS)* is a self-report measure that assesses trauma history and DSM-IV criteria for PTSD. All measures have acceptable reliability	**Who is the target of the intervention?** Women experiencing IPV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The initial growth curve analyses indicated that both PTSD ($b1=-0.17$, $t=-12.38$, $p<0.001$, $\Delta\sigma^2=0.56$) and depressive symptoms ($b1=-0.16$, $t=-12.16$, $p<0.001$, $\Delta\sigma^2=0.50$) exhibited significant mean-level decreases from pre- to post-treatment. PTSD and depressive symptoms were highly correlated at baseline, and change in PTSD symptom severity during treatment was also highly correlated with change in depression symptom severity. A series of hierarchical multiple regression analyses further examined the association between the PTSD and depression symptom change parameters and IPV levels at the 6-month follow-up assessment. There were significant associations between change in PTSD ($b=3.37$, $t=3.06$, $p<0.05$, squared partial regression coefficient (pr^2)=0.07) and depressive symptoms ($b=3.49$, $t=2.93$, $p<0.05$, $pr^2=0.07$) over time and IPV at the 6-month follow-up, even after controlling for pre-treatment IPV levels and prior exposure to interpersonal trauma.	**Limitations identified by author:** Results may not be generalisable to men or to people suffering from PTSD secondary to other types of trauma (i.e., motor vehicle accidents, natural disasters). All three groups received treatment for PTSD, so cannot be certain that gains were related to treatment instead of the passage of time alone, repeat assessments, or clinician attention. Differences between completers and non-completers may limit generalisability. Was not possible to simultaneously examine the effects of decreased PTSD and depression symptoms on IPV victimization in the same regression model due to collinearity (r=0.82) between these variables. Study did not include measures of sexual and emotional IPV and therefore the study findings may not generalize beyond the reduction of physical IPV **Limitations identified by review team:** Self-report biases **Evidence gaps and/or recommendations for**

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
in a sample of women survivors of interpersonal violence **Study design:** Randomized controlled trial **Quality score:** [+] **External validity:** [+]	*Annual income:* 54% had income <$20,000/year; *Marital status:* 20% married or cohabiting; *Abuse:* 84% reported adult physical assault, 81% reported adult sexual victimization, 78% reported child sexual abuse (60% penetrative sexual abuse), 77% reported childhood physical abuse. The average length of time since the index event was 14 years, because a significant portion of participants (45%) reported child sexual or physical abuse as their index event. Overall, 19% of the ITT sample reported IPV as their index event. **Setting:** Therapy sessions	the full CPT protocol except for the omission of the detailed writing account and readings of the written trauma account. The therapy was also trauma-focused but emphasized additional Socratic questioning and cognitive work in lieu of the account. There was an additional emphasis on cognitive skills, including further applications of event-thought-emotion worksheets for cognitive skills practice and generalization. The *WA* protocol was developed to maintain the integrity of the written account intervention in the full CPT protocol by expanding upon the written account component of CPT (i.e. participants were asked to engage in their writing during therapy sessions and reading it back to the therapist). **Control/comparison(s) description:** See intervention description **Sample size(s):** Total n=150; Full CPT n=53; CPT-C n=47; WA n=50 **Baseline comparisons:** NR **Study sufficiently powered:** NR	and validity. Participants were assessed at pre-treatment, every week during the six-week therapy, and at 6-months post-treatment. **Secondary outcomes:** NR **Follow up periods:** 6 months **Methods of analysis:** A series of hierarchical multiple regression analyses, growth curve analyses		**Secondary outcomes:** N/A **Attrition details:** Out of 150, 24 did not return for their first session of therapy, 126 women completed one or more therapy sessions (i.e., treatment starters) and 86 women completed all 12 hours of therapy (i.e., treatment completers). 121 completed the 6-month follow-up assessment, therefore providing IPV outcome data; these women attended more hours of treatment, had lower post-treatment PTSD, and had lower post-treatment depression severity, than those who didn't complete the 6-month follow-up	**future research**: Replication of the present findings with a larger, more heterogeneous sample. Longer follow-up period. Sexual coercion and psychological abuse from an intimate partner should be examined. Examine the extent to which other positive outcomes associated with treatment (i.e., increased self-esteem or posttraumatic growth) and whether women's use of other types of community interventions (i.e., victim advocacy, legal actions) may also play a role in reducing risk for future IPV. Dissemination and implementation research is needed to understand how psychosocial treatments, such as CPT, transfer to community and social services settings to reduce psychological distress and revictimization. **Source of funding:** National Institute of Mental Health

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Johnson, D. M., Zlotnick, C., & Perez, S. **Year:** 2011 **Citation:** Cognitive behavioural treatment of PTSD in residents of battered women's shelters: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology, 79*(4), 542-551 **Country of study:** USA **Aim of study:** To determine if a new shelter-based treatment, Helping to Overcome PTSD through Empowerment (HOPE), would reduce depression, post-traumatic stress disorder (PTSD), and re-abuse once women leave the shelter and increase	**Source population(s):** Abused women attending DV shelters **Eligible population(s):** Women in one of two inner-city battered women's shelters in a midsized Midwestern city who had an incident of IPV on the Conflict Tactic Scales-Revised during the month prior to shelter admission and met diagnostic criteria for IPV-related PTSD or sub-threshold PTSD according to the Clinician-Administered PTSD Scale **Selected population(s):** Eligible women who agreed to participate **Excluded population(s):** Women who had symptoms of psychosis, met lifetime diagnostic criteria for bipolar disorder, were in concurrent individual therapy, had any	**Method of allocation:** One week after baseline, the first author randomly assigned participants to one of the conditions using an urn randomization procedure stratifying participants according to PTSD status (i.e., PTSD and sub-threshold PTSD) and medication status (i.e., on psychotropic medications or not). **Intervention(s) description:** All participants received standard shelter services (SSS). Participants randomized to HOPE also received a maximum of 12 sessions approximately twice weekly while in shelter over a maximum of 8 weeks. All sessions occurred at shelter, and childcare was provided. Sessions lasted approximately 1-1.5 hours. HOPE is a manualized, individual, cognitive-behavioural treatment. HOPE addresses the cognitive, behavioural, and interpersonal dysfunction associated with PTSD that can interfere with battered women's ability to effectively utilize shelter resources and establish safety. Beginning sessions focus on psycho-education regarding interpersonal violence, PTSD, and safety planning. Earlier sessions also focus	**Primary outcomes:** The *Clinician-Administered PTSD Scale (CAPS),* a structured interview with established reliability and validity, was used to assess for IPV-related PTSD diagnosis and past-week symptom severity. The *Conflict Tactic Scales-Revised (CTS-2),* a self-report measure with established validity and reliability was used to assess for IPV the month prior to shelter admission and in the last month at each follow-up period. The mood, anxiety, and substance-use modules of the *Structured Clinical Interview for Axis I disorders (SCID-I/P)* were used to assess current (i.e., last month) Axis I comorbidity to PTSD. Interrater reliability (k=0.87).The *Trauma History Questionnaire (THQ)* was used to assess lifetime history of traumatic events other than IPV. **Secondary outcomes:** The *Beck Depression Inventory (BDI)* was used to assess severity of depression symptoms over the past week with established reliability and validity and had excellent internal consistency in the	**Who is the target of the intervention?** Women attending DV shelters **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** No significant differences were found for PTSD diagnostic status in the ITT sample ($p>0.05$). There was a significant effect for time in both the ITT sample (chi-squared=118.75, $p<0.0001$) and MA sample (chi-squared=73.54, $p<0.05$), indicating PTSD severity decreased over time. Chi-square analyses for PTSD diagnostic status in the MA sample were only significant at 3-months post-shelter (chi-squared=4.69, $p<0.05$), indicating that participants in HOPE (15.8%) were less likely to meet criteria for PTSD relative to controls (45.5%, OR=4.44, 95% CI: 1.08-18.22, RR=2.88, 95% CI: 0.95-8.68). In both the ITT and MA samples, there were significant differences in re-abuse rates over the 6-month follow-up period (chi-squared=8.68, $p<0.01$; chi-squared=15.70, $p<0.0001$, respectively). In the ITT sample, participants in HOPE (47%) were significantly less likely to report re-abuse than were control participants (82%, OR=5.1, 95% CI: 1.66-15.70, RR=1.75, 95% CI: 1.17-2.61). In the MA sample, participants in HOPE (26%) were also significantly less likely to report re-abuse than were control participants (82%, OR=12.6, 95% CI: 3.26-48.65, RR=3.11, 95% CI: 1.44-6.71). **Secondary outcomes:** There was a significant effect of time on BDI scores in the ITT group, in which participants reported fewer depressive symptoms over the	**Limitations identified by author:** Relatively small sample size and resulting high variability in effect size estimates. Sub-threshold PTSD was used as inclusion criteria so population may not be representative of that used in other clinical trials of PTSD. Unable to assure that interviewers were masked to participants' treatment condition, and study therapists were used to rate adherence and competence rather than outside raters. **Limitations identified by review team:** Self-report prone to bias. High attrition rate **Evidence gaps and/or recommendations for future research**: HOPE with a credible attention control condition in order to determine whether "active ingredients" specific

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
empowerment, resources and access to support **Study design:** Randomized controlled trial **Quality score:** [+] **External validity:** [+]	change in psychotropic medications in the past month, or exhibited significant suicidal ideation or risk **Sample characteristics:** *Mean age:* 32.55; *Ethnicity:* 50% African American, 43% Caucasian; *Education:* 27% less than high school, 23% high school/GED, 43% completed some college; *Employed:* 27%; *Have children:* 90%; *IPV-related PTSD status:* 87% PTSD status, 13% sub-threshold PTSD status; *Current comorbid psychiatric disorders:* 47% depression, 8% substance use disorders, 51% anxiety disorders; *On psychotropic medication:* 21%; *IPV in month prior to shelter:* 100% reported psychological abuse, 93% reported physical abuse, 67% reported sexual abuse	on teaching women information and skills that empower her to establish her independence and to make informed choices. Later sessions of HOPE incorporate established cognitive-behavioural skills to manage PTSD and its associated features (e.g., cognitive-restructuring, managing triggers) and optional modules that address some of the co-occurring problems frequently found in battered women (e.g., substance use and grief). The first author, as well as five additional therapists who held a minimum of a master's degree in psychology or counselling and had at least 1 year of prior experience in working with traumatized populations, conducted HOPE. HOPE training included a 12-hr workshop with the first author that provided an overview of the HOPE theoretical approach and specific instructions on how to deliver each module. All therapists were supervised weekly by the first author. All interviews were conducted by trained graduate students in psychology or counselling. **Control/comparison/s description:** Standard	present study (alpha=0.89). The *Personal Progress Scale-Revised (PPS-R)* was used to measure positive self-evaluation and self-esteem; a favourable comfort distress ratio; gender-role and cultural identity awareness; a sense of personal control/self-efficacy; self-nurturance and self-care; effective problem-solving skills; competent use of assertiveness skills; effective access to multiple economic, social, and community resources; gender and cultural flexibility; and socially constructive activism women's empowerment. It has acceptable reliability and validity. The *Conservation of Resources-Evaluation (COR-E)* assesses the degree to which participants experienced loss in material, energy, work, interpersonal, family, and personal resources in the past month and has high validity and reliability (alpha=0.96). The *Inventory of Socially Supportive Behaviours* measured social support. **Follow up periods:** 1 week, 3 months, 6 months		course of the follow-up (chi-squared=117.71, p<0.0001). A significant treatment effect was also found, (t=-3.13, p<0.01), in which participants in HOPE reported fewer depression symptoms over follow-up relative to the control group. Analyses with the MA sample were similar in that a significant treatment effect was found (t=-2.510, p<0.05) (MA participants reported fewer depression symptoms over follow-up). There was a significant effect of time on PPS scores in the ITT sample (chi-square=99.96, p<0.01) with participants scoring higher on empowerment over the follow-up period. A significant treatment effect was also found (t=2.09, p<0.05), in which women randomized to HOPE reported higher levels of empowerment relative to controls over the follow-up period. There were no significant treatment effects for empowerment in the MA sample. There were no significant effects of time or treatment group for both the ITT and MA samples on COR-E scores (all p's>0.05). With the ITT sample, scores on the ISSB revealed a significant effect of time (chi-squared=95.19, p<0.05), in which participants reported greater degree of social support over the follow-up period. There was also a significant treatment effect (t=2.11, p<0.05), in which women in HOPE reported more social support over the follow-up period than did women in the control group. There were no significant effects of time or treatment group in the MA sample	to HOPE are responsible for observed treatment effects over factors common to psychotherapy in general. Longer follow-up period is needed to evaluate the durability of treatment effects. Unknown whether findings generalize to IPV victims who do not seek shelter **Source of funding:** National Institute of Mental Health grant K23 MH067648

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Setting: Urban shelter	shelter services which includes case management, a supportive milieu environment, and attendance at educational groups offered through the shelter (i.e., parenting and support groups) **Sample size(s):** Total n=70; Intervention n=35; Control n=35 **Baseline comparisons:** Participants randomized to the control condition had a significantly higher rate of comorbid major depressive disorder (MDD) than did those randomized to HOPE (chi-squared(1,70)=10.94, p<0.01); therefore, presence of MDD was controlled for in analyses. There were no other significant differences between the two treatment groups on any demographic, diagnostic, trauma/IPV characteristics at baseline, or on the length of shelter stay, occurrence of contact with abuser, or receipt of therapy over the follow-up period (all p's>0.05). **Study sufficiently powered:** NR	**Methods of analysis:** For each outcome, two analyses were run: intent to treat (ITT) analyses included all participants regardless of the number of HOPE sessions completed, and minimal attendance (MA) analyses were conducted with participants who completed a minimum of 5 sessions and completed all follow-up assessments. Hierarchical linear modeling (HLM) was used to evaluate continuous outcomes.		(all p's>0.05). **Attrition details:** All but one participant (97%) attended at least one session of HOPE, with 22 (63%) attending 5 sessions, and nine (26%) attending all 12 sessions. Two (7%) participants withdrew from the treatment phase (i.e., refused further treatment while still in shelter), but were still followed post-shelter. The remaining 24 participants who did not complete all 12 sessions (69%) left shelter prior to completing HOPE. No significant demographic differences were found between participants who completed a minimum of 5 sessions and those who did not (all p's>0.05). Retention rates for each follow-up time point are as follows: 97% at 1-week PS (n=68), 94% at 3-months PS (n=66), 95% at 6-months PS (n=66). Participants lost to follow-up were less likely to receive public assistance (chi-square(1,70)=4.99, p>0.05).	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Kendall, J., Pelucio, M. T., Casaletto, J., Parker, K., Thompson, S. B., Pettit, E., & Aldrich, M. **Year:** 2009 **Citation:** Impact of emergency department intimate partner violence intervention. *Journal of Interpersonal Violence, 24*(2), 280-306. **Country of study:** USA **Aim of study:** To assess the impact of emergency department (ED) IPV counselling and resource referrals on patient-perceived safety and safety planning **Study design:** Cross-sectional study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Abused males and females in a mixed-class, multicultural city with a metropolitan population of 614,000 **Eligible population(s):** Male and female patients aged 12 and older in the city who visited an emergency department **Selected population(s):** Eligible participants who screened positive for IPV and accepted consultation with an IPV advocate **Excluded population(s):** Critically ill patients and patients who did not speak English **Sample characteristics:** *Gender:* 97% female, 3% male; *Ethnicity:* 64%	**Method of allocation:** NA **Intervention(s) description:** The study commenced shortly after the inception of a new emergency department IPV advocacy programme, the Domestic Violence Healthcare Project (DVHP), which was linked to a large local community service organization. All ED nurses and attending and resident physicians at the study hospital were trained via a 1-hour conference conducted by several of the project coordinators. In addition, educational posters and literature were made available to all ED staff and patients. The screening portion of the protocol began at triage. The questions used in this study were derived from the previously validated Partner Violence Scale and were asked directly off the triage sheet in a scripted form. Physicians were informed of positive screens, and patients were offered consultation with a trained IPV advocacy counsellor. Physicians were also encouraged to redirect questioning if clinical evidence suggested IPV even if the initial screening was negative. Those patients screening positive and who accepted consultation with an IPV advocacy counsellor were enrolled in the study. During weekdays, the majority of the counselling was done by full-time DVHP staff counsellors with MSW degrees. Volunteer IPV advocates were recruited and received 30 hours of crisis	**Primary outcomes:** The participants were contacted via telephone at each follow-up time, and asked about the number of steps instituted from their safety plan, if they felt their environments were safer, which community resources they contacted, and which resources were felt to be beneficial in improving safety **Secondary outcomes:** NR **Follow up periods:** 2 days, 2 weeks, 6 weeks, and 12 weeks post-intervention **Methods of analysis:** Descriptive statistics. Spearman's correlation coefficients were used to test for relationships between the variables.	**Who is the target of the intervention?** Abused males and females who visited EDs **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** 96% perceived that their living situation was safer at the 12-week follow-up. Patients completed a mean percentage of 49%-59% of their safety plan at various follow-up intervals. There was no significant correlation between percentage of safety plan completed, and any of: age, income, length of relationship, or race. For the most beneficial resource in improving their safety, of the 116 victims who provided an answer: 38 credited law enforcement, 15 IPV counselling, 13 legal help, 13 battered-women's shelter, 7 clergy, 4 victims' services, 4 crisis intervention, 4 social services, 1 mental health, 1 alcohol and drug rehabilitation, and 1 vocational services/employment. **Secondary outcomes:** N/A **Attrition details:** Approximately 30% of eligible patients were likely not screened at triage. Participation rate: 10%.Of these victims, 44% were contacted for at least one	**Limitations identified by author:** Convenience sample of patients. Overall participation rate was estimated at 10%. Results may not generalize to other populations. Measures are self-reported and subject to bias. Follow-up was limited **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	African American, 26% Caucasian, 8% Latin; *Mean age (SD):* 32 (10); *Mean length of relationship between victim and perpetrator*: 5 years; *Relationship to the perpetrator:* 62% heterosexual partners, 21% spouses, 15% ex-partners, and 2% homosexual partners/other **Setting:** Urban hospital ED	intervention training for IPV prior to counselling patients. Assessment was undertaken in a quiet, secure, and private room, if possible after necessary medical care was initiated or completed. To guide their evaluation, counsellors used a DVHP Interpersonal Violence Assessment Form which assessed the victim's circumstances, including information regarding the type of abuse suffered and demographic information of the victim and abuser. After this initial assessment was completed, the IPV advocacy counsellor helped the patient develop an individualized 5-point safety plan to make the patient's environment safer. Finally, if requested, the counsellor helped arrange transfer to a shelter. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=360; Patients with follow-up data for at least one time point n=157 **Baseline comparisons:** NR **Study sufficiently powered:** NR			follow-up interval, with <1% of victims able to be contacted at all four follow-up intervals.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Kiely, M., El-Mohandes, A. A. E., El-Khorazaty, M. N., & Gantz, M. G. **Year:** 2010 **Citation:** An integrated intervention to reduce intimate partner violence in pregnancy: A randomized trial. *Obstetrics and Gynecology, 115*(2), 273-283. **Country of study:** USA **Aim of study:** To estimate the efficacy of a psycho-behavioural intervention in reducing intimate partner violence recurrence during pregnancy and postpartum and in improving birth outcomes in African-American women **Study design:** Randomized controlled trial **Quality score:** [+] **External validity:** [+]	**Source population(s):** Minority women living in DC who experience IPV and who are pregnant **Eligible population(s):** Minority women who attend Children's National Medical Centre, Georgetown University, George Washington University Medical Centre, Howard University **Selected population(s):** Self-identified as being a minority and were at least 18 years old, 28 weeks pregnant or less, a DC resident, English speaking **Excluded population(s):** Women who were potentially suicidal **Sample characteristics:** *Weeks of gestation at recruitment:* 63% before 22 weeks, 17% 22-25 weeks, 20% 26-28 weeks; *Mean age:* 24.5;	**Method of allocation:** Computer generated randomization. Telephone interviewers and their supervisors were blinded to the participants' randomization group. **Intervention(s) description:** Women were screened at six community-based prenatal care sites serving mainly minority women. After initial consent, participants were screened for the four risk factors (cigarette smoking, environmental tobacco smoke exposure, depression, and IPV) using an audio-computer assisted self-interview. Women randomly assigned to the intervention group received an integrated cognitive-behavioural intervention. The intervention was delivered during routine prenatal care visits at the clinics by trained interventionists. At each intervention session, the woman identified which of the four risks she was experiencing. The intervention was targeted to address all risks reported at each session, regardless of previously reported risks. The intervention for IPV emphasized safety and provided information about the types of abuse a danger assessment component to assess risks, and preventive options women might consider as well as the development of a safety plan. A list of community resources was provided. The intervention was delivered in 4 to	**Primary outcomes:** Intimate partner violence was identified by the *Abuse Assessment Screen,* a measure designed and validated for use in pregnancy if a woman reported physical or sexual abuse by a partner in the previous year. For baseline and follow-up interviews, the frequency of physical assault and sexual coercion (partner to self) was measured by the *Conflict Tactics Scale.* **Secondary outcomes:** Rates of low birth weight (LBW) (less than 2,500g) and very low birth weight (VLBW) (less than 1,500g) **Follow up periods:** 22-26 and 34-38 weeks of gestation, and 8-10 weeks postpartum **Methods of analysis:** Bivariate analyses were conducted to compare the baseline characteristics and pregnancy outcomes	**Who is the target of the intervention?** Minority women who are pregnant and are being abused or at risk for abuse **Did they conduct any aspect of sex, gender or diversity analysis?** Yes, see results **Do they report sex, gender or diversity based factors in findings?** Yes, see results **Did this study examine or discuss links between DV and substance use or issues of trauma?** Yes. Alcohol use during pregnancy measured at baseline and depression were associated with the chance of recurrent episodes of IPV (adjusted	**Primary outcomes:** At baseline, 32% reported IPV in the previous year. Women in the intervention group were less likely to have recurrent episodes of IPV (OR=0.48, 95% CI: 0.29–0.80), and were less likely to be victimized by their partners at the first or second follow-up interviews. Women with severe IPV showed significantly reduced episodes postpartum (OR=0.39, 95% CI: 0.18-0.8). Women with minor IPV were significantly less likely to experience further episodes during pregnancy (OR=0.48, 95% CI: 0.26-0.86, OR=0.53, 95% CI: 0.28-0.99) and postpartum (OR=0.56, 95% CI: 0.34-0.93). **Secondary outcomes:** Rates of LBW were not different in the two groups (intervention: 12.8%, usual care: 18.5%, p=0.204). Rates of VLBW were lower among women in the intervention group. **Attrition details:** 306	**Limitations identified by author:** Low power. Low participation. Limited generalisability. **Limitations identified by review team:** Self report biases **Evidence gaps and/or recommendations for future research**: Conduct larger studies that test effectiveness of similar interventions **Source of funding:** Eunice Kennedy Shriver National Institute of Child Health and Human Development and the National Centre on Minority Health and Health Disparities

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Mean time participants initiated prenatal care: 13 weeks of gestation; *Marital status:* 76% single; *Education:* 68% at least high school; *Enrolled in Medicaid:* 79%; *Smoked during pregnancy:* 22%; *Self-identified as being at risk for environmental tobacco smoke exposure:* 78%; *Depressed:* 62%; *Alcohol use:* 32%; *Illicit drug use during pregnancy:* 17% **Setting:** Urban prenatal clinic	8 sessions. Two additional postpartum booster sessions were provided to reinforce risk-specific intervention goals. Intervention activities addressing all of the individually identified risks at each session lasted for an average of 35 ± 15 minutes. **Control/comparison(s) description:** Determined by the standard procedures at the prenatal care clinic **Sample size(s):** Total n=1044; Control n=523; Intervention n=521 **Baseline comparisons:** No significant differences **Study sufficiently powered:** Yes, Assuming a 5% level of significance, 80% power allowed the detection of 10–20% reductions in risk-specific factors among women in the intervention group.	of women assigned to the intervention and usual care groups and to compare women who reported a recurrence of IPV during pregnancy or postpartum with those who did not. Logistic regression was used to model recurrence of IPV based on care-group assignment, controlling for relevant covariates. Logistic models also were created to predict minor, severe, physical, and sexual intimate partner violence reported at each interview.	OR=1.85, 95% CI: 1.09-3.12 and adjusted OR=1.90, 95% CI: 1.11-3.25, respectively).	(91.1%) completed at least one of the follow-up or postpartum interviews. No significant differences were found between those with follow-up data and those without.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Koopman, C., Ismailji, T., Holmes, D., Classen, C. C., Palesh, O., & Wales, T. **Year:** 2005 **Citation:** The effects of expressive writing on pain, depression and posttraumatic stress disorder symptoms in survivors of intimate partner violence. *Journal of Health Psychology, 10*(2), 211-221. **Country of study:** USA **Aim of study:** To examine the effects of expressive writing on symptoms of depression, PTSD and pain among women who have experienced IPV **Study design:** Randomized controlled trial	**Source population(s):** Women who experienced IPV in the San Francisco Bay area **Eligible population(s):** Having been a victim of IPV, being over 18 years of age, ability to converse and write in English, living in conditions that participant judged as providing herself safety from the abuse **Selected population(s):** Eligible women who contacted the research team and agreed to participate **Excluded population(s):** Romantic involvement with abusive partners within the previous 30 days or had lived with them within the previous 6 months **Sample characteristics:** *Mean age (SD):* 36.5 (8.9); *Marital status:* 19% married or living with a new partner, 38% single; *Race:* 68% White/European American, 13% Latina/Hispanic, 6%	**Method of allocation:** Random assignment to either the expressive writing condition in which the participant wrote about the most stressful event(s) of her life or to the neutral writing condition in which she wrote about her daily schedule **Intervention(s) description:** For the expressive writing task, women were instructed to explore their deepest emotions and feelings: 'Today I want you to write about the most traumatic experience of your life; really exploring your very deepest emotions and thoughts.' These instructions were inserted within a journal that each woman used for all of her writing sessions. Each woman was asked to do the writing without discussing it with the research assistant. Each writing session was 20 minutes in duration, and each woman completed 4 writing sessions, scheduled at weekly intervals. At the preference of each woman, these writing sessions were either done in a university office or at a coffee shop or restaurant near the participant's residence. **Control/comparison(s) description:** For the neutral writing task, women were asked to write about how they used their time and were further instructed: 'I am not interested in your emotions or opinions. Rather be as objective	**Primary outcomes:** The study used the *Bodily Pain Scale of the SF-36 Health Survey,* comprising two items. The *Beck Depression Inventory (BDI),* a widely used self-report instrument, assessed depression. Cronbach's alpha for this sample was 0.85. The *PTSD Checklist-Specific Version (PCL-S)* was used to assess current PTSD symptoms. Cronbach's alpha for this sample was 0.92. All measures had good reliability and validity. **Secondary outcomes:** NR **Follow up periods:** 4 months **Methods of analysis:** Descriptive statistics. Multiple regression analysis was used to assess differences in BDI, PCL-S, and Bodily Pain Scale scores in which the independent variables in the regression model were: baseline score on the dependent measure and the experimental condition, as well as the	**Who is the target of the intervention?** Women who experienced IPV in the past **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** At baseline, 40% of women reported significant levels of pain, 53% met criteria for likely PTSD and 40%met screening criteria for clinical depression. The models for Bodily Pain, BDI scores and PCL-S scores were highly significant ($p<0.001$, adjusted R^2s were 0.39, 0.49, and 0.57, respectively). For each model, the baseline symptoms score was strongly and positively predictive of the score at the four-month follow-up. The stressful writing condition, compared with the neutral writing control condition, did not show significantly greater reductions of symptoms of depression, PTSD or pain as main effects in the overall sample. However, writing condition significantly ($p=0.05$) interacted with depression in the predicted direction. Women who were more depressed at baseline demonstrated significantly greater decreases in	**Limitations identified by author:** Sample was predominantly White/European American, fairly well educated and on average had no or few children - limits generalisability. Small sample size. Low statistical power. Cannot generalize these results to women who continue to stay in the abusive relationship. Short length of intervention **Limitations identified by review team:** Self-report measures subject to bias **Evidence gaps and/or recommendations for future research**: Examine the long-term benefits of the written narrative intervention. Determine impact of longer or a greater number of writing sessions. Analyse the content writings depending on the women's baseline status and type of writing instructions to consider how the content of women's writing might lead to different effects for subgroups of women. Explore the impact of

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Quality score: [+] **External validity:** [+]	Middle Eastern, 6% African American; *Employment:* 43% employed full time, 21% part time, 36 % not employed; *Children:* 60% no children, 32% one or two children, 8% three or more children; *Sexual orientation:* 83% heterosexual, 4% lesbian, 9% bisexual; *Income:* 60% had household income <US$40,000 **Setting:** NR	as possible.' **Sample size(s):** Total n=47; Intervention n=25; Control n=22 **Baseline comparisons:** 28% of the women in the expressive writing group were married, compared to 9% of the neutral writing group. Women in the expressive writing group had significantly higher (p=0.01) education (mean=16.8 years, SD=3.0) compared with the control group (mean=14.8 years, SD=1.9). **Study sufficiently powered:** NR	interaction of the baseline continuous score with the experimental condition.		depression when they were assigned to the experimental stressful writing condition compared to the neutral writing condition. **Secondary outcomes:** N/A **Attrition details:** 20% drop-out rate (originally 59 participants). No significant differences were found between those completing the study and those not completing the study.	expressive writing in reducing symptoms of survivors of other kinds of traumatic events. Collect detailed data about previous and current experiences with psychotherapy and medication to determine whether these factors affect the influence of expressive writing in reducing distress and pain **Source of funding:** Drs. Bala Manian and Tasneem Ismailji

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Laughon, K., Sutherland, M. A., & Parker, B. J. **Year:** 2011 **Citation:** A brief intervention for prevention of sexually transmitted infection among battered women. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 40*(6), 702-708. **Country of study:** USA **Aim of study:** To test the feasibility and acceptability of a combined brief nursing intervention to prevent STIs, including HIV, and reduce IPV among rural female family planning clients in central Virginia in preparation for a longer, more rigorous study **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Women attending two rural family planning clinics **Eligible population(s):** English speaking, age 18 or older, screening positive for IPV in the past year **Selected population(s):** 19 women met the criteria **Excluded population(s):** NR **Sample characteristics:** *Ethnicity*: 26% African American, 68% White; *Mean age (SD):* 28 (9); E*ducation*: 28% <high school, 72% high school or higher **Setting:** Rural health department family planning clinic	**Method of allocation:** N/A **Intervention(s) description:** In a private room, a PhD nurse or a doctoral student who was a nurse practitioner (both with extensive clinical experience) conducted a 10 minute one-on-one educational intervention from the March of Dimes. The IPV components were: IPV information delivered with a brochure, danger assessment and consciousness raising, safety planning & options discussion and a list of resources. The STI/HIV prevention component consisted ofSTI/HIV information, safer sex options, and STI/HIV safety planning. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=18 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** Changes in the *Severity of Violence Against Women Scales (SVAWS)* for threats, physical violence, and sexual violence. The *Safety Behaviour Checklist* was used to measure safety behaviours. Safer sex strategies were measured using the *STI Protective Behaviours Checklist*. **Secondary outcomes:** NR **Follow up periods:** 3 months **Methods of analysis:** Wilcoxon sign-rank tests were used to assess changes in: total score on the SVAWS, subscale scores for SVAWS-threats, SVAWS-physical violence, and SVAWS-sexual violence, IPV safety behaviours, and safer sex	**Who is the target of the intervention?** Rural women **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Frequency and severity of violence decreased from baseline to the 3 months follow-up. There was a statistically significant decrease in the subscales of physical violence (p=0.02), threats of violence (p=0.04), and sexual violence (p=0.05). Women also increased the number of attempted safety behaviours and safer sex strategies, but the difference between baseline and 3 months was not statistically significant. **Secondary outcomes:** N/A **Attrition details:** 1 woman consented to the study but was unable to complete it at that time, so was lost to follow-up	**Limitations identified by author:** No control group. Small sample size precludes generalization to clinical populations of women experiencing IPV **Limitations identified by review team:** Very low education sample for an education-based intervention. No report of participation rate **Evidence gaps and/or recommendations for future research**: This study needs to be replicated as a randomized clinical trial with a larger sample size, a control group, and longer follow-up period. **Source of funding:** NR

Appendix O

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): McWhirter, P. T. **Year:** 2006 **Citation:** Community therapeutic intervention for women healing from trauma. *The Journal for Specialists in Group Work, 31*(4), 339-351. **Country of study:** USA **Aim of study:** To pilot test a group intervention for women in housing transition who are vulnerable to abuse **Study design:** Non-randomized controlled trial **Quality score:** [+] **External**	**Source population(s):** Women in family transition housing **Eligible population(s):** NR - appears to be women presenting at a transition housing programme **Selected population(s):** All participants were selected because of their recent experiences with major life transitions **Excluded population(s):** Those who did not complete the minimum number of group sessions **Sample characteristics:** Intervention: *Education:* 30% less than high school, 38% high school, 27% some college, 6% no response; *Ethnicity:* 51% Caucasian, 27% Latina,13.5% African American, 8% Native American; *Median age:* 32 (majority between 24-45). Comparison: *Education*: 9.5% high school, 35.5% some college, 26% college graduates, 29% graduate degree; *Ethnicity:* 90% Caucasian, 6.5% African American, 3% Latina; *Median age:* 51 (majority between 45-54)	**Method of allocation:** Comparison group treatment selected based on participant population **Intervention(s) description:** Groups of 8-11 women were facilitated by a certified professional counsellor with training in DV and substance abuse. Childcare was provided. Sessions were 90 minutes weekly for 5 weeks structured on cognitive-behavioural and Gestalt techniques. The five session curriculum covered: exploring personal belief systems, especially concerning difficult experiences; understanding the various forms of abuse; understanding and expressing feelings; recognizing healthy relationships; and finding healthy ways to cope with stress. **Control/comparison(s) description:** Comparison was a not-for-profit employee mentoring organization available to women experiencing a major life transition, focused on employment and social stability, but which did not offer opportunities for participation in any therapeutic group interventions. Women were assigned a mentor, with weekly email or phone contact, and 2 face-to-face sessions. They were also provided job skills training, resume writing, job interviewing	**Primary outcomes:** Intervention measurements were taken at week 1 and week 5 (end of treatment). Surveys were completed in 20-40 minutes. Surveys were mailed to the comparison group three days prior to week 1 and week 5. The authors used the *Quality of Social Support Scale*, a self-efficacy scale produced for the study, the *Family Economic Pressure Scale*, and the *Family Attachment Scale* of the *Student Survey of Risk and Protective Factors*. **Secondary outcomes:** NR **Follow up periods:** Post-treatment **Methods of analysis:** 2 (treatment) x 2 (time) repeated measures ANOVAs	**Who is the target of the intervention?** Women in family transition housing **Did they conduct any aspect of sex, gender or diversity analysis?** They checked ethnic baseline differences, and reported no difference in study measures by ethnicity **Do they report sex, gender or diversity based factors in findings?** Authors report no significant differences in outcomes by ethnicity **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The comparison group had significantly more improvement in social support ($p<0.05$). The intervention group had significantly more improvement in self-efficacy ($p<0.05$). There were no significant treatment effects for financial stress, family conflict, or family bonding **Secondary outcomes:** N/A **Attrition details:** In the intervention group, 6 left shelter, and 3 did not complete the minimum number of group sessions. Total inclusion rate was 77.5%	**Limitations identified by author:** Non-equivalent comparison group. No previous validity or reliability data were available for the self-efficacy measure used in this study. **Limitations identified by review team:** No report of recruiting participation. Non-equivalent drop-out rates between intervention and comparison groups **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** State of Arizona's Governor's Innovative Prevention Grant

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
validity: [+]	**Setting:** Transitional housing	role-play, and consultation on appropriate professional attire, if requested. **Sample sizes:** Total n=68; Intervention n=37; Comparison group n=31 **Baseline comparisons:** The comparison group was significantly more educated, older, and had a different ethnic composition. The authors state that ethnicity had no significant impact on study variables. **Study sufficiently powered:** NR				

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): McWhirter, P.T. **Year:** 2011 **Citation:** Differential therapeutic outcomes of community-based group interventions for women and children exposed to intimate partner violence. *Journal of Interpersonal Violence, 26*(12), 2457-2482. **Country of study:** USA **Aim of study:** To assess the clinical effectiveness of two community-based treatments to reduce family violence and increase psychosocial well-being of women and children previously exposed to IPV through addressing posttraumatic coping strategies	**Source population(s):** Women and children in temporary family homeless shelter **Eligible population(s):** Women who had experienced IPV within the past 12 months AND had children aged 6-12 who had witnessed IPV **Selected population(s):** Women with a score of 15 or higher on the Hurt-Insult-Threaten-Scream (HITS) scale **Excluded population(s):** NR **Sample characteristics:** *Violence history:* 89% physical, 80% emotional, 89% financial; *Education*: 35% <high school, 30% high school, 35% some college, 2% college graduate; *Ethnicity*: 47% White, 20% Latino, 16% African American, 11%	**Method of allocation:** Computer generated randomization list. Code was used to keep the project manager who allocated women into the two conditions blinded. Participants were blinded during the study. **Intervention(s) description:** There were two interventions: emotion-focused and goal-focused. Both interventions had 60-minute sessions for women only (4-5 participants), with concurrent 45-minute sessions for children, followed by 60 minutes conjoint therapy with women and their children (8-10 participants). Groups were held weekly for 5 weeks. The goal-oriented intervention was a cognitive behavioural approach with motivational interviewing and the transtheoretical model, and participants chose a goal in relational, personal, or functional areas. The children's goal intervention utilized art activities and visual aids to help them select goals they wanted to achieve (e.g. fighting less with siblings, completing their homework). The emotion-focused women's group was comprised of behavioural and gestalt therapeutic interventions, with a focus on: exploring personal belief systems, understanding the various forms of abuse, understanding and expressing feelings, recognizing healthy relationships, and finding healthy ways to cope with stress. The emotion-focused children's group placed emphasis on emotional awareness and expression, with activities and discussion centered on dealing with stress and strong emotions, dealing with family and peer pressure, identifying and making good friends, and handling interpersonal and familial conflict. The joint mother-child sessions built on the themes initially presented during the separate women's and children's groups.	**Primary outcomes:** For women, the *Student Survey of Risk and Protective Factors* was used to measure family conflict and family bonding, and the *Quality of Social Support Scale* to assess quality of social support. Other measures were the *Centre for Epidemiological Studies Depression Scale, Generalized Self-Efficacy Scale,* and *Readiness to Change/Confidence Ruler*. Self-efficacy for discontinuing alcohol use was measured. **Secondary outcomes:** For children, measures were: a visual graph emotional barometer (faces), and child self-report of peer and family conflict, and self-esteem **Follow up periods:** Post-treatment **Methods of analysis:** ITT reported. Repeated measures ANOVAs	**Who is the target of the intervention?** Women with children exposed to IPV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** There were significant improvements ($p<0.05$) in depression, family bonding, self-efficacy, readiness to decrease violence, readiness for therapeutic change, and facilitators' report of readiness to change. Women in the goal-oriented group had greater decreases in family conflict ($p<0.05$), whereas women in the emotion-oriented group had greater increases in quality of social support ($p<0.05$). **Secondary outcomes:** Children's outcomes: Both groups had significant improvement ($p<0.05$) for emotional well-being, peer conflict, family conflict, and self-esteem. **Attrition details:** 1 participant in the emotion-focused group and 3 in the goal-oriented group dropped out of the study because they	**Limitations identified by author:** NR **Limitations identified by review team:** No follow-up period to see if gains were maintained **Evidence gaps and/or recommendations for future research**: Further development and research is needed on effective practice-based community interventions designed to better meet the needs of this high-risk population. **Source of funding:** State of Arizona Governor's Innovative Prevention Grant

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Study design: Randomized controlled trial **Quality score:** [+] **External validity:** [++]	Native, 2% Asian American; *Mean age*: 30, range=18-47 **Setting:** Urban women's shelters	**Control/comparison(s) description:** See above **Sample size(s):** Women n=46 (22 in the emotion-focused group, 24 in the goal-oriented group); Children n=48 **Baseline comparisons:** No significant differences were found at pre-treatment between the two groups. **Study sufficiently powered:** Sample size was determined a priori based on the number of groups employed (2), expected effect size (large), preferred power (0.95), and alpha level			were relocated to a permanent living situation	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Miller, E., Decker, M. R., McCauley, H. L., Tancredi, D. J., Levenson, R. R., Waldman, J., Schoenwald, P., & Silverman, J. G. **Year:** 2011 **Citation:** A family planning clinic partner violence intervention to reduce risk associated with reproductive coercion. *Contraception, 83*(3), 274-280. **Country of study:** USA **Aim of study:** To determine whether an intervention administered in clinic settings would reduce effects of IPV and reproductive coercion and convince women to leave abusive relationships **Study design:** Randomized	**Source population(s):** Abused women in Northern California **Eligible population(s):** Women attending 4 urban family planning clinics in Northern California **Selected population(s):** English and Spanish-speaking women, ages 16 to 29, who completed at least 3 surveys over a 24-week period of study follow-up and evaluation **Excluded population(s):** NR **Sample characteristics:** *Age 24 or younger:* 76%; *Ethnicity:* Majority self-identified as non-white **Setting:** Urban	**Method of allocation:** The 4 clinics were randomized into either intervention or control **Intervention(s) description:** The intervention, collectively designed by a team of counsellors, clinic professionals, and paraprofessionals, consisted of improved IPV screening focused on teaching clients about reproductive coercion, the multiple forms of IPV and how these affect sexual and reproductive health, timing of pregnancy, and contraceptive choices. Participants were taught how to develop and identify harm-reduction behaviours, and with clinic staff, participants would contact resources or services while attending the clinic. **Control/comparison(s) description:** The control arm consisted of women undergoing usual care, which involved responding to 2 violence-screening questions. If participants' responses were positive for IPV, clinic staff documented the IPV in the client's record, filed mandatory reports, and provided the woman with a list of counselling services and resources. **Sample size(s):** Total n=906 **Baseline comparisons:**	**Primary outcomes:** The *Revised Conflict Tactic Scales* measured the intensity of IPV. Reliability ranges from 0.79 to 0.95. The study also used the *Sexual Experiences Survey;* its reliability and validity was originally assessed by using college students in the 1980s ($r=0.73$, $p<0.001$). The authors amended both surveys to further assess pregnancy coercion and contraceptive sabotage. **Secondary outcomes:** NR **Follow up periods:** 24 weeks **Methods of analysis:** ITT analysis was conducted. Logistic regression determined effects of the intervention on pregnancy coercion, contraceptive sabotage, and awareness and use of IPV services. Baseline report of the outcome (IPV) as predictor enabled researchers to adjust for clinic effects (intervention vs control)	**Who is the target of the intervention?** Women in abusive relationships experiencing reproductive coercion **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Among women reporting IPV within the previous 3 months, women in the intervention clinics showed a 71% reduction in the odds of pregnancy coercion when compared with women in the control clinics (AOR=0.29, 95% CI: 0.09-0.91). Among women who did not report IPV within the previous 3 months, the intervention was not associated with any significant changes in reports of pregnancy coercion. Awareness of IPV services and reports of their use increased in both groups, although there were no differences between them. When changes in relationship status were analysed across the total sample, more women in the intervention arm reported that they stopped dating a man within the previous 3 months because the relationship was perceived as unsafe (AOR=1.63, 95% CI:	**Limitations identified by author:** Small number of clinics and participants. Little discussion about the reliability and validity qualities of the two instruments used or why they were selected. Short follow-up period. **Limitations identified by review team:** Modifying psychometric instruments can result in lowered validity of instrument **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
controlled trial **Quality score:** [+] **External validity:** [+]		Baseline findings for groups from intervention and control clinics were similar when IPV, pregnancy coercion, and contraceptive sabotage were reported. The percent of Hispanic/Latina participants was higher in the intervention clinics, whereas the control clinics had higher proportions of African American participants. **Study sufficiently powered:** NR	on IPV that were sustained over time (clinics served as the unit of randomization).		1.01-2.63). **Secondary outcomes:** N/A **Attrition details:** Overall participation rate of 75% (25% lost to follow-up). No differences were noted between participants and those who did not complete the study.	

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Morales-Campos, D. Y., Casillas, M., & McCurdy, S. A. **Year:** 2009 **Citation:** From isolation to connection: Understanding a support group for Hispanic women living with gender-based violence in Houston, Texas. *Journal of Immigrant Minority Health, 11*, 57-65. **Country of study:** USA **Quality score:** [+]	**What was/were the research question(s)?** What were participants' experiences of the La Rosa Family Services (a community-based organization (CBO)) support group for immigrant Hispanic women? **Theoretical approach:** NR **How were the data collected?** Data was collected via archival research, oral interviews, and participant observation. Archival research consisted of examining the CBO's internal documents relating to its history, its philosophy and practices, and intake records. The first author observed five support group sessions over a period of two months to understand the process that takes place in the support groups, to become familiar with the interactions between the providers and clients, and to determine the range of	**What population was the sample recruited from? How were they recruited?** The programme served immigrant Hispanic women in the Houston, Texas area. Women were recruited using both fliers and oral invitations given by CBO staff at various support group sessions. **How many participants were recruited?** 30 **Inclusion and exclusion criteria:** Inclusion criteria for interviews: being 18 years old or older, seeking assistance for violence or abuse from January 1995 until August 2005 at the CBO, speaking English or Spanish **Population demographics:** *Race:* 90% Mexican/Mexican American, 3% Central American, 3% South American, 3% other; *Mean age:* 41, range=25-71; *Marital status:* 50% married,	**Description of intervention(s):** Approximately 20–25 women attended each support group during a week. All support groups were conducted in Spanish by a psychologist from Mexico. No other details provided **Intervention setting:** Community organization support group	**Method and process of analysis:** Interviews were transcribed verbatim and ATLAS.ti was used for the qualitative data analysis. The research team independently coded transcripts and met regularly to discuss emerging themes and coding options. The team resolved disagreements by reviewing the transcripts together, tracking down the source of disputes, and discussing them until consensus was reached. Researchers met weekly to reconcile code lists and merge those codes that were deemed to be similar enough in meaning. To transition from coding the textual to the conceptual level, authors created networks of those codes (concepts) and their relationship to each other. **Key themes relevant to this review:** The support group fostered a sense of community among group members through the sharing of stories, which aided in healing and provided members with support: "They give me emotional support that sometimes you can't even find in your own family", "…[S]timulating the new women who come into the group. They can find out how we have progressed and how we can speak with such certainty. It encourages them to one day feel good or better than us". Many women also learned by listening to the responses from the counsellor and the advice from other group	**Did they conduct any aspect of sex, gender or diversity analysis?** No. The sample consisted entirely of Hispanic women, so there was no variability in terms of sex or gender. **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Hispanic women experiencing gender-based violence and/or abuse	**Limitations identified by author:** Limited size and scope of the study. Recruitment efforts were limited to women from the current support groups (which may have introduced bias) that contained new and older participants at different stages in the healing process. Information on the immigration status of the women attending the support group was not collected, so it cannot be determined whether documented women attended support groups more than undocumented women or vice versa. The sample of women interviewed may not be representative of Hispanic immigrant women in other parts of the country. **Limitations identified by review team:** Very limited description of the intervention itself. No interview protocol provided. Reported findings are quite broad and don't speak directly to DV. **Evidence gaps and/or recommendations for**

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
	issues that are addressed in the support group. The first author conducted individual interviews which included open-ended questions about women's experiences of violence and experiences at the CBO and with its support group. The interviews were conducted in an office at the CBO and in the participant's language of choice (English or Spanish). Participants received a five dollar ($5.00) incentive as compensation. All interviews were tape-recorded and ranged in length from 40 to 140 min.	20% separated, 20% divorced, 7% common law, 3% single; *Immigration status:* 43% US citizens, 30% residents, 27% undocumented immigrants; *Mean # of years in the US:* 37, range=3-46; *Range of months in the support group:* 2-96		members: "If someone tells you something, then they are doing it for your good or giving you advice or an idea that you could use….We're a group where we're all united, we're in the same situations, and everything we talk about or tell you is to help you". The women also talked about learning coping tools and life lessons which assisted them in dealing with life stressors and feeling more confident about themselves: "[The support group] has also helped me with my children. First, if we're going to talk, but I'm very upset I've learned that I need to calm down...", "I learned to better recognize my values as a woman, as a human being. And I learned that there is an enormous potential within each of us and we only need to find a way to reach it and keep it developing". There was also mention of learning to become less dependent on one's partner: "You have to prepare yourself, to do something for yourself, so as not to depend so much on the husband, because sometimes they take advantage of this. You have to prepare yourself so that you can depend more on yourself in case something does happen."		**future research:** Future research could look into whether support groups are an effective strategy for gender-based violence prevention (particularly in Hispanics), why women drop out of support groups, determining effective methods for recruiting and retaining women, determining the impact of immigration status on women's experiences in the group, evaluating existing support groups, and determining whether women actually change their lives as a result of their participation. **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Poole, N., Greaves, L., Jategaonkar, N., McCullough, L., & Chabot, C. **Year:** 2008 **Citation:** Substance use by women using domestic violence shelters. *Substance Use & Misuse, 43*(8), 1129-1150. **Country of study:** Canada **Aim of study:** To explore the relationships between the use of alcohol and other substances, using-to-cope behaviour, and levels of stress in substance-using women who temporarily resided in a DV shelter. The impact of the alcohol/substance use interventions available in the shelters was also considered. **Study design:** Before and after study **Quality score:** [+] **External validity:** [++]	**Source population(s):** Shelters: The British Columbia and Yukon Society of Transition Houses (BCYSTH) is a non-profit association of over 60 DV shelters and other organizations that serve the needs of abused women and their children. Women: Entering a provincial DV shelter (n=13) between Oct 2002-June 2003 **Eligible population(s):** Shelters: Of the shelters that expressed interest, the research team selected 13 based on the estimated number of women with alcohol and substance-use-related issues who enter the shelter per year, the urban/rural status of the shelter, and the substance use policy of the service. Women who self-reported use of one substance (excluding nicotine) 5 or more times a week, used multiple substances at least once a month, identified as having a current problem **Selected population(s):** NR	**Method of allocation:** N/A **Intervention(s) description:** Participants were recruited from 13 different shelters and interventions were not standardized across the sites. The authors report that intensity of substance programming did not have an impact on the rates of reduction. **Control/comparison(s) description:** N/A **Sample size(s):** Completed in-shelter interview n=125; Completed 3 months post-exit interview n=74 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** The *Brief Michigan Alcohol Screening Test (BMAST)* measured various drinking-related behaviours and issues; The *Drinking Motives Questionnaire (DMQ*) assessed how often respondents drink to manage or cope with negative emotions, to maintain or enhance positive affective states, or to achieve certain social goals. On the *Timeline Followback Calendar (TLFB)* participants recorded their use of alcohol and other substances during the 3 months preceding the Time 1 interview and the 3 months preceding the Time 2 interview. The *Index of Spouse Abuse (ISA*) identified abusive actions inflicted on a woman by her spouse or partner. **Secondary outcomes:** Stress was measured by the *Stressors Questionnaire (SQ)*; participants indicated how much stress they experienced in different areas of their life (e.g., housing, relationships with partner)	**Who is the target of the intervention?** Women entering DV shelters **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Yes, that was the primary outcome of the study.	**Primary outcomes:** No relationship was found between the severity of abuse and the likelihood of a BMAST score that "indicates alcoholism." Significant decreases in motivations for drinking were observed between Time 1 and 2 for all three subscales ($p<0.001$), with the largest decrease occurring in the Coping motives. Tobacco use remained consistent (77% at intake to 73% at follow-up, $p=0.251$). Alcohol use (mean days>3 drinks) decreased significantly (from 15.75 to 4.42, $p=0.003$). Stimulant use decreased significantly (20% days of use to 4%, $p<0.001$). Depressants did not show a significant decrease (19% days of use to 13%, $p=0.493$). Medical depressants did not decrease significantly (18% days of use to 15%, $p=0.345$). **Secondary outcomes:** At Time 1, the most common factors causing "great stress" were money issues (82%), relationship with partner (73%), and housing (65%). At Time 2, the most common factors were money issues (66%),	**Limitations identified by author:** Small percent of eligible women participated, high attrition rate **Limitations identified by review team:** Potential for self-selection bias **Evidence gaps and/or recommendations for future research**: Future studies of substance use and experiences of DV will need to address social and structural factors in greater detail. An extended period of follow-up will help to determine whether the observed changes are sustained among women over a longer period following the shelter stay. **Source of funding:** Alcoholic Beverage Medical Research Foundation

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Excluded population(s): Shelters that had policies that refused access to women who use substances **Sample characteristics:** *Education:* 33% completed high school; *Social assistance:* 49%; *Income:* 82% less than $20,000; *Race:* 62% White, 24% First Nations; *Sexual orientation*: 88% heterosexual; *Children:* 88%*; Partner status:* 49% single **Setting:** Urban and rural DV shelters		**Follow up periods:** 3 months **Methods of analysis:** Paired samples t-tests were conducted to compare participants' level of alcohol and other substance use at Time 1 and 2. To examine any variation due to the level of alcohol intervention at the shelter, data were stratified as "significant intervention" or "no/minimal intervention" and the paired samples t-tests were conducted again.		housing (43%), and legal issues (42%). Level of stress significantly decreased for: relationship-with-partner ($p<0.001$), mental health ($p=0.001$), legal issues ($p=0.002$), housing ($p=0.012$), and physical health ($p=0.021$). No significant decrease was observed in stress caused by relationship with parents, relationship with children, or money issues. **Attrition details:** There was a 59% follow-up rate.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Price, P., Rajagopalan, V., Langeland, G., & Donaghy, P. **Year:** 2008 **Citation:** *Domestic Violence Intervention Project: Improving Women and Children's Safety.* **Country of study:** UK **Aim of study:** To present the service outcomes of the first 18 months of the project **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Female victims of DV in the London Boroughs of Barking & Dagenham, Newham and Waltham Forest **Eligible population(s):** Female partners of men in the Domestic Violence Intervention Project (DVIP) **Selected population(s):** NR **Excluded population(s):** NR **Sample characteristics:** NR **Setting:** Urban. children's centre or social work centre	**Method of allocation:** N/A **Intervention(s) description:** The DVIP contacted by letter (with an information pack) the women partners of men referred to the programme. Following this, proactive contact was made and a range of interventions was offered, including: one-to-one and structured group programmes, on-going telephone work and outreach meetings arranged at the children's centers or social work offices. The programme conducted safety planning, addressed mental health issues, provided education on DV, promoted realistic expectations about their partner, and promoted women's empowerment. The average number of contacts per woman was 4.7 in Newham, 5.6 in Barking & Dagenham, and 6 in Waltham Forest. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=98 women, 23 of whom attended the group programme. 47 questionnaires were received over 3, 6, and 18 month follow-up. **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** Women's self-report survey (no details in the study) and caseworker assessments of women's and children's safety **Secondary outcomes:** Findings related to the abusers' intervention are reported in the evidence table in the Abusers section **Follow up periods:** 3, 6, and 18 months for the women's questionnaire **Methods of analysis:** Descriptive statistics	**Who is the target of the intervention?** Female partners of male DV perpetrators **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** 88% of referring social workers assessed the woman as 'much safer' or 'safer', and 78% of referring social workers assessed the children as 'much safer' or 'safer' after engagement with the DVIP. From the women's feedback, 65% reported feeling safer or much safer, and 35% said it was the same. 69% assessed their children's level of safety as safer or much safer, and 31% said it was the same. 93% reported their quality of life as much improved or improved, and 7% said it was the same. **Secondary outcomes:** Findings related to the abusers' intervention are reported in the evidence table in the Abusers section **Attrition details:** NR	**Limitations identified by author:** Response rate. Measures used **Limitations identified by review team:** Survey instrument not described. Self-report bias **Evidence gaps and/or recommendations for future research:** Further, fully-resourced longitudinal study of the project's outcomes is needed. **Source of funding:** NR

Appendix O

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Rasmussen, L. A., Hughes, M. J., & Murray, C. A. **Year:** 2008 **Citation:** Applying motivational interviewing in a domestic violence shelter: A pilot study evaluating the training of shelter staff. *Journal of Aggression, Maltreatment & Trauma, 17*(3), 296-317. **Country of study:** USA **Aim of study:** To evaluate the effectiveness of motivational interviewing (MI) to enhance outcomes of regular treatment services **Study design:** Non-randomized controlled trial **Quality score:** [+] **External validity:** [+]	**Source population(s):** Women seeking services at a domestic shelter **Eligible population(s):** Had been in shelter for at least 48 hours **Selected population(s):** Convenience sample **Excluded population(s):** NR **Sample characteristics:** Control: *Mean age (SD):* 36.8 (9.3); *Race:* 50% Caucasian, 30% Latina*; Marital status:* 78% married*; Relationship with batterer:* 70% spouse; *Education:* 55% diploma; *Employed:* 10%; *Left relationship:* 78%. Intervention: *Mean age (SD):* 37.3 (10.2); *Race:* 40% Caucasian, 40% Latina*; Marital status:* 50% married*; Relationship with batterer:* 50% spouse; *Education:* 50% diploma; *Employed:* 30%; *Left relationship:* 33% **Setting:** Urban shelter	**Method of allocation:** The control group was conducted prior to counsellors receiving MI training. All control group participants had left the shelter before the intervention group was treated. **Intervention(s) description:** The counsellors conducted regular treatment with the control group. After all the control participants had completed treatment and left the shelter, the counsellors were trained in MI and conducted the intervention. MI is both client-centred and problem focused and it helps clients identify differences between their stated goals and current behaviour, increase their self-efficacy, and take the necessary steps to make and maintain behavioural changes. **Control/comparison(s) description:** Regular treatment: individual counselling once a week for 4 weeks (duration not reported) **Sample size(s):** Total n=20; Intervention n=10; Control n=10 **Baseline comparisons:** NR **Study sufficiently powered:** NR	**Primary outcomes:** The study used the *University of Rhode Island Change Assessment Scale (URICA)*, a 32-item self-reported measure to assess participants' readiness for change. It consists of four subscales: pre-contemplation, contemplation, action, and maintenance. **Secondary outcomes:** The *Process of Change in Abused Women Scales (PROCAWS)* was used to measure readiness to change, cognitive discrepancy, and perceived self-efficacy. It has 51 self-report items. It is a new and unvalidated tool. **Follow up periods:** Post-intervention **Methods of analysis:** Fisher's Exact test and the Mann-Whitney test were used.	**Who is the target of the intervention?** DV shelter residents **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Fisher's exact test indicated intervention participants were significantly more motivated for change at post-test (p=0.029). A Mann-Whitney test found no significant differences. Five in the control group actually regressed in readiness to change; nine in the intervention group improved, and one regressed. **Secondary outcomes:** There were no significant differences between groups on the PROCAWS. **Attrition details:** 39 were recruited. 2 declined to participate. 17 dropped out of the study (9 did not complete pre-test, 8 did not complete post-test) and were excluded.	**Limitations identified by author:** Small sample size. Data collected at different points in time for control vs. intervention group. Use of unvalidated tools lacking normative data. Lack of bilingual versions of tools. **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Need for a larger sample size, more diverse sample, and randomization to groups. Testing of long-term sustainability of change **Source of funding:** Dean's Research Award of the College of Health and Human Services at San Diego State University

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Reed, G. L. & Enright, R.D. **Year:** 2006 **Citation:** The effects of forgiveness therapy on depression, anxiety, and posttraumatic stress for women after spousal emotional abuse. *Journal of Consulting and Clinical Psychology, 74*(5), 920-929. **Country of study:** USA **Aim of study:** To determine if individuals who participated in Forgiveness Therapy (FT) would demonstrate less depression, anxiety, and posttraumatic stress symptoms and more self-esteem, environmental mastery, and finding meaning in suffering than those who engaged in the more standard therapeutic procedure which does not directly target the amelioration of this resentment	**Source population(s):** Psychologically abused women in a Midwest city **Eligible population(s):** Must have been divorced or permanently separated at least 2 years from an emotionally abusive spouse or romantic partner **Selected population(s):** Score of 41 or higher on Psychological Abuse Survey **Excluded population(s):** Currently in abusive relationship. History of childhood physical abuse. Psychiatric illness such as psychosis or suicidal ideation **Sample characteristics:** *Mean age (SD):* 44.95 (7.01); *Race:* 90% Caucasian; *Education:* 20% high school, 30% some college, 20% college degree; *Employment:* 15%	**Method of allocation:** Yoked pairs were matched for age, duration of abusive relationship, time since separation, and then one individual from each pair was randomly assigned to the intervention and the other to the comparison group. **Intervention(s) description:** 1-hour weekly individual sessions using the Enright forgiveness process model and a manualized protocol. Mean treatment time across the intervention and control groups was 7.95 months (SD=2.61, range=5-12 months). Only one counsellor delivered both intervention and comparison treatments. Sessions covered: forgiveness, psychological defenses, anger, shame and self-blame, cognitive rehearsal, commitment to forgiving, grieving the pain and losses, reframing the former abusive partner, empathy and compassion, practicing goodwill, finding meaning in unjust suffering, and considering a new purpose in life of helping others. Therapy was terminated when each participant reported that she had completed the work of forgiving her former partner. **Control/comparison(s) description:** Weekly 1-hour individual participant led discussion of current life concerns impacted by prior abuse. Matched for time with intervention pair. Treatment was manualized and worked with anger validation, assertiveness strategies,	**Primary outcomes:** The outcome instruments were: *Psychological Abuse Survey, Enright Forgiveness Inventory, Coopersmith Self-Esteem Inventory, State-Trait Anxiety Inventory, Beck Depression Inventory–II, Environmental Mastery Scale, Finding Meaning in Suffering, PTSS checklist,* and story measures, which asked participants to describe their current perspective on the role that spousal psychological abuse had in her life story. **Secondary outcomes:** NR **Follow up periods:** Mean=8.35 months (SD 1.53) **Methods of analysis:** Matched pair t-tests	**Who is the target of the intervention?** Women who have experienced spousal abuse **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Pre-test to post-test, intervention participants had significantly improved on all measures except state anxiety ($p<0.05$ for self-esteem, trait anxiety, depression, environmental mastery, finding meaning, PTSS; $p<0.01$ for new story, and $p<0.001$ for new story and forgiveness). Intervention pre-test to follow-up had $p<0.05$ for within-group improvements in self-esteem, state anxiety, and trait anxiety. Forgiveness gains had a large effect size (Cohen's effect=1.79). Post-test gains were retained at follow-up. **Secondary outcomes:** N/A **Attrition details:** No drop outs	**Limitations identified by author:** Self-selection of volunteers. Lack of ethnic diversity. Stringent exclusion criteria. Having only one intervener in the study may mean findings may be due partially to an intervener effect. **Limitations identified by review team:** High education level of participants. Low IRR on story measures (76%). Highly intensive intervention and comparison treatments **Evidence gaps and/or recommendations for future research**: It would be helpful to test the efficacy of FT with respect to other recovery strategies for traumatic relationships. FT research should also explore how the benefits of FT transfer from the forgiver through emotional regulation and goodwill to a larger

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Study design: Randomized controlled trial **Quality score:** [+] **External validity:** [+]	unemployed, 25% part-time employment, 60% full-time employment; *Mean time since separation (SD):* 5.00 (2.61), range=2-10 years **Setting:** Urban	and interpersonal skills. **Sample size(s):** Total n=20; Intervention n=10; Control n=10 **Baseline comparisons:** NR **Study sufficiently powered:** A power calculation was conducted. To achieve power of 0.80 to detect an effect size of 1.2, a sample of 24 was needed.				circle of personal relationships. **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Resick, P. A., Galovski, T. E., Uhlmansiek, M. O., Scher, C. D., Clum, G. A., & Young-Xu, Y. **Year:** 2008 **Citation:** A randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. *Journal of Consulting and Clinical Psychology, 76*(2), 243–258. **Country of study:** USA **Aim of study:** To examine the components of Cognitive Process Therapy, singly and compared with the full protocol; To determine when change occurs during the course of treatment and examine the effects of the three therapy conditions on depression, anger,	**Source population(s):** Women recruited from an urban area **Eligible population(s):** Women who experienced sexual or physical assault in childhood or adulthood, met criteria for PTSD, were abstinent from substance use for at least 6 months (for those with current substance dependence), and were at least 3 months post trauma **Selected population(s):** Eligible women who agreed to participate **Excluded population(s):** Illiteracy, current psychosis, suicidal intent, or dependence upon drugs or alcohol. Participants could not be in a currently abusive relationship or being stalked **Sample characteristics:**	**Method of allocation:** Randomized by data manager **Intervention(s) description:** Delivered by 8 master or doctoral level clinicians in clinical psychology. Each therapist delivered all 3 interventions: Full Cognitive Process Therapy (CPT), Cognitive Therapy component only (CPT-C), and Written Account only (WA). All groups had 12 hours of therapy time, though they were delivered slightly differently. CPT and CPT-C consisted of twelve 60-minute sessions held twice a week. The WA group had two 1-hour sessions in the first week, and then had five 2-hour weekly sessions. CPT sessions included education, writing a detailed account of a traumatic incident at home, cognitive therapy with Socratic questioning, re-writing incidents, competing worksheets, confronting beliefs. CPT-C was the same but with the WA component replaced with event-though-emotion worksheets. The WA group did their writing in-session (rather than at home, as the CPT and CPT-C	**Primary outcomes:** The *Clinician-Administered PTSD Scale (CAPS)* was used to assess DSM–IV PTSD diagnosis and PTSD symptom severity. CAPS diagnoses and symptom severity scores have demonstrated reliability and validity. Cronbach's alpha on CAPS total score for this study was 0.91. The *Structured Clinical Interview for DSM–IV Axis I Disorder (SCID)* is a semi structured interview designed to assess the presence of DSM–IV Axis I disorders. The *Sexual Abuse Exposure Questionnaire (SAEQ)* assessed child sexual abuse, and has demonstrated reliability and validity in a treatment-seeking sample, including 2-week test-retest reliability ranging from 0.73 to 0.93. The *Physical Punishment Scale of the Assessing Environments-III (*AE-III-PP) was used to assess childhood physical abuse; it has demonstrated reliability and validity, including acceptable test-retest reliability over a 2-month period. The *Physical Assault Scale of the Revised Conflict Tactics Scales* was used to assess adult physical assault victimization. It has demonstrated reliability and validity, including internal consistency of 0.86. **Secondary outcomes:** Other outcome measures that were used were: *Beck Depression Inventory (BDI), The Experience of Shame*	**Who is the target of the intervention?** Women with trauma history experiencing PTSD **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** PTSD at 6 months: 40% CPT, 44% WA, and 38% CPT-C. CAPS rates for PTSD at 6 months: 26% CPT, 27% WA, and 21% CPT-C. For SCID, no significant differences. CAPS scores decreased significantly over time but no significant differences. For ITT, CAPS decreased 36.1 points on average from baseline ($p<0.001$) for CPT, 31.9 points ($p<0.001$) for WA, and 40.8 points ($p<0.001$) for CPT-C group. On the completer analyses (all p's<0.001), the CPT group decreased 37.7 points, WA group decreased 36.5 points, and CPT-C decreased 42.1 points. **Secondary outcomes:** There were no significant differences between treatments on total Therapeutic Outcome Questionnaire scores, PDS. Treatment improvement in PDS at week 2 for CPT-C, at week 3 for CPT, and 5 weeks for WA. Improvement in BDI-II at week 3 for CPT-C, week 4 for CPT, and week 6 for WA	**Limitations identified by author:** Limited power. Difference in WA protocol **Limitations identified by review team:** Low-income only sample **Evidence gaps and/or recommendations for future research**: Examine mediators of change in treatment. If high levels of fear activation and emotional processing are not needed for symptom reduction, then there may be a more direct route to symptom improvement through change in cognitions, potentially resulting in shorter or more palatable treatments that can be implemented in group as well as individual settings. **Source of funding:** National Institute of Mental Health

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
anxiety, and cognitions (including guilt, shame, and other dysfunctional cognitions) **Study design:** Randomized controlled trial **Quality score:** [++] **External validity:** [++]	*Mean age (SD):* 35.4 (12.4); *Average education:* 13.8 years; *Marital status:* 20% married or cohabiting; *Race:* 62% White, 34% African American; *Mean years since index event:* 14.6; *On psychotropic medication:* 41% **Setting:** Urban	groups did) and spent more time on exposure therapy. **Control/comparison(s) description:** See above **Sample size(s):** Total n=150; CPT n=53; CPT-C n=47; WA n=50 **Baseline comparisons:** The CPT intervention group had significantly lower income (79% <$20,000 compared with 42% in WA group and 46% in CPT-C). There were no significant differences between groups at baseline on any other demographic or trauma variables. **Study sufficiently powered:** 80% power to detect difference of 0.46 within condition and 80% power to detect 0.57 for condition comparison, and 80% for 0.26 in three treatment comparison.	*Scale (ESS), The Personal Beliefs and Reactions Scale (PBRS), Posttraumatic Diagnostic Scale (PDS), State-Trait Anger Expression Inventory (STAXI), State-Trait Anxiety Inventory (STAI), Therapeutic Outcome Questionnaire,* and *Trauma-Related Guilt Inventory (TRGI).* **Follow up periods:** Weekly during treatment, 2 weeks post-treatment, and 6 months post-treatment **Methods of analysis:** ITT analysis conducted. Chi-square, hierarchical linear modeling, mixed effects regression, Tukey-Kramer paired t-tests, and Hedges' g over time		**Attrition details:** Of those who started treatment and did not run out of time, drop-out rates were: 34% CPT, 26% WA, 22% CPT-C. African American participants were significantly more likely to drop out (p=0.004, 37% completers, compared to 67% for Caucasians). Lower income participants were less likely to complete the full course of therapy (p=0.004). Income model checked and no change in results	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Rychtarik, R. G. & McGillicuddy, N. B. **Year:** 2005 **Citation:** Coping skills training and 12-step facilitation for women whose partner has alcoholism: Effects on depression, the partner's drinking, and partner physical violence. *Journal of Consulting and Clinical Psychology, 73*(2), 249-261. **Country of study:** USA **Aim of study:** To test the effectiveness of two interventions on levels of depression in the spouse or partner of men with problem drinking **Study design:** Cluster randomized controlled trial **Quality score:** [++] **External validity:** [+]	**Source population(s):** Women responding to a media ad offering a programme for women experiencing stress as a result of their partner's drinking. No other description of source **Eligible population(s):** Women currently living with their partner, married or cohabiting for at least 1 year, free of a substance use disorder of their own by scoring <9 on the Alcohol Use Disorders Identification Test (AUDIT) and <4 on the Drug Abuse Screening Test (DAST), and inactive in Alcoholics Anonymous (AA) or another treatment programme related to their partner's drinking in the last 3 months **Selected population(s):** Based on the woman's report, the partner had to obtain a score of ≥9 on the AUDIT, have been actively drinking in the last 3 months, and not have attended AA or formal treatment for substance abuse in that period. Participants had to provide the name of an individual for a corroborating source. **Excluded population(s):** Women who did not complete pre-treatment assessments, and participants in danger (DV shelter)	**Method of allocation:** Randomized into cohorts for each consecutive set of 4-6 participants. The randomization procedure controlled for potential confounding because of seasonal differences in treatment populations, treatment condition sequence, and staff changes. Procedures led to de facto staff blinding **Intervention(s) description:** Interventions were delivered by Master's level alcoholism or rehabilitation certified counsellors. Both interventions were 8 week groups. Coping skills training (CST) provided the stress and coping model; an explanation of the relationship between thoughts, feelings, behaviours, and their consequences on their partners reaction; and an introduction to a problem-solving approach. 12-step facilitation (TSF) sessions focused on Al-Anon steps 1-5, enabling behaviours and detachment, codependency relapse, and briefly on Al-Anon steps 6-12. Both treatments were manualized, and situations for discussion were presented in the same order. **Control/comparison(s) description:** Delayed treatment was used as the control group, then randomized into treatment group.	**Primary outcomes:** Primary measures of participant depression not applicable to this review **Secondary outcomes:** Effect of treatment on partner violence measured at 6 and 12 months with the *Conflict Tactics Scale Physical Violence* subscale **Follow up periods:** Post-treatment assessment, telephone assessments 3 and 9 months post-treatment, in-person interview at 6 and 12 months post-treatment **Methods of analysis:** Significant difference in employment	**Who is the target of the intervention?** Women living with partners with untreated problem drinking **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Yes	**Primary outcomes:** Depression in participants - N/A to this review **Secondary outcomes:** Partner violence: *CST* 21% (SD 0.88); TST 31% (SD 2.17, $p<0.05$). There was a significant Treatment x Time interaction. CST declined significantly from 50% violence at baseline to 37% ($p<0.05$, PV=0.14 medium, approaching large effect). TST had non-significant increase from 44% to 51%. For participants experiencing violence pre-treatment, CST 63% and TST 85% reporting violence at follow-up. **Attrition details:** 98% followed-up post-treatment. 87% completed one interview. 73% completed all assessments.	**Limitations identified by author:** Self-report and women's report of partner behaviour. Professionally modified TSF approach results cannot be extended to Al-Anon **Limitations identified by review team:** High rates of violence, and high rates of continuing violence. Women with drug problems excluded (but high comorbidity) **Evidence gaps and/or recommendations for future research**: Additional research exploring the nature of these complex relationships is needed. **Source of funding:** National Institute on Alcohol Abuse and Alcoholism

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Sample characteristics: Women: *Mean age (SD)*: 42.60 (9.79); *Mean years of education (SD):* 13.44 (2.09); *Race:* 84% White; *Employment:* 85% employed full or part time; *Marital status:* 87% married. Partners: *Mean AUDIT score (SD):* 23.48 (6.19); *Mean years of problem drinking (SD):* 19.02 (10.72) **Setting:** NR	**Sample size(s):** 36 cohorts for 3 groups. Total n=171; CST n=55; TSF n=58; Delayed treatment n=58 **Baseline comparisons:** At baseline, participants in the CST group had significantly ($p<0.01$) fewer months of employment in the past 3 years. All other demographic and symptom scores were equivalent. **Study sufficiently powered:** NR	stability not adjusted for. ITT used for all analyses			

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Sanders, C. K., Weaver, T. L., & Schnabel, M. **Year:** 2007 **Citation:** Economic education for battered women: An evaluation of outcomes. *Affilia: Journal of Women and Social Work, 22*(3), 240–254. **Country of study:** USA **Aim of study:** To increase access to and knowledge of financial resources and women's self-confidence in managing and coping with financial problems independently **Study design:** Randomized controlled trial **Quality score:** [+] **External validity:** [-]	**Source population(s):** Women in St. Louis, MO, USA **Eligible population(s):** Women in shelter programme at designated site, resident at least 2 days, and over age 18 **Selected population(s):** Shelter residents who chose to take the programme **Excluded population(s):** Under 18, showing overt signs of mental illness **Sample characteristics:** *Education:* 19% <high school, 48% high school, 28% some college, 5% college; *Age:* 15% 18-25, 36% 26-35, 48% 36-50; *Race:* 74% African American; *Mean time with partner (SD):* 69 months (78) **Setting:** Urban women's shelter	**Method of allocation:** 4 shelter sites were chosen, 2 for intervention and 2 for control, matched as dyads for programme characteristics and population. The process continued until 30 women were recruited for each group. **Intervention(s) description:** Based on the curriculum "Realizing Your Economic Action Plan", the intervention was a 12-hour group format emphasizing the connection among poverty, oppression, and violence and providing in-depth, concrete financial information. Four class sessions covered money and power, developing a cost-of-living plan, building and repairing credit (major component), and banking and investing. Groups had 3-7 women. **Control/comparison(s) description:** Matched shelters with no intervention **Sample size(s):** Total post-test n=67; Intervention n=64 (post-test n=32); Control n=53 (post-test n=35) **Baseline comparisons:** The intervention group had significantly higher average time with partner (84 vs. 48 months, p<0.05). This was accounted for in the final analysis, yet time with partner proved to be a significant factor. Groups were equivalent on demographic and abuse measures. **Study sufficiently powered:** NR	**Primary outcomes:** Participants were evaluated with the *Psychological Maltreatment of Women Inventory*. The authors created their own 35 item 4-point Likert scale instrument (Cronbach's alpha=0.81) to measure financial literacy and the *Domestic Violence-Related Financial Issues scale* for financial self-efficacy. **Secondary outcomes:** NR **Follow up periods:** 2 weeks **Methods of analysis:** Chi-square, t-test, with means and SD for pre-test-post-test and change scores. No ITT	**Who is the target of the intervention?** Women in DV shelters **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** For financial literacy, the intervention group had a significantly greater increase than the control group (p<0.05), but this was not significant when controlling for length of relationship. For financial self-efficacy, the intervention group had significantly improved scores (p<0.05) which remained when controlling for length of relationship. Controlling for differences in the length of time with the partner was found to be a significant predictor of change in the financial knowledge score. That is, the longer a woman had been with her abuser, the more her financial literacy score improved. **Secondary outcomes:** N/A **Attrition details:** 43% attrition rate. Dropouts were significantly more likely to have higher scores on sexual coercion. No difference in this measure between intervention and control group	**Limitations identified by author:** Attrition does not permit generalization. Self-selection of participants. Shelter environment and crisis challenges. Authors created instrument **Limitations identified by review team:** Very short-follow-up period. Self-report of attitudes; not actual financial behaviours **Evidence gaps and/or recommendations for future research**: Need for research on more economic literacy programs for battered women, studies with larger sample sizes, and qualitative assessment **Source of funding:** National Endowment for Financial Education, the Centre for Social Development, and the Fahs-Beck Fund for Research and Experimentation

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Sullivan, C. M., Bybee, D. I., & Allen, N. E. **Year:** 2002 **Citation:** Findings from a community-based programme for battered women and their children. *Journal of Interpersonal Violence, 17*(9), 915-936. **Country of study:** USA **Aim of study:** To examine the effectiveness of an advocacy and child education programme for improving the self-esteem of children and the psychological well-being of mothers who have experienced DV **Study design:** Randomized controlled trial **Quality score:** [++] **External validity:** [+]	**Source population(s):** Women who had been in a DV shelter (79% of sample) or other social service **Eligible population(s):** Women with at least one child aged 7-11 living with them, women who experienced physical violence from their partner in prior 4 months **Selected population(s):** Children interested in participating in programme **Excluded population(s):** If there was more than 1 child in programme, only 1 child was randomly selected for data **Sample characteristics:** Women: *Race:* 49% White, 39% African American; *Mean age:* 31; *Income <35,000:* 77%; *Receiving social assistance:* 88%; *Employed:* 44%. Children: *Mean age:* 8.3; *Mean grade:* 3; *Gender:* 55% female **Setting**: In-home and in urban community for children's programme	**Method of allocation:** Randomized at recruitment (method not reported) **Intervention(s) description:** 16 week intervention. Trained women undergraduates worked as paraprofessionals who were supervised weekly. The advocacy intervention was a home visit twice a week to provide advocacy in 5 phases: assessment, implementation, monitoring, secondary implementation, and termination. Assistance for mothers covered housing, employment, education, transportation, childcare, social support, and/or material goods; and for children, recreational activities, help with school, and/or obtaining material goods. A 10 week group programme for children, the Learning Club, was run by 5 minority leaders, to educate on safety, feelings, and respect for themselves and others. It included physical activities. **Control/comparison(s) description:** Control group received no services **Sample size(s):** Total n=78; Intervention n=45; Control n=33 **Baseline comparisons:** Significant differences in child age, number of events witnessed, involvement in child protective services, prior parenting training, and mother's drug use **Study sufficiently powered:** NR	**Primary outcomes:** Child's well-being was measured by the *Self-Perception Profile for Children.* Mothers were measured with the *Andrews and Withey Quality of Life Social Support Scale, CES-D,* and *Rosenberg Self-Esteem Inventory.* **Secondary outcomes:** NR **Follow up periods:** Post-intervention and 4 months post-intervention **Methods of analysis:** Compared groups using MANCOVA and ANCOVA and Condition x Time interaction	**Who is the target of the intervention?** Women with children living at home **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Children's overall well-being was significantly higher for the intervention ($p<0.01$) and significantly less likely to be in contact with abuser (chi-squared=0.04). Significant ($p<0.05$) differences were found in global self-worth, physical appearance, and athletic subscales. Women's well-being improvement was described as moderate ($p<0.08$). Mothers who received the advocacy intervention also reported higher quality of life than mothers in the control group, although this difference was not statistically significant. Similarly, children who received the advocacy intervention showed increased self-competence from the pre-intervention period to their 4-month follow-up interview, although the self-competence of children in the control group remained relatively unchanged overall. **Secondary outcomes:** N/A **Attrition details:** 95% retention rate; 2 declined further participation and 2 lost contact	**Limitations identified by author:** Small sample size. Limited time frame to observe improvement **Limitations identified by review team:** Scales were combined in an unconventional way to create an index **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** National Centre for Injury Prevention and Control of the Centres for Disease Control and Prevention

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Sullivan, M., Egan, M., & Gooch, M. **Year:** 2004 **Citation:** Conjoint interventions for adult victims and children of domestic violence: A programme evaluation. *Research on Social Work Practice, 14*(3), 163-170. **Country of study:** USA **Aim of study:** To determine the effectiveness of a 9 week mother-child dyad cognitive behavioural intervention to reduce mental ill-health and self-blame for mothers and children **Study design:** Before and after study	**Source population(s):** NR **Eligible population(s):** NR **Selected population(s):** Women with children seeking help from DV **Excluded population(s):** NR **Sample characteristics:** *Children's mean age:* approximately 7; no further data given on sample **Setting:** NR	**Method of allocation:** N/A **Intervention(s) description:** The intervention was a 9-week group intervention with concurrent mothers' and children's groups and a conjoint group of mothers and children based on cognitive behavioural and systemic intervention approaches and safety planning. The key components of the group were personal safety planning, resolution of trauma issues related to witnessing DV, self-blame, and developing conflict resolution skills. The concurrently-held mothers' group had three components: developing safety planning and parenting skills and providing social support in a group of peers. Safety planning skill education mirrored that of the children's group and emphasized empowerment and self advocacy. Parenting skills learning helped the mothers develop ways of relating to their children's differing views and experiences of family violence. The last component was a multifamily group at the conclusion of each session	**Primary outcomes:** The *Child Behaviour Checklist: Parent Report Version (CBCL)* is appropriate for children ages 4 to 18, is completed by parents or guardians, and includes several behavioural problem areas including externalization, internalization, withdrawal and depression. Reliability coefficients range from 0.62 to 0.96, with a good test-retest mean. The *Trauma Symptom Checklist for Children (TSCC)* is a measure completed by children and is most appropriate for children ages 8 through 16. Reliability coefficients reported range from 0.82 to 0.8. The TSCC subscales include Anxiety, Depression, Anger, posttraumatic stress disorder (PTSD), and three measures of dissociation. The *Parenting Stress Index (PSI)* has two main domains. The child domain measures parents' perceptions of their children's distractibility or hyperactivity, adaptability, reinforcement of the parents, demandingness, mood, and acceptability. The parent domain measures parents' perceptions of their own competence, isolation, attachment, health, role restriction, depression, spouses, and life stress.	**Who is the target of the intervention?** Mothers with children who experience DV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Anxious/depressive behaviours ($t(76)=1.99$, $p=0.05$) internalizing behaviours ($t(76)=2.41$, $p=0.02$) and externalizing behaviours ($t(76)=1.95$, $p=0.05$) scores reduced significantly from pre to post-test. A total of 11 (10 plus total score) of the 14 domain scores were significantly reduced at post-test in the clinical subsample. For those t values found significant in the clinical subsample, the percentage of variance explained ranged from 0.27 to 0.92. *Clinical Pre-test M (SD) vs. Clinical Post-test M (SD):* Anxiety or Depression 73.93 (7.29) vs.66.45 (8.32) ($p<0.001$); Internalizing 73.14 (5.43) vs. 65.91 (12.06) ($p<0.01$); Externalizing 71.88 (4.23) vs. 64.53 (12.36) ($p< 0.05$); Withdrawn 76.41 (6.68) vs. 69.76 (8.71) ($p<0.01$); Somatic 70.13 (5.83) vs. 64.31 (8.70) ($p<0.05$); Thought Problem 70.25 (4.07) vs. 63.50 (6.01) ($p<0.001$); Delinquent 69.92 (2.40) vs. 69.92 (2.40) ($p<0.01$); Total 72.00 (5.30) vs. 36.94 (9.59) ($p<0.05$). The intervention significantly reduced trauma symptoms in the clinical subsample and significantly reduced the Anger subscale in the entire sample. On the PSI, there was significant improvement in adaptability, mood, reinforcing parent, and distractibility or hyperactivity ($p<0.05$) on the children's scale. In the parent domain, isolation, life stress, and health of the parent were significantly improved at post-test ($p<0.05$). On the CPIC, children's self-blame was significantly reduced at post-test in the overall sample	**Limitations identified by author:** Small sample size. The sample includes only those mothers and children who completed the programme. It might be argued that the sample is significantly different from those who dropped out. The data were collapsed over time rather than following one group from beginning to completion of the programme; thus, participants in the programme may have differing internal threats to validity such as history and maturation. Because the three components of the programme were implemented in combination the findings cannot be linked specifically to one component or another. No control group **Limitations identified by review team:** Outcome measures were self-reported. **Evidence gaps**

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Quality score: [+] **External validity:** [-]		of the mothers' and the children's groups to facilitate communication between the mothers and their children. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=125; Mothers n=46; Children n=79 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	Reliability coefficients range from 0.70 to 0.83, with good test-retest stability of 0.82 and 0.71 during a 3-week interval. *Children's Perception of Interpersonal Conflict (CPIC)* is a self-report measure for children. Alpha coefficient (n=174) was 0.85 for the Self-Blame dimension. **Secondary outcomes:** NR **Follow up periods:** Immediately before and after the intervention **Methods of analysis:** T-scores were used in the analysis of the CBCL measure. The clinical cut-off points were computed with T-scores (i.e., TSCC or CBCL) or percentile scores (i.e., PSI) so that comparisons could be easily made between clinical and nonclinical samples within and across specific measures. Only those children and their mothers who completed the intervention programme and both pre-test and post-test measurements during a 5-year period were analysed.		(t(56)=2.37, p=0.02). Overall, the group intervention was effective in reducing blame and trauma symptoms. Parents generally perceived the intervention more helpful for their children than for themselves, but scores indicated that parents' feelings of isolation, stress levels, and health problems decreased significantly. **Secondary outcomes:** N/A **Attrition details:** No significant differences in demographic variables of race, gender, or age were found between the sample under study and the total population of children completing pre-tests but not the intervention programme. Fisher's exact chi-square indicated race (chi-square (5,1432)=0.849, p=0.131) and gender (chi-square(1,1432)=0.263, p=0.644) were similarly distributed in the population and the sample. Only the mothers' pre-test scores on role restriction were significantly different, (F(1,207)=6.41, p=0.012). In children only, depression was significantly different, with completers having higher mean scores (F(1,383)=4.02, p=0.05).	**and/or recommendations for future research**: Research is needed that employs larger samples, longitudinal designs, and designs that include control groups. **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Taft, A. J., Small, R., Hegarty, K. L., Watson, L. F., Gold, L., & Lumley, J. A. **Year:** 2011 **Citation:** Mothers' AdvocateS In the Community (MOSAIC) - non-professional mentor support to reduce intimate partner violence and depression in mothers: A cluster randomised trial in primary care. *BMC Public Health, 11*, 178 **Country of study:** Australia **Aim of study:** To determine the effectiveness of non-professional mentor support in reducing IPV and depression among pregnant and recent mothers experiencing, or	**Source population(s):** Pregnant women and new mothers experiencing, or at risk for, IPV attending general practices and maternal & child health clinics in the NW Melbourne area of Australia **Eligible population(s):** Sites: 790 general practice clinics (one or two GPs) and 12 maternal and child health (MCH) teams (involving ~180 MCH clinics with one or two nurses). Participants: Women aged 16 and over attending the selected GPs or MCHs from Jan 06-Dec 07 who were pregnant or had at least one child 5 years or younger, and disclosed IPV or exhibited psychosocial distress indicative of abuse. 258 women were referred, of whom 215 were eligible **Selected population(s):** Sites: 24 general practices (27 GPs) and 8 MCH teams (82 clinics). 4 of the general practices were Vietnamese. Participants: 174 of the 215 eligible women agreed to participate	**Method of allocation:** Randomization occurred at 2 public meetings, with a guest external to the project selecting opaque envelopes containing randomization possibilities. GP clinics were randomized by # of GPs participating. MCH clinics were randomized by team, stratified by # of births per local government area **Intervention(s) description:** The intervention was mentorship from non-professionals providing befriending, advocacy, parenting support and referrals. There were 6 hours of IPV training for all clinicians in both intervention and control arms, to enhance their capacity to identify, respond to and refer women at risk for or experiencing IPV. Mentors had a five-day initial training including befriending, DV advocacy, working with depression, parenting support, safety and self-care. Mentors then met at regular intervals for further training and support. 58% of participants met with their mentor weekly, 18% fortnightly, and 20% reported no regular pattern. Participants reported being offered information most often about legal, self-care and parenting services.	**Primary outcomes:** The *Composite Abuse Scale (CAS)* was used to measure IPV, and is a validated measure. A cut-off score of ≥7 was used to indicate IPV. The *Edinburgh Postnatal Depression Scale (EPDS)* assessed maternal depression. **Secondary outcomes:** General health and well-being were assessed with the SF-36. *Mother-child bonding* was expressed as parenting stress and attachment (using the attachment sub-scale) of the *Parenting Stress Index Short form (PSI-SF).* Social support was assessed with the *Medical Outcomes Scale Short Form (MOS-SF)*. Use of, and satisfaction with, primary care services was also assessed. **Follow up periods:** 12 months **Methods of analysis:** The analyses were conducted as intention-to-treat, though 10 women refused the intervention and one	**Who is the target of the intervention?** Pregnant women and new mothers experiencing, or at risk for, IPV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Adjusted difference in total CAS score from baseline was greater in the intervention arm (Adj Diff=-8.67, 95% CI: -16.2 to -1.15, p=0.03), but the evidence for this difference was weaker after propensity score (PS) adjustment (Adj Diff=-8.75, 95% CI: -18.2 to 0.70, p=0.07). The odds of experiencing violence at follow-up, adjusted for baseline abuse, were 0.47 (95% CI: 0.21 to 1.05), or 0.58 (95% CI: 0.21 to 1.58) after PS adjustment. Difference in mean depression scores in the intervention arm was -1.90 (95% CI: -4.12 to 0.32, p=0.09), or -1.92 (95% CI: -4.25 to 0.41, p=0.11) after PS adjustment. Odds ratios for experiencing depression were 0.42 (CI: 0.17 to 1.06, p=0.07), or 0.72 (CI: 0.24 to 2.13, p=0.5) after PS adjustment. **Secondary outcomes:** *Mental health mean score:* Adj diff=2.26 (CI: -1.48 to 6.00, p=0.2) or 3.42 (CI: -0.52 to 7.37, p=0.09) after PS adjustment. *Physical health mean score:* Adj diff=2.79 (CI: -0.40 to 5.99, p=0.09) or 2.14 (CI: -2.07 to 6.36, p=0.3) after PS	**Limitations identified by author:** Fewer than desired number of referrals, particularly for the comparison arm, decreased the study's power. Measures were self-reported. No follow-up was done after the end of the 12 month study **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: The authors recommend further research to add to the evidence base for non-professional mentoring models, and if positive effects are found, to see whether they can be sustained over the longer term. They also recommend

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
at risk of IPV **Study design:** Cluster randomized controlled trial **Quality score:** [++] **External validity:** [+]	**Excluded population(s):** Women with a serious mental illness who were not taking medication. Women whose English or Vietnamese was inadequate for informed consent **Sample characteristics:** Intervention: *Mean age:* 32.4; *Married*: 26%; *One child*: 53%; *Education:* 51% 12 years or less; *Pension/ welfare:* 53%; *Depression, as indicated by EPDS score of 13+:* 70%; *Experiencing parenting stress:* 49%. Control: *Mean age:* 32; *Married*: 32%; *One child*: 46%; *Education:* 47% 12 years or less; *Pension/ welfare:* 62%; *Depression, as indicated by EPDS score of 13+:* 58%; *Experiencing parenting stress:* 33% **Setting:** Meetings with mentors occurred at women's home and "elsewhere" (not specified).	**Control/comparison(s) description:** Clinician care only (i.e. no mentor support) **Sample size(s):** Total n=174; Intervention n=113; Control n=61 **Baseline comparisons:** NR **Study sufficiently powered:** Pre-recruitment power analysis: The authors aimed to detect a 16% difference in IPV or depression with 80% power and 95% confidence, assuming an intra-class correlation of 0.02 and attrition of as much as 45%. This resulted in a target recruitment of 350 participants in each arm. Post-recruitment power: Due to lower than expected numbers of recruited participants, the authors calculated that their achieved sample size would have 80% power and 95% confidence to detect a 22% reduction in IPV, 18% for depression, and a difference of two units in the mental component score (MCS) of the SF36.	woman in the control group mistakenly received the intervention. The main analyses included a comparison of the primary outcomes pre- and post-intervention. Due to differing numbers of women in the two arms of the trial, a propensity score analysis was done to balance the arms for potential confounding from possible selection bias, after multiple imputation for missing data. Odds ratios and adjusted difference scores were calculated for outcome measures.		adjustment. *Parental distress (%):* OR=0.6 (CI: 0.32 to 1.49, p=0.3) or 0.82 (CI: 0.34 to 2.01, p=0.7) after PS adjustment. *Parent-child dysfunctional interaction (%):* OR=1.0 (CI: 0.44 to 2.71, p=0.8) or 1.16 (CI: 0.88 to 3.49, p=0.8) after PS adjustment. *Total parenting stress (%):* OR=1.0 (CI: 0.45 to 1.49, p=0.9) or 0.86 (CI: 0.32 to 2.33, p=0.8) after PS adjustment. *Social support mean scores:* Adj diff=-0.21 (CI: -0.82 to 0.40, p=0.5) or -0.29 (CI: -0.91 to 0.34, p=0.4) after PS adjustment. *Other:* 32% of intervention participants had taken up or returned to training/education over the study, compared to 16% of control participants (OR=2.4, CI: 1.08 to 5.02). **Attrition details:** 41 out of the original sample of 174 did not complete the 12 month study. Women lost to the study were more likely to be more severely abused. In the intervention, 20% (23/113) did not complete. In the control group, 30% (18/61) did not complete.	further investigation into what more can be done to enhance clinician care when IPV is present. **Source of funding:** National Health and Medical Research Council, VicHealth (Victorian Health Promotion Foundation). Victorian Government Community Support Fund Grant Programme. Beyondblue (the national depression initiative)

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Zlotnick, C., Capezza, N. M., & Parker, D. **Year:** 2011 **Citation:** An interpersonally based intervention for low-income pregnant women with intimate partner violence: A pilot study. *Archives of Women's Mental Health, 14*(1), 55-65. **Country of study:** USA **Aim of study:** To examine the initial feasibility, acceptability, and effects of an intervention in reducing PTSD and depressive symptoms from pregnancy until 3 months postpartum in a sample of low-income, pregnant women with IPV within the last year	**Source population(s):** Female patients at three Rhode Island sites: two primary care clinics and one private OBGYN clinic **Eligible population(s):** Pregnant women, between 18 and 40 years of age, attending prenatal care visits **Selected population(s):** Women who screened positive for past year IPV on the Revised Conflict Tactic Scale (CTS2) were invited to participate in the next phase of the study. **Excluded population(s):** Women with current affective disorders, PTSD and substance use were referred to treatment and excluded from the study. **Sample characteristics:** Overall: *Mean age (SD):* 23.8 (4.6); *Race*: 43% Hispanic; *Marital Status:* 44% single; *Education*: 57% high school; *First pregnancy:* 43%; *Mean acts of*	**Method of allocation:** Computer-generated randomized allocation schedule was concealed in consecutively numbered, sealed envelopes by the principal investigator who was masked to the women's intake assessments **Intervention(s) description:** Four 60-minute sessions based on Interpersonal Psychotherapy (IPT) over a 4-week period before delivery and one 60-min individual "booster" session within 2 weeks of delivery. The intervention was designed to help participants improve their interpersonal relationships, change their expectations about them, assist them in building, or improving their social support networks, and master their role transition to motherhood. The first session focused on rationale for the programme, evaluation of healthy relationships, types of interpersonal disputes, and abusive relationships. Session 2 included stress management skills, consequences of abuse, cycle of abuse, and making a safety plan. Session 3 included emotional risks of abuse-signs and symptoms of "baby blues," and postpartum depression, PTSD and substance use, and the management of role transitions with an emphasis on transition to motherhood and self-care. Session 4 included the development of a support system, techniques for asking for support,	**Primary outcomes:** The *Revised Conflict Tactic Scale (CTS2)* was used for the interval period from the last assessment to date for the most recent partner. The CTS2 has demonstrated excellent reliability and validity. The *Longitudinal Interval Follow-up Examination (LIFE),* a brief standardized interview, was used to assess for the presence of a major depressive disorder and PTSD from intake until 3-months postpartum. Studies have found interrater reliability and long-term test-retest reliability for the LIFE to be good to excellent. The *Edinburgh Postnatal Depression Scale (EPDS)* was used to measure the depression level. The *Davidson Trauma Scale* is a 17-item measure that assesses each DSM-IV symptom of PTSD on five-point frequency and	**Who is the target of the intervention?** Pregnant women attending prenatal care **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The intervention did not significantly reduce the likelihood of a major depressive episode, PTSD, or IPV during pregnancy or up to 3-months postpartum. However, it found moderate effects for the intervention in reducing symptoms of PTSD ($F(1,44)=7.50$, $p=0.009$) and depression ($F(1,34)=4.07$, $p=0.05$) during pregnancy. When the presence of childhood sexual trauma was controlled, the overall effect size for PTSD symptom reduction was larger ($F(1,42)=5.67$, $p=0.022$), increasing the intervention effect size from d=0.59 to d=0.69. **Secondary outcomes:** N/A **Attrition details:** 40% of eligible	**Limitations identified by author:** Study is underpowered. The study did not recruit women whose partners were present. Perhaps a percentage of the women with partners present for their prenatal visit may have had partners who were particularly controlling and abusive. At least 54% of women approached to be in the study denied any IPV or refused to participate in the study. It is therefore unknown as to what percentage of these women may have had IPV experiences and if participants in the study were representative of women with IPV. Participants were recruited from a limited geographic location **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Findings of moderate effects for reducing symptoms of PTSD and depression during pregnancy and a large effect for PTSD

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Study design: Randomized controlled trial **Quality score:** [+] **External validity:** [+]	*abuse (physical, sexual, and/or psychological) in past year:* 35.9. Intervention: *Mean age (SD)*: 24.2 (4.4); *Race*: 43% Hispanic; *Marital status:* 39% single; *Education:* 64% high school; *First pregnancy:* 36%; *Mean acts of abuse (physical, sexual, and/or psychological) in past year:* 33.4. Control: *Mean age (SD):* 23.5 (4.7); *Race*: 42% Hispanic; *Marital status:* 50% single; *Education*: 50% high school; *First pregnancy:* 50%; *Mean acts of abuse (physical, sexual, and/or psychological) in past year:* 38.7 **Setting:** Primary care and private OBGYN clinic	resolving interpersonal conflicts, and goal-setting. The last session provided an opportunity to review and reinforce the content of the previous sessions and address any new issues related to the birth of the infant. **Control/comparison(s) description:** Women in standard care received usual medical care provided for pregnant women at their clinic, as well as educational material and a listing of resources for IPV **Sample size(s):** Total n=54; Intervention n=28; Control n=26 **Baseline comparisons:** There were no statistically significant differences at baseline. **Study sufficiently powered:** Power calculations were reported, but the study was underpowered (50 participants required in each group for 80% power)	severity scales. It is widely used with good reliability and validity. *Criterion A* from the *PTSD module of the SCID-NP* was used to assess for history of trauma. **Secondary outcomes:** NR **Follow up periods:** 5-6 weeks after intake, 2 weeks after delivery, and 3-months postpartum **Methods of analysis:** All analyses were conducted on the intent-to-treat sample. Primary analyses we assessed for a major depressive disorder and PTSD using repeated-measures analysis of variance. In secondary analyses the presence of childhood sexual trauma was controlled for.		participants could not be reached. Three intervention and four control participants were lost to follow up.	symptoms from pregnancy up to 3 months postpartum suggest that the intervention may be efficacious with a larger trial. Future studies should include an attention-matched control group to determine if positive intervention outcomes are attributable to differences in attention between the conditions or to the "active ingredients" of the IPT-based intervention. **Source of funding:** National Institute of Mental Health

Table 63. Research Question 3 (Perpetrator Interventions) Evidence Tables

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Alexander, P. C., Morris, E., Tracy, A., & Frye, A. **Year:** 2010 **Citation:** Stages of change and the group treatment of batterers: A randomized clinical trial. *Violence and Victims, 25*(5), 571-587. **Country of study:** USA **Aim of study:** To compare the efficacy of a stages-of-change motivational interviewing (SOCMI) group intervention vs. a cognitive behavioural therapy gender reeducation (CBTGR) group intervention on	**Source population(s):** Male batterers in Maryland **Eligible population(s):** Male batterers referred to the Montgomery County, Maryland Abused Persons Programme **Selected population(s):** Male batterers referred to the Montgomery County, Maryland Abused Persons Programme who attended at least one session. For those with previous substance use, they had to have 1 month of sobriety before beginning group treatment. **Excluded population(s):** Clients unable to communicate in English or Spanish. Clients actively abusing alcohol or other drugs **Sample characteristics:** English-speaking men in CBTGR group: *Mean age (SD):* 35.4 (10.4); *Mean education (presumably years of education; SD):* 13.0 (3.3); *Mean of victim's age (SD):* 32.9 (10.2); *Mean of victim's education (SD):* 13.4 (2.4); *Court-mandated:* 97%; *Employed:* 46%; *Ethnicity:* 30% White, 46% African American, 14% Latino, 10% other; *Immigrant:* 23%; *With children:*	**Method of allocation:** Randomised to one of the two group conditions, within the constraints of work schedules **Intervention(s) description:** Both intervention and comparison were 26-week group sessions for male batterers led by masters-level mental health professionals. Groups in both conditions had 10-12 men per group. The intervention arm was the SOCMI group treatment, in which the first 14 sessions were targeted to men in the precontemplation and contemplation stages of change and the last 12 sessions focused on behavioural change processes. The SOCMI relied on motivational interviewing principles (e.g. encouraging reflection, focusing on clients' values and motivations, making reflective statements). **Control/comparison(s) description:** The comparison was a standard CBTGR treatment, which used behavioural techniques (e.g. time out strategies, anger journals). It also immediately addressed the minimization and denial that surround IPV by working to have clients directly acknowledge their use of abuse in the first session and to engage in a meaningful discussion of pros and cons of abuse by the second session.	**Primary outcomes:** The *Conflict Tactics Scales-Revised (CTS2)* measured batterers' self-reported psychological aggression and physical assault towards partners. Reliable and valid. The *University of Rhode Island Change Assessment (URICA)* measured stage of (readiness for) change with respect to one's violence against one's partner. Reliable. Victims completed the CTS2 and the *Danger Assessment Scale (DAS)* which measures IPV risk. Reliable. **Secondary outcomes:** NR **Follow up periods:** Batterers completed outcome measures at intake and post-treatment. Partners of batterers were followed up at 6- and 12-months post-intake. **Methods of analysis:** The authors only included batterers who	**Who is the target of the intervention?** English or Spanish speaking male batterers **Did they conduct any aspect of sex, gender or diversity analysis?** They compared English-speaking groups to Spanish-speaking groups. **Do they report sex, gender or diversity based factors in findings?** Language spoken neither predicted outcome nor interacted with treatment. **Did this study examine or discuss links between DV**	**Primary outcomes:** SOCMI led to significant reductions in victims' reports of physical aggression at follow-up (p-value for relevant beta coefficient in the logistic regression <0.05), but not to changes in batterers' self-reported aggression. Victim-reported physical aggression scores also decreased the longer the time between group start-date and follow-up (p-value for relevant beta coefficient<0.05). For victim-reported physical aggression, men who were initially less ready to change benefited more from the SOCMI approach while men who were more ready to change benefited more from the CBTGR approach (treatment and treatment x readiness-to-change beta coefficients both had p<0.05). Neither treatment type, language spoken, nor their interaction	**Limitations identified by author:** Low number of partner follow-ups (<25%). Low number of therapists who regularly audiotaped their sessions **Limitations identified by review team:** Uneven number of intervention vs. comparison groups among the Spanish-speaking participants **Evidence gaps and/or recommendations for future research**: Explore mediators of treatment outcomes (e.g. therapeutic alliance, group cohesion). Evaluate outcomes with a longer follow-up **Source of funding:** National Institute of Justice Grant

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
IPV, including whether efficacy varied depending on the batterer's readiness to change **Study design:** Individual randomised controlled trial **Quality score:** [+] **External validity:** [+]	73%. English-speaking men in SOCMI group: *Mean age (SD):* 36.6 (9.9); *Mean education (SD):* 12.5 (4.1); *Mean of victim's age (SD):* 34.2 (9.6); *Mean of victim's education (SD):* 13.7 (2.3); *Court-mandated:* 93%; *Employed:* 56%; *Ethnicity:* 30% White, 46% African American, 11% Latino, 13% other; *Immigrant:* 28%; *With children:* 67%. Spanish-speaking men in CBTGR group: *Mean age (SD):* 33.3 (8.4); *Mean education (SD):* 8.2 (4.8); *Mean of victim's age (SD):* 31.9 (7.3); *Mean of victim's education (SD):* 9.4 (4.2); *Court-mandated:* 100%; *Employed:* 28%; *Ethnicity:* 2% White, 0% African American, 96% Latino, 2% other; *Immigrant:* 76%; *With children:* 79%. Spanish-speaking men in SOCMI group: *Mean age (SD):* 31.4 (7.0); *Mean education (SD):* 8.9 (4.8); *Mean of victim's age (SD):* 28.6 (6.6); *Mean of victim's education (SD):* 10.0 (3.5); *Court-mandated:* 95%; *Employed:* 31%; *Ethnicity:* 0% White, 0% African American, 93% Latino, 7% other; *Immigrant:* 72%; *With children:* 83% **Setting:** Urban group treatment, but location of sessions was not specified	**Sample size(s):** Total n=528; Intervention n=247 (200 English, 47 Spanish); Control n=281 (175 English, 106 Spanish) **Baseline comparisons:** Due to scheduling constraints, there were more Spanish-speaking control groups (10 groups, totalling 106 men) than Spanish-speaking intervention groups (4 groups, totalling 47 men). Spanish-speakers were younger, less educated, less likely to be employed, more likely to be Latino, and more likely to be an immigrant, with younger and less educated partners. Spanish-speaking couples were more likely to have children. Spanish-speakers reported having perpetrated less psychological and physical aggression against their partners, but were more likely to be discrepant from their partners in reports of lifetime physical aggression. Spanish-speaking men in the SOCMI condition were less likely to have been court-mandated and more likely to have been self-referred. **Study sufficiently powered:** NR	had completed at least one session. Therapists' adherence to their particular treatment approaches was confirmed using a blind rating of randomly selected audiotapes from both treatment groups. Logistic regressions were used to assess main effects of treatment, follow-up time for victims, and language, as well as interaction effects of treatment and readiness-to-change. Two-way ANOVA was used to assess the effect of treatment type and language on readiness-to-change as measured by the URICA.	**and substance use or issues of trauma?** No	predicted change in URICA from intake to post-treatment. **Secondary outcomes:** N/A **Attrition details:** The study only included men who attended at least one session. There was no significant effect of treatment condition on attendance. A total of 91 victims had usable follow-up data; whether or not a partner had been contacted for follow-up did not differ as a function of treatment completion, treatment type, or language spoken.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Bowen, E., Gilchrist, E., & Beech, A. R. **Year:** 2008 **Citation:** Change in treatment has no relationship with subsequent re-offending in U.K. domestic violence sample: A preliminary study. *International Journal of Offender Therapy and Comparative Criminology, 52*, 598. **Country of study:** UK **Aim of study:** To assess the extent of both statistically and clinically significant psychological change across a variety of measures (pro-DV attitudes, anger, locus of control, interpersonal dependency) assessed pre- and post-treatment, and their association with post-treatment re-offending within an 11-month follow-up period **Study design:** Before and after study **Quality score:** [+]	**Source population(s):** Male DV offenders in the West Midlands, UK **Eligible population(s):** Male DV offenders sentenced to attend the Domestic Violence Perpetrator Programme (DVPP) offered by West Midlands Probation Area. Non-offenders (who served as the comparison group to provide data for clinically significant change) had to be male, heterosexual, 20-59 years old, and currently in a relationship. **Selected population(s):** The sample consisted of offenders who attended both pre-treatment and end-of-treatment measures. Non-offenders were selected from members of staff at West Midlands Probation Service. **Excluded population(s):** Offenders who did not attend both pre-	**Method of allocation:** No allocation to the intervention - all DV offenders were referred to the programme. To assess clinically significant change, a non-offender comparison group was selected, comprised of members of staff at West Midlands Probation Service. **Intervention(s) description:** The DVPP is a profeminist psycho-educational treatment programme consisting of 5 modules delivered over 24 sessions (2-2.5 hours long) offered once or twice per week, and 5 monthly follow-up sessions of 2.5 hours. The 5 modules examined the nature of DV, male socialization, victim empathy, sexual respect within relationships, and accountability. Sessions were offered during the day for unemployed offenders and during the evening for employed offenders. Groups were scheduled quarterly and operated on a cohort basis so that the same group of offenders participated in the whole programme together. **Control/comparison(s) description:** To assess clinically significant change, a non-offender comparison group was selected, comprised of members of staff at West Midlands Probation	**Primary outcomes:** The Sympathy for Battered Women Scale (alpha=0.86) of the *Inventory of Beliefs About Wife Beating (IBWB)* assessed attitudes toward DV. The *Novaco Anger Scale (NAS)* was used to measure levels of anger. Part A covers three domains: Cognitive, Arousal, Behavioural and Part B is a 25-item provocation inventory. Alphas from 0.82 to 0.89. The Emotional Reliance Upon Others subscale of *The Interpersonal Dependency Inventory* was used to measure interpersonal dependency. Alpha=0.87. *The Multidimensional Locus of Control* scale was used to measure the extent that offenders felt in control of their lives and the extent to which they perceived chance and powerful other people as influencing their life events. There are three subscales (alphas from 0.63 to 0.79): Self, Chance, and Powerful Others. *The Balanced Inventory of Desirable Responding (BIDR)* was used to measure two components of desirable responding: self-	**Who is the target of the intervention?** Male DV offenders **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Programme completers achieved limited significant psychological change; there were changes in sympathy for battered women and locus of control, but even these changes disappeared when adjusting for social desirability. Results varied by individuals: 27% did not achieve reliable change across measures, 27% had pre- and post-treatment scores within the range of the normal population, 17% achieved clinically significant change, and 5% went from "functional" to "dysfunctional" scores. The proportions of individuals falling into a given clinically significant change category depended on the outcome measure. The level of psychological change achieved had no association with re-offending. **Secondary outcomes:** N/A **Attrition details:** Only those with complete	**Limitations identified by author:** Some measures (e.g. re-offences via police records) are proxies only and may under- or over-estimate true outcomes. Follow-up period should have been at least 12 months. The use of questionnaires to detect psychological change may be biased. The non-offender group may not be comparable to the offender group **Limitations identified by review team:** Potential lack of generalisability since only a subset of referred men was included in the study (52/120 men referred to the programme=43%) **Evidence gaps and/or recommendations for future research**: Future research should try to ensure partner report is achieved to provide a more valid measure of offender behaviour. Longitudinal studies

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]	treatment and end-of-treatment measures **Sample characteristics:** Offenders: *Mean age (SD):* 35.0 (9.0); *Mean # of children (SD):* 1.6 (1.6); *School leaving age (SD):* 15.9 (1.0); *White British:* 84%; *With previous convictions:* 78%; *Employed:* 55%; *History of alcohol abuse:* 59%. Non-offenders: *Mean age (SD):* 40.2 (9.0); *Mean # of children (SD):* 1.4 (1.0); *School leaving age (SD):* 17.0 (1.3); *White British:* 97%; *With previous convictions:* 6%; *Employed:* 100%; *History of alcohol abuse:* 19% **Setting:** Urban setting, no further details provided	Service. **Sample size(s):** Total n=84; Offenders n=52; Non-offenders n=32 **Baseline comparisons:** The non-offender sample was older, more likely to be employed, less likely to have a history of alcohol abuse, less likely to have previous convictions, and less likely to have left school at an earlier age than the offender group. **Study sufficiently powered:** NR	deception and impression management. Alpha=0.70. Police records were used to provide re-offending data. **Secondary outcomes:** NR **Follow up periods:** 11 months post-treatment **Methods of analysis:** Overall post-treatment change was measured with MANCOVA, with and without control for pre-treatment social desirability. The impact of the programme on offenders' psychological characteristics at the end of treatment was examined using a series of paired t tests adjusted for multiple testing using a Bonferroni correction. The end-of-treatment psychological change was then examined to determine the extent of clinically significant change achieved by each individual within the sample on each measure.		data were included in the study	are needed to assess the causal association between psychological change and re-offending. This research should be replicated with larger samples to determine whether there are sub-samples who experience negative change as a result of participation in programs like this (as was observed for a small percentage of this sample). **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Carney, M. M. & Buttell, F. P. **Year:** 2006 **Citation:** An evaluation of a court-mandated batterer intervention programme: Investigating differential programme effect for African American and White Women. *Research on Social Work Practice, 16*(6), 571-581. **Country of study:** USA **Aim of study:** To evaluate a batterer intervention programme for women involuntarily placed in treatment and investigate the differential effectiveness of this programme for African American vs. White batterers **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Female batterers mandated to treatment in the southern US **Eligible population(s):** Women who completed the 16-week programme (63 out of 198 women who were referred to the programme) **Selected population(s):** Women who completed the programme and had complete data **Excluded population(s):** Non-completers, those still in the programme, and 4 of the 63 completers who had high (>13) scores on the Balanced Inventory of Desirable Responding Impression Management subscale (it was believed that including their scores would reduce accuracy) **Sample characteristics:** *Married:* 42%; *Arrest prior to programme*: 81%; *Ethnicity:* 51% African American, 49% White; *Alcohol use at one time:* 93%; *Mean age (SD):* 32.7 (8.3);	**Method of allocation:** N/A **Intervention(s) description:** The intervention programme was feminist informed and cognitive-behavioural in orientation and was designed for male batterers. It was a 16-week group treatment programme focusing on anger management and skills development. There were three phases: orientation and intake (2 sessions), psychoeducational classes (12 sessions), and group therapy regarding termination (2 sessions). Groups had ~15 batterers and met one night each week for about 2 hours. The 12-week psychoeducational programme curriculum had three parts. The first 3 weeks covered how to recognize and overcome defense mechanisms (e.g. minimization, denial, blame). The next 3 weeks challenged the batterers' beliefs and values that promote violent behaviour. The final 6 weeks helped clients increase interpersonal skills and provided them with alternative and appropriate behaviours. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=59 **Baseline comparisons:** African American women in this sample	**Primary outcomes:** The *Spouse-Specific Assertiveness Scale (SSAS)* was used to measure assertive behaviours and passive/aggressive responses directed toward one's partner. Internal consistency reliability was 0.87 for the Assertiveness subscale and 0.82 for the Aggressive subscale. The *Control of Partner Scale (CPS)* was used to measure controlling behaviour with regard to a partner. It has excellent internal consistency reliability (coefficient alpha=0.95) and criterion validity. The *Propensity for Abusiveness Scale (PAS)* was used to measure participants' likelihood of using physical force on their partner. Internal consistency reliability was adequate (Cronbach's alpha=0.88). **Secondary outcomes:** NR **Follow up periods:** Post-intervention	**Who is the target of the intervention?** Female batterers mandated to treatment in the US **Did they conduct any aspect of sex, gender or diversity analysis?** They compared African American vs. White participants using logistic regression **Do they report sex, gender or diversity based factors in findings?** Yes, see "Primary Outcomes" **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Scores on the SSAS Passive/Aggressive subscale decreased pre- to post-treatment (t=3.64, p=0.001, effect size d=0.44), indicating that the sample was less passive-aggressive after treatment. Scores on the CPS decreased pre- to post-treatment (t=2.30, p=0.025, d=0.30), indicating a reduction in controlling behaviour. Scores on the PAS decreased pre- to post-treatment (t=2.49, p=0.013, d=0.23) indicating that the sample was less likely to use physical force on their partner after the treatment. There were no other significant differences from pre- to post-treatment. For the logistic regression analysis, only the change in score from pre- to post-treatment for spouse-specific assertiveness behaviour significantly contributed to the prediction of racial group membership (Wald chi-square=5.168, p=0.023). **Secondary outcomes:** N/A	**Limitations identified by author:** Sample was drawn from a predominantly rural, southern state which may limit generalisability of results. Sample was court-mandated, which may not be generalisable to women who volunteer for DV intervention **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: More research is needed on differences in effectiveness of interventions for sub-types of female batterers. **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Mean years of education (SD): 12.8 (1.9); *Mean length of current relationship in months (SD):* 71.2 (54.8); *Still involved with victim:* 69%; *Mean monthly income (SD):* $1,412 (1,275) **Setting:** A non-profit domestic abuse centre in urban Columbia, South Carolina	were (all p's<0.05) less likely to be still involved with the victim, less likely to report alcohol or "other" drug use at one time, and had more children on average. **Study sufficiently powered:** NR	**Methods of analysis:** Paired sample t-tests comparing pre-treatment scores to post-treatment scores. Logistic regression with race as the outcome variable to compare African American vs. White participants		**Attrition details:** N/A	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Connors, A. D., Mills, J. F., & Gray, A. L. **Year:** 2011 **Citation:** An evaluation of intimate partner violence intervention with incarcerated offenders. *Journal of Interpersonal Violence, 27*(6), 1176-1196. **Country of study:** Canada **Aim of study:** To evaluate the effectiveness of an IPV prevention programme for incarcerated offenders **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Incarcerated male perpetrators of IPV in Canada **Eligible population(s):** Federally incarcerated male offenders in Canada screened into the programme based on their level of estimated risk for DV (those in the moderate range on the Spousal Assault Risk Assessment) and having at least one prior incident of abuse against an intimate partner (through official documents, a conviction, or self report) **Selected population(s):** Eligible offenders who agreed to participate (those who refused did so with the knowledge that it might affect their release opportunities) **Excluded population(s):** NR	**Method of allocation:** N/A **Intervention(s) description:** The Moderate Intensity Family Violence Prevention Programme (MIFVPP) for incarcerated male offenders incorporates the Risk, Need, and Responsivity principles, which propose that higher risk offenders should receive higher levels of intervention (risk principle), targets for intervention should be those modifiable areas (criminogenic needs) related to the criminal behaviour (need principle), and delivery of intervention should take into account specific offender characteristics that may influence intervention efficacy (responsivity principle). The programme consists of 29, 3-hr group sessions, with at least three individual counselling sessions. Each group has a maximum of 12 participants and is delivered by two facilitators, who were specially trained correctional programme delivery officers, with an effort to have the team gender balanced. The MIFVPP was comprised of six modules: Motivational Enhancement, Awareness and Education (incorporates components of the Duluth Model), Managing Thoughts and Emotions Related to Abuse (identifying , disputing and replacing cognitive distortions), Social Skills, Self- Management/Relapse Prevention Plan, and Healthy Relationships. The teaching of the skills incorporated adult learning principles and followed cognitive-behavioural therapy strategies. After each module, there was an in-group closed book quiz to	**Primary outcomes:** Jealousy was assessed with the *Interpersonal Relationship Scale (IRS)* where higher scores indicate lower jealousy. The *Aggression Questionnaire-Revised (AQ-R)* has three subscales measuring specific aspects of anger such as awareness, understanding, self-regulation, and self-management. Increase in scores from pre- to post indicates improvement. The *Abusive Relationship Inventory (ARI)* has four subscales: Rationales for Hitting, Need for Control, Legal Entitlement, and Batterer's Myths. Lower scales indicate more positive functioning. There were 14 *Facilitator Structured Ratings (FSR)* completed by both facilitators independently with differences negotiated by consensus at early-, mid-, and post-programme. These 14 ratings covered Programme Treatment Targets related to violence against a partner (11 ratings: acceptance of responsibility for abusive/violent behaviour, acknowledges use of power and control tactics, shows empathy for victims, extent of skills development, recognizes cognitive distortions/beliefs and neutralizations, minimizes consequences, understands lifestyle dynamics, understands abusiveness pattern, identify relapse prevention concepts, discloses personal information, overall quality of plan on release), Motivation to Change (1 rating), Overall Participation (1 rating), and	**Who is the target of the intervention?** Incarcerated male IPV offenders in Canada **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** There was significant (all p's<0.001) improvement from pre- to post-programme in the self-report questionnaires (IRS, AQ-R, and ARI), all FSR's, and the DVVs. Mean changes in readiness to change were in the positive direction from pre- to post on both self-report and facilitator ratings (p<0.001 for both). There was significantly greater pre-post change (p's<0.05) among those rated as "ready to change" vs. "not ready" for the IRS, AQ-R, DVV's, and content knowledge in quizzes 1-5, but not for the ARI. A positive improvement in motivation was correlated with improvement in programme outcomes (the following p's<0.05: DVVs' and FSR's for offender- and facilitator-rated changes in motivation; AQ-R and ARI only for offender-rated changes in motivation). Significant within, between, and interaction effects were	**Limitations identified by author:** This sample does not fit the typical profile of a perpetrator who completes programs in the community. Ratings by facilitators means there is possible bias. Lack of ethnic diversity in the sample. No measure of recidivism; only pre-post programme performance. The sample may have been externally motivated (for release purposes) to participate **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Further examine the relationship

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Sample characteristics: *Mean age (SD):* 36.6 (9.4); *Married or partnered:* 72%; *Ethnicity:* 61% White, 22% Aboriginal, 6% African American, 11% other racial minority; *Has children:* 81%; *Number of assaults, self-report:* 10% never, 34% one assault, 24% two assaults, 9% three, 4% four, 11% five to ten, 2% ten to twenty, 1% twenty-one or more **Setting:** Minimum, medium, and maximum security institutions, as well as within the community for offenders on various forms of release. Urban vs. rural setting not specified	test for content knowledge. Remedial sessions were provided for participants who struggled with the material as determined by self-report, facilitator identification, or by quiz results. Completion of the programme required 100% attendance, (sometimes in the form of makeup sessions), completion of all homework assignments, and a completed realistic relapse prevention plan. Ongoing evaluations for programme content knowledge were conducted by way of quizzes administered at the end of each of the first five modules, personalized homework assignments, and the development of a relapse prevention plan. Throughout the programme there were personalized role plays for skill development, autobiographies focused on the offenders' development of abusive behaviour, establishing offence pathways and identifying high risk situations, including both thought patterns and a relapse prevention plan. **Control/comparison(s) description:** N/A - there was no allocation. Classification into the "ready" and "not ready" to change groups was based on participant and facilitator ratings at the end of the programme **Sample size(s):** Total n=298 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	Overall Programme Performance (1 rating). The latter two ratings were reported for the mid- and post-programme only. Responses for each rating were anchored along a 5-point scale ranging from -2 to +2 where each score on the continuum had an accompanying description. *Domestic violence vignettes (DVV)* employed a structured interview and vignettes to evaluate participant responses to potential risk situations relevant to family violence. Skills are assessed in three domains: behavioural response, interpretation, and perspective taking. *Offender's self-rated readiness to change (OSRC)* was measured pre- and post-programme. **Secondary outcomes:** NR **Follow up periods:** Post-programme (within 10 days following group completion) **Methods of analysis:** Pre-/post-differences were assessed with t tests. Relationship between motivation and change was assessed using t tests and correlations. Change in programme performance over time and between motivated vs. unmotivated offenders were assessed with a mixed within/between design		found when participant programme performance over time was compared among grouped post-programme ratings of motivation. While participants as a whole improved over time, those who were rated as motivated at the end of the programme had improved at a higher rate. **Secondary outcomes:** N/A **Attrition details:** 16% attrition rate	between motivation and outcomes like recidivism **Source of funding:** None

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Author(s): Cranwell Schmidt, M., Kolodinsky, J. M., Carsten, G., Schmidt, F. E., Larson, M., & MacLachlan, C. **Year:** 2007 **Citation:** Short term change in attitude and motivating factors to change abusive behaviour of male batterers after participating in a group intervention programme based on the pro-feminist and cognitive-behavioural approach. *Journal of Family Violence, 22*, 91-100. **Country of study:** USA **Aim of study:** To assess short term changes in attitude and motivating factors to change abusive behaviour after completion of a 27-session programme for male batterers **Study design:** Before and after study **Quality score:** [+]	**Source population(s):** Male batterers in Vermont **Eligible population(s):** Participants in the Domestic Abuse Education Project (DAEP) in Burlington, Middlebury, and St. Albans, Vermont from Nov 1999 to Nov 2002 **Selected population(s):** Participants with complete data **Excluded population(s):** Participants with incomplete data, or who did not complete the programme within the time frame of the study **Sample characteristics:** *Mean age:* 33 (range 18 to 73); *Ethnicity:* 83% Caucasian, 9% African American, 2% Hispanic, 2% Native American, 2% Asian or Pacific Islander, 2% mixed; *Mean monthly income:* $1,291 (range 0-8000) **Setting:** NR	**Method of allocation:** N/A **Intervention(s) description:** The intervention was a 27-session group programme based on a pro-feminist, cognitive behavioural approach to DV modeled after the Duluth programme. The purpose of DAEP is to "give the participant the information he needs in order to eliminate abusive and violent behaviour in his relationships and life". The objectives of the programme are to: expand men's understanding of the wide range of behaviours used to control partners; increase men's awareness of the intentions and thinking that support their choices to abuse; increase men's understanding of the impact of their abuse on themselves, their partners, children, and others; challenge men's efforts to deny or justify their abuse and attempts to minimize or shift responsibility; increase men's motivation to engage in a process of change that supports safe, equitable and respectful relationships; and support men in creating specific plans for ensuring their partners' safety. **Control/comparison(s) description:** N/A **Sample size(s):** Pre-test n=278; Post-test n=165.	**Primary outcomes:** The survey instrument was designed for this study but based on previous research. It included 23 statements measuring attitudes and beliefs, using a 5-point Likert agreement scale (alpha=0.72). It also included 9 yes/no questions asking participants which factors motivate them to have a non-abusive relationship (alpha=0.72). Pre- and post-surveys were anonymous, so the people who completed the post-test may or may not be the same as the people who completed the pre-test. **Secondary outcomes:** NR **Follow up periods:** Post-intervention **Methods of analysis:** Cross-tabulations and Mann-Whitney test	**Who is the target of the intervention?** Male batterers in Vermont **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Post-test, more men saw alcohol and drugs as a cause for violence, but completers showed a shift towards the hypothesized disagreement with the statement: "Alcohol and/or drugs cause violence"	**Primary outcomes:** After the programme, participants reported a positive change in attitudes (i.e. disagreeing that abuse is ok) on 14/15 items regarding abusive behaviour (p's≤0.01), such as: it is ok to be abusive if you feel hurt, abuse is a part of human nature, women want to be dominated by men, and men are treated unfairly by the legal system. There was also a positive change in attitude for 6/8 items regarding support of a nonviolent relationship (p's<0.01), such as: what my partner thinks or feels is important even if I disagree. Participants were also more motivated to change their behaviour by the effect abuse has on their family relationships (p's<0.05 for several items on the motivation scale). However, many participants continued to agree that insecurity, jealousy, and alcohol and drug use can cause violence. **Secondary outcomes:** N/A	**Limitations identified by author:** Pre- and post-test responses were not matched, due to anonymity concerns, so analyses were conducted at the aggregate level. Low response rate **Limitations identified by review team:** No follow-up beyond post-intervention **Evidence gaps and/or recommendations for future research**: Include assessment of behavioural change and data from partners or arrest records. Include a 6-12 month follow up with offenders and victims **Source of funding:** Kid-Safe

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External validity: [-]		**Baseline comparisons:** N/A **Study sufficiently powered:** NR			**Attrition details:** 726 attended orientation. 375 completed the programme. 278 completed the pre-test. 165 completed the post-test.	Collaborative of Chittenden County, Vermont

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): DeLeon-Granados, W., Wells, W., & Long, J. **Year:** 2005 **Citation:** Beyond Minneapolis: A preliminary theoretical model for alleviating conceptual ruts in domestic violence intervention research. *Western Criminology Review, 6*(1), 43-58. **Country of study:** USA **Aim of study:** To test the effect of two batterer interventions based on alternative theoretical models of recidivism, and advance the theoretical debate on	**Source population(s):** DV offenders on the West Coast of USA **Eligible population(s):** DV offenders arrested in one of 15 police jurisdictions in a West Coast county **Selected population(s):** All eligible participants were included in the study **Excluded population(s):** NR **Sample characteristics:** *Ethnicity:* 54% Anglo, 28% Latino, 14% African American, 3% Asian, Native American, or other **Setting:** Urban. Individual-level intervention occurred at the jail. Community-	**Method of allocation:** A volunteer for treatment 1 (individual-level) was called for each arrest. When a volunteer was available and the arrestee agreed to see the volunteer, they received treatment 1. An arrestee was coded as having received treatment 2 (community-level) if a community-based activity occurred in an arrestee's place of residence up to 30 days before or 30 days after the arrest that brought them into the study. A suspect's residence was defined as their street address surrounded by a two-block catchment area. **Intervention(s) description:** There were four groups compared in this study: arrest only, arrest and treatment 1 (individual-level treatment which attempted to stimulate a "stake in conformity"), arrest and treatment 2 (community-level treatment aiming to stimulate collective efficacy with regard to DV norms), and arrest plus treatments 1 and 2. For treatment 1, former DV offenders volunteered to meet with newly arrested batterers through the booking process. All volunteers completed a 52-week batterer intervention programme. When a volunteer was paged to the jail, and an arrestee agreed to meet with him, the volunteer met with the arrestee for ~30 minutes. The volunteer confronted the suspect's use of violence, provided the suspect with information about community services, and urged them to attend a batterer support group. The volunteers' presence at the jail demonstrated that formerly violent men could serve an important role in the community, working with law enforcement and victim advocates, to help others change their behaviour. Treatment 2, the community-level treatments, were implemented under the direction of a manager (a professional community trainer paid by the victim advocate organization) who would either offer training to established community organizations and other social service providers, or meet with informal community groups (such as church groups) and	**Primary outcomes:** Recidivism as measured by official police records on DV-related offences **Secondary outcomes:** NR **Follow up periods:** The first analysis was done with a 6-month follow up period from the time of first arrest. Survival analysis was conducted using offenders' entire length of time in the study, which was variable. **Methods of analysis:** Analyses were conducted such that only those who actually received treatment 1 were counted in that group. Baseline differences were reported but not adjusted for. Descriptive statistics only were used for the 6-month follow-up, and survival analysis was used to look at recidivism over the course of the entire study.	**Who is the target of the intervention?** Arrested DV offenders (gender not specified) **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Percent recidivism at six months was: 8% for arrest only, 14% for arrest + treatment 1, 4% for arrest + treatment 2, and 2% for arrest + treatments 1 and 2. Using survival analysis (i.e. looking at recidivism for the entire length of time an arrestee was in the study), the combination of both treatments was better than either arrest only or arrest + treatment 1, and arrest + treatment 2 was better than arrest + treatment 1 (all p's<0.05). **Secondary outcomes:** N/A **Attrition details:** NR. Presumably, all participants entering the study were included since entering the study with an arrest automatically put them into one of the four comparison groups.	**Limitations identified by author:** Due to the quasi-experimental nature of the study, the groups may not have been equivalent - for example, the community-level intervention was significantly associated with seriousness of offenses. Over 75% of cases were censored in the survival analysis (i.e. did not experience re-arrest in the study time frame). Rearrests outside the county were not tracked. **Limitations identified by review team:** Use of a single outcome variable. No rationale provided for lack of inferential statistics in the 6-month follow up analysis. It would be useful to know how many arrestees declined treatment 1, as that might influence the findings.

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effective deterrence **Study design:** Non-randomised controlled trial **Quality score:** [+] **External validity:** [+]	level intervention occurred in communities, which were of four main types: high-density housing populated by impoverished migrant Latinos; subsidized housing populated mainly by African American residents; lower- to middle-class suburbs with Latino, African American, and Anglo residents; and communities of well-to-do Anglos living in some of the most expensive real estate in the country	train volunteers to perform outreach to others in the community. Outreach included events like training workshops, rallies, marches, and informational presentations (lasting 1-1.5 hours in length) made to various community groups. Events were scheduled in an area when an interested group contacted the DV advocate agency and requested an event or when advocates contacted respected groups in the community and asked for cooperation in scheduling an event. It is unknown whether any particular batterer included in the study attended or was directly exposed to the community-level intervention, but the theory behind this intervention was that batterers would receive messages informally through the actions and messages of other members in their community who had been exposed to such education and activities. **Control/comparison/s description:** The "arrest only" group served as a control. **Sample size(s):** Total n=474; Arrest only n=138; Arrest + treatment 1 n=78; Arrest + treatment 2 n=138; Arrest + treatments 1 and 2 n=120 **Baseline comparisons:** There was a significant relationship (p=0.02) between offense seriousness and delivery of the community-level treatment, such that those charged with a single felony were less likely to have received community-level treatment compared to: those with a misdemeanour only, those with multiple felonies, or those with felonies plus misdemeanour offenses. Demographics of those receiving and not receiving the individual level treatment were comparable. **Study sufficiently powered:** NR				**Evidence gaps and/or recommendations for future research**: Explore the mechanisms at play in the community-level intervention. Use other outcome measures of beliefs among offenders/community members **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Gondolf, E. W. & Jones, A. S. **Year:** 2001 **Citation:** The programme effect of batterer programs in three cities. *Violence and Victims, 16*(6), 693-704. **Country of study:** USA **Aim of study:** To test the programme effect of three established batterer programs **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Men entering a DV batterers programme **Eligible population(s):** First 20 men enrolling in the programme each month **Selected population(s):** Men with partners reporting on reassaults **Excluded population(s):** Pittsburgh site dropped from analysis due to its atypical intervention and jail penalty for non-completion **Sample characteristics:** *Participation:* 82% court referred, 18% voluntary; *Mean age (SD):* 32 (8.8); *Employment:* 64% blue collar, 64% full-time, 36% part time or unemployed; *Ethnicity:* 45% White, 55% minority; *Education:* 24% not completed high school, 36% some college; *Housing:* 49% living with partner, 51% not living with partner; *Mean length of abusive behaviour (SD):* 3.5 years (4.3) **Setting:** Urban. DV programme	**Method of allocation:** N/A **Intervention(s) description:** The Denver programme was 9 months and had evaluations, alcohol treatment, individual psychotherapy, and a women's case manager. Completion rate was 53%. The Dallas programme was 3 months and had evaluations, individual counselling, and a women's group. Completion rate was 60%. The Houston programme was 5.5 months with referrals for substance abuse and a women's group. Completion rate was 49%. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=640 batterers; n=480 at least one partner contact **Baseline comparisons:** NR **Study sufficiently powered:** NR	**Primary outcomes:** Telephone interviews with partner every 3 months for 15 months with open-ended questions, the *Conflict Tactics Scale*, and any reports of injuries **Secondary outcomes:** NR **Follow up periods:** 15 months from start of programme **Methods of analysis:** Instrumental viariable analysis, bivariate probit modeling	**Who is the target of the intervention?** Men committing DV assaults **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Based on women's reports, 42% of drop-outs reassaulted, and 26% of completers reassaulted ($p<0.0001$). Length of programme was not significantly associated with drop-out rate. Programme completion reduced the probablility of re-assault by 44% (bivariate probit) to 64% (two-stage specification) ($p<0.005$), a moderate effect size. **Secondary outcomes:** N/A **Attrition details:** Full reponse rate for 15 months: 67%. At least one report: 77%	**Limitations identified by author:** Statistical tests limited. Need for individualized approaches indicates that the system should be evaluated as a whole **Limitations identified by review team:** Based on partner report, so those splitting from partner do not appear to have been evaluated **Evidence gaps and/or recommendations for future research:** Retesting the hypothesis on a different dataset **Source of funding:** US Centers for Disease Control and Prevention, and US Department of Health and Human Services

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Gondolf, E. W. **Year:** 2008 **Citation:** Outcomes of case management for African-American men in batterer counselling. *Journal of Family Violence, 23*, 173–181. **Country of study:** USA **Aim of study:** To evaluate the impact of case management and contact with additional services on batterer outcomes **Study design:** Cross sectional study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Male batterers in Pittsburgh **Eligible population(s):** Male batterers in Pittsburgh, Pennsylvania who were court-ordered to treatment **Selected population(s):** Men court-ordered to treatment who were referred to counselling programme **Excluded population(s):** Men not arrested for violence against a female partner. Men who refused to participate **Sample characteristics:** Case-management sample: *Income >3000:* 57%; *Relationship status:* 46% married. Control: *Income >3000*: 45%; *Relationship status:* 35% married **Setting:** Urban	**Method of allocation:** The case management sample was comprised of all African-American men at intake from March 2003 to May 2004. The control sample was drawn from an evaluation completed immediately prior to the case management project. **Intervention(s) description:** The intervention in this study was case management at the Domestic Abuse Counselling Centre (DACC) in Pittsburgh, Pennsylvania. Case management involved programme staff conducting a brief assessment of the batterer's prior abuse, other criminal activity, alcohol and drug use, psychological and physical health, employment history and job status, educational needs, and parenting issues. A background questionnaire of self-reported needs and problems in these areas served as a guide in this assessment. Based on the questionnaire and follow-up questioning, the staff made appropriate referrals to community services including employment and educational service, parenting classes, and alcohol and psychological treatment. The case manager made periodic follow-up phone calls to the men in order to monitor their referral contacts and offer additional support. A computerized tracking and contact form indicated the number, nature, and result of calls to the batterer programme participants, and any new problems or needs along with	**Primary outcomes:** Re-assaults were assessed through a series of questions that included "How is the relationship going?", descriptions of any conflicts and their circumstances, and an inventory using the categories of the *Conflict Tactics Scale*. Re-arrests were determined from the criminal histories of the programme participants drawn from the statewide database of arrests. Records were requested for a subsample of 100 subjects randomly drawn from men in the case-management sample and 100 randomly drawn from the comparison sample. For service contact, used in the analysis of "treatment received", the women were asked about their partner's service contact in three areas: any assistance or support other than the programme, and then more specifically, any treatment for alcohol and drug abuse, counselling other than the DV programme, and any other assistance. Women's perception of safety was measured by asking them to estimate how safe they felt at each follow-up interview, and the likelihood that their partner would hit them in the	**Who is the target of the intervention?** African-American men who batter **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Yes, see primary outcomes	**Primary outcomes:** The case management project did not appear to improve the programme dropout rates of the men in counselling (48 vs. 45%). The rate of re-assault was nearly identical across the two samples for each of the follow-up periods (0-12 months: 26 vs. 24%), and the women's perceptions of safety, the likelihood of further hitting, and the men's change also did not statistically differ across the samples. There was a tendency towards a lower rate of threats in the case-management sample, but the difference was not statistically significant. In the regression analyses controlling for batterer characteristics, case management was not a significant predictor of re-assault during the 0-12 month follow-up (OR=0.25, p=0.35). The characteristics that were significant predictors included the man's parents hitting one another (OR=0.70, p=0.02) and the man's perception that his partner felt "very safe" (OR=−0.47, p=0.01). The equation was statistically significant (model chi square=15.93, p=0.001) but it accounted for only a small portion of variance	**Limitations identified by author:** The sample is not representative of the batterer population because the programme is closely linked with the DV court and over half of its participants are of African-American descent, and Pittsburgh faced several years of financial cutbacks that may have adversely affected available referral sources. Results may not generalize to other populations or cities **Limitations identified by review team:** Social desirability biases **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** Pennsylvania

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	counselling centre	the new referrals and recommendations for those problems. The case management was an additional component to the regular programme offered by DACC. The regular programme involved weekly sessions of 1.5 hours for groups of 13-18 men. Participants were referred from the court for DV offenses and required to attend 16 weekly group sessions. A staff counsellor followed a primarily instructional or didactic approach that conformed to a gender-based, cognitive-behavioural curriculum. **Control/comparison(s) description:** The comparison group went through the regular programme of 16 weekly group sessions, but did not receive case management. **Sample size(s):** Total n=684; Intervention n=202; Control n=482 **Baseline comparisons:** The intervention group had a significantly greater portion of men with high income (p<0.01) and a marriage relationship (p<0.05), but with a lower proportion of men reporting drug use (p<0.05), drunkenness (p<0.05), threats (p<0.01), and bruised partners (p<0.05). **Study sufficiently powered:** NR	next three months. The women were also asked to rate how much the man had changed since entering the programme. **Secondary outcomes:** NR **Follow up periods:** 12 months total, at three month intervals **Methods of analysis:** Outcomes were cross-tabulated by the case-management and no-case management samples. Fisher's Exact Test was computed for each. Logistic regression was run for the dichotomous outcome of "re-assault" versus "no re-assault" during the 12-month follow-up. Equations were also computed for other follow-up time frames (0-6 months and 3-12 months). Logistic regressions were also computed for the outcome variable indicating a DV arrest during the follow-up, and then for arrest for any violence and for any crime during the follow-up.		(Cox and Snell R-squared=0.03). The logistic regression for DV re-arrest showed that being in the case management project was not a significant predictor for that outcome (OR=−0.12, p=0.83). However there were significant predictors: drug use during past year (OR=4.77, p=0.02), and previous mandate to a batterer programme (OR=3.172, p=0.05). This equation was statistically significant (model chi square=9.07, p=0.03). Regarding service contact, the extent of additional assistance among the intervention was significantly higher for men under case management (44 vs. 29%, p<0.01). However, contacting additional services did not significantly improve re-assault or re-arrest rates. **Secondary outcomes:** N/A **Attrition details:** Response rate: 72% at the 3-month follow-up, 65% at the 6-month follow-up, and 62% at the 12-month follow-up. The response rates were equivalent for the case-management and no-case-management samples.	Commission on Crime and Delinquency

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Gondolf, E. W. **Year:** 2009 **Citation:** Outcomes from referring batterer programme participants to mental health treatment. *Journal of Family Violence, 24*, 577-588. **Country of study:** USA **Aim of study:** To determine if referral to supplemental mental health treatment (i.e., the intention-to-treat) would reduce batterer behaviours, and to determine if treatment contact would improve outcomes (i.e., treatment received)	**Source population(s):** Male batterers in Pittsburgh, Pennsylvania **Eligible population(s):** Male batterers in Pittsburgh, Pennsylvania **Selected population(s):** Male batterers in Pittsburgh, Pennsylvania who were court-ordered to attend the Domestic Abuse Counselling Centre (DACC) and who had a positive screen on the Brief Symptom Inventory (BSI) (a "positive" screen was a score of >62 on the Global Severity Index of the BSI) **Excluded population(s):** NR **Sample characteristics:**	**Method of allocation:** The three referral groups were sequentially recruited (i.e. all eligible participants at the start of the study were allocated to one group, the next group of participants were allocated to another, and the last participants to be recruited were all allocated to another) **Intervention(s) description:** DACC provides weekly sessions of 1.5 hours to groups of 13-15 men for a required duration of 16 weeks. A staff counsellor follows a primarily instructional approach including a gender-based cognitive-behavioural curriculum. The court-referred men were administered a background questionnaire and a mental health screening instrument, the Brief Symptom Inventory (BSI). At the orientation meeting the following week, the men who screened positive on the BSI were asked to remain after the meeting. The programme staff presented these men with a simplified list of instructions for referral, contact information for the mental health clinics, and compliance verification forms to present to the clinic. The referred men were to call the mental health clinic within a few days and schedule an appointment for a mental health evaluation. The mental health treatment was provided through outpatient clinics and the "standard of care" for referrals generally included an initial appointment, a 30-50 min individual clinical evaluation, and a prescribed treatment plan combining individual psychotherapy, group therapy, and possibly medication. The "partial referral" group of men were required as part of their court order to comply with the referral as well as the batterer programme attendance. Under the fully implemented "mandatory referral" stage, a system coordinator and case manager monitored the	**Primary outcomes:** Programme completion of the required 16 weekly sessions was measured as attending all sessions without dismissal for unexcused absences or failure to pay assessed fees. Re-assault was defined as physical abuse of the subject's female partner reported by that partner during phone interviews conducted every 3 months over the 12-month follow-up period. It was identified through a series of questions that included an open-ended question about how the "relationship is going", descriptions of any conflicts and their circumstances, and an inventory using the categories of the *Conflict Tactics Scale*. Re-arrests were assessed by reviewing the arrest records in a state-wide database of criminal histories. **Secondary outcomes:** NR	**Who is the target of the intervention ?** Male batterers **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The intention-to-treat comparison showed a slightly lower but not statistically significant completion rate for the mandated referrals (no referral 57% vs. partial referral 60% vs. mandated referral 52%). The treatment-received condition showed an increase in batterer programme completion for those men who obtained a mental health evaluation (evaluated 76% vs. not 38%, $p<0.05$) and those who received mental health treatment (treated 68% vs. non 45%, $p<0.05$). Men who obtained a mental health evaluation were six times more likely to complete the batterer programme, even after controlling for batterer characteristics (OR=6.30, $p<0.001$). The re-assault rates were similar across the referral stages for the full 12-month follow-up, as were the re-assault rates following the batterer programme (3-12 months). Women reported a significantly lower sense of safety during the mandated referral stage both in terms of the likelihood to be hit ("very unlikely to be hit": none 67% vs. partial 66% vs. mandated 50%, $p<0.05$) and their feelings of safety ("feel very safe": none 73% vs. partial 69% vs. mandated 54%, $p<0.05$). Men who obtained an evaluation under the mandated referral were nearly a third less likely to re-assault their partner during the full 12-month follow-up (no-evaluation 31% vs. evaluation 22%), and a third less likely to re-assault if they received treatment (no-treatment 30% vs. treatment 19%), though neither of these differences were statistically significant. The batterer characteristics significantly associated with re-assault in	**Limitations identified by author:** Failure to establish a robust group of men who actually received supplemental mental health treatment - one of the treatment-received conditions. Relatively low compliance rate. The BSI may have included many false positives, which may have contributed to the low compliance of the referrals and neutralized the effect of supplemental treatment. **Limitations identified by review team:** Social desirability response patterns from both male and female subjects may bias findings

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Study design: Non-randomized controlled trial **Quality score:** [+] **External validity:** [+]	*Age:* 44% <30 years old; *Ethnicity:* 51% African American; *Education:* 31% some college; *Unemployed:* 50%; *Not living with partner:* 55%; *Previously arrested:* 49%; *Substance use:* 31% reported being drunk at least monthly **Setting:** Urban counselling centre; outpatient clinic	implementation to ensure that the notification, verification, and reporting to the court were complete. This entailed calling the referred men within 3 weeks of programme intake to discuss their compliance and monitoring the notification, verification, and reporting to the court. **Control/comparison(s) description:** To establish a quasi-control group of "no referral", men who screened positive on the BSI were initially informed that the referral was in their interest but voluntary. **Sample size(s):** Analysis 1: Total n=479; Men court-mandated to seek mental health treatment n=148; Men under a partially implemented mandate n=149; Voluntarily referred subsample n=182. Analysis 2: Total n=148 (mental health referral was mandated by the courts); Men who obtained a clinical evaluation n=48; Men who did not obtain a clinical evaluation n=100; Men who received mental health treatment along with an evaluation n=28; Men who did not receive treatment n=120 **Baseline comparisons:** The "no referral", "partial referral" and "mandated referral" participants were relatively similar on most baseline variables. However, a smaller portion of the mandated referrals had previously attended a batterer programme compared to the other groups (no referral 18% vs. partial referral 23% vs. mandatory referral 12%, $p<0.05$). **Study sufficiently powered:** NR	**Follow up periods:** 3, 6, 9, 12 months **Methods of analysis:** Analyses examined the effect of supplemental mental health treatment on the follow-up outcomes using both intention-to-treat and treatment-received analytical frameworks. Chi square tests or Fisher's exact test (for the two-way treatment tabulations) were used to assess whether the outcomes were significantly lower for the men under mandatory referral or who actually received treatment. Logistic regressions were also run.		the evaluation equation were not being married (OR=2.31, $p<0.01$), living with a partner (OR=2.05, $p<0.01$), and having been previously arrested for DV (OR=2.44, $p<0.01$). These predictors were similarly significant in the treatment-received equation. Men under mandatory referral were 40% less likely than the voluntary referrals to be re-arrested for both domestic and other violence, but the differences were not statistically significant (DV: no referral 7% vs. mandated referral 4%; other violence: none 11% vs. mandated 6%). The mandated referrals were also significantly less likely to be re-arrested for crimes other than violence or alcohol and drug offenses (other crimes: none 12% vs. mandated 3%, $p<0.05$), and as a result less likely to have been re-arrested for any crime during the 12-month follow-up (none 29% vs. mandated 18%, $p<0.1$). **Secondary outcomes:** N/A **Attrition details:** No evidence of non-response or attrition bias on the follow-up sample as a whole or for the referral subsamples. Completion of 16 sessions: No referral: 57% completion rate. Partial referral: 60% completion rate. Mandated referral: 52% completion rate. Response rate from female partners for the full 12 months of follow-up was 65%. 79% of women completed at least one follow-up during this period.	**Evidence gaps and/or recommendations for future research**: More research is needed on improving the implementation of coordinated or more comprehensive interventions, as well as on the relationship of mental health problems to DV. **Source of funding:** National Institute of Justice of the U.S. Department of Justice in Washington, D.C

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Kistenmacher, B. R. & Weiss, R. L. **Year:** 2008 **Citation:** Motivational interviewing as a mechanism for change in men who batter: A randomized controlled trial. *Violence and Victims, 23*(5), 558-570 **Country of study:** USA **Aim of study:** To determine the potential effectiveness of motivational interviewing (MI) in changing the way batterers think about their violent behaviour **Study design:** Randomized controlled trial **Quality score:** [+] **External validity:** [-]	**Source population(s):** Batterers in Lane County, Oregon **Eligible population(s):** Men arrested for DV in Lane County, Oregon **Selected population(s):** Men who were arrested for partner violence, mandated to batterers' treatment, and who had not yet attended the first mandated group **Excluded population(s):** NR **Sample characteristics:** Full sample: *Mean age (SD):* 37.3 (10.9); *Mean monthly income:* $1,381 ($1,144); *Highest education completed in years (SD):* 11.2 (2.9); *Committed at least one severe act of partner violence in past year:* 48%; *Mean number of*	**Method of allocation:** Assignment to control or intervention was randomly made before participants agreed to be in the study **Intervention(s) description:** During the first (time 1) visit, both experimental and control participants completed a battery of self-report questionnaires. Participants assigned to the experimental group then met with one of four trained therapists for 50-60 minutes; the therapist provided objective feedback on the results of the Conflict Tactics Scale (CTS) and the Stages of Change Questionnaire (SOCQ) using motivational interviewing strategies. Two male and three female therapists were trained over the course of four months on MI strategies. After two weeks, individuals in the experimental group met with the same therapist as in time 1 for 50-60 minutes. During the session, the therapist used MI strategies to engage the participant in a discussion about his battering behaviour and required entry into treatment. The session focused on unearthing the client's ambivalence about his battering behaviour, using OARS techniques (i.e. open-ended questions, affirmations, reflections, and summaries), strategies for handling resistance (e.g. reflection), and strategies for eliciting change talk (e.g. evocative open-ended questions, inviting elaboration of change talk, looking forward,	**Primary outcomes:** The *Conflict Tactics Scale Form N (CTS)* measures the extent to which partners use certain tactics to handle relationship conflict. For husband-to-wife conflict, internal consistency reliability is alpha=0.50 for the reasoning subscale, 0.80 for the verbal aggression subscale, and 0.83 for the violence subscale. The *Revised Gudjonsson Blame Attribution Inventory (BAI-R)* is a forced choice, self-report measure of an individual's attributions for a particular crime. Two-month test-retest reliability for the external attribution subscale is 0.85. The *Stages of Change Questionnaire (SOCQ)* measures an individual's readiness for changing a problem behaviour. The SOCQ has high internal consistency with subscale alpha coefficients ranging from 0.88 to 0.89 in one study. To determine fidelity to the MI model, therapist speech was coded by four	**Who is the target of the intervention?** Men who batter **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Precontemplation, contemplation, and action difference scores from the SOCQ served as the dependent variables. The group main effect was statistically significant (Wilks's λ=0.70, $F(3,22)=3.3$, $p=0.04$). The MI group demonstrated a pre-to-post increase in action, and the control group showed a decrease in action. There was a pre-to-post increase in contemplation, and the control group showed a pre-to-post decrease in contemplation. This difference was not statistically significant, although a trend was present ($p=0.11$). The control group demonstrated a pre-to-post decrease (trend) in precontemplation, and the MI showed a slight increase in precontemplation ($p=0.06$). The strength of association between the independent variable (group) and the linear combination of dependent variables was eta-squared=0.31, indicating that 31% of	**Limitations identified by author:** Small sample size. Short intervention duration **Limitations identified by review team:** Self-report biases **Evidence gaps and/or recommendations for future research**: The effectiveness of MI in reducing DV behaviour should be examined. MI should be paired with a particular treatment protocol, and behaviours such as treatment compliance and violent behaviour should be measured. An equivalent control condition should be created to equalize the amount of effort required to participate across the two conditions and to test whether MI is responsible for changes as opposed to the experience of receiving attention from a therapist. The impact of a higher "dosage" of MI on readiness to change and external blame should be explored in future studies.

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	arrests for any crime (SD): 6.94 (10.97); *Had ever been referred to drug and/or alcohol treatment:* 64%. Treatment group: *Mean age (SD):* 35.1 (9.3); *Mean monthly income:* $1,102 ($884); *Ethnicity:* 75% Euro American; *Highest education completed in years (SD):* 11.2 (2.6). Control group: *Mean age (SD):* 39.4 (12.1); *Mean monthly income:* $1,626 ($1,310); *Ethnicity:* 94% Euro American; *Highest education completed in years (SD):* 11.2 (3.3) **Setting:** Rural university outpatient clinic	exploring goals and values, etc.). The goal of the session was to provide a collaborative, nonjudgmental environment in which the therapist could invite the client to make his own arguments for change and ultimately experience increased motivation for reducing or ending battering behaviour. Finally, at the end of the second visit, experimental and control participants completed the same battery of questionnaires. **Control/comparison(s) description:** Control received nothing **Sample size(s):** Total n=33; Intervention n=16; Control n=17 **Baseline comparisons:** A series of independent-samples t tests and chi-square tests were conducted on demographic variables between groups. There were no significant differences between participants and nonparticipants, MI participants and control participants, or drop-outs and completers. **Study sufficiently powered:** NR	undergraduate research assistants. **Secondary outcomes:** NR **Follow up periods:** NR **Methods of analysis:** MANOVA, t-tests, descriptive statistics		the variance in the dependent variables is attributable to group differences. The MI group, relative to the control group, demonstrated a significantly greater pre-to-post decrease in external attributions using a one-tailed t-test (t=-1.9, p=0.04). **Secondary outcomes:** N/A **Attrition details:** Total approached to participate=123 (73% refusal rate). Out of the original 33, 85% completed both phases of the study (94% control participants and 75% of intervention). Fisher 's exact test indicated that dropout rates between the two groups was not statistically significant (p=0.18).	**Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Lawson, D. M., Dawson, T. E., Kieffer, K. M., Perez, L. M., Burke, J., & Kier, F. J. **Year:** 2001 **Citation:** An integrated feminist/cognitive-behavioural and psychodynamic group treatment model for men who abuse their partners. *Psychology of Men & Masculinity, 2*(2), 86-99. **Country of study:** USA **Aim of study:** To evaluate the effectiveness of a group programme for men who abuse their intimate partners **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Men in Texas who abuse their intimate partners **Eligible population(s):** Men who are on probation for abusing their intimate partners **Selected population(s):** NR **Excluded population(s):** Men exhibiting severe psychopathic behaviour or profiles and those with severe substance abuse problems **Sample characteristics:** *Mean age (SD):* 33(11.6); *Ethnicity:* 42% Hispanic, 35% African American, 23% Caucasian **Setting:** Therapy. Urban vs. rural setting not specified	**Method of allocation:** N/A **Intervention(s) description:** Groups consisted of 8-10 men led by male-female therapist teams of advanced counselling psychology doctoral students. Each of the 15 weekly group sessions lasted about 2.5 hours. Significant time was spent on relaxation training, cognitive restriction and self-instructional training related to violence behaviour and gender issues. A balance of challenge and support was critical to reaching the emotional level necessary to challenge the abuser's insecure attachment expectations. The goals of this component of therapy were: to create an atmosphere of optimal trust, to allow expectations to be enacted, to assist the client in being aware of what he is doing while he is doing it, to interdict the client's typical enactment of complementary roles based on his working model, forcing him to rethink, modify and correct the assumptions that underlie his working model. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=21 **Baseline comparisons:** N/A **Study sufficiently powered:**	**Primary outcomes:** The *Minnesota Multiphasic Personality Inventory-2 (MMPI-2), Conflict Tactic Scale 2 (CTS-2)*, and the *Marital Satisfaction Inventory (MSI-R)*, were used. **Secondary outcomes:** Self- and partner- (who remained with their abusive partners) reported outcomes including recidivism **Follow up periods:** Post-intervention **Methods of analysis:** Heyman and Schlee's correction factor was used to estimate the "true" rate of pre-treatment abuse (1.3 x men's report of overall aggression and 2.4 x men's report of severe acts). Multivariate analysis of variance was performed.	**Who is the target of the intervention?** Male probationers who have battered their partners **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Significant reductions were noted in the CTS-2 subscales: Physical Assault ($F(1,40)=9.72$, $p=0.003$), Psychological Aggression ($F(1,40)=8.81$, $p=0.005$), and Injury ($F(1,40)=6.5$, $p=0.015$). Significant reductions were found only on the Aggression subscale of the MSI-R ($F(1,40)=53.33$, $p=0.000$). **Secondary outcomes:** The frequency of violence was significantly reduced from pre-group to during group ($p<0.05$) and from pre-group to post-group ($p=0.05$). In some cases, violence ceased completely. 12 of the 13 women reported: a decrease in the frequency of violence, a change to a less severe form of abuse, or a cessation of physical abuse from before partner attended group to after partner attended group. This change was much more dramatic for those women reporting a large number of violent acts before treatment. The time out procedure and improved communication skills were mentioned most often as being the greatest help in decreasing violence. **Attrition details:** Of the 37	**Limitations identified by author:** Low internal validity due to lack of control group. Questionable validity resulting from the men's tendencies to deny and minimize violence, psychological issues related to accurate reporting such as trauma bonding and self-selection by the participating men and women. Retrospective accounts. Women who stayed with their abusive partners would have a greater tendency to minimize and underreport violent behaviours. **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
		NR			men who started the programme, 31 completed treatment. There was no significant demographic difference between completer and non-completers. Only 21 of the men were still living with the women they had abused before entering the programme, and only 13 of these women completed the follow-up interview.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Lawson, D. M., Barnes, A. D., Madkins, J. P., & Francois-Lamonte, B. M. **Year:** 2006 **Citation:** Changes in male partner abuser attachment styles in group treatment. *Psychotherapy, 43*(2), 232-237. **Country of study:** USA **Aim of study:** To examine attachment pattern change and its relationship to symptom change with partner violent men **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Men on probation for partner violence in Texas **Eligible population(s):** Men who were attending group treatment as a condition of their probation **Selected population(s):** NR **Excluded population(s):** Participants who missed more than two sessions **Sample characteristics:** *Mean age (SD):* 32.8 (8.7); *Race:* 42% African American, 27% White, 27% Hispanic; *Marital status:* 33% single/divorced, 42% married; *Mean years education:* 11.8; *SES:* 100% Low or lower-middle class **Setting:** Therapy. Urban vs. rural setting not specified	**Method of allocation:** N/A **Intervention(s) description:** 17 weeks of integrated cognitive-behavioural/psychodynamic group treatment co-led by a male/female team who had been members of a DV research team for at least 1 year before co-leading groups **Control/comparison(s) description:** N/A **Sample size(s):** Total n=33 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** Partner abuse was measured by the *Conflict Tactics Scale (CTS)*. It possesses good concurrent and construct validity. Only the physical violence scale (9 items) was used in the study. A "Severity Weighted Scale" was computed that included both the injury producing potential of the violence (mild to severe) and the frequency of violence. Increasingly more severe types of partner violence were more heavily weighted. The degree of agreement between responses on the CTS was checked with the police report and discrepancies were only found with 4 of the men. With permission from the men, CTS forms were altered to reflect the violence indicated on the police report. **Secondary outcomes:** *Outcome Questionnaire-45 (OQ-45)* measures client progress based on 3 domains: Symptom Distress (SD; anxiety and depression), Interpersonal Relations (IR; friendships and family), and Social Role (SR; life satisfaction). Higher scores indicate more distress. **Follow up periods:** Post-intervention **Methods of analysis:**	**Who is the target of the intervention?** Men on probation for partner violence **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The total sample reported significant reductions in partner violence from pre- to post-treatment ($F(1,30)=6.06$, $p<0.05$). **Secondary outcomes:** There was a significant increase in the number of men reporting a secure attachment from pre- to post-treatment (chi square=5.06, p=0.024). Subsequent analysis indicated that secure-changed men reported significant increases in comfort with closeness and depending on others from pre- to post-treatment ($t(13)=4.88$, $p<0.001$). From pre- to post-treatment, insecure and secure-unchanged men reported an increase in avoidance of closeness ($t(12)=2.33$, $p<0.05$ and $t(6)=2.43$, $p<0.05$, respectively). Additionally, secure-changed men reported lower anxiety and depression than insecure men at post-treatment ($p<0.05$). **Attrition details:** 42 men started the	**Limitations identified by author:** Lack of control group. Lack of collateral data from partners to corroborate the men's report. Small sample size. Potential for socially desirable answers. Reliance on self-report. No long-term follow-up **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Future research needs to examine more thoroughly differences between the 3 groups (e.g., readiness to change or personality) and how these differences are related to change processes, treatment matching, and reduction in partner violence. It would be particularly critical to distinguish more clearly between secure-unchanged and secure-changed. **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
			Outcomes were compared using chi-square tests and ANOVAs		programme. Nine were dropped from treatment either after missing more than 2 sessions (probation policy) or dropping out of treatment, leaving 33 who completed the treatment and study. Two men who changed from secure to insecure were excluded from further analysis because they did not fit in any of the groups.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Lawson, D. M. **Year:** 2010 **Citation:** Comparing cognitive behavioural therapy and integrated cognitive behavioural therapy/psychodynamic therapy in group treatment for partner violent men. *Psychotherapy Theory, Research, Practice, Training, 47*(1), 122-133. **Country of study:** USA **Aim of study:** To compare the effectiveness of cognitive behavioural therapy (CBT) to integrated CBT and psychodynamic therapy (CBT/PT) in reducing partner violence (PV) **Study design:** Non-randomized controlled trial **Quality score:** [+] **External validity:** [-]	**Source population(s):** Male perpetrators of PV **Eligible population(s):** Men attending treatment for PV in the study area (unspecified) **Selected population(s):** Men with complete data **Excluded population(s):** Men who missed more than two sessions (probation policy), men who did not complete all measures, men who refused consent or whose partners refused consent **Sample characteristics:** CBT/PT group: *Ethnicity:* 41% African American, 26% Caucasian, 19% Hispanic, 4% Native American, 11% omitted response; *Mean*	**Method of allocation:** Men were assigned to the next available group. CBT and CBT/PT groups alternated. **Intervention(s) description:** Treatment groups were led by masters level male and female co-therapists (four were assigned CBT and four were assigned CBT/PT). There were 7-10 men per group. Each of the 17 weekly sessions lasted 2.5 hours. Focal elements of the CBT treatment included motivation to change, commitment to nonviolence, self-monitoring of cues that trigger anger and violence, time-out procedures, exploring/changing attitudes toward women and PV, responsibility plans, anger and stress management, relaxation training, cognitive restructuring/coping statements, communication skills, and assertiveness. There was a strong emphasis on building and maintaining a therapeutic alliance through supportive listening. Supportive listening did not include interpersonal processing of in-session and partner relationships. Skills acquisition included practice in-session and homework. **Control/comparison(s) description:** The CBT/PT model included the CBT elements plus a psychodynamic component consistent with Time-Limited Dynamic Psychotherapy. This aspect of treatment focused on maladaptive interpersonal patterns	**Primary outcomes:** The *Conflict Tactics Scale (CTS)*, completed by men's partners, was used to assess partner violence. It assesses three types of aggression (current study alphas): psychological aggression (0.76), mild physical aggression (0.75), and severe physical aggression (0.88). The *Adult Attachment Scale (AAS)* assessed three attachment dimensions (current study alphas): close (measures comfort with intimacy, 0.64), depend (measures comfort depending on others, 0.70), anxiety (measures worry about being rejected, 0.68). the *Inventory of Interpersonal Problems (IIP-SC)* was used to assess interpersonal function. It has eight subscales (present study alphas ranged from 0.68 to 0.84): domineering, vindictive, overly cold, socially avoidant, nonassertive, exploitable, overly nurturant, and intrusive. The *Outcome Questionnaire-45 (OQ-*	**Who is the target of the intervention?** Male perpetrators of PV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Results indicated that the CBT/PT groups showed significantly more improvement than the CBT groups on severe PV ($p<0.05$, eta squared=0.94), avoidance attachment ($p<0.05$, eta squared=0.11), and scores on the intrusive-socially avoidant scale ($p<0.01$, eta squared=0.14) at post-treatment. Conversely, the CBT groups showed significantly more improvement than the CBT/PT groups on measures of psychological/behavioural functioning (as measured by the GAS, $p<0.05$, eta squared=0.12) and general symptom and relationship distress (as measured by the OQ-45, $p<0.05$, eta squared=0.10). Finally, there was a significant difference between the treatment groups on recidivism rate, with the CBT/PT groups having the lowest rate (22% vs. 50% in the CBT group, $p<0.05$) **Secondary outcomes:**	**Limitations identified by author:** Modest sample size. No follow-up post-treatment. Risk of socially desirable responding. Lack of random assignment to treatments **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Examine whether PT alone would be better than CBT **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	age (SD): 30.1 (7.6), range 20-51; *Mean years of education (SD):* 10.4 (0.6), range 9-13. CBT group: *Ethnicity:* 50% African American, 17% Caucasian, 33% Hispanic; *Mean age (SD):* 35.8 (9.6), range 20-54; *Mean years of education (SD):* 10.6 (0.7), range 9-14 **Setting:** Group treatment. Urban vs. rural setting not specified	learned in childhood that are associated with conflict and PV. The psychodynamic elements of treatment were integrated into the more content-based elements of CBT. **Sample size(s):** Total n=45; CBT n=18; CBT/PT n=27 **Baseline comparisons:** Compared to the CBT/PT group, the CBT group was assessed by therapists to function at a significantly lower level psychologically (Global Assessment Scale). There were no other significant differences between the two groups. **Study sufficiently powered:** NR	*45)* was used to measure client progress on three domains (current study alphas from 0.71 to 0.93): symptom distress, interpersonal relationships, and social role (life satisfaction). The *Global Assessment Scale (GAS)* assessed overall psychological functioning (intraclass correlations from 0.69 to 0.91). The *Millan Clinical Multiaxial Inventory III (MCMI-III)* was used to assess for psychopathology. Current study alphas from 0.64 to 0.85 **Secondary outcomes:** NR **Follow up periods:** NR **Methods of analysis:** Adjustments were made for significant baseline differences between groups.		N/A **Attrition details:** The initial pool of participants was 74 men. 14 were dropped because they missed more than two sessions (probation policy); of these, six were from the CBT/PT group and 8 were from the CBT group but completers and non-completers did not differ significantly on any variable. 8 did not complete all measures. 4 refused consent. 3 of the men's partners refused consent.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Lee, M.Y., Uken, A., & Sebold, J. **Year:** 2004 **Citation:** Accountability for change: Solution-focused treatment with domestic violence offenders. *Families in Society, 85*(4), 463-476. **Country of study:** USA **Aim of study:** To evaluate the effectiveness of a solution-based DV group treatment in terms of: effects on self-esteem, recidivism rates following programme completion, programme completion rates, and relational context change as evaluated by partners **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Men and women who abuse their intimate partners in Ohio **Eligible population(s):** Men and women DV offenders who were ordered into treatment by the court and offered an opportunity to avoid prosecution by completing group treatment and abstaining from future violence **Selected population(s):** Offenders who opted for treatment, or who were court mandated to treatment **Excluded population(s):** N/A **Sample characteristics:** *Gender:* 86% male; *Ethnicity:* 84% White; *Age:* 74% 31-50;	**Method of allocation:** N/A **Intervention(s) description:** The Plumas Project is a solution-based, goal-directed DV group treatment programme co-led by a female and male therapist. The programme uses a treatment approach that holds DV offenders accountable for solutions rather than responsible for problems. Solution-focused treatment for DV offenders postulates that positive and long-lasting change can occur in a relatively brief period of time by focusing on solution talk instead of problem talk. Focusing on and emphasizing solutions, competencies, and strengths in offenders must never be equated with a minimization of the destructiveness of their violent behaviours. Treatment includes eight 1-hour group sessions over a 3-month period. The programme utilizes a goal to create a context for participants to identify, notice, rediscover, and reconnect with their strengths and resources. Participants are required to develop a personally meaningful goal. Major themes of goals were goals focusing on self, goals focusing on relationships, and goals focusing on developing helpful attitudes. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=87	**Primary outcomes:** Recidivism rates, the rate of participants' recommitting violent behaviours, were collected from the victim witness office, the probation office, and the district attorney's office. Additionally, reports from participants and their partners were collected during telephone interviews during follow-up and they were asked to rate the perceived level of violence out of 10. **Secondary outcomes:** The *Index of Self-esteem (ISE)* was used to measure self-reported degree and severity of a problem with the client's self-esteem. It has good reliability and validity. The *Solution Identification Scale (SIS)* captured the spouse's evaluation of relational behaviour. **Follow up periods:** 6 month follow-up. Official records followed for 6 years **Methods of analysis:** A series of paired-sample t tests were used to	**Who is the target of the intervention?** Men and women DV offenders **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No significant differences in recidivism rates were found between genders. **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Using an inclusive definition of recidivism, the rate was 16.7% (district attorney's office=6.7%, probation office=4.4%, and victim witness office=15.5%). Partner's perceived level of violence decreased significantly from 5 pre-treatment to 0.3 at follow-up ($t(21)=6.7$, $p<0.001$). **Secondary outcomes:** There were improvements in participants' relational skills in intimate relationships as evaluated by their partners post-treatment ($t(33)=3.6$, $p<0.001$) and during follow-up ($t(21)=4.1$, $p<0.001$), and an increase in their self-esteem based on self-reports both post-treatment ($t(81)=-2.2$, $p<0.5$) and during follow-up ($t(47)=-3.1$, $p<0.01$). **Attrition details:** 97% of participants agreed to participate in the study. 94% completed the post-intervention questionnaire, and 55% completed the follow-up	**Limitations identified by author:** Small sample size. Lack of control group. Lack of control of external factors such as divorce, relocation and incarceration that might influence the outcome. Response rates were low (55%). Dependence on self reports, which may have led to underreporting **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Utilizing larger sample sizes, using control groups, developing research sites that include urban and rural locations, higher and lower socioeconomic status communities and localities with more ethnic and racial diversity, developing strengths oriented instruments and frameworks in the process of evaluation, expanding the focus of evaluation to include offenders' behaviours, the social impact on consumers, including

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Education: 49% high school; *Occupation:* 55% labourers, 20% unemployed; *Marital status:* 47% married **Setting:** Therapy in an urban setting	**Baseline comparisons:** N/A **Study sufficiently powered:** NR	compare the pre- and post-measures.		interview. Only 40 partners agreed to participate in the study; of them, 85% completed the post-intervention questionnaire and 55% were successfully contacted during the 6 month follow-up.	the victims, and organizational components that contribute to positive outcomes **Source of funding:** Lois and Samuel Silberman Fund, The New York Community Trust, Social Work Faculty Awards Programme (1999-2000)

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Lee, M. Y., Uken, A., & Sebold, J. **Year:** 2007 **Citation:** Role of self-determined goals in predicting recidivism in domestic violence offenders. *Research on Social Work Practice, 17*(1), 30-41. **Country of study:** USA **Aim of study:** To evaluate the effectiveness of a solution-based DV group treatment to investigate the role of self-determined goals in predicting recidivism **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Men and women who abuse their intimate partners in Ohio **Eligible population(s):** Men and women DV offenders who were ordered into treatment by the court and offered an opportunity to avoid prosecution by completing group treatment and abstaining from future violence **Selected population(s):** Offenders who opted for treatment, or who were court mandated to treatment between October 1996 and February 2004 **Excluded population(s):** N/A **Sample characteristics:** *Gender:* 80% male; *Ethnicity:* 88% White; *Age:* 74% 31-50; *Education:* 49% high school; *Occupation:* 49% labourers, 15% unemployed; *Marital status:* 50% married	**Method of allocation:** N/A **Intervention(s) description:** The Plumas Project is a solution-based, goal-directed DV group treatment programme (For more details see Lee 2004). **Control/comparison(s) description:** N/A **Sample size(s):** Total n=88 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** Recidivism rates, the rate of participants' recommitting violent behaviours, were collected from the victim witness office, the probation office, and the district attorney's office. Goal commitment, goal agreement, and goal specificity were measured on a three point scale by the facilitator. Confidence to continue working on their goals upon completion of the programme was self-reported on a 10 point scale. **Secondary outcomes:** N/A **Follow up periods:** One year follow-up **Methods of analysis:** Results from path analysis with categorical variables produced a probit regression coefficient for each regression relation in which the dependent variable was categorical and an ordinary least squares regression coefficient for each regression relation in which the dependent variable was continuous. A weighted least squares parameter estimate with conventional standard errors and chi-square test statistics that use a full-weighted matrix was	**Who is the target of the intervention?** Men and women DV offenders **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No significant differences in recidivism rates were found between the genders. **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The recidivism rate for participants who completed the programme was 10.2%. The final model accounted for a total of 58% of variance in recidivism. The final model indicated that goal specificity and goal agreement positively predicted confidence to work on goals (r=0.45 and 0.20, respectively), which negatively predicted recidivism (probit coefficient=-0.08, SE=0.04). A probit coefficient of -0.08 indicated that one unit increase in the confidence to work on goals results in a decrease of 0.08 standard deviations in the predicted z-score of a cumulative normal probability distribution of recidivism. In addition, goal specificity showed a direct path to recidivism and negatively predicted	**Limitations identified by author:** Small sample size. Lack of control group. Use of self-reports to measure process variables including goal commitment, goal specificity, goal agreement, and confidence to work on goals. Group facilitators' evaluation of participants' goal characteristics can be influenced by factors such as relationship; that is, facilitators who had a better relationship with a particular programme participant might tend to provide more positive evaluation of goal specificity and agreement. No measure of spouses or partners of participants' reported recidivism **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Larger sample size that uses representative samples, include control or comparison groups using randomized assignment procedures, use more refined, multiple-item, and/or standardized instruments to measure variables that would decrease the likelihood of measurement errors, use multiple reporting sources to avoid reporting bias, use multiple reporting sources to measure recidivism rates, and carefully monitor the data collection process to reduce problems in measurement attrition

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Setting: Therapy in an urban setting		employed as the estimator in the analysis.		recidivism (probit coefficient=-0.82, SE=0.28). **Secondary outcomes:** N/A **Attrition details:** 127 participants started the programme. Data from 39 was missing and these participants were dropped from the analysis.	**Source of funding:** Lois and Samuel Silberman Fund, The New York Community Trust, Social Work Faculty Awards Programme (1999-2000)

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Maxwell, C. D., Davis, R. C., & Taylor, B. G. **Year:** 2010 **Citation:** The impact of length of domestic violence treatment on the patterns of subsequent intimate partner violence. *Journal of Experimental Criminology, 6*(4), 474-497. **Country of study:** Germany **Aim of study:** The current study was a reanalysis of Davis (2000) and sought to better understand the timing and trends in new arrests in order to address the question of whether the intervention temporarily suppressed abusing behaviour or whether the programme produces lasting changes **Study design:** Randomized controlled trial **Quality score:** [++] **External validity:** [++]	**Source population(s):** Male criminal court defendants charged with assaulting their intimate female partners in Brooklyn New York City (NYC) **Eligible population(s):** All misdemeanour DV offenders in Kings County (Brooklyn) between February 1995 and March 1996 **Selected population(s):** Men who the judge, prosecutor, and defendant agreed to send to batterer treatment **Excluded population(s):** Men who did not agree to batterer treatment **Sample characteristics:** *Ethnicity:* 36% African American, 28% Hispanic, 20% West Indian; *Education:* ~33%	**Method of allocation:** Group assignments were made during sentencing after all parties (judge, prosecutor, and defendant) had agreed to batterer treatment based on the random assignment process if the treatment was available. If all three agreed, the prosecutor called the Alternatives to Violence office to request that their intake officer meet the defendant in court and bring him to their office for an interview. After the defendant completed the interview, his name and case identifier were written on the next line of a logbook. Each line had a pre-assigned designation (batterer treatment or community service) set by using a random number table. **Intervention(s) description:** The batterer education programme was based on the Duluth model. The programme was rooted in a feminist perspective that asserts that DV is a by-product of male and female sex roles which result in an imbalance of power. The curriculum included defining DV, understanding the historical/cultural aspects of domestic abuse, and reviewing criminal/legal issues. Through a combination of instruction and discussion, participants were encouraged to take	**Primary outcomes:** Recidivism rates were calculated using outcomes captured by New York's official records system (Criminal Justice Agency and the NYC Police Department). Additionally the district attorney's computer database was searched to determine whether the victim in the new incident was the same as the victim in the original incident (only instances involving the same victim were analysed). **Secondary outcomes:** Recidivism rates during the 15 months post-treatment **Follow up periods:** Recidivism rates were measured continuously for the 15 months post-treatment **Methods of analysis:** Using a modified version of Cox regression that can capture the time dependence of treatment effects, first the effect of treatment as it was assigned and then treatment actually	**Who is the target of the intervention?** Male criminal court defendants charged with assaulting their intimate female partners **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Those assigned to the 26-week treatment group took longer to reinitiate their violence (if at all) compared to those who were assigned to receive no treatment ($b=0.55$, $p<0.05$). Assigning a defendant to treatment (in either the 8- or 26-week group) had a significant preventative effect ($b=-0.87$, $p=0.01$) during the assigned treatment. On average, the hazard rate was nearly 70% smaller when someone actually attended treatment. Paradoxically, therefore, it appears that the act of a judge assigning someone to treatment has a concurrent protective effect but if an offender actually attends treatment sessions the positive effect of the assignment is somewhat mitigated. **Secondary outcomes:** Those assigned to receive treatment during each observation period had a significantly ($b=-0.77$, $p<0.01$) reduced frequency of violence reported to the police during that period. Those assigned to receive more treatment during each successive period did not have significantly less violence reported during any given observation period ($b=-0.07$, $p=0.58$). Actually receiving treatment during a particular	**Limitations identified by author:** Limited by the measures collected and follow-up periods of the previous research **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Reanalysing the other RCT's that have been conducted on DV **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	no high school, ~33% high school or GED; *Employment:* 64% employed; *Mean income:* $16,000 **Setting:** Urban. New York City Victim Services	responsibility for their anger, actions, and reactions. One male and one female leader conducted sessions in either English or Spanish. The programme mandated 40 hours of attendance at weekly group meetings over at least eight weeks. **Control/comparison(s) description:** Participants designated to receive community service were assigned to renovate housing units, clear vacant lots for community gardens, paint senior citizen centers, and clean up playgrounds. **Sample size(s):** Total n=376; 26-week intervention n=129; 8-week intervention n=61; Control n=186 **Baseline comparisons:** There was no difference in the level of supervision assigned across the two groups **Study sufficiently powered:** NR	received was examined. Used the strengths of a hierarchical linear model (HLM) framework to address the prevalence (no or any violence) versus the frequency question. HLM is well known for its ability to investigate effects at multiple levels, evaluating individual variability while accounting for grouping factors. HLM can incorporate in the modeling process the concept of change in the outcome variable over time (i.e., growth curve modeling).		period also significantly reduced frequency of violence during that period ($b=-0.10$, $p<0.05$), although the preventive benefits of attending treatment were substantially smaller than assignment to treatment, and the effect of assigning treatment did not last throughout the entire follow-up. The quantity of treatment received was no longer significantly related to the quantity of violence during any given period across the follow-up observation ($b=-0.02$, $p>0.05$). Thus, by the end of the observation, all subjects had about the same average frequency of police incidents regardless of the amount of treatment any of them received or were assigned to receive during the course of follow-up. **Attrition details:** 67% of men assigned to the 8-week group completed compared to 27% of men assigned to 26-week group.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): McGregor, M., Tutty, L.M., Babins-Wagner, R., & Gill, M. **Year:** 2002 **Citation:** The long term impacts of group treatment for partner abuse. *Canadian Journal of Community Mental Health, 21*(1), 67-84. **Country of study:** Canada **Aim of study:** To evaluate the effectiveness of a group programme for men who are abusive towards their intimate partners **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Men who are abusive towards their intimate partners and are either self or court referred to treatment in Calgary, Alberta **Eligible population(s):** Participants had to be engaged in individual sessions with primary therapists, and had reached at least the contemplation stage of the transtheoretical model of change. **Selected population(s):** Participants who completed at least 9 of 14 sessions **Excluded population(s):** N/A **Sample characteristics:** Post-intervention: *Mean age:* 34.5; *Average length of relationship:* 7.6 years; *Education:* 46% some high school, 47% some post-secondary;	**Method of allocation:** N/A **Intervention(s) description:** Responsible Choices for Men was a group programme that focused on second-order or belief-system change. It had two hour weekly sessions and ran for 14 weeks. The major objectives included: decreasing all forms of abusive behaviour, accepting responsibility for one's behaviour, increasing self-esteem, increasing assertive behaviour, improving family relations, decreasing stress, increasing empathy, and assisting parents to cease physically abusing their children. A male-female team co-facilitated the group. The group had four main components: challenging the victim-blaming stance, challenging their belief system, reconnecting with their emotions, and inviting the men to experience empathy. Partner checks were conducted at three points to monitor the men's progress and assess the partner's safety. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=76; Follow up n=22 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** Pre and post-intervention: *Physical Abuse of Partner Scale (PAPS)* measures level of perceived physical abuse perpetration, as reported by the abuser. *Non-Physical Abuse of Partner Scale (NPAPS)* measures levels of perceived non-physical abuse perpetration. The PAPS and NPAPS have a Cronbach alpha in excess of 0.90. *Index of Self-Esteem (ISE)* measures the degree to which an individual has problems with self-esteem and has a Cronbach alpha of 0.93. *Index of Clinical Stress (ICS)* measures the perceived level of personal stress and has a Cronbach alpha of 0.96. *Index of Family Relations (IFR)* measures the severity of family problems as perceived by the respondent and has a Cronbach alpha of 0.95. *Generalized Contentment Scale (GCS)* measures the presence and severity of nonpsychotic depression. It has a reliability coefficient of 0.92. *Adult Self-Expression Scale (ASES)*, is a measure of assertiveness and has a high test-retest reliability. *Sex Role Ideology Scale (SRIS)* measures the respondent's attitudes about behaviour and roles for women and men. It has an alpha	**Who is the target of the intervention?** Men who are abusive toward their intimate partners **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** There were significant differences post-intervention among the mean scores of all 8 scales ($F=10.8$, $p<0.001$). **Secondary outcomes:** The follow-up data showed continued improvement and the pre-/post-/follow-up measures were significantly different, showing improvement across time for all 8 scales ($F=6.7$, $p<0.001$). On average men reported a 41% improvement on self-esteem, 59% improvement on family relations and 68% improvement in depression. The follow-up scores remained significant when accounting for length of follow-up ($F=1.9$, $p<0.05$). **Attrition details:** 220 men started the programme in the study year, 176 completed the programme. Only 76 men attended at least 9 sessions and filled out both the pre- and	**Limitations identified by author:** Lack of control group and randomization. Low follow-up rate. Abusive men tend to underreport their own abusive behaviour. The follow-up only included people who had completed the programme and volunteered to participate in the follow-up. **Limitations identified by review team:** Does not actually measure recidivism **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** Calgary Foundation, Muttart Foundation

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Referral: 40% probation. Follow-up: *Mean age:* 37; much less likely to be referred by probation and more likely to report psychiatric history than those not followed-up **Setting:** Urban counselling centre		coefficient of 0.81 for women and 0.85 for men. All of the scales demonstrated good construct validity, and the PAPS, NPAPS, and ISE demonstrate good content validity. **Secondary outcomes:** Same measures at follow-up **Follow up periods:** 5 to 28 months post-intervention (average 14 months) **Methods of analysis:** Repeated measures MANOVA was used to examine differences in pre-/post-/follow-up scores on outcome variables.		post-programme measures. Only 22 men were followed up longer term.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Milner, J. & Singleton, T. **Year:** 2008 **Citation:** Domestic violence: solution-focused practice with men and women who are violent. *Journal of Family Therapy, 30*, 29-53. **Country of study:** England **Aim of study:** To determine the effectiveness of a solution-focused programme aimed at reducing DV **Study design:** Before and after study **Quality score:** [+] **External validity:** [-]	**Source population(s):** Men and women who abused their intimate partners in Huddersfield, England **Eligible population(s):** All participants who entered the solution-focused programme **Selected population(s):** Participants who received counselling from Dr. Milner (the only female counsellor) **Excluded population(s):** N/A **Sample characteristics:** *Gender:* 76% male; *Mean age:* 37; *Ethnicity:* primarily White (aside from 3 Black men, 1 Asian man, and 1 Black woman); *Sexual orientation:* primarily heterosexual (aside from 3 lesbian women); *Employment:* primarily working class and employed **Setting:** Therapy sessions. Urban vs. rural setting not specified	**Method of allocation:** N/A **Intervention(s) description:** Solution focused brief therapy does not attempt to impose an explanation for violent behaviour, but does hold violent offenders responsible for finding their own solutions to their behaviour. The programme utilizes a "signs of safety approach" which accepts that risk assessment cannot be quantified and instead offenders are helped to identify existing signs of safety which are measurable and to develop these signs and expand them so that a safe care plan can be put into place. Sessions offered reflected participants' preferences for individual, couple or family sessions. The number and spacing of sessions also varied according to participants' needs and the complexity of homework. The average number of sessions was 4.3. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=50 (46 cases) **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** Recidivism rates based on self reports, partner reports and police reports **Secondary outcomes:** Successful completion rate of the programme **Follow up periods:** NR **Methods of analysis:** Rates based on self, partner and police reports	**Who is the target of the intervention?** Men and women who abused their intimate partner **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** Yes. See secondary outcomes **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** All participants that successfully completed the programme were violence-free. 57% of those that dropped out were known to have continued to be violent, three were non-violent, and the outcome was not known for three. 75% of those that were asked to leave remained violent. The success rate of the programme was 73.5% (78% counting the men who were asked to leave the programme). **Secondary outcomes:** 30 men completed the programme, as did four men who attended with their partners. All 16 women, including four who attended as couples completed the programme. **Attrition details:** 68 participants started the programme, and 50 completed the programme (four men were asked to leave and 14 dropped out).	**Limitations identified by author:** Participants and partners may have underreported cases of DV. Police reports may have also underreported recidivism as not all cases are reported to the police. **Limitations identified by review team:** Does not mention follow-up period for recidivism **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** Kirklees Domestic Violence Forum

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Morgan, M. & O'Neill, D. **Year:** 2001 **Citation:** Pragmatic post-structuralism (II): An outcomes evaluation of a stopping violence programme. *Journal of Community & Applied Social Psychology, 11*(4), 277-289. **Country of study:** New Zealand **Quality score:** [+]	**What was/were the research question(s)?** What discursive resources do the men bring to the programme? Are there any changes in the men's accounting repertoires over the course of the programme? How do they relate to the organization's discursive structure as identified in the participant observation exercise? **Theoretical approach:** Post-structuralist perspective, discursive analysis **How were the data collected?** Open-ended semi-structured interviews were conducted pre- and 3 months post-intervention. No additional discussion of who conducted the interviews, where, etc.	**What population was the sample recruited from? How were they recruited?** Men who had physically assaulted their partners and were attending the Men for Non-Violence (MFNV) stopping violence course in a provincial New Zealand city. No discussion of recruitment procedure **How many participants were recruited?** 13 men completed the pre-intervention interview. 11 men completed the follow-up interview. **Inclusion and exclusion criteria:** NR **Population demographics:** *Mean age:* 31, range 24-45. Six of the men had been ordered by the courts to attend the programme.	**Description of intervention(s):** A nine session educational programme was developed by a national grassroots organization (MFNV) with a Liberal Humanist perspective. Liberal Humanist discourse positions subjects as agents, rational entities who are fully conscious and in control of their free-willed, goal-directed behaviour. The programme combines constructs of choice, awareness and personal responsibility with teaching anger management skills and socio-cultural consciousness raising. Identifying primary emotions, which underlie secondary anger, was a key part of the anger management and masculinity consciousness raising components of the programme. **Intervention setting:** Therapy	**Method and process of analysis:** Transcripts were read for coherent systems of meaning, variations and contradictions in the men's talk. Cultural discourses being employed within men's construction of their violent events were identified. The analysis was sensitive to various ways of speaking which emerged both between and within the participant's interviews. Where appropriate, the recurring features of men's narratives were categorized using a post-structuralist taxonomy including: medical pathology, romantic expressive-tension, liberal humanist instrumentalism, structuralist social systematic constraints and learned behaviour. **Key themes relevant to this review:** Interview analyses indicate that the programme had an impact on the men's subjectivities in relation to their understanding of their violence. The course appears to have had the effect of increasing accountability. In the first interview men tended to talk about their violence in terms of "expressive tension" and "pathological" discourses - their violence was a manifestation of their "inner tension" with which they could not cope. "A lot of pressure.. built up and up and all of a sudden I snapped". The construction of this temporary "abnormality" in times of stress and tension allowed the men to be excused of responsibility for their behaviour. "I wasn't really conscious of what I was doing, it just happened". Post-intervention the "expressive tension" model of violence was retained as a dominant account for men's violence. However, many men were more likely now to recount their violence through a Liberal Humanist "instrumental" discourse, attributing intention to their behaviours. More men were acknowledging the intent of their behaviour and their control over their actions. "I choose how I react.. at the end of the day the decision's mine." The programme also appeared to have the effect of enhancing emotional articulateness. The men were noticeably more emotionally expressive during the second interview.	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Men who abuse their intimate partners	**Limitations identified by author:** Study does not address the effects from the point of view of the women who were subjected to the violence of these men. Short follow-up period **Limitations identified by review team:** No triangulation of data. No link to recidivism **Evidence gaps and/or recommendations for future research:** Longer term follow up necessary to determine if the Liberal Humanist accounts of intentional action are long-term features of the men's repertories or if there is "fading" **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Morrell, T. M., Elliott, J. D., Murphy, C. M., & Taft, C. T. **Year:** 2003 **Citation:** Cognitive behavioural and supportive group treatments for partner-violent men. *Behaviour Therapy, 34*, 77-95. **Country of study:** USA **Aim of study:** To explore the relative effectiveness of cognitive behavioural therapy compared to supportive group therapy **Study design:** Non-randomized controlled trial **Quality score:** [+] **External validity:** [+]	**Source population(s):** Court mandated men **Eligible population(s):** 118 men presenting for intake at a DV centre. Had to be at least 18 years old with documented DV. Partners also had to consent. Participants on psychiatric medications had to be approved by their primary therapist. Those with substance use in the past 6 months had to be enrolled in substance abuse treatment. **Selected population(s):** Of 118 during the recruitment period, 2 refused, 20 failed to complete intake, 5 failed to comply with substance abuse treatment requirement, and 5 did not attend treatment. Those who did not participate in the study did not differ significantly from study participants. **Excluded population(s):** Any sign of psychosis	**Method of allocation:** Not true randomization; participants assigned to next treatment group which alternated **Intervention(s) description:** Group size was 7-10 men. Sessions were led by a clinical psychology graduate student and a Masters level staff member. The training consisted of 5 hours on partner-violent men, and 8 hours each on CBT and supportive group therapy. Sessions were reviewed weekly with a supervising psychologist. The programme ran 16 weeks with 2-hour sessions consisting of ending abusive behaviour and commitment to nonviolent relationships; crisis-management strategies such as time-out; anger management techniques; and communication skills. Each session had allotted time to discuss ongoing personal and relationship issues not addressed during the structured portion of the session. The programme was based on social learning theory. **Control/comparison(s) description:** Brief training in the crisis-management skill of time-out, but otherwise minimal therapist-directed intervention beyond encouragement of a mutually supportive environment and focus on relationship issues and ending abusive behaviour. Group	**Primary outcomes:** The *Revised Conflict Tactics Scales (CTS2)* was used to measure partner aggression with subscales for negotiation, sexual coercion, injury, psychological aggression, and physical assault. State criminal records were obtained at 22-36 months post-treatment for 63 of 86 participants. Partners answered structured questions for reports of physical violence. *Global Impression of Change* was created from a sum of partner interview, with alpha=0.90 at follow-up, measuring the partner's assessment of the frequency and severity of abuse. Problems with communication behaviours were ascertained with the partner's report on the *Verbal Problem Checklist*. The participant's state of change was tested with the *Safe at Home* instrument. **Secondary outcomes:** Participant self-esteem was measured with the *Rosenburg Self-Esteem Scale.* The self-efficacy scale indicated the participant's confidence in their ability to handle difficult situations in their relationship, with an internal consistency alpha=0.93 for verbal aggression and alpha=0.95 for physical aggression.	**Who is the target of the intervention?** Men committing DV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Treatment fidelity was very high with 86% of the participants attending at least 75% of sessions. Across treatments, there were significant decreases pre-treatment to 6 months follow-up on physical assault ($p<0.001$), psychological aggression ($p<0.001$), injuries ($p<0.001$) and sexual coercion ($p<0.01$). Global index was not significant. There were no significant differences between intervention and control outcomes on partner aggression and re-arrest reports. **Secondary outcomes:** Control was significantly more effective in self-report of improving self-efficacy for abstaining from verbal aggression ($p<0.05$), and negotiation ($p<0.05$). For both groups, pre-intervention to post-intervention, self-esteem increased significantly ($p<0.01$), and efficacy to abstain from verbal abuse ($p<0.001$). Significant increase on preparation/action ($p<0.01$) and decrease in contemplation ($p<0.01$).	**Limitations identified by author:** Lack of true control group. Low rate of 6 month follow-up (61%) **Limitations identified by review team:** Difficulties in delivering intervention as "CBT participants had considerable difficulty implementing anger-control strategies and communication skills such as active listening and emotional communication, even with frequent coaching from the therapists". Mandatory attendance **Evidence gaps and/or recommendations for future research**: More detailed analyses of CBT interventions and further development of CBT approaches

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Sample characteristics: *Mean age (SD):* 34 (7.8); *Mean years of education (SD):* 13 (2.7); *Mean monthly income (SD):* $1,800 (1,900); *Ethnicity:* 60% Caucasian, 30% African American, 3% Asian American, 2% Native American, 2% other **Setting:** Urban DV centre	members set the agenda and refrained from skill-training. **Sample size(s):** Total n=86; Intervention n=48; Control n=38 **Baseline comparisons:** No significant differences between intervention and control groups. **Study sufficiently powered:** NR	**Follow up periods:** 6 months post-treatment **Methods of analysis:** All participants who attended at least one session were analysed as "exposed to treatment". ANOVA was the primary method. Log transformations of the physical assault, injury, and sexual coercion variables were used to correct for non-normality. Treatment adherence and contamination were tested at random with one session per 4 weeks by blinded coders (IRR=89%).		**Attrition details:** Treatment fidelity (exposure to 12 or more sessions): Intervention: 41 of 48; Control: 33 of 38. Partner interview completion rates: 91% baseline, 72% post-treatment, and 61% at follow-up, with no significant differences in reporting between groups. Treatment drop outs were significantly younger ($p<0.05$).	for this population are needed. **Source of funding:** National Institutes of Health and the University of Maryland

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Muftic, L. R. & Bouffard, J. A. **Year:** 2007 **Citation:** An evaluation of gender differences in the implementation and impact of a comprehensive approach to domestic violence. *Violence Against Women, 13*(1), 46-69. **Country of study:** USA **Aim of study:** To determine if there are differences in the effectiveness of the intervention for male and female offenders **Study design:** Cross-sectional study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Male and female DV offenders **Eligible population(s):** Male and female DV offenders from a small urban community (population ~180,000) in North Dakota. Data for male offenders was from Jan 1, 2003-Dec 31, 2003. Data for female offenders was from Jan 1, 2001-Dec 31, 2003. **Selected population(s):** Eligible participants where the victim and offender were in a heterosexual relationship **Excluded population(s):** Individuals where the relationship between victim and offender was either homosexual or familial	**Method of allocation:** N/A **Intervention(s) description:** The intervention was a coordinated community response. The first component of the intervention was a probable cause arrest policy. Whether or not an arrest was made, police had to file a report for each incident, and the report was forwarded to the state's attorney's office and to the victim advocacy agency. In cases of an arrest, a victim advocate contacted the victim involved in the incident. In cases where an arrest was not made, a letter was mailed to the victim outlining resources available in the community, including shelter information and counselling contacts. In cases where the offender was then prosecuted, the victim advocate provided support to the victim, including accompanying the victim to meetings with the prosecutor and attending the DV court hearing(s) with the victim. Predisposition "no-contact" (or protection) orders were automatically placed by the state's attorney's office when a DV arrest was made, stipulating no contact between the defendant and victim for a specified amount of time (usually 1 year), which could only be lifted if the offender underwent an assessment and completed recommended treatment. In addition to criminal no-contact orders, victims could also apply for a civil protection order (restraining order). If the offender was successfully prosecuted for DV	**Primary outcomes:** Dichotomous yes/no variables representing completion of various stages of the intervention were collected from various sources, and included: whether or not the offender appeared at the community corrections agency as ordered, whether or not an intake interview and screening tool were completed for those offenders who appeared at the community corrections agency as ordered, and whether the offender successfully completed whatever was included in his or her court order. These were summed to indicate how far the offender went in the intervention process. Recidivism (general and DV-related) was tracked from official arrest records collected from the local police department. An offender was considered to have recidivated if he or she was rearrested at any time after the date of sentencing.	**Who is the target of the intervention?** Male and female DV offenders in heterosexual relationships **Did they conduct any aspect of sex, gender or diversity analysis?** Yes, the purpose of this study was to compare male and female DV offenders, so all analyses were conducted by gender. **Do they report sex, gender or diversity based factors in findings?** Yes, see main findings **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** After a court judgement was in place, offenders had to participate in: an intake interview and DV inventory screening; clinical assessment and development of treatment recommendations; and follow-through and completion of treatment recommendations. Overall, female offenders completed more components of this model (2.3 vs. 2.0) than did male offenders ($t=-1.765$, $p<0.05$). Female offenders were significantly more likely to complete their court order regardless of the content of that order (46%) than were males (17%, $\chi2=8.4$, $p<0.01$). In terms of treatment recommendations, female offenders were more likely to be referred to either anger management (29% vs. 16%) or some other type of treatment intervention, such as individual counselling (39% vs. 17%). Male offenders were more likely to be sent to a DV treatment group (37% vs. 2%). These differences in treatment recommendations were statistically significant ($\chi2=25.750$, $p<0.001$), though note that in this community, there were no DV treatment programs for	**Limitations identified by author:** The sample was predominantly White, which limits generalisability. The study included only those offenders arrested and successfully prosecuted. Using official records to measure criminal offending histories may be subject to under-reporting bias. Variables such as employment, education, marital status, parental status, number of children, and familial background were necessarily excluded from the multivariate analyses (since this data was collected at intake, and so was not available for those who did not attend intake). **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research:** Further research into gender differences in use and type of violence (for example, to see if women's use of violence is motivated

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Sample characteristics: Males: *Mean age:* 31; *Ethnicity:* 12% non-White; *Education:* 11% no high school/GED, 47% high school/GED, 36% some college, 6% college graduate; *Employment:* 23% unemployed; *Relationship with victim:* 28% married, 24% divorced/separated, 28% cohabiting, 20% dating/not cohabiting; *Previous offence:* 31% DV related, 21% not DV related, 48% none. Females: *Mean age:* 30; *Ethnicity:* 17% non-White; *Education:* 13% no high school/GED, 42% high school/GED, 32% some college, 13% college graduate; *Employment:* 43% unemployed; *Relationship with victim:* 25% married, 7% divorced/separated, 35% cohabiting,	(resulting in a conviction), the offender had to report to a local independent, non-profit community corrections agency. This agency conducted an intake, collected demographic info, administered a DV inventory screening tool, explained programme expectations, and monitored the offender's compliance with the completion of a clinical DV assessment (conducted by a local treatment agency) and with any treatment that was deemed necessary by the treatment agency as a result of this assessment. When a recommendation for treatment ensued from the assessment, the recommendation became part of the court judgement, and the offender was required to complete it. In this community, one of the most commonly used treatments was a 24-week DV treatment programme that was available for male offenders only. Another commonly utilized intervention was a 5-hour anger management seminar that was available for both men and women. Other recommendations for treatment may have included individual counselling, chemical dependency evaluation, chemical dependency treatment, or some other recommendation (e.g., meet with police, psychiatric evaluation). In about one fourth of the cases, a recommendation for no treatment was made. **Control/comparison(s) description:** N/A	**Secondary outcomes:** NR **Follow up periods:** The average time-at-risk for recidivism (i.e. post-intervention follow-up time) was 10.4 months over the entire sample. Females had an average time-at-risk of 14.9 months compared to 8.1 months for males, because of the longer time frame used to gather a sufficiently large sample size of female offenders. **Methods of analysis:** Chi-squared tests and t-tests		female offenders. However, when treatment of any type was recommended by the treatment agency, female offenders were significantly more likely to complete it (47%) than males (19%, $\chi 2=7.539$, $p<0.01$). Although female offenders appeared to recidivate at a slightly higher rate when compared to male offenders (29% vs. 24% for any rearrest charge; 80% vs. 66% for DV rearrests only), this was not statistically significant. To address whether the intervention affected recidivism differently for men versus women, logistic regression models (one for any rearrest, and one for DV-related rearrests only) were generated, including these predictor variables: the relationship between the victim and offender, dual-arrest status, race, prior arrests, age, time at risk, total number of intervention components completed, and gender. When looking at the logistic regression model for the likelihood of rearrest on any charge, those offenders who had a prior arrest ($exp(b)=3.416$, $p<0.01$) and greater time at risk ($exp(b)=1.058$, $p<0.05$) had a higher likelihood of recidivating. Individuals who	more by self-defence). Also, further research examining the motivations of judges when making decisions in their response to DV would be useful. **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	33% dating/not cohabiting; *Previous offence:* 16% DV related, 17% not DV related, 67% none **Setting:** Urban community-based intervention	**Sample size(s):** Total n=201; Male n=131; Female n=70 **Baseline comparisons:** Female offenders in the sample were more likely to be unemployed (43% for females vs. 23% for males), and cohabiting or dating-but-not-cohabiting with the victim. Male offenders were more likely to have previous DV-related offences (31% vs. 16% for females) and more likely to be either married or divorced/separated from the victim. Females were more likely arrested as part of a dual arrest (32% vs. 20%) than males ($\chi2=3.356$, $p<0.05$). Males were more likely to be currently charged with criminal assault as compared to some other type of charge (75%) than were females (56%, $\chi2=20.229$, $p<0.001$), and more likely to be charged with more serious offenses (26% vs. 5%, $\chi2=11.240$, $p<0.001$). In terms of the outcomes of court proceedings, deferred sentences (a more lenient sentence) were imposed significantly more often for female offenders (46% vs. 22%, $\chi2=9.903$, $p<0.001$). In cases with a male offender, no-contact orders were imposed 83% of the time, whereas only 70% of cases with a female offender had a no-contact order ($\chi2=5.42$, $p<0.05$). **Study sufficiently powered:** NR			were involved in a dual arrest were less likely to recidivate (exp(b)=0.196, $p<0.01$). The results for the second logistic regression model (predicting any DV-related rearrest) revealed that the likelihood of recidivism was lower for offenders who were married to the victim in comparison to offenders dating the victim (exp(b)=0.183, $p<0.05$) and for offenders in dual-arrest incidents (exp(b)=0.122, $p<0.01$), but higher when the offender had a prior arrest record (exp(b)=3.792, $p<0.01$). Neither gender nor the number of intervention components completed demonstrated statistically significant impacts on either recidivism measure. Thus, although women were more likely to complete their treatment recommendations and their entire court order, they were not less likely to recidivate. It also does not appear from these results that the intervention reduced the recidivism (general crime or DV) of either gender. **Secondary outcomes:** N/A **Attrition details:** N/A	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Musser, P. H., Semiatin, J. N., Taft, C. T., & Murphy, C. M. **Year:** 2008 **Citation:** Motivational interviewing as a pregroup intervention for partner-violent men. *Violence and Victims, 23*(5), 539-557. **Country of study:** USA **Aim of study:** To examine motivational interviewing (MI) as a pregroup preparatory intervention for partner-violent men **Study design:** Non-randomized controlled trial **Quality score:** [+] **External validity:** [+]	**Source population(s):** Men entering DV treatment **Eligible population(s):** Men presenting for treatment at the Domestic Violence Centre of Howard County, Maryland **Selected population(s):** Self-selection. 12 declined **Excluded population(s):** Men whose difficulties did not involve partner abuse, and cases referred for individual therapy **Sample characteristics:** *Referral status:* 79% court-ordered to treatment, 6% had a court case pending, 16% had no legal involvement for domestic abuse; *Ethnicity:* 50% White, 44% African American, 3% Asian, 2% Aboriginal, 2% Latino; *Mean age (SD):* 35.7 (8.6); *Mean years of education (SD):* 13.1 (2.6); *Employment:* 82% full-time, 9% part-	**Method of allocation:** Participants were assigned to the intervention or control groups in alternating cohorts, with each sequential block of 12 cases assigned to the same study condition **Intervention(s) description:** Both intake conditions were conducted over two sessions, approximately two weeks apart. At the first intake assessment, clients completed demographic and stages of change measures, and then met a therapist to review clinical policies and forms. This was followed by a 45-minute individual MI session, and completion of a set of measures. After the first MI session, the counsellor sent a personalized, handwritten note to encourage the client to attend the next meeting and to facilitate collaboration. At the second session 2 weeks later, participants were given feedback based on self-report from testing on the State Trait Anger Expression Inventory, the Dyadic Adjustment Scale, and the Conflict Tactics Scale, and those with drug or alcohol issues received feedback for those issues. The feedback lasted around 10-15 minutes and was followed by a second MI interview lasting around 30 minutes. Interviews were conducted by 1 male and 8 female doctoral students. MI training for the intake therapists was 15 hours plus 2 videotaped role-plays rated by independent reviewers. **Control/comparison(s) description:** In the control condition, the first session was conducted in an individual format where the intake worker reviewed agency policies and forms, set fees for	**Primary outcomes:** Abusive behaviour was measured with partner telephone interviews with the *Conflict Tactics Scale (CTS)* delivered at intake and 6 months post-treatment. The scale was summed with all positively endorsed items. Readiness to change abusive behaviour was assessed with the *Safe-at-Home Instrument for Assessing Readiness to Change Intimate Partner Violence (SIRC)*, a 35-item self-report scale with subscales measuring precontemplation, contemplation, and preparation/action (alphas=0.91, 0.79, and 0.59 respectively). The therapeutic working alliance was assessed with the *Working Alliance Inventory*. CBT homework compliance was assessed with the *Assignment Compliance Rating Scale*. Session attendance was recorded. Other help seeking was assessed with a self-report questionnaire at the end of the group programme. Videotapes of CBT group treatment sessions were recorded in the early, middle, and late phases	**Who is the target of the intervention?** Partner-violent men **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** There were no significant changes in partner report of physical assault, injury, and psychological aggression between the two groups. Physical assault approached significance (p=0.07), with control participants over twice as likely as intervention participants to physically assault or injure their partners (26% vs. 12%). However, they do note greater compliance with CBT homework (effect size d=0.54 and d=1.23, early and late in treatment, respectively), more help seeking outside of the programme (66% of the MI group received outside help vs. 41% of the control group) and higher therapist ratings of the working alliance (late in treatment, but not early in treatment) for those in the MI intake group (all p's<0.05). There was no significant effect of the intervention on number of sessions attended or motivation to change. **Secondary outcomes:** N/A **Attrition details:** Those missing 3 intake	**Limitations identified by author:** Data only for treatment completers. Low follow-up rates. Court-mandated treatment may not be compatible with norms of autonomy in MI. Assignment to conditions was not random. May have limited generalisability beyond the demographics represented in this sample (i.e., suburban, court-mandated, mostly White and African American). The format of the second session differed between conditions. **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** Directed Research Initiative Fund of the University of Maryland, Baltimore

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	time, 7% unemployed, 2% seasonal lay-off; *Mean gross income:* ranged from $25,000-$30,000 **Setting:** Urban treatment centre	counselling, completed a set of structured interviews, and administered the same set of self-report measures as in the intervention group. In the second session, there was a treatment orientation conducted in a small group format. In an effort to equate therapist contact time across conditions, individuals in the control group were administered two structured interviews not given to the intervention group: the Antisocial Personality Disorder Section of the SCID-II, and structured interview questions about casual sexual relationships, violence in priori intimate relationships, anticipatory behaviours before engaging in partner violence, conciliatory behaviours after partner violence, and emotional reactions to violence. Both groups received a 16-week CBT programme. **Sample size(s):** Total n=108; Intervention n=55; Control n=53 **Baseline comparisons:** No significant differences **Study sufficiently powered:** NR	of the programme, and coded by trained research assistants for three variables: denial/acknowledgment of behaviour/responsibility; client's role in the group and interaction with other group members; and general perceptions of the value of the group. **Secondary outcomes:** NR **Follow up periods:** 6 months post-treatment **Methods of analysis:** No ITT, ANOVA		appointments were dropped. Partner reports of abusive behaviour at 6 month follow-up were available for 68% of the intervention and 66% of the control group.	County, and the National Institute of Mental Health

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Price, P., Rajagopalan, V., Langeland, G., & Donaghy, P. **Year:** 2008 **Citation:** *Domestic Violence Intervention Project: Improving Women and Children's Safety.* **Country of study:** UK **Aim of study:** To report on the outcomes of the first 18 months of the Domestic Violence Intervention Project (DVIP) **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Men perpetrating DV in the London Boroughs of Barking & Dagenham, Newham and Waltham Forest **Eligible population(s):** Men in the Domestic Violence Intervention Project (DVIP) **Selected population(s):** NR **Excluded population(s):** 34 referrals for assessment were not deemed "appropriate" **Sample characteristics:** NR **Setting:** Urban, not specified	**Method of allocation:** N/A **Intervention(s) description:** The intervention included an assessment and group treatment. Assessments took 2-4 hours, and an additional 2 hours with the partner if Children's Services was involved.Assessments covered the history and risk of violence, as well as motivational and attitudinal issues (e.g. perpetrator's level of empathy and denial). After the assessment, a report was given to social workers with recommendations on how to manage the presenting risk. If the report recommended attendance at the perpetrator programme, reassessments are done at week 12 and end of treatment (week 32). The intervention was delivered over 32 weeks, with 60 hours of programming in 2.5 hour weekly group sessions. The programme was designed to help men understand why they have used abusive behaviour, how they could change this, and how they could work towards constructing respectful relationships with women. Men were challenged to take responsibility for their actions rather than blaming their partners or outside factors, and learned to critically assess their gender-based expectations of themselves and their partners. The programme used cognitive, behavioural, social learning theory, psychodrama, psychotherapeutic and relationship skills teaching. A third of the sessions were on ending physical and sexual violence, and the rest on other forms of abuse, parenting, and relationship skills. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=47 for completed case assessments, which were used to measure repeat victimization **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** Repeat victimization was measured with women's reports (via a questionnaire) of men's behaviour and data from risk identification reports. **Secondary outcomes:** Findings related to the victims' intervention are reported in the evidence table in the Victims section **Follow up periods:** Post-treatment **Methods of analysis:** Descriptive statistics	**Who is the target of the intervention?** Male perpetrators of DV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** From the women's self-reports, 70% reported no further violence since their involvement with the DVIP, and 78% reported that their partner's abusive behaviour was reduced or eliminated. The incidence of repeat victimisation was reduced by between 87.5% and 89% based on case assessments. **Secondary outcomes:** Findings related to the victims' intervention are reported in the evidence table in the Victims section **Attrition details:** 202 were referred, 168 were eligible for assessment, and 71 did not attend the assessment at all. Of the 97 that completed the assessment, 76 entered treatment, 33 completed the violence prevention modules, and 14 completed 60+ hours of treatment. 20 men were still in treatment at the time of this evaluation and were excluded from analyses.	**Limitations identified by author:** Did not track cases where perpetrators were not engaged with the intervention and did not examine post-assessment from partner agencies **Limitations identified by review team:** High non-participation and dropout rates. Limited description of methods **Evidence gaps and/or recommendations for future research:** Further, fully-resourced longitudinal study of the project's outcomes is needed. **Source of funding:** NR

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Rosenberg, M. S. **Year:** 2003 **Citation:** Voices from the group: Domestic violence offenders' experience of intervention. *Journal of Aggression, Maltreatment & Trauma, 7*(1-2), 305-317. **Country of study:** USA **Quality score:** [+]	**What was/were the research question(s)?** To examine the outcomes of DV intervention programs from the experiences of the probationers. This study is a qualitative subset of a larger study. **Theoretical approach:** NR **How were the data collected?** Data were collected by telephone and in-person interviews on trauma history, quality of life, post-treatment physical and psychological violence, and perceptions of the treatment programs. One question was whether they had learned anything from the programme that they still used today.	**What population was the sample recruited from? How were they recruited?** The first 224 case files at one year post-treatment was the sample set. Two researchers conducted recruiting by telephone. 70 interviews were completed (31% response rate). **How many participants were recruited?** Male n=57; Female n=13 **Inclusion and exclusion criteria:** The study included court-mandated batterers, both male and female **Population demographics:** *Gender:* 81% male	**Description of intervention(s):** One year of 2-hour weekly group sessions. This intervention was delivered in one of six certified DV intervention programs based on process-oriented, cognitive-behavioural or educational approaches with much of the content dictated by state law. **Intervention setting:** NR	**Method and process of analysis:** The authors created a table of responses to an interview question, and presented the percentage of interviewees reporting the item (simple tally). **Key themes relevant to this review:** 84% reported continuing to use the "time-out" during stressful situations at home and work. For example, some respondents said they now handled angry customers or bosses differently, by not engaging with them or becoming defensive. 30% reported on their improved ability to talk with their partners, employer, employees, and others rather than storing up or "stuffing" their thoughts and feelings. 14% reported the ability to consider consequences, recognize anger triggers, set boundaries, and take responsibility.	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Court mandated batterers	**Limitations identified by author:** Only a sub-sample was interviewed. Difficulties in locating sample individuals. Only treatment completers were interviewed. **Limitations identified by review team:** Multiple treatment programs **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** County Probation Department

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Schrock, D. P. & Padavic, I. **Year:** 2007 **Citation:** Negotiating hegemonic masculinity in a batterer intervention programme. *Gender & Society, 21*(5), 625-649. **Country of study:** USA **Quality score:** [+]	**What was/were the research question(s)?** How do men's interactions construct their masculinity which might explain batterer intervention programme ineffectiveness? **Theoretical approach:** Symbolic interactionist perspective and Goffman's self-presentation. Hegemonic masculinity was defined as "the most honoured way of being a man" as a cultural ideal constructed in face-to-face interactions. Grounded theory guided methodology **How were the data collected?** 8 months of group observations from a one-way mirror, with data recorded by note-taking followed by sit-in observation for 3 years in total	**What population was the sample recruited from? How were they recruited?** Court mandated male batterers **How many participants were recruited?** NR. There were three years of weekly groups of 10-18 participants in a 26-week programme **Exclusion criteria:** Excluded (and remanded to court) if missing more than 3 sessions **Population demographics:** *Ethnicity:* 50% African American, 40% White, 10% Latino; *Employment:* 75% working class. Graduates were far less likely than dropouts to be recharged (11% vs. 42%) and far more likely to be living with their victims (42% vs. 14%).	**Description of intervention(s):** Duluth model programme which aims to transform men into nonthreatening, nonjudgmental listeners who are empathetic, honest, accountable, and egalitarian in their parenting, housework, and familial decision making. Some programs add anger-management and skill-building approaches, focusing on improved communication, assertiveness training, and conflict management. The programme was 26 weeks of 2-hour sessions, court-mandated, and led by a male and a female facilitator. The group session (10-18 men) had check-ins and responsibility statements, followed by facilitator-led exercises. The treatment goal was for men to give up their desire to control women. There was a	**Method and process of analysis:** Ethnographic methodology, with data analysis running concurrently with collection. Memos identified emerging themes, and hypotheses were developed. Notes were grouped by type of interaction. Facilitator's manual for programme goals and treatment fidelity. A second author reviewed the field notes and examined interactional tactics. **Key themes relevant to this review:** The check-in procedure resulted in pseudo responsibility. Facilitators had success in getting the men to agree to take responsibility, use egalitarian language, control anger, and choose nonviolence, but the men were successful in resisting taking victims' perspectives, deflecting facilitators' overtures to be emotionally vulnerable, and defining themselves as hardworking men	**Did they conduct any aspect of sex, gender or diversity analysis?** For the group, emotional invulnerability and identity as breadwinner was central to hegemonic masculinity. **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** There was an emphasis on rational control of anger. When asked: "Is violence worth the price?" the group responded with a chorus of "No!" Tapping into the resentment caused by jail time, court appearances, and having to pay for and attend the programme, the male facilitator easily won converts to the school of rational masculinity. Virtually all the men's accounts of their DV indicated that they became angry because women were not acting sufficiently subservient. Yet the facilitators and some participants also used the notion that rational self-control could enable men to control women in relationships. In discussion, men were shamed into taking rhetorical responsibility and using egalitarian language, but they gave little indication of truly acknowledging responsibility for their acts or respect for their partners. The men's use of disengagement and diversionary tactics deflected facilitators' attempts to get them to talk about	**Limitations identified by author:** NR **Limitations identified by review team:** Data collection on facilitator-participant interactions, not on post-group behaviour outcomes. Self-report. No post-treatment follow-up **Evidence gaps and/or recommendations for future research:** Future research should compare the negotiation of masculinity in effective and ineffective programs to determine more effective practices to counter men's resistance. **Source of funding:** NR

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
			facilitator handbook. **Intervention setting:** Urban community service centre	entitled to a patriarchal dividend. Resisting vulnerability and empathy occurred through disengagement and diversion, usually with silence or by being inexpressive. Two participants who discussed empathic feelings were marginalized by group members. For the group, emotional invulnerability and identity as breadwinner was central to hegemonic masculinity.	their own or their victims' feelings, thereby confirming and enacting the cultural ideal of masculine invulnerability. Participants also secured facilitators' deference when they used valuable meeting time to hijack the curriculum and present themselves as diligent and long-suffering workers, culturally respected masculine attributes. Finally, facilitators and participants, regardless of intentions, together persuaded newcomers to present themselves as men who could use rationality to control not only their anger but also their partners' actions. **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Male batterers in court system	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Schumacher, J. A., Coffey, S. F., Stasiewicz, P. R., Murphy, C. M., Leonard, K. E., & Fals-Stewart, W. **Year:** 2011 **Citation:** Development of a brief motivational enhancement intervention for intimate partner violence in alcohol treatment settings. *Journal of Aggression, Maltreatment & Trauma, 20*(2), 103-127. **Country of study:** USA **Aim of study:** To improve IPV treatment outcomes by increasing motivation to change IPV and IPV-related behaviours **Study design:** Individual randomized controlled trial **Quality score:** [+] **External validity:** [+]	**Source population(s):** Men in two residential substance abuse treatment programs (28-30 days) **Eligible population(s):** Married or co-habiting at least 1 year, one self-reported IPV incident in the past year, consenting to partner participation, and alcohol dependent **Selected population(s):** Those in 2nd week of treatment **Excluded population(s):** 5 men whose partners had sustained medically treated IPV **Sample characteristics:** *Ethnicity:* 16 White, 7 Black; *Education:* 12 high school or equivalent, 6 some college or trade; *Employment:* 7 currently employed; *Past year acts of aggression:* 64.9 psychological aggression, 11.6	**Method of allocation:** Eligible male participants were randomized via urn randomization to either the treatment group or control group, using the following balancing variables: recruitment site, alcohol dependence severity, antisocial personality disorder symptoms, frequency of physical partner violence, and readiness to change IPV. **Intervention(s) description:** 90 minute motivational interviewing intervention conducted by trained doctoral therapist, with written feedback and discussion which resulted in a plan for change in a worksheet. Participants also received a packet of self-help handouts, and list of resources. **Control/comparison(s) description:** List of resources only **Sample size(s):** Total n=23; Intervention n=11; Control n=12 **Baseline comparisons:** There were more White men in the intervention (p=0.03). No other demographic differences were significant, although more men in the control group had less than high school. No significant differences in any baseline measures	**Primary outcomes:** The *Revised Conflict Tactics Scale (CTS2)* was used to measure physical and psychological aggression. The *Personal Assessment of Intimacy in Relationships (PAIR)* measured expected vs. actual intimacy in relationship. The *Change Questionnaire Version 1.2* was used to measure motivation to change behaviour. The *University of Rhode Island Change Assessment (URICA)* was used to assess readiness for change. Participants were also asked about their help-seeking behaviours. Post-treatment, participants completed the *Change Questionnaire Version 1.2*. **Secondary outcomes:** NR **Follow up periods:** Base-line, post-treatment, 3 months, and 6 months **Methods of analysis:** Appears to have used	**Who is the target of the intervention?** Men in alcohol use treatment who report IPV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** 10 participants chose the goal of staying drug and alcohol free. Men's self-reported percentage of days abstinent from alcohol had a significant main effect for time ($F(2,10.19)=41.36$, $p<0.001$), a significant Group×Time interaction,	**Primary outcomes:** At 2 weeks post-treatment, the intervention condition reported greater help-seeking compared to the control condition ($p=0.04$, Cohen's $d=0.90$). At 3- and 6-month follow-up, both groups showed improvement over time in self-reported alcohol outcomes ($p<0.000$), anger ($p<0.000$), and CTS2 measures of psychological aggression ($p<0.000$) and physical aggression ($p=0.036$ for male partner's report, and $p=0.024$ for female partner's report). There was also a significant group main effect for intimacy ($p=0.049$) and a marginally significant group x time interaction effect ($p=0.065$), reflecting an increase in intimacy over the six-month follow-up among the intervention group participants, but no change for the control group. **Secondary outcomes:** N/A **Attrition details:** Only 12 participants (52%)	**Limitations identified by author:** Small sample size. Two different facilities for recruitment. Lack of spouse reports. Men's self-report **Limitations identified by review team:** Education as confounder. Self-selected sample. Short one-time treatment exposure **Evidence gaps and/or recommendations for future research**: Future research should examine for whom the treatment is most effective, whether the intervention could bolster men's resilience to recurrences of IPV in the face of alcohol/drug relapse, and whether the treatment could act as a segue to lengthier treatment for IPV.

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	moderate physical assault, 4.8 severe physical assault **Setting:** Residential treatment facility. Urban vs. rural setting not specified	**Study sufficiently powered:** NR	ITT based on table caption	(F(2,10.19)=9.51, p=0.005), and a marginally significant level group effect, (F(1,11.81)=4.02, p=0.068).	completed one or both 3 or 6 month follow-ups.	**Source of funding:** National Institute on Alcohol Abuse and Alcoholism

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Schwartz, J. P. & Waldo, M. **Year:** 2003 **Citation:** Reducing gender role conflict among men attending partner abuse prevention groups. *The Journal for Specialists in Group Work, 28*(4), 355-369. **Country of study:** USA **Aim of study:** To test a group intervention to reduce gender role conflict among men who had committed partner abuse **Study design:** Non-randomized controlled trial **Quality score:** [+] **External validity:** [+]	**Source population(s):** Men who have abused their partners; "majority" mandated to treatment **Eligible population(s):** Men attending a partner abuse prevention programme at a DV shelter **Selected population(s):** Assigned groups **Excluded population(s):** NR **Sample characteristics:** Intervention: *Ethnicity:* 12 Mexican American, 2 White, 1 African American; *Mean age (SD):* 31 (8). Control: *Ethnicity:* 6 Mexican American, 1 White; *Mean age (SD):*33 (5) **Setting:** DV centre. Urban vs. rural setting not specified	**Method of allocation:** No randomization. One group volunteered by facilitator to act as control group **Intervention(s) description:** Two psychologists experienced in men's DV groups. Eight 2-hour sessions addressing conflict between work and family, restricted emotionality, affectionate behaviour between men, and success, power, and competition. First, members constructed genograms of their fathers' and grandfathers' behaviour, and were taught positive non-verbal communication. Next was the feelings awareness wheel and expressive speaking skills. Then empathic listening skills, and finally confrontation skills. **Control/comparison(s) description:** The standard Duluth model treatment, a sociocultural/feminist model focusing on education and confrontation of abuse as a tactic of male power and control. Conducted by male psychologist **Sample size(s):** Total n=21; Intervention n=14 (2 groups of 7); Control n=7 (1 group of 7) **Baseline comparisons:** No significant differences between groups on all test measures **Study sufficiently powered:** NR	**Primary outcomes:** The *Gender Role Conflict Scale (GRCS)* measures four areas of gender role conflict: Success, Power, and Competition - the emphasis on career success, authority and control over others; Restrictive Emotionality - difficulty and fear about expressing emotions, and being uncomfortable with the emotional expression of others; Restrictive Affectionate Behaviour Between Men - discomfort expressing feelings and thoughts with other men, and avoidance of expressing caring for them; and Conflict Between Work and Family Relations - difficulties balancing work-school and family relations resulting in health problems or stress. **Secondary outcomes:** The *Critical Incident Questionnaire (CIQ)* was used to assess the therapeutic factors that group members experienced while participating in the experimental group. **Follow up periods:** Post-intervention **Methods of analysis:** 2×2 (Group × Time) repeated-measures MANOVA	**Who is the target of the intervention?** Men who had abused their partners **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The overall MANOVA was significant for the main effect of time, $F(1,19)=6.74$, $p<0.05$), and for the interaction of Group×Time ($F(1,19)=4.50$, $p<0.05$). The intervention group had significantly greater reduction over time in Restrictive Emotionality ($p<0.016$) and Restrictive Affectionate Behaviour Between Men ($F(1,19)=12.77$, $p=0.002$). Other measures were not significant. **Secondary outcomes:** During the forming stage, when the group addressed conflict between work and family, the predominant therapeutic factors reported by members were family reenactment (33%), information (23%) and socializing techniques (19%). During the storming stage, when the group addressed restricted emotionality, the predominant therapeutic factors were catharsis (50%), cohesion (15%) and universality (15%). During the norming stage, when the group addressed affectionate behaviour between men, the predominant therapeutic factors were information	**Limitations identified by author:** Small sample size. Lack of randomization. Lack of follow-up assessment. No assessment of actual abstinence from violence **Limitations identified by review team:** Almost completely Latino men, which limits generalisability to other populations **Evidence gaps and/or recommendations for future research**: Assess if changes in gender role conflict are sustained and determine if a decrease in gender role conflict leads to a decrease in abusive behaviour. Determine what therapeutic factors help to prevent DV and recidivism. Compare therapeutic factors between the experimental and control groups. Conduct research on how to apply the gender role conflict

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
					(30%), interpersonal learning (25%) and socializing techniques (15%). During the performing stage, when the group addressed success, power, and competition, the predominant therapeutic factors were information (40%) altruism (30%) and socializing techniques (20%). **Attrition details:** NR	approach to current partner abuse prevention curriculums **Source of funding:** NR

Appendix O

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Smith, M. E. **Year:** 2011 **Citation:** A qualitative review of perception of change for male perpetrators of domestic abuse following abuser schema therapy (AST). *Counselling and Psychotherapy Research: Linking Research with Practice, 11*(2), 156-164. **Country of study:** UK **Quality score:** [++]	**What was/were the research question(s)?** To discover what perpetrators perceive to have changed following abuser schema therapy **Theoretical approach:** Person-centered theory **How were the data collected?** Data were collected by the therapist, who was also the researcher. Interviews were semi-structured and held in a private room.	**What population was the sample recruited from? How were they recruited?** Self-referred men with abuse problems that had not been in the justice system. Participants were informed of the study by their GP. **How many participants were recruited?** Total n=18 **Inclusion and exclusion criteria:** Inclusion criteria: Literacy level sufficient to complete homework. Exclusion criteria: under age 18, prior cognitive behavioural therapy for anger, or any time in prison **Population demographics:** *Mean age:* 34, range 21-48	**Description of intervention(s):** Abuser schema therapy is based on person-centered theory, attachment theory and cognitive behavioural psychotherapy. The intervention was manualized with session plans and participant handouts. It included individual one hour sessions for 20 weeks. Partners of participants were given access to integrative counselling with other clinic counsellors. The intervention consisted of a pre-therapy assessment, 2 sessions on introduction to the intervention, 2 on identification of triggers for abusive behaviours through assessment and self-monitoring diaries, 3 on coping strategies, 5 on automatic thoughts and situational behaviours, 1 on consolidating therapy components and problem solving, 4 on Critical Life Events schedule, and 3 on maintenance strategies. Follow-up sessions were at 3, 6, 9, and 12 months post-treatment. Partners had access to clinic therapists. **Intervention setting:** Free NGO clinic	**Method and process of analysis:** 21 pre-coded variables relating to change in abusive behaviour were drawn from previous research. Variables were deleted and added following manual content analysis that broke the data into 107 endorsements of the variables, which were then ranked. Both coding and analysis were externally reviewed. **Key themes relevant to this review:** Note: The number of participant endorsements is show in parentheses for each theme: Reduced anger (18): "I don't lose my temper all the time and I know it's not specific to me all the time. I'm not afraid of anger anymore. I feel happier, freer than before. I don't feel guilty anymore and the baggage seems smaller - before it was like dragging rocks - now they're pebbles. I'm now able to say things in small bits rather than take it out on X (partner). I feel calmer." Increased ability to communicate and assertiveness (17): "I can be verbally assertive rather than verbally aggressive. I am able to listen to other people's arguments and constructive criticisms. I don't feel hostile to anyone anymore. They have their own point of view." Reduced reaction to anger-provoking events (10): "I think a lot more. The aggression isn't there even when I feel angry. I know it's up to me to sort things out for myself." Responsibility for personal power (9): "I feel I could handle things differently than before...therapy has helped me to be more assertive, calmed me down. I used to be influenced by outside influences."	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Male perpetrators of DV before entering the justice system	**Limitations identified by author:** Purposeful sample. Self-selection **Limitations identified by review team:** Findings limited to programme completers **Evidence gaps and/or recommendations for future research:** Further study is required to determine whether the partners benefited in any way from the perceived changes in the perpetrators of the abuse. **Source of funding:** National Lottery Commission

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Taft, C. T., Murphy, C. M., Elliott, J. D., & Morrel, T. M. **Year:** 2001 **Citation:** Attendance-enhancing procedures in group counselling for domestic abusers. *Journal of Counselling Psychology, 48*(1), 51-60. **Country of study:** USA **Aim of study:** To examine the effectiveness of straightforward and easily implemented retention procedures during the course of group counselling for male domestic abuse perpetrators	**Source population(s):** Battering males from Baltimore, Maryland and Washington, DC **Eligible population(s):** Males who sought counselling for perpetration of domestic abuse at the Domestic Violence Centre of Howard County, Maryland **Selected population(s):** NR **Excluded population(s):** Those who did not attend any group sessions were excluded from the sample. **Sample characteristics:** *Race:* 60% Caucasians, 33% African Americans, 2% Hispanics, 2% Asians, 2% Native Americans, 1% other; *Referral system*: 31% self-referred to	**Method of allocation:** Treatment retention cohort (TRC) participants were assigned in groups to receive either supportive therapy (ST) or cognitive-behavioural therapy (CBT) on the basis of their order of entry into the counselling programme **Intervention(s) description:** Participants received treatment containing 16 weekly 2-hr sessions, conducted in closed-group. Those in the TRC participated in a comparative study of a CBT programme with a supportive therapy ST alternative. In ST, therapists provided training in time-out during an early session but did not otherwise impose structured content on the treatment sessions. The therapists encouraged group members to develop a supportive group atmosphere focused on domestic conflict and ending abusive behaviour. Whether exposed to CBT or ST, all participants in the TRC received identical treatment retention procedures. The two group co-therapists divided up the work related to session attendance, which was structured into the weekly routine. The therapist wrote a handwritten note to express interest in working with the client. Second, during the week before group start-up, the therapist telephoned the group member to make sure that he had received the announcement and to express verbally that the therapist looked forward to working together in group. Regardless of whether telephone contact was made, the therapist mailed out a brief, personalized handwritten note expressing sorrow that the client had missed the session and hope or enthusiasm about the prospect of seeing the client at the next session. If the client had not been reached by telephone and had not informed the therapist in advance about the absence, the note also contained a brief expression of concern, No specific requests were made of the client other than the expressed interest in seeing him at the next scheduled	**Primary outcomes:** Session attendance and dropouts were measured, with a dropout defined as failure to attend at least 75% of scheduled group. Relationship abuse was assessed by partner report on the *Revised Conflict Tactics Scale (CTS-2)*. The Injury, Psychological Aggression and Physical Assault subscales were used. Criminal recidivism was assessed through a review of participants' criminal histories, obtained 22 to 36 months after the scheduled completion of treatment through an electronic database for the State of Maryland.	**Who is the target of the intervention?** Male batterers with difficulties with attending treatment **Did they conduct any aspect of sex, gender or diversity analysis?** Yes, they examined racial differences in treatment attendance and variations in demographic factors relating to treatment attendance. **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Yes, see primary	**Primary outcomes:** In the TRC, a significantly greater number of sessions were attended (F(1,188)=7.313, p=0.007; 12.89 vs. 11.22 sessions). TRC experienced about 10% more of the total treatment on average. In the CC, 30% of participants dropped out from treatment compared with only 15% in the TRC (p=0.011). The multiple regression analysis revealed a significant Race x Cohort interaction in the prediction of attendance (F(1,179)=4.384, p=0.038). Differences in dropout rates were less pronounced for Caucasians. All correlations between session attendance and victim-reported outcomes were in the negative direction, indicating that higher attendance was associated with fewer problem behaviours. Partial R; CTS-2 Physical Assault: post-treatment (-0.31, p<0.05), 6 months follow-up (-0.17); CTS-2 Injury: post-treatment (-0.46, p<0.01), 6 months follow-up (-0.47, p<0.01); CTS-2 Psychological Aggression: post-treatment (-0.13), 6 months follow-up (-0.13). No significant associations were found between session attendance and CTS-2 psychological aggression. Criminal justice data indicated	**Limitations identified by author:** It is possible that increases in session attendance were due to other improvements in the treatment programme or greater therapist competence over time. It is possible that the groups differed on other unmeasured and uncontrolled variables. **Limitations identified by review team:** Self-report biases **Evidence gaps and/or recommendations for future research**: Future research should examine the effectiveness of these and other techniques within different contexts. **Source of funding:** National Institute of Mental

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Study design: Non-randomized controlled trial **Quality score:** [+] **External validity:** [+]	treatment, 69% court referred; *Employment*: 82% full time, 6% part time, 12% unemployed, 11% working sporadically; *Relationship status*: 30% married and living with their spouses, 70% were not married, 1% separated from their spouses at the time of programme intake; *Mean age (SD)*: 34.2 (7.7), range=19-53; *Mean education level in years (SD)*: 12.8 (2.2), range=5-18; *Mean net monthly income (SD)*: $1,593 ($1597), range=$0-$12,000 **Setting:** Urban DV centre	session. Group homework assignments were sometimes mailed along with the handwritten note. **Control/comparison(s) description:** All participants in the control cohort (CC) received a CBT programme designed to enhance the motivation to change, to provide self-regulation skills involving stress and anger management, and to develop alternatives to abusive behaviour, including communication, problem solving, and assertiveness skills. No special techniques were being used to retain clients in treatment. After intake, clients were mailed a letter informing them of the date and time of the group. The week following the group treatment session, a therapist would call those who did not present for the first session. Clients who did not present for later sessions were given a week to contact the therapist on their own to discuss or explain the absence. After two consecutive absences, a therapist would call the client to inquire about the reasons for the absences and to find out whether the client intended to return to the group. **Sample size(s):** Total n=189; Intervention n=83; Control n=106 **Baseline comparisons:** The cohorts differed significantly in their net monthly income (F(1,187)=4.082, p=0.045). **Study sufficiently powered:** NR	**Secondary outcomes:** NR **Follow up periods:** 6 months **Methods of analysis:** Multiple regression analyses and correlations between dependent and independent variables	outcomes	that higher session attendance was associated with less recidivism. The partial correlation between number of sessions attended and number of recidivist incidents, controlling for treatment condition and extent of pre-treatment arrest history, was significant and of substantial magnitude (r=-0.49, df=57, p<0.001). Of 11 participants who dropped out of treatment, 54% generated criminal charges during the follow-up period. Of the 50 individuals who completed at least 75% of treatment sessions, 10% generated criminal charges during the follow-up period, which was highly significant (chi squared(1,61)=9.3, p=0.002). **Secondary outcomes:** N/A **Attrition details:** Of the 83 participants included for analysis in the TRC, partner data were available on 75 pre-treatment, 59 post-treatment, and 47 at follow-up.	Health Individual National Research Service Award, Directed Research Initiative Fund of the University of Maryland Baltimore County, National Institute of Mental Health Grant

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Tutty, L. M., Bidgood, B. A., Rothery, M. A., & Bidgood, P. **Year:** 2001 **Citation:** An evaluation of men's batterer treatment groups. *Research on Social Work Practice, 11*(6), 645-670. **Country of study:** Canada **Aim of study:** To evaluate the effectiveness of an intervention based on family-of-origin treatment **Study design:** Before and after study **Quality score:** [++] **External validity:** [+]	**Source population(s):** Self-referred and court mandated male batterers **Eligible population(s):** Men who attended treatment **Selected population(s):** 15 treatment groups **Excluded population(s):** Men with substance abuse, psychosis, or refusal to accept responsibility for violent behaviour **Sample characteristics:** *Mean age (SD):* 34 (8.9); *Marital status:* 53% living with partner, 76% of those separated hoping to reunite; *With children:* 87%; *Mean monthly income (SD):* $1,948 ($1,175); *Abuse History:* 56% childhood violence, 8% observed DV, 23% childhood abuse **Setting:** 3 urban DV agencies in a network that provides support groups for battered women	**Method of allocation:** N/A **Intervention(s) description:** The intervention was based on a model by Pressman and Sheps that is feminist, based on gender roles, and works with childhood traumas, developing new problem solving skills with a focus on ending abusive behaviours. Groups (6-8 men) were for 12 weeks of 2-hour sessions, or 10 weeks of 3-hour sessions. The intervention was delivered by social workers (male and female pair) with training in family violence. Overall attendance rate was 67%. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=104 **Baseline comparisons:** NR **Study sufficiently powered:** NR	**Primary outcomes:** Social support from the *Interpersonal Support Evaluation List (ISEL)* was used to assess level of social supports. Locus of control was measured with the *Internal-External Control Scale*. Perceived stress was measured with the *Perceived Stress Scale*. Physical and non-physical abuse was measured with the *Index of Spouse Abuse (ISA)*. The *Family Assessment Measure-Dyadic Relationship (FAM-DR)* measured marital functioning, with 7 subscales. Therapists rated client functioning in 11 areas. **Secondary outcomes:** Differences in outcomes between court-mandated and voluntary participants **Follow up periods:** 6 months - mail-in assessment; not reported as part of the results **Methods of analysis:** Chi-square and t tests. Self-report measures adjusted with results of Marlowe Crowne Social Desirability Test	**Who is the target of the intervention?** Male batterers **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** The treatment specifically included work on men's trauma histories and their shame from these experiences, with a family-of-origin therapy. The study specifically excluded those with substance abuse.	**Primary outcomes:** There were statistically significant reductions after adjusting for social desirability (all p's<0.000) in Physical and Nonphysical Abuse, Appraisal Support, Perceived Stress, Locus of Control, and the FAM-DR scales of Control, Affective Expression, and Communication. Therapists reported significant change for verbal abuse, accepting responsibility, and changes in traditional views of women. **Secondary outcomes:** No difference in results for court-mandated vs. voluntary participants **Attrition details:** 68% (64 of 104) completed pre and post assessment. Drop-outs were compared with completers, with no significant differences	**Limitations identified by author:** No control group. No partner report to confirm reduction in abuse. No long-term outcomes **Limitations identified by review team:** Self-report for abuse. Therapist evaluation questions and data not congruent with participant questions or outcomes **Evidence gaps and/or recommendations for future research**: Family of origin treatment is different from anger management or cognitive-behavioural approaches, and is worth further evaluation. **Source of funding:** Waterloo Region Social Resources Council

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Tutty, L. M., Babins-Wagner, R., & Rothery, M. A. **Year:** 2006 **Citation:** Group treatment for aggressive women: An initial evaluation. *Journal of Family Violence, 21*, 341-349. **Country of study:** Canada **Aim of study:** To evaluate the "Responsible Choices for Women" programme for effectiveness **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Women batterers **Eligible population(s):** Women working with a clinic therapist **Selected population(s):** 72 women who had participated in the programme to that point **Excluded population(s):** NR **Sample characteristics:** *Mean age (SD):* 32 (6.9), range=19-48; *Marital status:* 50% continuing to live with partner, 21% separated, 10% divorced, 15% single; *With children:* 72% (oldest child's age ranged from <2 to 17); *Mean income (range):* $15,000 ($0-$100,000); *History:* 84% prior counselling, 68% psychiatric history **Setting:** Calgary Counselling Centre (urban setting)	**Method of allocation:** N/A **Intervention(s) description:** 15 weeks of 2-hour groups (6-12 women), based on social learning and cognitive behavioural therapy. Facilitators were a male-female team with at least one experienced senior therapist. A team of 3-6 watched from a one-way mirror and joined the session during the last 20 minutes to provide feedback. Techniques included cognitive restructuring, relaxation, communication skills, role socialization, logs, time-outs, and audio-visual materials. Three partner checks were made during treatment. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=33 at final analysis **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** The *Abuse of Partner Scales,* Physical and Nonphysical, measure the magnitude of physical and sexual assaults made on a spouse or partner, and abuse or coercive behaviour. The *Hudson Index of Self-Esteem* indicates level of difficulty with self-esteem. The *Generalized Contentment Scale* measures the severity of depression. The *Index of Clinical Stress* rates the severity of perceived stress. The *Adult Self-Expression Scale* reflects verbal assertiveness. The *Index of Marital Satisfaction* measures severity of problems in couple's relationships. The *Index of Family Relations* shows severity of problems in family relationships. *Nowicki-Strickland Internal Locus of Control* examines the extent of beliefs that events are contingent on behaviour or externally. *Sex-Role Ideology Short form* identifies the extent of beliefs as feminist or traditional. **Secondary outcomes:** NR **Follow up periods:** Mid-treatment and post-treatment **Methods of analysis:** ANOVA	**Who is the target of the intervention?** Women who abuse their partner or children **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Women reported improvements that were significant on five variables: non-physical abuse of partner (p=0.000), self-esteem (p=0.001), general contentment (p=0.001), clinical stress (p=0.000) and adult self-expression (p=0.004) **Secondary outcomes:** N/A **Attrition details:** The 42 women who completed the group scored no differently than the 24 non-completers on any of the standardized measures or any demographic characteristics. Missing midpoint measurements reduced the final analysis to 33.	**Limitations identified by author:** Difficulties in distinguishing violence from self-defence. Length of intervention **Limitations identified by review team:** Very small sample. 9 completers (20+%) were missing data and were excluded. **Evidence gaps and/or recommendations for future research**: Closely monitor the impact of dual arrests where the woman is subsequently mandated to treatment, particularly in cases where they were primarily acting in self defence **Source of funding:** Calgary Foundation and the Muttart Foundation

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Tutty, L. M., Babins-Wagner, R., Rothery, M. A. **Year:** 2009 **Citation:** A comparison of women who were mandated and nonmandated to the "Responsible Choices for Women" group. *Journal of Aggression, Maltreatment & Trauma, 18*(7), 770-793. **Country of study:** Canada **Aim of study:** The primary goal of Responsible Choices for Women is to assist women who are abusive in intimate relationships to become violence free. The research asks "do women change as a result of participation"? **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** All women who had participated in the programme since 1995 **Eligible population(s):** Participants had to be clients of a primary therapist in the agency **Selected population(s):** Programme completers **Excluded population(s):** NR **Sample characteristics:** *Mean age (SD):* 31 (8.3); *Marital status:* 21% married, 21% common law, 7% divorced, 32% single; *Mean income (SD):* $16,937 ($18,127); *Children:* 65% had children, oldest child's mean age (SD) was 9 years old (6); *History:* 79% prior counselling, 29% psychiatric problems, 8% sexual abuse,10% substance abuse,	**Method of allocation:** N/A **Intervention(s) description:** Group therapy with 6-12 women, with 14 weekly sessions, 2 hours each (except 3 hours for the first and last session). The intervention included cognitive restructuring, relaxation techniques, communication skills, sex role socialization strategies, "responsible choices logs," timeouts, role playing, audio-visual material, and behaviour modeling by therapists. A team (3-6 members) watched sessions from behind a one-way mirror, and joined during the last 20 minutes of the session to contribute their observations. Completion rate was 64%. No report of treatment fidelity. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=293; Population data n=261; Treatment completers with measurement n=154 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** 8 scales: *Abuse of Partner Scales: Physical and Nonphysical*, which measure the magnitude of physical and sexual assaults made on a spouse or partner, and abuse or coercive behaviour. The *Partner Abuse Scales: Physical and Nonphysical (PASPH)* for the degree of experience of abuse by partner. The *Generalized Contentment Scale* measures the severity of depression. The *Index of Clinical Stress* rates the severity of perceived stress. The *Rosenberg Self-Esteem Index* rates self-esteem, and the *Marlowe-Crowne Social Desirability Test Short Form* tested the propensity to make oneself appear more competent, to test for biasing of self-report. **Secondary outcomes:** NR **Follow up periods:** None **Methods of analysis:** Pearson chi-square and mixed factorial ANOVA.	**Who is the target of the intervention?** Women, almost exclusively English speakers **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The 154 women who completed both pre- and post-tests reported statistically significant improvements on five variables (all p's=0.001): generalized contentment (depression), clinical stress, nonphysical abuse of partner, partner nonphysical abuse of the woman, and partner physical abuse of the woman. Self-esteem worsened significantly (p=0.001) after the group programme and remained in the clinical range. In terms of clinically significant change, the generalized contentment scales, clinical stress, partner physical abuse, and nonphysical abuse against partner scores moved from the clinical into the nonclinical range. Notably, although the scores on partner physical abuse decreased and nonphysical abuse by their partners did not decrease, these are not within the women's control and should be viewed descriptively	**Limitations identified by author:** Short length of programme. Difficulties in identifying women who acted in self-defence **Limitations identified by review team:** Some outcomes described as significant although only one outcome indicated significance **Evidence gaps and/or recommendations for future research**: Closely monitor the impact of dual arrests where the woman is subsequently mandated to treatment, particularly in cases where they were primarily acting in self defence **Source of funding:** Family and Community Support Services of the City of Calgary

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	62% family violence in childhood **Setting:** Urban specialized treatment centre		Calculated p-values of 0.009 for alpha of 0.10 for significance		only. The only variable that differentiated the mandated and non-mandated women was nonphysical abuse of partner, with the mandated women reporting use of fewer abusive behaviours at pre-test (p=0.006). **Secondary outcomes:** N/A **Attrition details:** 185 of 290 completed the programme: 64%. No significant differences	

Appendix O

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Waldo, M., Kerne, P. A., & Van Horn Kerne, V. **Year:** 2007 **Citation:** Therapeutic factors in guidance versus counselling sessions of domestic violence groups. *The Journal for Specialists in Group Work, 32*(4), 346-361. **Country of study:** USA **Aim of study:** To explore if using a counselling approach within a guidance based programme will result in the men experiencing different therapeutic factors **Study design:** Cluster randomized controlled trial **Quality score:** [+] **External validity:** [+]	**Source population(s):** Court-mandated participants to DV treatment **Eligible population(s):** Members of 6 men's DV groups **Selected population(s):** All group members reported to have given consent **Excluded population(s):** NR, but final analysis excluded 24 responses **Sample characteristics:** *Mean age (SD):* 30 (8.7), range=18-56; *Ethnicity:* 75% Hispanic, 15% White, 3% African American, and one each Asian American and Native American; *Marital status:* 37% single, 48% married or cohabitating, 14% divorced or separated; *Education:* 29% <high school, 31% high school, 29% some college, 10% university degree or higher; *Sessions attended before intervention (SD):* 12 (7) **Setting:** Urban DV treatment centre	**Method of allocation:** Group session was randomly assigned to usual treatment session or one time intervention session. The order of sessions was also randomized. **Intervention(s) description:** 3 doctoral student facilitators, each in partnership with 2 masters' students, facilitated the sessions. The sessions were based on Yalom's "here and now", self-disclosure of successes and challenges, group feedback, and ending with a focus on positive changes. **Control/comparison(s) description:** The comparison was usual treatment sessions based on the Duluth model of nonviolence, non-threatening behaviour, sexual respect, honesty and accountability, support and trust, partnership, respect, negotiation and fairness, and the effects of violence on children. **Sample size(s):** Total n=99; Intervention n=60 (47 analysed); Usual care n=72 (61 analysed) **Baseline comparisons:** NR **Study sufficiently powered:** NR	**Primary outcomes:** The authors measured 10 factors. The 6 highlighted in the outcomes were: Universality, recognize that they are not the only ones who have engaged in abuse; Hope, learn that they can change; Cohesion, experience closeness to group members; Interpersonal learning, open to group's corrective feedback; Information, learning about DV; and Existential, recognize that they do not control many aspects of the world. Measurement instrument was the *Critical Incident Questionnaire*, with an IRR above 90%, administered immediately after the session. **Secondary outcomes:** Participants' opinions of the usefulness of the session **Follow up periods:** Post-treatment **Methods of analysis:** Two blinded researchers coded the CIQ with 83% compared and 100% agreed IRR. Reponses differing by more than 3% were deemed as significant without inferential statistical testing.	**Who is the target of the intervention?** Men who have committed DV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Higher comparison group scores (%) in Hope (3%) and Information (6%). Higher intervention group scores in Universality (12%), Cohesion (7%), and Interpersonal learning (3%). Because control groups focus on conveying information rather than on the relationships between group members, they may be less likely to foster universality, cohesion, and interpersonal learning. **Secondary outcomes:** No differences in participants' satisfaction with the session **Attrition details:** N/A. 24 responses were excluded for illegible handwriting	**Limitations identified by author:** One session may have limited impacts. Small sample size. Excluded responses. Predominance of Latino participants. Prior group training and comfort with regular format **Limitations identified by review team:** Number of participants does not add up **Evidence gaps and/or recommendations for future research**: Comparing therapeutic factors in guidance and counselling groups is a potentially productive direction for future research. **Source of funding:** NR

Table 64. Research Question 3 (Elder Interventions) Evidence Tables

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Nahmiash, D. & Reis, M. **Year:** 2001 **Citation:** Most successful intervention strategies for abused older adults. *Journal of Elder Abuse & Neglect, 12*(3-4), 53-70. **Country of study:** Canada **Quality score:** [+]	**What was/were the research question(s)?** To rate the success or non-success of various interdisciplinary elder abuse intervention strategies in the community Project CARE study **Theoretical approach:** Content analysis **How were the data collected?** (See intervention prior to reading this section). The IOA was completed by the trained intervenors after a two-to-three hour home assessment. The success of each intervention strategy was rated, on the AID form, by a consensus of 3-5 members of the multidisciplinary team following a case presentation. Each intervention strategy was rated as accepted or refused, and as	**What population was the sample recruited from? How were they recruited?** This sample was selected from a group of 218 older adults who had been identified by professionals as victims of abuse and neglect using the Brief Abuse Screen for the Elderly (BASE). **How many participants were recruited?** 83 AID forms, corresponding to 83 abuse cases seen during the time of the study **Inclusion and exclusion criteria:** The sample only included abuse and neglect cases in which there was an abuser who was a caregiver and usually a family member. In all cases, the caregiver abuser offered some regular care or	**Description of intervention(s):** The intervention model was based on five elements and coordinated by a small multidisciplinary team of home care professionals and paraprofessionals. A Home Care Intervention Team performed home assessment visits and provided and arranged services. The team identified abuse and neglect cases involving agency clients aged 55+. Abuse cases also were confirmed as they progressed over time by a smaller 3-5 member advisory Multidisciplinary Intervention Team, using the model intervention's newly developed Tool Package, which included the Indicators of Abuse (IOA) checklist and other screening measures. The IOA helped identify indicators of abuse present in the abused persons and in abusers and also helped the professional intervenors and Multidisciplinary Team to plan intervention strategies. Items of the IOA focused intervenor attention on many of the specific problems (e.g. substance abuse problems, social isolation, relationship problems). This tool helped the intervenors plan individual and group intervention strategies to reduce or resolve each problem area identified. Following the case discussion by the Multidisciplinary Team, intervention strategy plans were drawn up by Home-care Team members, using the Abuse Intervention Description (AID). The AID form was based on intervention forms commonly used by health and social service agencies with the addition of an evaluation component. It was used to roughly prioritize the need for intervention, and listed both abuse and non-abuse problems and each problem's corresponding specific concrete intervention	**Method and process of analysis:** Criteria for rating success or non-success included stopping or reducing abuse and/or neglect or solving the identified problem, such as isolation. An initial sorting of the AID intervention plans was conducted by two independent raters after having carefully read all of the intervention plans. A trained research assistant and an expert abuse consultant each categorized a total of 473 intervention strategies into 10 mutually exclusive intervention activities. The categories were then regrouped into strategies for caregivers and strategies for care receivers. Each of the 83 intervention plans for the individual abuse cases were coded independently by the research assistant and the research consultant. Codings were then compared for inter-rater agreement. Disagreements in categorizations were discussed until a consensus was reached. Project CARE nurses, social workers, and physical and occupational therapists completed 83 AID forms. The percent of successful categories was calculated. **Key themes relevant to this review:** 8% of the overall	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Yes, that was the nature of the study. **Target of intervention:** Elderly clients who are abused by their caregivers	**Limitations identified by author:** A number of strategies were still in progress and could not be rated, which limits the results of this study. Additionally, the findings were limited to those abused older adults dependent on a caregiver for their care and where the caregiver was the abuser. **Limitations identified by review team:** There are multiple ways to define success of programme elements which may not be shared between the clients of the programs and the researchers. **Evidence gaps and/or recommendations for future research:** The authors

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
	successful, partially successful, in progress or not available, by a nurse, a homemaker, a social worker, a day centre coordinator, and an abuse intervention consultant. This group met on a bi-weekly basis to evaluate the interventions after an average of three or four months of intervention.	service to the abused older adult on a regular basis. The sample did not contain elders who engaged in self-abuse or neglect. **Population demographics:** *Gender:* 1/3 of abuse victims were male, 2/3 were female. The sample contains all types of abuse (physical, psychological, financial, and neglect by a caregiver). No other demographic data was provided.	strategies. The AID form also provided for: a pre-set date for reviewing the progress of each problem and its corresponding strategies; the strategies' acceptance or refusal by clients; and the levels of success relating to whether the abuse was reduced or stopped or whether the problem identified was resolved partially or completely. Other intervention elements were: an Expert Consultant Team that provided unpaid specialized professional information and advice and consisted of members of the criminal justice system; public guardianship representatives; and financial, human rights, and psychological and psychogeriatric experts. Volunteer Buddies were trained non-professional volunteers who met regularly with abused older adults and/or their abusers on a one-to-one basis to decrease their isolation; to advise them of their rights; and to accompany them, when needed, through the intervention process. A weekly Empowerment Support Group for abused older adults increased awareness of abusive acts, identified means of dealing with their problems, and sometimes enabled the abused adults to leave their abusive situations. The Family Support Group, specifically for abusive or potentially abusive caregivers, aimed to prevent abuse, decrease caregiver isolation, and offer support/resource information. Finally, an autonomous Community Senior Abuse Committee focused on prevention of abuse, raising community awareness and advocacy. **Intervention setting:** Home care	intervention strategies were rated as successful or partially successful and 20% were rated as unsuccessful. The most accepted and successful categories were the general medical, nursing and rehabilitation strategies for abused persons (23%), the abuser caregiver strategies such as individual counselling to reduce anxiety, stress, and depression (17%), home making services for abused older adults, such as giving a bath, providing shopping, and laundry services (15%), and the support groups, such as the empowerment group, volunteer buddies, self-care counselling, and education strategies and information about rights and resources (13%). The most frequently refused intervention strategies were those aimed at increasing the socialization of clients in community activity programs or day centre programs outside of the agency (only 10% were successful). Approximately 23% of the intervention strategies were still in progress after four months of intervention and could not be categorized as successful or not successful at the time of this study.		recommend further research using the AID form in a variety of abuse cases, intervention settings, and with culturally-diverse client populations. Intervention strategies should be offered to abusers or potential abusers and not only to abused older adults. **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Phillips, L. R. **Year:** 2008 **Citation:** Abuse of aging caregivers: Test of a nursing intervention. *Advances in Nursing Science, 31*(2), 164-181. **Country of study:** USA **Aim of study:** To test the effect of a nursing intervention intended to decrease the frequency of physical and verbal/psychological aggression toward older caregiving wives and daughters by care recipients and improve selected abuse related outcomes for older caregivers including anger, depression, anxiety, confusion, and 2 dimensions of caregiving burden **Study design:** Randomized controlled trial **Quality score:** [+]	**Source population(s):** American, Mexican and Mexican-American women who provided care for older family members. Caregiving was defined as providing unpaid assistance at home with at least 1 activity of daily living at least weekly **Eligible population(s):** Women older than 50 who provided care to elders older than 55 who had been exposed to at least 1 type of verbal/psychological aggression at least once a month, or one type of physical aggression at least once or twice a year **Selected population(s):** Subjects were recruited from community agencies and advertising on the television, radio, newspapers, and church bulletins. **Excluded population(s):** Hispanic, Latino, or Chicano, and identified with a country of origin other than Mexico (e.g., Cuba, Puerto Rico, and Spain) **Sample characteristics:** Intervention (Male Elder): *Caregiver mean age (SD):* 65 (11.1); *Elder's mean age (SD):* 76 (9.9); *Number of*	**Method of allocation:** Random assignment via coin flip **Intervention(s) description:** 12-week psychoeducative nursing intervention intended to decrease the frequency and intensity of physical and verbal/psychological aggression toward older caregiving wives and daughters by care recipients and improve selected abuse-related outcomes. The intervention, which focused on pattern identification, advocacy counselling, reframing of the caregiving situation, and nonconfrontational caregiving strategies, was individualized and highly interactive with emphasis placed on mutual problem solving and mutual planning. At each session, caregivers were asked to identify specific problems or instances of aggression they were encountering. The interventionist helped the caregiver analyse the problem and sequence of events to identify triggers and patterns in relationship to aggression. Caregivers were encouraged to envision other ways of dealing with the problem. The "take home message" of the intervention was to "stop, plan, and practice," a slogan that was given to each caregiver on a refrigerator magnet as a reminder. Thus, they were taught to recognize when tension was building, to stop and analyse the situation, to think of a different way of achieving the same outcome, and, when possible,	**Primary outcomes:** The *Revised Conflict Tactic Scale (CTS-R)* measured past and current aggression. The pre-intervention time frame for spouses was "before you became a caregiver;" and the time frame for daughters was "when you were younger (in the years before you became a caregiver)." The alpha reliabilities with subjects in this sample were 0.82 and 0.88 for the physical aggression subscale and verbal/psychological aggression subscale, respectively. For current aggression the version included the modifications of the scale developed by Steinmetz in her study of elder abuse and abuse against caregivers. Like Steinmetz, items were added such as "She/he has called police or other help for imaged threats," that are specific to situations encountered by caregivers. The scale contained 37 items rated by caregivers on a 6-point scale representing frequency of occurrence	**Who is the target of the intervention?** Older caregiving wives and daughters **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** There were no significant differences between the groups for physical aggression from baseline to post-intervention. Effect of the intervention on mood states and burden was rejected for all 4 mood states and for the 2 types of burden. For depression, there was a significant main effect × time interaction (F=4.22, p=0.04), with all subjects showing a decrease over time. In the case of anger (F=3.99, p=0.05), caregivers of men in the intervention group showed a significant decrease in anger over time. In the case of confusion (F=4.74, p=0.03), caregivers of men in the intervention group showed a significant decrease in confusion over time. **Secondary outcomes:** N/A **Attrition details:** Fifteen subjects were lost prior to baseline data collection because the caregiver changed	**Limitations identified by author:** Relied on self-report by caregivers. No information about the elder's perspective on the situation and no independent verification of information about the elder, such as mental status. The study was underpowered. Ideally this study should have had an attention control group. **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** National Institutes of Aging in collaboration with the National Institute of Justice and National Institute of Drug Abuse

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]	*years the caregiver knew elder:* 45 (18.9); *Ethnicity:* 19% White; *Marital status:* 19% married; *Employment:* 8% working. Intervention (Female Elder): *Caregiver mean age (SD):* 56 (7.1); *Elder's mean age (SD):* 83 (6.7); *Number of years the caregiver knew elder:* 54 (10.2); *Ethnicity:* 13% White; *Marital status:* 16% married; *Employment:* 17% working. Control (Male Elder): *Caregiver mean age (SD):* 67 (9.5); *Elder's mean age (SD):* 74 (8.4); *Number of years the caregiver knew elder:* 43 (17.7); *Ethnicity:* 21% White; *Marital status:* 22% married; *Employment:* 5% working. Control (Female Elder): *Caregiver mean age (SD):* 59 (7.0); *Elders mean age (SD):* 85.4 (8.4); *Number of years the caregiver knew elder:* 57 (12.6); *Ethnicity:* 23% White; *Marital status:* 18% married; *Employment:* 23% working **Setting:** At home and by telephone. Urban vs. rural setting not specified	to rehearse what they were going to say before they said it. **Control/comparison(s) description:** No intervention **Sample size(s):** Total n=83; Intervention n=38; Control n=45 **Baseline comparisons:** Univariate analysis of variance and chi-square analysis showed no differences between intervention and control groups on demographic variables. However, caregivers in the intervention group had significantly higher baseline depression and confusion scores. **Study sufficiently powered:** NR	(range from never to daily). The alpha reliabilities with subjects in this sample using baseline data were 0.89 and 0.86 for the physical aggression subscale and verbal/psychological aggression subscale, respectively. Negative mood states were measured using the short version of the *Profile of Mood States Scale (POMS)*. Caregiving burden was measured using the *Caregiving Burden Scale*. Two dimensions of burden were used in this study: social function and disruptive behaviour burden. **Secondary outcomes:** NR **Follow up periods:** 3 months **Methods of analysis:** Hypotheses were tested using repeated-measures analysis of variance using group and gender of elder as between-subjects factors and time as the within-subjects factor.		her mind, the elder died or was relocated to a nursing home. The reasons for losses post-intervention were that the elder died (n=12), the elder relocated to a nursing home (n=4), the caregiver was too busy or had her own health problems (n=6), and the caregiver did not complete the intervention within 12 weeks (n=2).	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Reay, A. M. C. & Browne, K. D. **Year:** 2002 **Citation:** The effectiveness of psychological interventions with individuals who physically abuse or neglect their elderly dependents. *Journal of Interpersonal Violence, 17*(4), 416-431. **Country of study:** UK **Aim of study:** This study aimed to investigate education and anger management to address cases of elder maltreatment **Study design:** Interrupted time series **Quality score:** [+] **External validity:** [-]	**Source population(s):** Families experiencing elder abuse in the UK **Eligible population(s):** Families experiencing elder abuse in the UK from which patients were referred to intervention by their GP or psychiatrist **Selected population(s):** Patients who were referred to intervention by their GP or psychiatrist **Excluded population(s):** NR **Sample characteristics:** Although some participants had been prescribed medication in the past, no participants were currently on any psychotropic medication. The victims lived constantly with their caregivers	**Method of allocation:** There was no allocation to different intervention groups. However, for the analyses, the perpetrators were divided into two groups: Group 1 with 6 males and 3 females, ranging in age from 65 to 72, who had admitted to physical abuse and Group 2 with 3 males and 7 females, ranging in age from 67 to 74, who had admitted to neglect. **Intervention(s) description:** After an explanation of what the study involved and their agreement given, a history was obtained as part of the routine assessment. Participants were given five assessments before the study began to establish baseline levels: Conflict Tactics Scale, Strain Scale, Beck Depression Inventory, Beck Anxiety Inventory, and Cost of Care Index. After 1 week, participants were then introduced to the education component of the study. The educational programme was done on a one-to-one basis by a clinical psychologist and took the form of a 90-minute semi-structured interview, where participants were given detailed information about the nature of their relatives' illnesses, the area services available (e.g. day care, groups for caregivers, etc.), resources available (e.g. attendance allowance), and the nature of caring for an elderly person (e.g.	**Primary outcomes:** The *Conflict Tactics Scale (CTS)* assesses the behaviours an individual might employ during a conflict situation. *Machin's Strain Scale (SS)* measures caregiver stress, encompassing domestic upset, personal distress, and negativity toward the dependent. The *Beck Depression Inventory (BDI)* assesses the severity of depression. The *Beck Anxiety Inventory (BAI)* measures the severity of anxiety. The *Cost of Care Index (CCI)* is designed as a case management tool to assist in family assessments and to identify actual or perceived problem areas in the care of elderly relatives. This 20-item questionnaire measures five dimensions: personal & social restrictions, physical & emotional health, value, care recipient as provocateur, and economic costs. CTS, BDI, and BAI have shown good test-retest reliability and validity. Although the SS is used by some health professionals, its test-retest reliability and validity are not documented. The reliability and validity of the CCI are also not clear from the available literature. **Secondary outcomes:** NR	**Who is the target of the intervention?** Families experiencing elder abuse **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Yes, that was the nature of the study.	**Primary outcomes:** CTS scores showed a trend for reduction from baseline (mean=20) to the end of treatment (mean=14) and at follow-up at 6 months (mean=13), for the physical abuse group ($z=4.8$, $p<0.09$), but no such trend was observed for the neglect group. The significant change in the reduction of conflict occurred after the anger management intervention ($p<0.05$), with the education component having no significant effect on conflict. On the SS, there was a highly significant reduction in levels of strain for both physical abusers and those who neglect their elderly dependents ($z=17.2$, $p<0.001$; $z=19.2$, $p<0.001$, respectively). For the neglect group, the largest change was following the education intervention, and for the physical abuse group, a similar degree of significant change (p's<0.01) was observed following both the education and anger management interventions. The significant reduction in strain was maintained at follow-up for both groups. On the BDI, there was a significant reduction in scores for both the physical abusers and those who neglected their elderly dependents ($z=16.2$, $p<0.001$; $z=20.0$, $p<0.001$, Friedman test; respectively). At each stage of the intervention, a significant reduction was observed (p's<0.01), and this reduction was maintained at follow-up for both groups. The neglect group changed most following the education intervention and remained significantly lower in their BDI scores	**Limitations identified by author:** Small sample size. No control group receiving no treatment **Limitations identified by review team:** Self-report biases. Very poor description of sample making it difficult to generalize to population **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	and were not suffering from any form of dementia. According to general practitioner files, all caregivers were retired and in good physical health, and the housing was deemed adequate for their needs. For 63% of cases the perpetrator of abuse (n=7) or neglect (n=5) was the elderly spouse of the victim. For 32% of cases, the offender was the victim's adult child (2 abused and 4 neglected), and in 1 case (5%), an elderly sister was the perpetrator of neglect. No other data on sample was provided. **Setting:** NR	isolation, loss of control, and stress in caregivers). Following this, assessments were readministered one week later. After a 1-month period, participants were then introduced to the anger management component, where they were taught how to manage the stages of anger on a one-to-one basis in the form of a therapeutic session for 90 minutes. The five assessments were again readministered after one week. After 6 months, participants were followed up at routine outpatient appointments where the five assessments were administered for the last time. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=19 **Baseline comparisons:** There was no significant difference between those who physically abused their elderly dependent and those who neglected them based on age and gender of the caregiver or age and gender of the victim. **Study sufficiently powered:** NR	**Follow up periods:** Assessments were given at pre-intervention, post-education, post–anger management, and 6-month follow-up. **Methods of analysis:** For both the physical abuse and neglect groups, a within-group analysis of scores was performed on each of the five assessments from baseline to follow-up. When an overall significant change was observed using Friedman's two-way ANOVA, significant differences between each of the four conditions (pre-intervention baseline, education, anger management and follow-up) were established within each group. Between-group differences were compared using the Mann-Whitney U test. This established whether there were any significant differences in the way the physical abuse group responded to the interventions in comparison to the neglect group.		in comparison to physical abusers throughout ($p<0.01$). On the BAI, both groups showed significant reductions in their scores ($z=15.2$, $p<0.0005$; $z=20.0$, $p<0.0001$, respectively). Significant changes were observed at each stage of the intervention ($p's<0.05$), with the physical abuse group showing the most change post-anger management and the neglect group showing the most change post-education. Post-intervention and at follow-up, the neglect group maintained a BAI score twice as high as the physical abusers ($p<0.01$). Mean CCI scores significantly reduced overall for both the physical abuse and neglect groups ($z=6.2$, $p<0.001$; $z=10.4$, $p<0.001$, respectively). There were no significant differences in the pattern of change between the physical abuse and neglect groups. The education intervention had no effect on the CCI, with the score slightly increasing for the neglect group and significantly increasing for the physical abuse group (i.e. they got worse, $p<0.01$). **Secondary outcomes:** N/A **Attrition details:** NR	

Table 65. Research Question 3 (Interventions for Couples) Evidence Tables

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Babcock, J. C., Graham, K., Canady, B., & Ross, J. M. **Year:** 2011 **Citation:** A proximal change experiment testing two communication exercises with intimate partner violent men. *Behaviour Therapy, 42*, 336-347. **Country of study:** USA **Aim of study:** To test the immediate impact of two interventions for IPV men in affecting emotional change during arguments with their partners **Study design:** Randomised controlled trial **Quality score:** [+] **External validity:**	**Source population(s):** Male batterers in Houston **Eligible population(s):** Male batterers responding to ads in free local papers and flyers posted around the Houston area asking for "couples experiencing conflict". Eligibility: married or living together as if married for at least 6 months, be 18 years of age, able to speak and write English. There had to be at least 2 incidents of male-to-female aggression in the past year, or no relationship violence but low female-partner satisfaction with the relationship. **Selected population(s):** Eligible couples who agreed to participate, were classified as IPV using the Conflict Tactics Scale-2 (CTS2) (i.e. "distressed nonviolent" couples were excluded), and completed both days of data collection **Excluded population(s):** Couples classified as "distressed nonviolent", those with incomplete data, and those where the female partner anticipated	**Method of allocation:** Randomized **Intervention(s) description:** Couples discussed an area of conflict twice, interrupted by a brief intervention. The two intervention conditions were an editing-out-the-negative skills training and an accepting-influence skills training. First, couples were separated to complete a questionnaire and then reunited for the videotaped conflict discussions. The Play-by-Play Interview was administered to clarify an actual conflict area in their relationship. Couples were asked to sit quietly for a 4-minute eyes-open baseline, then to engage in two 7.5-minute conflict discussions interrupted by the intervention or placebo task, where men received instruction according to treatment condition and their female partners listened to music on headphones. Both partners were asked to complete the About That Discussion (ATD) questionnaire after each conflict discussion. Finally, participants were interviewed separately and debriefed. In the editing-out-the-negative exercise, a grad student taught men to substitute their immediate negative response with a more	**Primary outcomes:** Conflict discussions were videotaped and coded by a team of 10 trained coders using the *Specific Affect Coding System (SPAFF).* Coders were blind to treatment condition and reliability was checked throughout the study. SPAFF codes were collapsed into global "verbal aggression" and "positive" categories. A project-designed *About That Discussion (ATD)* Likert-type questionnaire was given to men and women to assess self-report of positive and aggressive affect. Internal consistency was adequate (alphas for positive and aggressive affect were 0.77 and 0.82, respectively). **Secondary outcomes:** NR **Follow up periods:** Follow-up with female partners one week after participation to check that no violent incidents occurred. No follow-up for outcome measures was done, however. **Methods of analysis:**	**Who is the target of the intervention?** Men only **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** IPV men in both skills-training conditions showed greater decreases in aggressive feelings than IPV men in the time-out condition based on their self-report ($F(2,97)=3.37$, $p<0.05$, eta squared=0.71) and observed affective behaviour (positive affect $F(2,97)=3.38$, $p<0.05$, eta squared=0.014; aggressive affect ($F(2,97)=3.37$, $p<0.05$, eta squared=0.054). Women also reported feeling less aggressive when their husbands were assigned to one of the skills-training conditions as compared to the control (time-out) condition ($F(2,97)=3.44$, $p<0.05$, eta squared=0.056). **Secondary outcomes:** N/A **Attrition details:** Only those with complete data were included in the study analyses.	**Limitations identified by author:** Sample was recruited via advertisements and so may not be representative of court-mandated men or partners or women seeking shelter. Sample size too small for test of four-way interactions. Variability in participants' willingness to apply the taught skills. The time out in this study differs from time outs in real life (music typically not used, the study time-out was shorter than usual, men not allowed to leave the room in this study). Lack of follow-up outside the lab **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Examine the impact of teaching both partners accepting-influence and editing-out-the-negative on

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
[-]	increased violence from their partner if they participated **Sample characteristics:** *Mean age (SD):* 31.6 (9.7); *Mean education on 1-5 scale (SD):* 4.1 (1.8); *Mean annual gross family income (SD):* $30,769 ($4,209); *Mean length of relationship in years (SD):* 3.8 (2.7); *Number of acts of physical violence reported by female partners in the past year (SD):* 19.1 (24.4); *Ethnicity:* 48% African American, 18% Hispanic, 26% Caucasian, 2% Asian, 6% Native American or other **Setting:** Urban setting. No further details provided	neutral one. In the accepting-influence exercise, a grad student taught men to search for the "kernel of truth" of their partner's argument with which they could agree, recognizing that parts of the partner's statements are valid. In both intervention conditions, men were instructed to practice the skill in the upcoming argument without informing his partner what he was doing or why. **Control/comparison(s) description:** The control condition was a time out. Men listened to music for 8 minutes, with instructions to relax. **Sample size(s):** Total n=100; Editing-out-the-negative n=39; Accepting-influence n=30; Placebo/Time out n=31 **Baseline comparisons:** No differences at baseline between groups **Study sufficiently powered:** NR	Only those who completed data collection were included. Four mixed-model MANOVAs were conducted, with treatment as between-subjects factor and time as within-subjects factor. The first two MANOVAs used positive and aggressive affect from the ATD as dependent variables, for men's and women's self-reports separately. The second pair of MANOVAs used the SPAFF variables, again for men and women separately. The primary analyses of interest were the Two-Way Condition×Time and the Three-Way Condition×Time×Affect interactions. Planned post-hoc contrasts tested whether each intervention differed from the control condition in terms of affecting behaviour change.			aggressiveness and violence **Source of funding:** University of Houston and the National Institutes of Health

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Cleary-Bradley, R. P., Friend, D. J., & Gottman, J. M. **Year:** 2011 **Citation:** Supporting healthy relationships in low-income, violent couples: Reducing conflict and strengthening relationship skills and satisfaction. *Journal of Couple & Relationship Therapy: Innovations in Clinical and Educational Interventions, 10*(2), 97-116. **Country of study:** USA **Aim of study:** To evaluate the efficacy of Couple and Relationship Education (CRE) for low-income parent couples who exhibit situational violence **Study design:** Randomised controlled trial	**Source population(s):** Heterosexual low-income couples experiencing situational violence **Eligible population(s):** Couples that attend community-based organizations that offer services for low-income, distressed couples **Selected population(s):** Participants must have been romantically involved and in a committed relationship for at least 1 year, be at least 18 years old, speak English, be experiencing situational violence, have at least one child under age 12, and have a combined income below the local county median for a family of three ($73,000) **Excluded population(s):** Couples not	**Method of allocation:** Random assignment - no additional info. **Intervention(s) description:** The Creating Healthy Relationships Programme (CHRP) is a psychoeducational intervention based on the sound relationship house theory which describes characteristics of relationships and longevity. The sound relationship house includes seven levels that depict different “floors” of the house. Each floor represents a relationship domain that contributes to healthy relationships. CHRP content was tailored to meet the needs of low-income, situationally violent couples (e.g. low literacy levels). CHRP covered five content areas: Managing Stress; Establishing Emotional Connections in the Family with Partners and Children; Maintaining Intimacy; Creating Shared Meaning; and Managing Conflict. Pairs of male/female clinicians facilitated weekly 2-hour intervention sessions. Sessions were held with groups of 6-8 couples for 22 weeks. At the start of each session, couples were shown a video that showed diverse couples participating in a mock talk show focused on the session topic. After viewing the video, couples voiced their own thoughts and feelings about the topic. This discussion was followed by an educational component when facilitators shared relevant research-based information about the topic. Each session also	**Primary outcomes:** A dichotomous variable was created to denote whether couples remained together or dissolved their relationships. Relationship statisfaction was measured using the the *Dyadic Adjustment Scale*. Communication and interaction patterns were measured via the *Reduced Sound Relationship House* (*RSRH)* questionnaire. The RSRH includes statements regarding thoughts, feelings, and behaviours experienced by couples pertaining to the relationship. Statements are divided into three domains: skills-friendship, sex/romance/passion, and shared meaning. The RSRH was also used to measure conflict in the relationship. **Secondary outcomes:** NR **Follow up periods:** Post-test surveys were completed 0 to 6 months after treatment (i.e., approximately 6 to 12 months after the	**Who is the target of the intervention?** Heterosexual low-income couples experiencing situational violence **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Substance/alcohol use was statistically controlled for in all analyses for females due to significant relations between female substance use	**Primary outcomes:** 73% of couples remained together throughout both assessment periods; 26% ended their relationships. Relationship satisfaction: no effect on male reported satisfaction. For female reported satisfaction the time x group interaction was not significant, but satisfaction was higher post-test in the intervention group ($t=-2.18$, $p=0.04$). Relationship skills: no main effects on male or female reported. Relationship conflict: there were significantly lower post-treatment scores in the male treatment group ($t=4.18$, $p=0.001$); there was no main effect for female-reported conflict. **Secondary outcomes:** N/A **Attrition details:** Between baseline and post-test assessments, 41 subjects withdrew from the study (control n=21 (40%), treatment n=20 (32%)). Chi	**Limitations identified by author:** Modest sample size. Attrition rate. Intervention completion rates. Homogeneity of couples. Variability in timing of post-test assessments **Limitations identified by review team:** Self-report biases **Evidence gaps and/or recommendations for future research:** Additional work is needed to show whether such benefits last long after programme completion and whether specific features of the couple (e.g., knowledge retention), programme content (e.g., focus on conflict management), or programme structure (e.g., group-based format) may

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Quality score: [+] **External validity:** [+]	experiencing characterological violence or significant substance abuse issues or have antisocial personality disorder **Sample characteristics:** Males: *Age*: 35±8 years; *Ethnicity:* 79% Caucasian, 16% African American; *Education:* 35% finished high school, 19%, finished college (BA/BS), *Employment status:* 70% full-time; Females: *Age*: 34±8 years; *Ethnicity:* 87% Caucasian, 13% African American; *Education:* 33% finished college (BA/BS), 27% finished high school **Setting:** Community programme. Urban vs. rural setting not specified	included a skill-building segment, where couples engaged in exercises that enabled them to practice relationship skills. **Control/comparison(s) description:** Couples in the control group were referred to alternative resources available in the community. **Sample size(s):** Total n=115 couples; Intervention n=62 couples; Control n=53 couples **Baseline comparisons:** NR **Study sufficiently powered:** NR	baseline). **Methods of analysis:** Repeated-measures analysis of variance (RM-ANOVA) models were run to evaluate differences in continuously measured outcomes (relationship satisfaction, skills, and conflict) across groups (treatment vs. control, between-subjects factor) and time (baseline vs. post-test, within-subjects factor). Analyses were run separately for each partner (males and females) to maximize available data. All RM-ANOVAs were run twice-once using the intent-to-treat variable and once using the significant dosage variable. Participants in the intervention group who did not complete at least 50% of the sessions were excluded from significant dosage analyses. Baseline levels of male-reported dyadic adjustment were statistically controlled for in all analyses for males due to the attrition difference (see attrition).	and relationship quality.	square analysis showed no difference in attrition rates between groups. Scores for male overall dyadic adjustment at baseline were found to differ significantly between groups (λ=0.87, p=0.03), indicating that male-reported relationship adjustment may have influenced attrition (with those reporting lower adjustment being more likely to withdraw).	facilitate long-term gains. Evaluation of relationship quality and conflict via observational assessments (that capture what couples actually do while interacting) is also needed to further corroborate treatment-based change in these areas. Assess other potential benefits of participation in CRE outside of the relationship domain (e.g., parenting, child health). Replicate study to increase generalisability. Explore the null finding with regard to relationship stability **Source of funding:** U.S. Department of Health and Human Services, Administration for Children and Families

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Fals-Stewart, W., Kashdan, T. B., O'Farrell, T. J., & Birchler, G. R. **Year:** 2002 **Citation:** Behavioural couples therapy for drug-abusing patients: Effects on partner violence. *Journal of Substance Abuse Treatment, 22*, 87-96. **Country of study:** USA **Aim of study:** To compare the impact of Behavioural Couples Therapy and Individually-Based substance abuse Treatment on the prevalence of male-to-female partner violence **Study design:** Individual randomized controlled trial **Quality score:** [+] **External validity:**	**Source population(s):** Men in court-mandated (85%) treatment for substance abuse **Eligible population(s):** Aged 20-60 years old, married at least 1 year OR common law 2 years, have a clinical diagnosis of abuse or dependence on a psychoactive substance (with primary drug NOT alcohol), abstinent during treatment, not receiving any other substance abuse treatment **Selected population(s):** 154 married or cohabitating men entering an outpatient substance abuse programme (2 sites). 51 declined **Excluded population(s):** Female partner having psychoactive substance abuse disorder in past 6 months, either partner with mental or psychotic disorders, either partner participating in methadone programme. 17 couples were excluded. **Sample characteristics:** *Years of education (SD):* 11.9 (2.4); *Mean age*	**Method of allocation:** Decision tree algorithm based on man's primary drug dependency **Intervention(s) description:** 20 weeks with 56 total sessions of cognitive behavioural therapy for both groups to develop coping skills to remain alcohol and drug abstinent. Treatment was provided by state-certified substance abuse counsellors. After 4 weeks of orientation, for 12 weeks the male partner attended one individual 60-minute session and one 90-minute session. Couples attended a weekly 60-minute conjoint therapy for 12 weeks with the goal of supporting sobriety, and treatment consisting of sobriety checks, communication skills, and encouraging shared recreational activities. Couple sessions were delivered by Masters level therapists. This was followed by 8 weeks of once a week individual sessions of 60 minutes for discharge planning. **Control/comparison(s) description:** After 4 weeks of orientation, for 12 weeks, the man attended cognitive-behavioural therapy with two individual 60-minute sessions and one 90-minute group session per week. This was followed by 8 weeks of once a week sessions of 60 minutes for discharge planning.	**Primary outcomes:** Women's report of partner violence in the past year was measured with the *Conflict Tactics Scale (CTS).* **Secondary outcomes:** Data on the effect of the intervention on drug use, men's marital satisfaction **Follow up periods:** 1 year **Methods of analysis:** Binary logistic regression. ITT excluded. Mediational analysis reduced to no significance	**Who is the target of the intervention?** Men in substance abuse treatment **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The intervention had a significant reduction in the percentage reporting male-to-female physical aggression (n=7, 18%) compared to pre-treatment ($p<0.01$), while there was no significant reduction in the control group. At follow-up, the control group had a significantly higher percentage of couples reporting male-to-female aggression ($p<0.05$). **Secondary outcomes:** N/A **Attrition details:** In the control group, 3 men attended less than half of the sessions and were excluded from analysis. In the intervention, 3 couples attended fewer than half of the sessions and were excluded from analysis.	**Limitations identified by author:** No violence frequency measures. No examination of female-to-male aggression. Post hoc analysis. Court mandated sample **Limitations identified by review team:** Not directly a DV intervention **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** National Institute on Drug Abuse, the Alpha Foundation

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
[+]	*(SD):* 34 (7); *Length of relationship (SD):* 6 years (3.9); *Number of children (SD):* 2 (1); *Ethnicity:* 84% Caucasian, 13% African American, 4% Hispanic; *Years of problematic drug use (SD):* 8 (4) alcohol; 7 (3) opiates; 3 (7) cocaine; 7 (4) cannabis; *Current substance dependence:* 63% cocaine, 40% alcohol, 38% opiates, 35% cannabis **Setting:** Two community outpatient clinics. Urban vs. rural setting not specified	**Sample size(s):** Total n=86 couples; Intervention n=43; Control n=43 **Baseline comparisons:** The two treatment condition groups were compared and no significant differences were found **Study sufficiently powered:** NR				

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Fals-Stewart, W. & Clinton-Sherrod, M. **Year:** 2009 **Citation:** Treating intimate partner violence among substance-abusing dyads: The effect of couples therapy. *Professional Psychology: Research and Practice, 40*(3), 257-263. **Country of study:** USA **Aim of study:** To examine whether participation in couples therapy, compared with individual therapy, had a differential effect on the day-to-day relationship between substance use and IPV among married or cohabiting substance-abusing men **Study design:** Randomised	**Source population(s):** Couples where the male partner has perpetrated IPV against the female partner and has substance use issues **Eligible population(s):** Heterosexual couples where the male partner was entering an outpatient clinic for the treatment of a substance use disorder **Selected population(s):** Male partners had to: be between 20 and 60 years old, be married for at least 1 year or living with a significant other in a stable relationship for at least 2 years, meet DSM-IV criteria for a substance use disorder, have medical clearance to engage in abstinence-oriented treatment, agree to refrain from the use of alcohol or illicit drugs for the duration of treatment, and refrain from seeking additional substance abuse treatment except for self-help meetings, unless additional treatment was recommended by their primary individual therapist **Excluded population(s):** Couples were excluded if the female partner met DSM–IV criteria for a psychoactive substance use disorder in the past 6 months or if either	**Method of allocation:** Restricted randomization (i.e. covariate adaptive) was used to balance the groups in terms of size and in terms of a priori identified covariates (substance use severity, marital status, occurrence of IPV in previous 90 days). **Intervention(s) description:** The intervention was behavioural couples therapy (BCT). For the 32 sessions (60 minutes each) conducted as part of this condition, both partners attended 12 BCT treatment sessions together. In these 12 sessions, the non-substance-abusing partner was an active participant in the intervention. The BCT sessions were used to help male partners remain abstinent from alcohol and other drugs, teach more effective communication skills, and enhance relationship satisfaction and increase positive behavioural exchanges between partners. All BCT session content was manualized. As part of BCT, couples entered into a verbal agreement not to engage in any angry touching. Moreover, if their partners relapsed, women were coached not to engage in any kind of conflict resolution discussion with them, to use time-outs when conflicts escalated, to develop a safety plan if they felt threatened, to avoid striking, pushing, or shoving out of frustration, and so forth. In the remaining 20 sessions, male patients participated in	**Primary outcomes:** Substance use was measured with the *Timeline Followback Interview*, which uses a calendar and other memory aids to determine an individual's drinking and other drug use over a specified time period. Days on which substances were consumed are recorded on the calendar. From this, the percentage of days abstinent (PDA) was derived. Each partner was also interviewed separately with substance use modules of the *Structured Clinical Interview for DSM–IV*, administered by one of two master's-level interviewers. IPV was measured with the *Timeline Followback Interview–Spousal Violence*, an event history calendar interview used to determine days in the target interval for which episodes of partner violence occurred. Violence items recorded on this interview were taken from the Conflict Tactics Scale and differentiate non-severe violence from severe violence. The male-to-female percentage of days with any violence (MFPD-AV) and the male-to-female percentage of days with severe violence (MFPD-SV) were also calculated. These were derived by taking the number	**Who is the target of the intervention?** Men and women in relationships with male-to-female IPV and substance use issues **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** On days of no substance use, there was no difference in the likelihood of male-to-female IPV for those in BCT or IBT; both were equally	**Primary outcomes:** Both groups reported more substance-abstinent days and a decrease in IPV at post-treatment and at the 12 month follow-up (all p's<0.05). Couples in BCT reported lower levels of IPV and substance use at a 12-month post-treatment follow-up compared with couples with male partners in IBT (all p's<0.05). Moreover, treatment assignment was a significant moderator of the day-to-day relationship between substance use and IPV. Likelihood of non-severe ($p<0.01$) and severe ($p<0.05$) male-to-female partner violence on days of male partners' substance use was lower among couples who received BCT compared with IBT. **Secondary outcomes:** N/A	**Limitations identified by author:** No data collection on violence-reduction strategies used by female partners **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Determine why the BCT intervention was more effective on days of substance use; e.g., was it because of violence-reduction strategies and behaviours used by the female partners? **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
controlled trial **Quality score:** [++] **External validity:** [+]	partner met DSM–IV criteria for an organic mental disorder, schizophrenia, delusional (paranoid) disorder, or other psychotic disorder. **Sample characteristics:** BCT (intervention) couples: *Mean age of male partner (SD):* 32.8 (7.1); *Mean age of female partner (SD):* 31.6 (6.4); *Mean years of education for male (SD):* 14.5 (2.1); *Mean years of education for female (SD):* 14.8 (2.7); *Mean years married or cohabiting (SD):* 5.2 (2.4); *Mean # of children (SD):* 1.8 (1.3); *Mean family income (SD):* 44,127 (11.4); *Mean years of problematic substance use (SD):* 9.8 (6.1); *Ethnicity (M/F):* 67%/70% White, 19%/18% African American, 8%/6% Hispanic, 6%/6% other; *Substances for which males met DSM-IV substance dependence criteria:* 72% alcohol, 17% cannabis, 50% cocaine, 34% opiates, 20% other. IBT (comparison) couples: *Mean age of male partner (SD):* 33.3 (7.2); *Mean age of female partner (SD):* 32.0 (7.0); *Mean years of education for male (SD):* 14.9 (2.2); *Mean years of education for female (SD):* 15.0 (2.4); *Mean years married or cohabiting (SD):*	individual, 12-step facilitation sessions for the treatment of substance abuse, which the non–substance-abusing female partners did not attend. The individual sessions were drawn from the Individual Drug Counselling manual and are founded on the concept that alcoholism is a spiritual and medical disease, consistent with the philosophy espoused by Alcoholics Anonymous. Participants were encouraged to achieve and maintain abstinence from alcohol and other psychoactive substances and to attend Alcoholics' Anonymous self-help support groups. Therapists (n=6) providing the interventions (both BCT and IBT) all had master's degrees in social services and were certified substance-abuse counsellors. **Control/comparison(s) description:** The comparison group was individual-based treatment (IBT). For the 32 sessions (60 minutes each) conducted as part of this condition, the non-substance-abusing partner did not participate in the intervention after the pre-treatment assessment. Male patients were scheduled to attend all 32 sessions by themselves, and the intervention was carried out as an individual, 12-step facilitation treatment for substance abuse, drawing session material from the Individual Drug Counselling manual. More specifically, patients	of days of any (severe) male-to-female physical aggression, dividing that number by the number of days in the assessment interval during which partners had any face-to-face contact, and multiplying that result by 100. **Secondary outcomes:** NR **Follow up periods:** Every 3 months until 1 year post-treatment **Methods of analysis:** Growth curve modeling was used as the primary analytic tool for these analyses, which were estimated within a multilevel regression framework. PDA, MFPD-AV, and MFPD-SV were analysed with a multilevel negative binomial regression. Within conditions, PDA, MFPD-AV, and MFPD-SV scores at post-treatment and 12-month follow-up were compared with pre-treatment scores to determine changes compared with baseline. In addition, between-groups pairwise comparisons between BCT and IBT were made at each assessment point to determine if the groups were significantly different. To examine the main and interactive effects	effective. However, on days of drinking or drug use, the likelihood of IPV was significantly lower for the BCT group.	**Attrition details:** 81% of all couples provided complete data.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	5.4 (2.6); *Mean # of children (SD):* 1.6 (1.5); *Mean family income (SD):* 45,924 (13.2); *Mean years of problematic substance use (SD):* 10.1 (6.7); *Ethnicity (M/F):* 69%/70% White, 18%/16% African American, 7%/7% Hispanic, 6%/7% Other; *Substances for which males met DSM-IV substance dependence criteria:* 76% alcohol, 15% cannabis, 46% cocaine, 31% opiates, 23% other **Setting:** Community-based outpatient clinic. Urban vs. rural setting not reported	in this condition received the 20 individual-based sessions that were provided to substance-abusing patients in the BCT condition in addition to 12 other sessions with a 12-step facilitation focus. **Sample size(s):** Total n=207 couples; Intervention (BCT) n=103 couples; Comparison (IBT) n=104 couples **Baseline comparisons:** No significant differences at baseline **Study sufficiently powered:** NR	of daily substance use and treatment condition on the occurrence of male-to-female IPV, two-level multinomial multilevel logistic regression analyses were conducted. The analyses used female-reported IPV and male-reported substance use.			

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): O'Farrell, T. J., Murphy, C. M., Stephan, S. H., Fals-Stewart, W., & Murphy, M. **Year:** 2004 **Citation:** Partner violence before and after couples-based alcoholism treatment for male alcoholic patients: The role of treatment involvement and abstinence. *Journal of Consulting and Clinical Psychology, 72*(2), 202-217. **Country of study:** USA **Aim of study:** To examine the impact of behavioural couples therapy (BCT) on IPV in couples where	**Source population(s):** Heterosexual couples with an alcoholic male partner **Eligible population(s):** Heterosexual couples with an alcoholic male partner, who entered the Counselling for Alcoholics' marriages (CALM) Project at one of four addictions treatment programs in Massachusetts between Feb 1992 and Jun 1998. There were also advertisements, media announcements, and referrals to recruit participants for this study. **Selected population(s):** Inclusion criteria were: alcoholic patient and spouse were 21 to 65 years of age; couple was married or living together for at least 1 year; alcoholic patient met DSM–III–R criteria for diagnosis of current (past 6 months) alcohol abuse or alcohol dependence; patient accepted abstinence from alcohol at least for the duration of the BCT programme and agreed to seriously consider taking Antabuse (if medically cleared); patient's alcoholism diagnosis was at least as serious as any coexisting current drug problem diagnosis; neither spouse met DSM–III–R criteria for a	**Method of allocation:** No allocation, though a demographically matched, non-alcoholic comparison sample was included in order to provide a normative baseline against which to compare levels of partner aggression. The comparison sample was drawn from the 6,002 participants in the 1985 National Family Violence Re-Survey. Participants were matched on the following variables that are associated with partner violence risk and listed in rough order of the strength of this association: race–ethnicity, age, marital status (cohabiting vs. married), education level, family income, and relationship. For a small number of difficult-to-match cases, matching criteria were loosened and, if necessary, specific matching variables were dropped, with matching priority given to variables that have the strongest association with partner violence risk. **Intervention(s) description:** The BCT programme consisted of 20-22 weekly sessions over a 5-6 month period: 10-12 weekly 1-hr initial conjoint pre-group sessions with each couple followed by 10 weekly 2-hr couples group sessions. The programme included a daily Sobriety Contract to promote sobriety, instigation of positive couple and family activities, and training in communication and negotiation	**Primary outcomes:** IPV was measured using the Verbal Aggression and Violence subscales of the *Conflict Tactics Scale (CTS)*, a widely used and well-validated instrument. The higher of the male and female report in each couple for each CTS item was used to address concerns about possible underreporting. On the basis of self-reported drinking and drug use in each of 2 years after BCT, alcoholic patients were divided into remitted and relapsed groups. Frequency of drinking and abstinence by alcoholic patients was measured using the *Timeline Follow-Back Interview* to measure the number of days on which the alcoholic patient drank alcohol, used other drugs, or remained abstinent for the year before and 2 years after BCT. Number of BCT sessions attended by each couple came from a session attendance log. Extent of use of BCT-targeted	**Who is the target of the intervention?** Heterosexual couples with an alcoholic male partner **Did they conduct any aspect of sex, gender or diversity analysis?** Yes, results were presented for both males and females. However, in order to be more concise, this data extraction only reports on male-to-female aggression since the study looked at the role of substance abuse in IPV and only the male partners in this sample had substance abuse problems. **Do they report sex, gender or diversity**	**Primary outcomes:** In the year before BCT, 60% of alcoholic patients had been violent toward their female partner, 5 times the comparison sample rate of 12%. In the 1st and 2nd year after BCT, violence and verbal aggression both decreased significantly from the year before BCT (in both prevalence and frequency, all p's<0.001; Year 2 male-perpetrated effect sizes were: verbal aggression prevalence r=0.62, overall violence prevalence r=0.61, severe violence prevalence r=0.36, verbal aggression frequency=0.44, overall violence frequency r=0.38, severe violence frequency=0.19). At the 2-year follow-up, the treatment sample did not significantly differ from the comparison sample on overall or severe violence, but still had significantly higher rates of verbal aggression; relative	**Limitations identified by author:** No randomized control group. Inability to infer that continued drinking caused continued violence (i.e. can't infer causation). Some potential limitations on generalisability. Some methodological differences in how data was collected for the treatment vs. non-alcoholic comparison group. **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Examine details of how the BCT treatment works since the structural equation modeling was correlational and so limits inferences about causation. Examine the effects of treatment programs on children **Source of funding:** Grants AA08637, AA10356, AA10796, K02AA0234, and R21AA12433 from the National Institute on

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
the male partner abuses alcohol **Study design:** Before and after study **Quality score:** [++] **External validity:** [+]	current psychotic disorder; there was no evidence of organic impairment sufficient to impair project participation; if the couple was separated, they were willing to reconcile for the programme; and the male patient agreed to forgo other alcoholism counselling (other than self-help support groups such as AA) during the BCT programme. **Excluded population(s):** Couples were excluded if the female partner met criteria for current alcohol or drug abuse or dependence **Sample characteristics:** Males in the alcoholic sample: *Mean age (SD):* 43.3 (10.0); *Mean education on an 8-point categorical scale with 0=none and 8=advanced degree (SD):* 4.7 (1.3); *Mean annual family income:* between $40-50,000*; Mean length of relationship in years (SD):* 13.2 (10.7); *Ethnicity:* 95% White, 3% Black, 2% Hispanic; *Marital status:* 12% cohabiting, 88% married. Females in the alcoholic sample: *Mean age (SD):* 41.1 (9.9); *Mean education on 8-point scale (SD):* 4.9 (1.2); *Mean annual family income:* between $40-50,000; *Mean length of relationship in years (SD):* 13.2 (10.7); *Ethnicity:* 96%	skills. For most patients, the Sobriety Contract included daily Antabuse ingestion witnessed and verbally reinforced by the spouse. The Sobriety Contract also included 12-step meetings for patients who were willing and urine drug screens at each session for patients with a current drug problem. Violence was also addressed in the programme. For example, BCT therapists inquired about violence during each session for couples with a history of violence with a goal of preventing its recurrence. BCT also taught all couples norms of nonviolence and constructive communication to reduce hostile and negative interaction patterns that may escalate to violence. The sessions were conducted by master's-level therapists or pre-doctoral psychology interns. Therapists followed a session-by-session treatment manual, with the understanding that planned interventions could be modified, at the discretion of the therapist, to address emergency situations (e.g., patient's relapse). **Control/comparison(s) description:** See "method of allocation" for details on how the non-alcoholic comparison sample was derived **Sample size(s):** Total n=303 couples with an alcoholic male partner. The authors also derived a	behaviours in the prior 90 days was measured with two scales from the *Couples Behaviours Questionnaire (CBQ).* Relationship adjustment was measured with the *Areas of Change Questionnaire (ACQ)*, an inventory measuring the amount of desired changes in a partner, and the *Dyadic Adjustment Scale (DAS)*, a measure of overall relationship adjustment that assesses perceptions of consensus, cohesion, satisfaction, and affectional expression. **Secondary outcomes:** NR **Follow up periods:** Quarterly follow-ups for two years post-treatment **Methods of analysis:** They used ITT analysis. Cochran's Q, repeated measures ANOVA, and pairwise comparisons were used to measure change in aggression across time.	**based factors in findings?** Yes, they reported changes in violence and aggression for both men and women. However, in order to be more concise, this data extraction only reports on male-to-female aggression since the study looked at the role of substance abuse in IPV and only the male partners in this sample had substance abuse problems. **Did this study examine or discuss links between DV and substance use or issues of trauma?** Yes, this study only included couples with an alcoholic	risks for men were: verbal aggression=2.2, overall violence=1.2, severe violence=1.1. Patients whose alcoholism was remitted after BCT had clinically significant violence reductions; by the Year 2 follow-up, they did not differ from the comparison sample on male violence. Relapsed patients showed improvement but by Year 2, still had significantly more violence than the comparison sample on a number of measures. Days-with-drinking was significantly correlated with male-to-female aggression on a number of measures (overall violence prevalence & frequency, verbal aggression frequency, all p's<0.05, r's ranging from 0.13-0.20) but not others (verbal aggression prevalence & frequency, severe violence prevalence & frequency). Structural equation modeling indicated that greater treatment involvement (attending BCT	Alcohol Abuse and Alcoholism and by the Department of Veterans Affairs

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	White, 2% Black, 1% Hispanic, 0.3% Native American, 0.3% other; *Marital status:* 12% cohabiting, 88% married. Males in the non-alcoholic comparison sample: *Mean age (SD):* 43.3 (9.9); *Mean education on 8-point scale (SD):* 4.8 (1.2); *Mean annual family income:* between $40-50,000; *Mean length of relationship in years (SD):* 14.4 (10.5); *Ethnicity:* 94% White, 3% Black, 1% Hispanic, 1% Native American, 1% other; *Marital status:* 4% cohabiting, 96% married. Females in the non-alcoholic comparison sample: *Mean age (SD):* 41.1 (9.9); *Mean education on 8-point scale (SD):* 4.9 (1.2*); Mean annual family income:* between $40-50,000; *Mean length of relationship in years (SD):* 14.0 (10.3); *Ethnicity:* 96% White, 2% Black, 1% Hispanic, 1% Native American, 0.3% other; *Marital status:* 3% cohabiting, 97% married **Setting:** Treatment centre. Urban vs. rural setting not specified	matched comparison sample of 303 non-alcoholic couples. **Baseline comparisons:** The treatment group and matched comparison group did not differ on matching variables (all p's>0.15) except for marital status, where the alcoholic sample had more cohabiting and fewer married couples than the comparison sample. **Study sufficiently powered:** NR	Hierarchical logistic regressions and ANCOVAs were run to compare remitted vs. relapsed participants in the treatment group. Correlations were run to see if days-with-drinking were associated with greater violence. Structural equation modeling was used to assess whether greater treatment involvement was associated with lower violence.	male partner. See "Primary outcomes" for results	sessions and using BCT-targeted behaviours) was related to lower violence after BCT and that this association was mediated by reduced problem drinking and enhanced relationship functioning. **Secondary outcomes:** N/A **Attrition details:** 88% of the sample provided violence data at 1-year follow-up and 84% provided violence data at 2-year follow-up. Based on an analysis of completers and non-completers, it seems unlikely that this attrition would have affected the results significantly.	

Appendix O

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Schumm, J. A., O'Farrell, T. J., Murphy, C. M., & Fals-Stewart, W. **Year:** 2009 **Citation:** Partner violence before and after couples-based alcoholism treatment for female alcoholic patients. *Journal of Consulting and Clinical Psychology,* 77(6), 1136-1146. **Country of study:** USA **Aim of study:** To examine the impact of women's alcoholism treatment on partner aggression to find out if IPV decreases after women receive alcoholism	**Source population(s):** Heterosexual couples in Massachusetts where the female partner suffers from alcoholism **Eligible population(s):** Heterosexual couples in Massachusetts in which a female alcoholic patient and her husband or male partner entered the Counselling for Alcoholics' Marriages Project **Selected population(s):** Alcoholic patient and spouse were age 21 to 65; couple were married or living together for at least 1 year; alcoholic patient met criteria of the Diagnostic and Statistical Manual of Mental Disorders (DSM); patient accepted abstinence from alcohol as the treatment goal for the duration of the BCT programme and expressed a willingness to take Antabuse if medically cleared to do so; neither spouse met DSM–III–R criteria for a current psychotic disorder; the female patient agreed to forego other alcoholism counselling (other than self-help support groups, such as Alcoholics Anonymous) during the BCT programme **Excluded population(s):** Failure to complete pre-assessment measures	**Method of allocation:** Non-randomized. Participants were matched on various demographic variables **Intervention(s) description:** Women with alcoholism and their male partners were treated in a Behavioural Couples Therapy (BCT) programme. BCT consisted of 20–22 weekly sessions over a 5- to 6-month period. Participants in the current study received, on average, 16.7 sessions of BCT (SD=6.2). The BCT programme included a daily recovery contract to promote abstinence, instigation of positive couple and family activities, and training in communication and negotiation skills. For most patients, the recovery contract included daily Antabuse ingestion witnessed and verbally reinforced by the spouse. For patients who were unwilling or not medically cleared to take Antabuse, the recovery contract involved a brief discussion in which the patient stated her intent not to drink or use drugs that day, and the spouse expressed support for the patient's efforts to stay abstinent. The recovery contract also included 12-step meetings for patients who were willing and urine drug screens at each session for patients with a current drug problem. BCT also taught all couples norms of nonviolence and constructive communication to reduce hostile and negative	**Primary outcomes:** Partner aggression and violence was measured using the Verbal Aggression and Violence subscales of the *Conflict Tactics Scale (CTS)*. The authors used slightly different CTS indices for the alcoholic and comparison samples. In the intervention group, to minimize under-reporting, the higher of the female and male report in each couple for each CTS item was used. Change over time was examined as well as comparisons between remitted and relapsed cases. The non-alcoholic comparison sample had data from only one member of each couple. Partner collateral reports (i.e. husband report of wife aggression and wife report of husband aggression) were used rather than self-reports because the authors felt that reports by recipients of aggression appear to be less contaminated by social desirability response bias than are self-reports by perpetrators. For analyses comparing the alcoholic sample with the non-alcoholic sample, the authors used partner	**Who is the target of the intervention?** Heterosexual couples struggling with alcoholism and violence **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Yes, that was the nature of the study.	**Primary outcomes:** The relative increased risk of aggression attributable to being in the alcoholic rather than the non-alcoholic sample was substantial for both female- and male-perpetrated aggression (elevated verbal aggression for women=3.7, men=4.8; overall violence women=4.1, men=5.4; severe violence women=6.6, men=9.5). Partner aggression decreased from the year before to the 2 years after BCT: there were significant differences between the three time periods on each prevalence of aggression measure (female-to-male: elevated verbal aggression ($p<0.001$, $r=0.63$); overall violence ($p<0.001$, $r=0.58$); severe violence ($p<0.001$, $r=0.55$); male-to-female: elevated verbal aggression ($p<0.001$, $r=0.58$); overall violence ($p<0.001$, $r=0.59$), severe violence ($p<0.01$, $r=0.31$)). Repeated measures	**Limitations identified by author:** Various data substitution procedures showed that the lack of a predicted difference between remitted and relapsed patients on some measures might have been due to attrition. Without a control group, the declines in IPV following BCT cannot be causally attributed to specific procedures of the BCT intervention. The mechanism of action whereby IPV was reduced after BCT was not examined in the present study. The authors were unable to compare different violence assessment methods and how these might have impacted the results. No data was collected on reasons why some participants refused Antabuse or medication. The comparison sample was collected a number of years before the alcoholic sample raising the possibility of cohort or history effects on the comparison analyses. **Limitations identified by review team:** Poor description of treatment

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
treatment, as it does for men **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Sample characteristics:** 41% entered the BCT programme of the Counselling for Alcoholics' Marriages Project after completing inpatient alcoholism treatment (typically 3 to 10 days in length), 25% came from outpatient alcoholism treatment, and the remaining 34% came in response to advertisements, media announcements or other referral sources. Intervention: *Mean female age (SD):* 39.96 (8.10); *Mean male age:* 42.23 (9.30); *Female education:* high school or equivalent (avg); *Male education:* some college (avg); *Mean family income per year:* $45 000-50 000; *Mean relationship length in years (SD):* 11.17 (9.46); *Female's race:* 92% White, 3% Black; *Male's race:* 90% White, 4% Black; *Marital status:* 14% cohabitating, 86% married. Control: *Mean female age (SD):* 39.83 (8.14); *Mean male age (SD):* 42.21 (9.52); *Female education:* high school or equivalent (avg); *Male education:* some college (avg); *Mean family income per year:* $45 000-$50 000; *Mean relationship length in years (SD):* 12.64 (9.04); *Female's race:* 92% White; *Male's arce:* 90% White; *Marital status:* 1% cohabiting, 99% married	interaction patterns that may escalate to violence. The Behavioural Couples Therapy (BCT) sessions were conducted by master's level therapists or predoctoral psychology interns who followed a session-by-session treatment manual. Drinking measures were collected via in-person interviews with patients and their male partners before and after the BCT programme. The Conflict Tactics Scale measure of partner aggression was collected at entry to the BCT programme and at follow-up. **Control/comparison(s) description:** Non-alcoholic heterosexual couples in treatment for aggression **Sample size(s):** Total n=412 individuals; Intervention n=103 couples; Control n=103 men and 103 women **Baseline comparisons:** Groups differed on marital status ($p<0.01$) **Study sufficiently powered:** NR	reports from both samples to provide comparable scores. Frequency of substance use and abstinence by female alcoholic patients was measured with the *Timeline Follow-Back interview (TLFB)*, which measured the number of days on which the female patient drank alcohol, used other drugs, or remained abstinent in the year before and the 2 years after BCT. TLFB variables were based on the female patient's self-report. On the basis of their drinking and drug use in each of 2 years after BCT, female alcoholic patients were divided into "remitted" and "relapsed" groups. Each criterion for remission was based on patients' self-reports, which generally showed good reliability and validity within voluntary, treatment-seeking samples (no data provided). The remitted group met each of the following criteria: completely abstinent from alcohol or drinking no more than three standard drinks per day, for no more than 10% of the days in the year, free of illicit drug use except for		ANOVA showed significant differences between the three time periods on each frequency of aggression measure (female-to-male: verbal aggression, $p<0.001$, $r=0.67$; overall violence, $p<0.001$, $r=0.57$; severe violence, $p<0.001$, $r=0.51$; and male-to-female: verbal aggression, $p<0.001$, $r=0.56$; overall violence, $p<0.001$, $r=0.53$; severe violence, $p<0.01$, $r=0.26$). There were no significant differences between Year 1 and Year 2 in partner aggression. Comparison of remitted female patients with non-alcoholic comparison couples showed no significant differences. For comparison of remitted with relapsed patients, in the first year after BCT, 45% of patients with violence data remitted, and 55% were relapsed. In the second year after BCT, 49% remitted, and 51% relapsed (no data found on significance of	programme. Treatment programme varied by intensity of alcoholism **Evidence gaps and/or recommendations for future research**: Future research is needed to see if the BCT procedures aimed at improving communication and conflict resolution might have an impact on reducing IPV in addition to the BCT procedures for supporting sobriety. Research needs to examine the association between partners' substance use and violence on a day-by-day basis to better understand the temporal and possible causal ordering of these variables the degree to which polysubstance dependence and relapse to substances other than alcohol might contribute to IPV. It is important to better contextualize the occurrence of the IPV among women with alcoholism and their partners by assessing factors such as whether verbal arguments over drinking and problems related to drinking

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Setting: Urban community programme		occasional marijuana use, defined as no more than 10% of days in the year, no hospitalization for alcohol or drug problems; no legal or job problems or withdrawal symptoms or blackouts due to drinking or drug use. **Secondary outcomes:** NR **Follow up periods:** Drinking measures were assessed before and after the BCT programme, and at quarterly intervals for 2 years thereafter. Partner aggression was assessed at entry to the BCT programme and at 1- and 2-years post-intervention. **Methods of analysis:** Q analyses, ANOVAs, t-tests, relative risks		findings). In the year before BCT, 68% of female alcoholic patients had been violent toward their male partner, nearly 5 times the comparison sample rate of 15%. In the year after BCT, violence prevalence decreased significantly to 31% of the treatment sample. **Secondary outcomes:** N/A **Attrition details:** 88% provided violence data at 1-year follow-up, and 83% provided violence data at 2-year follow-up. Data on relapse versus remission status were available for all those who provided violence data. Dropouts at Year 1 were less likely to be married ($p<0.05$) when compared to completers.	escalated to violence, who initiated the violence, and whether the reported violence was in self-defence. Future studies of BCT should seek to examine the degree to which race and ethnicity might impact treatment outcomes including IPV. Researchers should examine whether other predisposing factors, such as antisociality or history of abuse victimization, might increase risk for IPV among women seeking alcoholism treatment and their partners. **Source of funding:** National Institute on Alcohol Abuse and Alcoholism and Department of Veterans Affairs

Appendix O

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Woodin, E. M., Sotskova, A., & O'Leary, K. D. **Year:** 2012 **Citation:** Do motivational interviewing behaviours predict reductions in partner aggression for men and women? *Behaviour Research and Therapy, 50*, 79-84. **Country of study:** USA **Aim of study:** To examine the impact of therapists' motivational interviewing behaviours on changes in partner aggression perpetration for men and women in a college couple's intervention **Study design:** Before and after study **Quality score:** [++] **External validity:** [++]	**Source population(s):** University students **Eligible population(s):** Couples experiencing physically aggressive dating behaviours **Selected population(s):** Eligibility criteria: aged 18-25, dating at least 3 months, no prior marriage or cohabitation, at least one act of physical aggression by male partner in the previous 3 months **Excluded population(s):** NR **Sample characteristics:** *Length of relationship (SD):* 24 months (22); *Median family income:* $70,000-$79,999. Women: *Mean age (SD):* 19 (1.4); *Ethnicity:* 8% African American, 44% Asian American, 48% Caucasian, 12% Hispanic, 12% multi-racial. Men: *Mean age (SD):* 20 (1.0); *Ethnicity:* 6% African American, 42% Asian American, 60% Caucasian, 6% American Indian, 6% Hawaiian/Pacific	**Method of allocation:** Although the larger study included a randomized control group, their data is not part of this study. **Intervention(s) description:** Therapist began with a conjoint 2 hour assessment and semi-structured interview, followed by a feedback session several weeks later. Individually, therapists provided this individualized feedback in an empathic and non-confrontational manner, discussed the possible impact of the aggression to the participant and to the relationship, and facilitated a discussion of possible behaviour change. Risk factors for aggression were discussed. Participants were asked to respond, and any statements indicating motivation to change were reinforced. Session length was no more than 45 minutes. It was followed by a 15 minute conjoint session not assessed in this study. Therapists were 5 advanced female graduate students with 20 hours of training, with ongoing supervision and assessment of treatment fidelity. Treatment was manualized. **Control/comparison(s) description:** N/A	**Primary outcomes:** All sessions were videotaped (with consent). The *Motivational Interviewing Treatment Integrity Code: Version 2.0 (MITI)* captured the global therapist characteristics of MI spirit and empathy, as well as specific behaviour frequencies for close-ended questions, open-ended questions, simple reflections, complex reflections, MI adherent behaviours (asking permission, affirm, emphasize control, support), and MI non-adherent behaviours (advise, confront, direct). Participant physical aggression was assessed with the *Revised Conflict Tactics Scales (CTS2)*. **Secondary outcomes:** NR **Follow up periods:** Online questionnaires at 3, 6, and 9 months **Methods of analysis:** When only one partner follow-up available, data used. Research assistants were blinded,	**Who is the target of the intervention?** Heterosexual couples exhibiting physical dating violence **Did they conduct any aspect of sex, gender or diversity analysis?** All outcome variables were modeled by gender (see outcomes). **Do they report sex, gender or diversity based factors in findings?** The authors did not observe any significant differences in therapist performance for men or women participants. The percentage of open-ended questions (bdiff=0.41, $p<0.05$) impacted aggression reductions significantly more for women than men. Global	**Primary outcomes:** Higher levels of global empathy were related to marginally greater aggression reductions for women (effect size r=0.14), but not for men. Global MI spirit was not significant for men or women. Higher reflection to question ratios were related to greater aggression reductions for both men ($r=0.30$, $p<0.001$) and women ($r=0.19$, $p<0.05$). A higher percentage of open-ended questions were related to greater aggression reductions for women ($r=0.19$, $p<0.05$), but not for men. Complex reflections and MI adherent behaviours were not significant. **Secondary outcomes:** N/A **Attrition details:** One or two partner data: 88% for 3 months, 90% at 6 months, 62% at 9 months. Gender comparison of response rate: Women: 84% at 3 months, 78% at 6 months, and 58% at 9 months. Men: 62% at 3	**Limitations identified by author:** Small sample size. Only female therapists. Confounding of therapeutic skills with non-MI factors **Limitations identified by review team:** Large percentage of Asian-American participants. Low follow-up rates for men in general and at 9 month follow-up **Evidence gaps and/or recommendations for future research**: Conduct a more detailed microanalytic coding system that taps sequential therapist and client behaviours. Further research is needed to examine potential gender differences in the impact of motivational interviewing behaviours, as well as to understand the mechanisms (such as attitudinal factors) that might

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Islander, 12% Hispanic, 20% men multi-racial **Setting:** Urban university counselling programme	**Sample size(s):** Total n=25 couples **Baseline comparisons:** N/A **Study sufficiently powered:** NR	and trained in MITI until 85% IRR was obtained, and independently by second coder. IRR reported as 0.69-0.92 for all variables except MI Spirit at 0.51-0.55. Data were analysed using two-level hierarchical linear modeling with a trajectory for partner change in aggression perpetration, with slopes and intercepts modeled for each member of the couple.	empathy and a higher percentage of open-ended questions were significant treatment factors for women, but not men (see outcomes). **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	months, 56% at 6 months, 40% at 9 months. Therapist competency did not significantly predict follow-up completion rates for either men or women.	explain the differential responses of men and women. **Source of funding:** National Institutes of Mental Health

Table 66. Research Question 4 (Children Exposed to DV) Evidence Tables

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Addressing Family Violence Programs **Year:** 2011 **Citation:** *The Current Work of the Addressing Family Violence Programs (AVPF): Peek-a-Boo Club Evaluation Report.* Melbourne: The Royal Children's Hospital Melbourne. **Country of study:** Australia **Aim of study:** To draw conclusions about the effectiveness of the Peek-a-Boo Club on mother's attachment (for all children) and social and emotional skills (for toddlers) **Study design:** Before and after study **Quality score:** [+] **External validity:**	**Source population(s):** Mothers and children exposed to DV in Melbourne, Tasmania and rural Victoria **Eligible population(s):** NR **Selected population(s):** NR **Excluded population(s):** NR **Sample characteristics:** Children: *Gender:* 44% female; *Age:* 42% under 12 months, 33% 12-24 months, 21% 24 months or older; *Ethnicity:* 56% non-indigenous Australians, 12% Aboriginal or Torres Strait Islander, 32% from cultural and linguistically diverse background. Mothers: *Relationship status:* 84% separated, 16% with partner; *Employment:* 83% no paid employment, 2% full time, 15% part time; *Child protection involvement:* 54%	**Method of allocation:** N/A **Intervention(s) description:** The "Peek-a-boo Club" is a 10 week "infant led" mother/infants group programme. It uses an experiential, activity based and interactive format that creates a therapeutic arena for the infant and mother to form and consolidate a healthy attachment. This group work intervention is based on the premise that exposure to intimate relational violence can inhibit a mother's ability to appropriately focus on her infant's attachment needs. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=206 (103 pairs of mothers and children); Toddlers n=27 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** Attachment was measured using the 19 item self-reported *Maternal Postnatal Attachment Scale (MPAS)*. **Secondary outcomes:** Toddler social-emotional and behavioural problems were measured using the *Brief Infant and Toddler Social and Emotional Assessment (BITSEA)* **Follow up periods:** Post-programme **Methods of analysis:** Descriptive statistics	**Who is the target of the intervention?** Mothers and their infants or toddlers who have been exposed to DV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity factors in finding?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** There were increases in mean attachment scores of 2 points (from 75.3 to 77.6), mother's acceptance and tolerance of her infant (from 17.9 to 18.4), and her pleasure in interaction with her infant (from 20.9 to 22.1). However, the post-group scores do continue to fall outside the range for "normal postnatal mothers". **Secondary outcomes:** Regarding toddler social-emotional and behavioural problems, there were decreases in mothers' reporting of significant social and emotional problems from pre-group (52% reported significant problems) to post (26% significant problems), and possible deficits/delays in competence reported pre-(11%) to post-group (7%). However, infants with significant social-emotional problems reported by mothers were over-represented in the Peek-a-Boo groups (63% pre and 37% post) while only 10-15% of 1 and 2 year olds in the normal population reportedly experience significant social-emotional problems. **Attrition details:** NR	**Limitations identified by author:** Many of the mothers may idealise the attachment they have to their infants (with some scoring extremely high pre-group scores) while post group scores display a more realistic, healthy and feasible internal working model of their relationship with their infant. **Limitations identified by review team:** No report of statistical significance for attachment scores. Reliance on mother's self report **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** AVFP, Sidney Myer Fund along with a small grant from the Alannah and Madeline Foundation

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
[+]	were involved with Department of Human Services; *Family Violence Orders:* 67% of mothers had taken out Family Violence Orders; *Types of violence:* 95% physical, 88% verbal, 58% emotional, 23% sexual, 17% financial **Setting:** Mother-infant group programme. Urban and rural					

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Bunston, W. & Dileo, J. **Year:** 2005 **Citation:** *Feeling is Thinking: (FisT)ful Thinking or A Proven, Children's Mental Health Group Work Intervention.* Melbourne: Royal Children's Hospital Mental Health Service. **Country of study:** Australia **Aim of study:** To evaluate the effectiveness of the FisT programme **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Australian children aged 8-12 years who experience problems in expressing their strong feelings, who have difficulties in their interpersonal relationships and who have lived, or are still living with family violence **Eligible population(s):** NR **Selected population(s):** NR **Excluded population(s):** NR **Sample characteristics:** *Mean age (SD):* 9.79 (1.07), range=8-12; *Gender:* 25% female, 75% male; *Referral source:* 31% referred from Victorian Child and Adolescent Mental Health Services, 69% referred from schools in the western and northwestern metropolitan suburbs of Melbourne, Australia **Setting:** Schools	**Method of allocation:** N/A **Intervention(s) description:** "Feeling is Thinking" (FisT) was an 8-week programme (90-minute weekly sessions) for boys and girls aged 8-12 years who were experiencing difficulty in naming, expressing and managing their feelings and other strong emotions. It aimed to provide an environment that would help children develop skills to resolve conflict and to interact better with others. The FisT programme had a Cognitive Behavioural Therapy focus; however an attention to the group processes was also prominent. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=88 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** The *Strengths and Difficulties Questionnaire (SDQ)* is a brief parent, teacher and self-informed behavioural screening questionnaire, with 5 subscales. It is strongly correlated to the Child Behavioural Checklist, with strong discriminative validity, reasonable internal consistency (0.76) and test-retest reliability (0.75). The *Social Skills Rating Scale (SSRS)* gives a broad assessment of child social behaviours that influence relationships at school and home. It includes teacher, parent and self-report forms. It includes subscales for co-operation, assertion, responsibility, empathy, self-control, externalising problems, internalizing problems, and hyperactivity. Normative data allows conversion of raw scores to standardized scores. It has adequate internal consistency (ranging from 0.73-0.95 across scales), test-retest reliability (ranging from 0.48 to 0.88) and interrater reliability (ranging from 0.54 to 0.93). **Secondary outcomes:** The *Children's Inventory of Anger (ChIA)* is a child self-reported assessment. It yields a total anger score, subscales for frustration, physical aggression, peer relationships and authority relations. Normative data allows	**Who is the target of the intervention?** Children aged 8-12 who experience problems expressing strong feelings, have difficulties in interpersonal relationships and who have lived, or are still living with family violence **Did they conduct any aspect of sex, gender or diversity analysis?** Yes, see below **Do they report sex, gender or diversity factors in finding?** Female participants reported significantly reduced peer problems following the programme,	**Primary outcomes:** Following participation in the FisT programme, teachers reported statistically significant improvement in these problem areas, whilst parents reported slight but less significant improvement. On the SDQ, there were no significant changes for parents. For teachers, strong improvements were reported on prosocial behaviour ($t(61)=4.31$, $p<0.01$, $d'=0.45$), total difficulties ($t(61)=4.02$, $p<0.01$, $d'=0.52$), peer problems ($t(61)=3.97$, $p<0.01$, $d'=0.42$), conduct problems ($t(61)=2.93$, $p<0.01$, $d'=0.38$), hyperactivity ($t(61)=2.89$, $p=0.01$, $d'=0.36$), and emotion symptoms ($t(61)=2.36$, $p=0.02$, $d'=0.45$). On the SSRS, parents reported statistically significant improvement in cooperation ($F(1,37)=2.72$, $p=0.01$, $d'=0.37$) and overall social skills ($F(1,37)=2.21$, $p=0.02$, $d'=0.30$). Improvement on all other scales was also reported, but not at statistically significant levels. Teachers reported statistically significant improvements in cooperation ($F(1,34)=2.72$, $p=0.03$, $d'=0.26$), self-control ($F(1,34)=1.99$, $p=0.05$, $d'=0.26$), externalising problems ($F(1,34)=2.54$, $p=0.02$, $d'=0.36$), internalising problems ($F(1,34)=2.42$,	**Limitations identified by author:** Limited sample size and poor statistical power may have introduced type two statistical errors. Mixed repeated measure ANOVAs are exploratory in nature and should be interpreted with caution due to small and unequal samples. Due to resource limitations, FisT programme facilitators also played the role in administering the assessment procedures, a situation which may have confounded informant responses due to expectancy bias. **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research:** Future research could benefit from complementing self-report and informant measures with double-blind clinician administered assessments. A longitudinal design

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
			standardization of scores and the identification of individuals in the abnormal or clinical range. The ChIA has demonstrated strong internal consistency (0.95), adequate test-retest reliability (0.66) and split-half reliability (0.83 to 0.95). **Follow up periods:** Post-programme **Methods of analysis:** Paired samples t-tests to assess differences between mean pre- and post-scores. Mixed repeated measures ANOVA were also conducted.	while no change was noted for males. Females reported higher levels of anger whilst males reported lower levels of anger. **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	p=0.02, d'=0.25), hyperactivity (F(1,34)=2.93, p<0.01, d'=0.34), and problem behaviours (F(1,34)=3.78, p<0.01, d'=0.44). For children's self-report, there was no statistical difference. **Secondary outcomes:** Children did not report any change across any of the ChIA subscales following the FisT programme. **Attrition details:** Only 25 children completed the ChIA. Not all scales were completed by all participants, and n's listed by subscale in tables.	could assess children at 6, 12 and/or 24 month follow up to explore the longer term effects of participation in the programme. Conduct a randomised controlled trial **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Finkelstein, N., Rechberger, E., Russell, L. A., VanDeMark, N. R., Noether, C. D., O'Keefe, M., Gould, K., Mockus, S., & Rael, M. **Year:** 2005 **Citation:** Building resilience in children of mothers who have co-occurring disorders and histories of violence: Intervention model and implementation issues. *Journal of Behavioural Health Services & Research, 32*(2), 141-154. **Country of study:** USA **Aim of study:** To describe the development and perceptions of an intervention designed for children aged 5-10 whose mothers had histories of abuse, substance use, and mental illness **Study design:** Mixed methods (cross-	**Source population(s):** Children of mothers with co-occurring substance use and mental health disorders and histories of violence **Eligible population(s):** Children aged 5-10 of women participating in the Women, Co-Occurring Disorders and Violence Study (for women with histories of sexual and/or physical abuse, substance abuse, and mental illness) who had at least weekly telephone or face-to-face contact with their English- or Spanish-speaking mothers **Selected population(s):** Children meeting the eligibility criteria. Only one child per family was included in data collection. In cases of multiple eligible children, the participating child was chosen based on the proximity of his/her birthdate to programme enrolment and (as necessary) the need to fill desired cells (e.g. male vs. female, younger vs. older). **Excluded population(s):** NR **Sample characteristics:** *Age range*: 5-10 years old; *Gender:* 52% male, 48% female; *Ethnicity:* 36.5% Caucasian; 24% multiracial; 20% Black, 15% other, 4%	**Method of allocation:** N/A **Intervention(s) description:** There were three components to the intervention. First, there were two initial clinical assessments by semi-structured interview, one with the child and one with the mother or caretaker. Second, resource coordinators linked children and families to critical mental health and educational services and to resiliency-promoting activities (e.g. scouting, dance, sports activities) and also assisted women in learning how to advocate and obtain services for their children. Third, there was a children's group which aimed to develop the children's coping skills related to self-protection, self-soothing, interpersonal relationships, and self-identity. The group included an orientation, 9 core weekly sessions lasting up to 75 minutes each, and two booster sessions (one at 30 days post-group, the other at 60 days). Groups consisted of children either 5-7 years old or 8-10 years old, so that the activities and curriculum could be tailored to each age group.	**Primary outcomes:** A post-group mother/caretaker evaluation form was used to gather their impressions of the programme's impact and suggestions for improvement. Another form was used to gather clinical perceptions of the effectiveness of the group intervention. **Secondary outcomes:** NR **Follow up periods:** 6, 9, or 12 months for the mother/caretaker evaluation **Methods of analysis:** Descriptive statistics	**Who is the target of the intervention?** Children of mothers with co-occurring substance use and mental health disorders and histories of violence **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity factors in finding?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** In response to the question "What did you like about your child's participation in the group?" on the mother/caretaker form, more than 1 in 3 mentioned learning (e.g. about safety and abuse; coping and healthy communication; drug abuse, addiction, recovery). One in 5 comments described positive child outcomes (e.g. child opened up, child was able to express self more honestly, child had a more positive attitude). 17% described aspects of the group process that were valued, such as the interaction with other children who were "going through the same thing". When asked "How much do you think the group helped your child?" nearly half of the mothers answered "very much" or "a lot". One third replied that the group had helped their children "somewhat," and 1 in 5 described the group as helping "a little" or "not at all" at all". 77% reported noticing changes in their children as a result of the group, such as improvements in communication (43%), attitude and behaviour	**Limitations identified by author:** NR **Limitations identified by review team:** No formal assessment of children's improvements. No control group **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
sectional study/qualitative study) **Quality score:** [+] **External validity:** [-]	American Indian; 1% Hawaiian or Pacific Islander, 36.5% Hispanic/Latino (percentages add to more than 100% since there was overlap between the Hispanic/Latino category and the other categories) **Setting:** Two primarily residential and two primarily outpatient treatment facilities in California, Colorado, and Massachusetts	**Control/comparison(s) description:** N/A **Sample size(s):** Total n=115; Completed mother/caretaker evaluation form n=42 **Baseline comparisons:** N/A **Study sufficiently powered:** NR			(31%), and increased knowledge and skills related to safety, coping, addiction, and recovery (20%). From the clinical perceptions data, all sites agreed that the group orientation was helpful by providing guidelines and information, and that the curriculum provided a structure for children to learn how to express themselves around shared difficult experiences. Examples given of group success were that children demonstrated memory of some of the key group messages, most notably “Abuse is not okay”. **Secondary outcomes:** N/A **Attrition details:** 40% did not complete all three components of the intervention	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Ghosh Ippen, C., Harris, W. W., Van Horn, P., & Lieberman, A. F. **Year:** 2011 **Citation:** Traumatic and stressful events in early childhood: Can treatment help those at highest risk? *Child Abuse & Neglect, 35*(7), 504-513. **Country of study:** USA **Aim of study:** To investigate whether child-parent psychotherapy (CPP) is efficacious with preschoolers exposed to multiple traumatic and stressful life events (TSEs) (study based on reanalysis of data from Lieberman et al., 2005, 2006) **Study design:** Randomized controlled trial **Quality score:** [++] **External validity:** [+]	**Source population(s):** Children who have been exposed to marital violence, and their mothers **Eligible population(s):** Child-mother dyads where recruited child was 3-5 years old, had been exposed to marital violence as confirmed by mother's report on the Conflict Tactics Scale 2, and where the father figure perpetrating the violence was no longer residing in the home **Selected population(s):** NR **Excluded population(s):** Mothers excluded for: abuse of child in study, current substance abuse, homelessness, mental retardation, and psychosis. Children with mental retardation or autistic spectrum disorder were excluded. **Sample characteristics:** Children*: Mean age (SD)*: 4.06 (0.82), range=3-5; *Gender:* 52% female, 48% male; *Ethnicity:* 39% mixed race (White/Latino majority), 28% Latino,15% African-American, 9% White, 7% Asian, 3% other; *Violence exposure:* 29% physical	**Method of allocation:** Random assignment to intervention or control (as conducted in Lieberman et al. 2005) **Intervention(s) description:** Weekly child-parent psychotherapy sessions, approximately 60 minutes each, were conducted over 50 weeks delivered by a clinician with at least a MA in clinical psychology **Control/comparison(s) description:** Case management and referrals to a mental health clinic by a PhD-level clinician. Mothers received at least monthly phone calls from the case manager generally lasting 30 minutes. 73% of mothers and 55% of children received individual treatment. **Sample size(s):** Total n=75 mother-child dyads; Intervention n=27; Control n=25 **Baseline comparisons:** NR	**Primary outcomes:** The study used the *Child Behaviour checklist (CBL 2/3 and 4/18)* and *Symptom Checklist-90* to evaluate the effect of the CPP treatment. **Secondary outcomes:** NR **Follow up periods:** 6 months **Methods of analysis:** Total child TSEs were based on data including coded family history interviews, DHS reports, diagnostic interviews with mothers, and the *Screening Survey of Children's Exposure to Community Violence: Parent Report Version.* Children with 4+ TSE's were considered "high risk" and those with less than 4 TSE's were "low risk". General linear model repeated measures analyses were conducted to investigate treatment effects by level of child TSE exposure.	**Who is the target of the intervention?** Children who have been exposed to marital violence **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity factors in finding?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Among children with four or more TSEs, those in the CPP group showed significantly greater improvements than children in the comparison group in PTSD and depression symptoms, number of co-occurring diagnoses, and total behaviour problems. The lower risk CPP group (with <4 TSEs) also showed significant improvement in PTSD symptom reduction, whereas the comparison group did not. Effect sizes were large (d>1) for PTSD, depression and co-occurring diagnoses, and medium for total behaviour problems. **Secondary outcomes:** Compared to the comparison 4+ group, children in the CPP 4+ group were also significantly less likely to be diagnosed with PTSD at post-treatment (5% versus 53% in the ITT sample and 0% versus 55% in the TC sample). **Attrition details:** Attrition rate at post-test was 14% (n=6) in the treatment group and 12% (n=4) in the comparison group. Analyses showed no differences between drop-outs and treatment completers on	**Limitations identified by author:** Small sample size. Use of maternal report. Dichotomizing children into high and low risk based on number of TSE's might not be as good a predictor of treatment outcome as other measures (e.g. type, frequency, and severity of risk). **Limitations identified by review team:** Different dosing/exposure between intervention and comparison. No indication of number of mother exclusions for homelessness and current substance use. Confounding from other types of violence (29% child physical and 12% sexual abuse) **Evidence gaps**

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	abuse,12% sexual abuse, 97% witnessing DV, 5% neglect, 5% caregiver criminal history,16% caregiver substance abuse, 88% caregiver mental illness; *Children's TSE exposure:* 12% had experienced 2 TSEs, 41% had 3 TSEs, and 47% had 4+ TSEs. Mothers: *Mean age (SD):* 31.48 (6.23); *Mean monthly income (SD)*: $1,817 (1,460), range=417-8,333 **Setting:** Clinical setting	**Study sufficiently powered:** NR	Both ITT and treatment completer analyses were run. For ITT analyses, the authors used the last observation carried forward (LOCF) method to address incomplete data.		outcome variables or children's level of trauma exposure, but children who dropped out tended to be older ($p<0.05$, $d=0.75$). At follow-up, an additional 2 treatment and 4 comparison group dyads dropped from the study. Seven additional treatment dyads were not assessed because their treatment ended before the 6-month follow-up was added to the study. Dyads who completed the follow-up did not differ from those who did not on any of the outcome variables.	**and/or recommendations for future research:** NR **Source of funding:** National Institute of Mental Health

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Grip, K., Almqvist, K., & Broberg, A. G. **Year:** 2012 **Citation:** Maternal report on child outcome after a community-based programme following intimate partner violence. *Nordic Journal of Psychiatry, 66*(4), 239-247. **Country of study:** Sweden **Aim of study:** To evaluate the impact of a community based programme for children exposed to intimate partner violence on: children's behavioural problems, degree of social impairment and prosocial ability. Also to determine whether the perceived effectiveness of the programme	**Source population(s):** Mothers with their children (aged 5-14) reporting for help for intimate partner violence in Sweden **Eligible population(s):** 75 mothers who reported physical, psychological or sexual violence against herself from a current or former male partner of hers. Children aged 5-14 years **Selected population(s):** 46 children and their 34 mothers **Excluded population(s):** Mothers still living with the perpetrator, with ongoing drug or alcohol abuse, or could not speak Swedish well enough to answer questions without an interpreter. 22 mothers declined to take part in the study, 11 mothers withdrew their consent or did not take part in the pre-assessment. **Sample characteristics:**	**Method of allocation:** N/A **Intervention(s) description:** The treatment unit was a community service for children exposed to IPV and their mothers. They provided a group programme of 15 weekly structured 90-minute sessions based on the "Children are people too" (CAP) programme. CAP was originally developed to prevent substance abuse among youth and was revised and adjusted to experiences of IPV. The core foci of the programme included: education about violence, safety planning, feelings, defenses, risks and choices and parent/child communication. The work with both the mother and child included a range of modalities (play, drawing, discussions and lessons). The groups were composed of six to eight children of similar age, led by two female social workers. The mothers' programme paralleled the children's. **Control/comparison(s) description:** N/A	**Primary outcomes:** The Swedish parental version of the *Strengths and Difficulties Questionnaire (SDQ)* was used, Cronbach's alphas: total problem scale=0.72, prosocial scale=0.70, impact scale=0.74. Semi-structured interviews were conducted to measure child and mother history and current life situation, child violence exposure, presence of trauma symptoms (intrusion, avoidance, arousal, worries and psychosomatic complaints). **Secondary outcomes:** The *Impact of Event Scale* was used to measure mother's trauma symptoms, Cronbach's alpha=0.98. **Follow up**	**Who is the target of the intervention?** Children exposed to IPV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity factors in finding?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** No children were rated as having worsened or deteriorated from pre- to post-assessment. On the SDQ total problem scale, children's behavioural problems were significantly reduced ($t=2.96$, $p<0.05$) from pre- to post-assessment and the effect size (Cohen' s d) was in the medium range (0.60, CI: 0.16-1.04). There was, however, no effect from pre- to the 1-year follow- up assessment ($t=1.73$, $p>0.05$) and the effect size confidence interval covered zero (0.35, CI: -0.06-0.76). Analyses with the LOCF sample from pre- to post-assessment also revealed a reduction in behavioural problems ($t=2.83$, $p<0.05$) but no change between pre- and the 1-year follow-up assessment. On the SDQ impact scale, the effect of the children' s behavioural problems on their daily activities also decreased ($t=2.09$, $p>0.05$), but there was no change from pre- to the 1-year follow-up assessment. Effect sizes pre- to post-assessment were small (0.43, CI: 0.00-0.84). The LOCF sample decreased from pre- to post-assessment ($t=2.42$, $p<0.05$) but not from pre- to the 1-year follow-up assessment ($t=1.30$, $p>0.05$). On the SDQ prosocial scale, no changes were found in children' s prosocial behaviour, in either analysis. **Secondary outcomes:** Mothers' initial trauma symptoms accounted significantly for the variance in the children' s change scores from pre to 1-year follow-up assessment (20% of the variance) in the multiple regression. The higher the mother's initial trauma	**Limitations identified by author:** Limited by the preliminary nature, lack of a comparison group and high attrition. Moreover, the use of the LOCF in the analysis of outcome as well as using only the mothers as informants is a limitation. **Limitations identified by review team:** Study may not be properly powered for analysis methods (small sample size) **Evidence gaps and/or recommendations for future research:** Future studies should make better use of normed outcome measures in order to detect changes in children both in the clinical and nonclinical range, and measure other aspects such as

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
was associated with children's exposure to IPV and the mother's trauma symptoms **Study design:** Before and after study **Quality score:** [++] **External validity:** [+]	Children: *Mean age (SD):* 9.2 (2.4), range=5-14 years; *Gender:* 54% girls, 46% boys. Mothers: *Mean age (SD):* 38.1 (5.5); *Mean SES on the Hollingshead Index:* 31.3 (low SES); *Mean # of years in abusive relationship (SD):* 6.8 (5.2) **Setting:** Group programme at a treatment unit	**Sample size(s):** Total n=46 children and their 34 mothers **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**periods:** At end of programme, and 1 year post-programme **Methods of analysis:** Pearson correlations, multiple regression, and independent samples t-tests were carried out. The Reliable Change Index was used to measure clinical significance from pre- to post-assessment.		symptoms, the greater the reduction in SDQ total. Children's violence exposure did not explain changes in SDQ total problem score over and above mothers' initial trauma scores. There was no association between mother' s self-reported change in trauma symptoms following her participation in the conjoint group for mothers, with her rating of her child's change in symptom level on SDQ total problem and impact scale. **Attrition details:** 24 children completed all measures (52%). The sample size reported here (n=46 children) is the Last Observation Carried Forward (LOCF) sample. Completers were compared to non-completers, and no differences were found except that children of the completer sample were rated as having been the target of abuse more frequently than the non-completer sample ($p<0.05$).	changes in attitudes to violence and psychological well-being. **Source of funding:** Children's Welfare Foundation Sweden and the Crime Victim Compensation and Support Authority

Appendix O

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Humphreys, C., Mullender, A., Thiara, R., & Skamballis, A. **Year:** 2006 **Citation:** 'Talking to my mum': Developing communication between mothers and children in the aftermath of domestic violence. *Journal of Social Work, 6*(1), 53-63. **Country of study:** UK **Quality score:** [-]	**What was/were the research question(s)?** To describe some of the "tactics of abuse" that can damage mother-child relationships, based on interim data from a longer action research project **Theoretical approach:** Action research **How were the data collected?** Face to face interviews were conducted with children and mothers separately after completing the activity packs. Also there were reflection sheets for children and mothers to fill in at the end of each activity.	**What population was the sample recruited from? How were they recruited?** Research sites included Refuge Essex (which includes all seven refuges in Essex), Panahghar in Coventry and Leicester, and Milton Keynes Women's Aid, UK **How many participants were recruited?** 14 **Inclusion and exclusion criteria:** Inclusion: Children witnesses of domestic abuse **Population demographics:** NR	**Description of intervention(s):** Six activity packs were developed to assist mothers and their children to re-build their relationships in the aftermath of DV. The packs were divided into three "woodland packs" for the youngest children, featuring a cast of animals, and three packs for older children and young people based on photos, as triggers for discussion and activity. Each pack covered a different stage in the lives of children and their mothers following separation, with the same three themes covered for each age group: "Early Days at the Refuge", "Talking About Things That Matter", and "Leaving the Refuge". A stand-alone activity pack was also developed for children and mothers not in refuge but who attend groups or outreach services. **Intervention setting:** Refuges and community-based settings	**Method and process of analysis:** NR **Key themes relevant to this review:** Early findings showed that those women and children living in refuges or using outreach services who chose to work together on the activities found the process beneficial. They provided critical feedback about how the project and activities could be revised for the second action research cycle. "The first group of mothers and children who worked with the packs were generally enthusiastic about the changes fostered in their relationships, and in their ability mutually to understand their situation, as a result of working on the activities together." (p. 59). Children also reported being enthusiastic about the process and content.	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in finding? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Children who have been exposed to IPV	**Limitations identified by author:** NR **Limitations identified by review team:** No tabulation attempted, nor were the contents of any "reflection sheets" quoted **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** Colchester Women's Aid funded by the Big Lottery

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Miller, L. E., Howell, K. H., Hunter, E. C., & Graham-Bermann, S. A. **Year:** 2012 **Citation:** Enhancing safety-planning through evidence-based interventions with preschoolers exposed to intimate partner violence. *Child Care in Practice, 18*(1), 67-82. **Country of study:** USA **Aim of study:** To assess baseline knowledge about safety-planning in preschoolers exposed to IPV and whether knowledge of safety-planning improves following participation in the Preschool Kids' Club Programme **Study design:** Randomized controlled trial **Quality score:** [+]	**Source population(s):** Families in Michigan, USA exposed to IPV **Eligible population(s):** Participants from a larger RCT (Graham-Bermann, 2006-2011) **Selected population(s):** Children 4-6 years old from southeast Michigan who were exposed to IPV within the past two years **Excluded population(s):** NR **Sample characteristics:** *Mean age of children (SD):* 4.93 (0.87), range=4-6; *Sex*: 50% male; *Ethnicity:* 40% European-American, 36% African-American,17% biracial, 5% Hispanic, 1% Native American; *Mean # of acts of psychological aggression reported by mothers in past year (SD):* 89 (52.70); *Mean # of acts of sexual violence reported by mothers in past year (SD):* 23 (36.14); *Mean monthly income (SD):* US$1,412 (1,596) **Setting:** NR	**Method of allocation:** Modified random assignment. The first five families were assigned to the experimental condition and the next five to the wait-list control condition, and so on. **Intervention(s) description:** Twice weekly sessions over 5 weeks, engaging preschoolers in activities such as role playing designed to help them identify and express emotions, learn safety planning and conflict resolution strategies, and consider gender roles in an age appropriate way **Control/comparison(s) description:** Wait-list control. While the experimental group was going through the intervention, the control group received treatment as usual, which consisted of community resources and support sought out by the mother or provided by the local DV shelter. **Sample size(s):** Total n=110; Intervention n=45; Control n=65 **Baseline comparisons:** Both groups had similar levels of violence exposure at baseline **Study sufficiently powered:** NR	**Primary outcomes:** The children were interviewed at baseline and post-intervention. The children were asked open ended questions about safety planning. **Secondary outcomes:** NR **Follow up periods:** 1 week **Methods of analysis:** Qualitative data from the children's interviews were thematically analysed by three coders (inter-rater reliability=89%). Responses were categorized into 10 subcategories, and grouped into adaptive and maladaptive safety planning behaviour.	**Who is the target of the intervention?** Children exposed to IPV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity factors in finding?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Changes in safety planning strategies from baseline to post-intervention showed that 10 children (26% of the group) from the intervention group reported active-help seeking strategies post-intervention, compared with just two children at baseline (4% of the group). There was no decrease in maladaptive safety-planning for the control group, but five fewer children in the experimental group reported maladaptive strategies at follow-up. **Secondary outcomes:** Three children from the control condition reported active help-seeking strategies at baseline, with no additional active help-seeking strategies at post-intervention follow-up **Attrition details:** 110 participants at baseline. 20 lost to follow up at post-intervention assessment. Of the 90 at the post-intervention follow-up approximately two thirds of children (63% of controls and 64 % of the intervention children) had no response.	**Limitations identified by author:** Large number of no responses from children. Problems with verbal ability for assessment. This study only addressed children's reports of possible safety strategies, rather than their actual use of these strategies when faced with IPV. **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research:** Future studies could attempt to understand the role of verbal ability in reports from pre-schoolers about safety-planning strategies, identify ways to

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]						engage other family members in safety planning, identify the most developmentally appropriate techniques for skill-building in the preschool population, and assess and compare which therapeutic strategies best improve retention and recall of safety strategies in pre-schoolers under stressful conditions. **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Noether, C. D., Brown, V., Finkelstein, N., Russell, L. A., VanDeMark, N. R., Morris, L. S., & Graeber, C. **Year:** 2007 **Citation:** Promoting resiliency in children of mothers with co-occurring disorders and histories of trauma: Impact of a skills-based intervention programme on child outcomes. *Journal of Community Psychology, 35*(7), 823-843. **Country of study:** USA **Aim of study:** To assess the effectiveness of an intervention to promote emotional and behavioural strengths in children who had been exposed to interpersonal violence and whose mothers had histories of co-occurring disorders	**Source population(s):** Children of mothers with co-occurring substance use and mental health disorders and histories of violence **Eligible population(s):** Children aged 5-10 of women or caretakers already enrolled in a larger study (Women, Co-Occurring Disorders and Violence Study) who had at least weekly telephone or face-to-face contact with their mother/caregiver **Selected population(s):** Children meeting the eligibility criteria. Only one child per family was included in data collection. In cases of multiple eligible children, the participating child was chosen based on the proximity of his/her birthdate to programme enrolment and (as necessary) the need to fill desired cells (e.g. male vs. female, younger vs. older). **Excluded population(s):** NR **Sample characteristics:** Children: *Mean age*: 7.28; *Gender:* 53% male, 47% female; *Ethnicity:* 19%	**Method of allocation:** Women were assigned using aggregate matching techniques, and based on the programme location. **Intervention(s) description:** There were three components to the intervention. First, there were two initial clinical assessments by semi-structured interview, one with the child and one with the mother or caretaker. Second, a service coordinator/advocate was assigned to each child enrolled. This service coordinator/advocate served as a "resiliency mentor" to the child and provided service coordination and advocacy for the child and his or her family throughout the intervention. Third, there was a children's group which aimed to develop the children's coping skills related to self-protection, self-soothing, interpersonal relationships, and self-identity. The group included an orientation, 9 core weekly sessions lasting up to 75 minutes each, and two booster sessions (one at 30 days post-group, the other at 60 days). Groups consisted of children either 5-7 years old or 8-10 years old, so that the	**Primary outcomes:** The primary outcomes of interest were mother/caretaker ratings of the emotional and behavioural characteristics and strengths of the target child, based on the *Behavioural and Emotional Rating Scale (BERS),* a 52-item interview-administered measure that has been shown to be valid and reliable. It assesses strengths across five subscales: Interpersonal Strengths (IS), Family Involvement (FI), Intrapersonal Strengths (IaS), Affective Strengths (AS), and School Functioning (SF). It also provides an overall strength quotient (BERS SQ), which was the main outcome of this study. Children's safety knowledge was assessed with a single item asking if the child "knows	**Who is the target of the intervention?** Children of mothers with co-occurring substance use and mental health disorders and histories of violence **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity factors in finding?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** At 6 months, mothers' outcomes was the strongest predictor of her child's improvement, but at 12 months, mothers' outcomes no longer played a significant role in predicting children's positive outcomes (as measured by the BERS SQ). At 12 months, there was a significant effect of treatment, with children in the intervention group having a higher mean BERS SQ than children in the control (p=0.004, effect size=0.462), higher scores on safety knowledge (p=0.028, effect size=0.322), and higher scores on the four BERS subscales that the authors analysed: IS (p=0.007, effect size=0.431), FI (p=0.000, effect size=0.520), AS (p=0.017, effect size=0.328), and IaS (p=0.003, effect size=0.461). A greater proportion of children in the intervention group showed increased BERS SQ scores compared to the control group at 6 months (54% intervention vs. 41% control) and 12 months (61% vs. 41%). At 12-month follow-up, witnessing of household violence was a significant predictor of improvement for: positive self-identity (p=0.016, effect size=0.276), relationship tools (p=0.056, effect size=0.168), family involvement (p=0.025, effect size=0.332), and capacity for closeness (p=0.048, effect	**Limitations identified by author:** Convenience sampling. Non-random assignment to groups. Child functioning data were from mothers, and so could have been influenced by the mother's treatment experiences. **Limitations identified by review team:** Need for data collection by external agent (not treatment provider) **Evidence gaps and/or recommendations for future research:** Conduct a randomized trial of treatment **Source of funding:** Department of Health and Human Services, Public

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
and trauma **Study design:** Non-randomized controlled trial **Quality score:** [+] **External validity:** [+]	Black or African American, 40% White or Caucasian, 21% another race, 20% multiracial, 34% Hispanic/Latino (percentages add to more than 100% since the Hispanic/Latino category overlaps with the other categories); *Children living with their mothers at baseline*: 49%; *Children's experience of abuse:* 10% had experienced physical abuse, 6.5% sexual abuse, 68% had witnessed violence in their households. Mothers: *Mean age:* 32.2; *Ethnicity:* 17% Black or African American, 50% White or Caucasian, 25% another race, 7% multiracial; 26.5% Hispanic/Latino **Setting:** Two primarily residential and two primarily outpatient treatment facilities in California, Colorado, and Massachusetts	activities and curriculum could be tailored to each age group. **Control/comparison(s) description:** "Services as usual" **Sample size(s):** Total n=253; Intervention n=115; Control n=138 **Baseline comparisons:** Baseline comparison showed equivalence in population characteristics for both mothers and children, but baseline psychological measurement on the Behavioural and Emotional Rating Scale (BERS) was marginally significant: children in the intervention group had lower mean BERS scores than the comparison group (p=0.077). **Study sufficiently powered:** NR	what to do to keep himself/herself safe when he/she feels threatened by another person", rated from "strongly disagree" (1) to "strongly agree" (4). **Secondary outcomes:** NR **Follow up periods:** 6 and 12 months **Methods of analysis:** Linear regression including the following covariates: treatment group, site, site x treatment group interaction, age, gender, race, witnessing of violence in the household, number of days since mother's baseline interview, and composite of mother's outcome. ITT used.		size=0.270). This was in contrast to the expectations of the authors, yet they note that this may be due to the fact that the standardized group intervention was originally designed to address issues for children exposed to violence and therefore may have been more helpful for this group. Younger children showed more improvement than older children. **Secondary outcomes:** N/A **Attrition details:** 77% of mothers completed both the 6-month and 12-month follow-ups (83% at 6 months, 86% at 12 months)	Health Service, Substance Abuse and Mental Health Services

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Parker, J. S., Stewart, G. S., & Gantt, C. **Year:** 2006 **Citation:** Research and intervention with adolescents exposed to domestic violence. *Family Therapy, 33*(1), 45-52. **Country of study:** USA **Aim of study:** To identify characteristics of adolescents exposed to DV and evaluate the efficacy of a group intervention **Study design:** Before and after study **Quality score:** [-] **External validity:** [-]	**Source population(s):** Adolescents in USA exposed to DV **Eligible population(s):** Adolescents exposed to DV connected to the Spartanburg County Department of Social Services **Selected population(s):** Adolescent females exposed to DV connected to the Spartanburg County Department of Social Services **Excluded population(s):** NR **Sample characteristics:** *Sex*: 100% female; *Ethnicity:* 11 Caucasian, 4 African American; *Mean age:* 14.3, range=12-17; *Households:* 6 in foster care, 9 in group home **Setting:** Group programme	**Method of allocation:** NR **Intervention(s) description:** Four 90-minute group sessions. Sessions involved a pre-assessment of present emotional state with the "How's It Going" rating form. Participants then wrote for 15 minutes about a personal traumatic experience related to DV and were given a list of "Positive Points" developed by the investigators to incorporate into their writing. Following a break, activities targeting self-esteem and relationship skills were conducted. **Control/comparison(s) description:** Same protocol as the treatment group, however the control group did not receive the Positive Points instruction for their writing assignment **Sample size(s):** Total n=15; Intervention n=9; Control n=6 **Baseline comparisons:** NR **Study sufficiently powered:** NR	**Primary outcomes:** Measures included: *Adolescent Anger Rating Scale (AARS), Reynolds Adolescent Depression Scale, 2nd Ed., Multidimensional Self-Concept Scale (MSCS)*, and *Dating attitudes* **Secondary outcomes:** NR **Follow up periods:** NR **Methods of analysis:** The data from the expressive writing were analysed in a programme called Linguistic Inquiry and Word Count. Percentage change in positive emotions pre- and post-writing intervention were calculated.	**Who is the target of the intervention?** Adolescents exposed to DV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity factors in finding?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** There was a 67% increase in positive emotions for the experimental AND the control conditions. There was a significant increase in the number of words related to "self" in the experimental group ($F(1,13)=13.46$, $p<0.003$). There were no differences detected in pre and post measures of anger, self-concept, or dating attitudes. There was a greater reduction in measures of depression among the treatment group, and post-test indicated less sadness among treatment group, though this was not significant ($F(1,3)=3.27$, $p<0.09$). **Secondary outcomes:** N/A **Attrition details:** NR	**Limitations identified by author:** NR **Limitations identified by review team:** Not concurrent control group - different times may lead to confounding factors. Small sample size. Only included females. Recruitment and allocation to treatment groups not discussed, so unable to determine bias **Evidence gaps and/or recommendations for future research:** Research the effects of a greater number of intervention sessions **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Puccia, E., Redding, T. M., Brown, R. S., Gwynne, P. A., Hirsh, A. B., Hoffman Frances, R. J., & Morrison, B. **Year:** 2012 **Citation:** Using community outreach and evidence-based treatment to address domestic violence issues. *Social Work in Mental Health, 10*(2), 104-126. **Country of study:** USA **Aim of study:** To determine if the intervention, Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) improves trauma symptoms in child witnesses to DV **Study design:** Before and after study **Quality score:** [+] **External validity:**	**Source population(s):** Children who have witnessed DV **Eligible population(s):** Child clients at the Community Counselling Centre treated with TF-CBT under the auspices of the Children's Initiative who had experienced or witnessed DV **Selected population(s):** Treatment completers **Excluded population(s):** 15 drop-outs, 4 still in treatment, and children not of the appropriate age to complete the outcome measures **Sample characteristics:** *Gender:* 58% female, 42% male; *Primary residence:* 78% with parent, 11% foster care, 4% with relatives, 4% treatment facility; *Mean age:* 11, range=4-19. *Ethnicity:* 84% White. *Other traumas in addition to DV:* 98% have additional traumas, averaging 5.3 different types of trauma per child, the most common types being emotional abuse (reported by 84% of clients), impaired caregiver (71%), and physical abuse (64%); *PTSD primary diagnosis:* 62%; *Problems:* 32 behaviour problems, 24 academic problems, 25 attachment problems; *Clients in clinical range on PTSD-RI:* 26% for overall PTSD-RI, 87% for re-experiencing, 55% for avoidance, 84% for arousal **Setting:** Urban	**Method of allocation:** N/A **Intervention(s) description:** The intervention was the Greater Portland Children's Trauma Response Initiative's trauma-focused cognitive behavioural therapy (TF-CBT) service. TF-CBT is a hybrid treatment model integrating cognitive behavioural, interpersonal, and family therapy principles with trauma sensitive interventions. In the first session the clinician determines if the treatment is appropriate, and may take additional sessions to get history. The eight treatment components are: conjoint parent-child sessions, psychoeducation and parenting skills, relaxation, affective expression and regulation, cognitive coping and processing, trauma narrative, in vivo exposure, and safety skills and safety planning. Four clients completed treatment at 3 months, 15 completed at 6 months, 6 at 9 months, and 1 at 12 months. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=45;	**Primary outcomes:** The study used the *Post Traumatic Stress Disorder Reaction Index (PTSD-RI)* for children aged 7-18, the *Trauma Symptom Checklist for Children alternate version (TSCC-A)* for children aged 8-16, a demographic and clinical assessment form,and a general trauma form and accompanying trauma detail form, all completed by the clinician with the client. The *Child Behaviour Checklist (CBCL)* for children aged 1.5 to 18 was also used, completed by the client's parent or guardian. **Secondary outcomes:** NR **Follow up periods:** Every 3 months and end of treatment **Methods of analysis:** Simple percentages of	**Who is the target of the intervention?** Children exposed to DV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** On the PTSD-RI (n=22), no participant was in the clinical range for overall PTSD at the end of treatment, whereas three clients had been in the clinical range at baseline. There was also improvement on the subscales of the PTSD-RI, with proportions of clients in the clinical range on re-experiencing dropping from 18 (64%) to 8 (36%), avoidance from 8 (36%) to 2 (1%), and arousal from 19 (86%) to 14 (64%). On the TSCC-A, only 33% of clients were in the normal range at baseline, but this improved to 100% of clients at programme completion. **Secondary outcomes:** N/A **Attrition details:** 15 dropouts from treatment, not included in analysis	**Limitations identified by author:** NR **Limitations identified by review team:** Drop-outs not compared in any way, skews treatment success rates. High drop-out rate. Some children excluded from study due to being out of the age range to complete measurement instruments **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** Substance Abuse and Mental Health Services Administration

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
[+]		PTSD outcome analyses were based on n=22 for the PTSD-RI and n=15 for the TSCC-A **Baseline comparisons:** NR **Study sufficiently powered:** NR	clinical range of score			

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Schultz, P. N., Remick-Barlow, G. A., & Robbins, L. **Year:** 2007 **Citation:** Equine-assisted psychotherapy: A mental health promotion/intervention modality for children who have experienced intra-family violence. *Health and Social Care in the Community, 15*(3), 265-271. **Country of study:** USA **Aim of study:** To test the efficacy of equine-assisted psychotherapy (EAP) in a group of children referred to a psychotherapist for various childhood behavioural and mental health issues **Study design:** Before and after study **Quality score:** [+] **External validity:** [-]	**Source population(s):** Children in the USA who have witnessed family violence **Eligible population(s):** Children with various childhood behavioural and mental health issues referred to equine-assisted psychotherapy over the course of 18-months **Selected population(s):** Children aged 4-16 seeing a particular psychotherapist for EAP **Excluded population(s):** NR **Sample characteristics:** *Sex*: 59% male, 41% female; *Age*: 4-16 years old; *Ethnicity*: 51% non-Hispanic White, 46% Hispanic, 3% Black; *Behavioural and mental health issues*: 57% mood disorders,16% ADHD, 8% PTSD, 5% adjustment disorder, 5% other disorders; *Abuse history:* 40% had a history of inter-parental violence in home, 27% history of abuse and/or neglect, 20% history of sexual abuse, 32% with a parent with a history of substance abuse **Setting:** Outdoor setting	**Method of allocation:** N/A **Intervention(s) description:** Psychotherapy using the horse as a therapeutic tool. EAP is an experiential approach to psychotherapy based on the use of metaphors. A basic goal of EAP is to encourage client insight through horse examples. Work with the horse supports and encourages the identification and expression of feelings. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=63; Outcome analyses were based on those who received more than 6 sessions, n=49 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** The *Children's Global Assessment of Functioning (GAF) Scale* (Cronbach's alpha=0.62-0.82) was used to measure psychological, social and school functioning for children. **Secondary outcomes:** NR **Follow up periods:** 3 months **Methods of analysis:** Descriptive statistics, chi-square test, unpaired and paired t-tests, Pearson's correlation coefficient, ANOVA	**Who is the target of the intervention?** Children who have witnessed family violence **Did they conduct any aspect of sex, gender or diversity analysis?** Yes, see below **Do they report sex, gender or diversity factors in finding?** Females had a significantly greater improvement in GAF scores than males (15% vs. 10%, t=2.46, p=0.02). **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** There was a statistically significant correlation between the percentage improvement of the GAF scores and the number of sessions given (r=0.73, p<0.001). Mean (±SD) pre and post-treatment scores were 54.1 ± 3.2 and 61.7 ± 5.0 (paired t=9.06, p<0.001). No statistically significant differences in pre- and post-treatment scores between those with and without histories of intra-family violence. When comparing children <8 years old, 8-12 years old, and >12 years old, the greatest improvement in the GAF scores occurred in the youngest of the subjects (F=4.9, p=0.01). **Secondary outcomes:** N/A **Attrition details:** 63 were recruited. 3 dropped out after one treatment session. 49 completed 6 or more sessions	**Limitations identified by author:** Only one general outcome measure (restricts understanding of effect). Long term effects of intervention unknown (no follow-up assessment). Sample is biased by being self-selected **Limitations identified by review team:** Only 40% of study participants exposed to DV (more research required to assess impact on various sub-populations and presenting problems) **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** NR

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Sharp, C., Jones, G., Netto, G., & Humphreys, C. **Year:** 2011 **Citation:** *We Thought They Didn't See: Cedar in Scotland: Children and Mothers Experiencing Domestic Abuse Recovery: Evaluation Report.* Edinburgh: Scottish Women's Aid. **Country of study:** Scotland **Quality score:** [+]	**What was/were the research questions?** To evaluate the outcomes of the groupwork programme for children/young people and their mothers, assess the impact of the partnership working model **Theoretical approach:** Action research **How were the data collected?** Interviews with children and mothers, and an online survey of facilitators	**What population was the sample recruited from? How were they recruited?** Children: 499 children, age 3-17, were referred to the pilot programme in Edinburgh, Fife or Forth Valley Scotland. Mothers: Mothers of referred children also participated in Cedar. Facilitators: Co-facilitators of the group work programme from partner agencies **How many participants were recruited?** Children n=27, Mothers n=25, Facilitators n=73 responses from 58 individuals (85% response rate) **Inclusion and exclusion criteria:** Included children and mothers who completed the 12-week group work programme, and who had English as a first language **Population demographics:** Children (all referrals): *Age:* 41% 5-8 years, 36% 9-12 years; *Gender:* 57% male; *Race:* 93% white-British. Facilitators: *Gender:* 24% men, 76% women; *Agency affiliation:* 5 local authority, 16 social work, 6 education, 1 police, 4 child	**Description of intervention(s):** Cedar (Children Experiencing Domestic Abuse Recovery) is a psycho-educational, multi-agency initiative. The goal was improving joint working and agencies' responses when supporting children and young people affected by domestic abuse. The 12-week group programme was delivered to children and mothers by the group coordinators in partnership with co-facilitators from partner agencies. Two Cedar coordinators managed, co-ordinated, and acted as a 'single point' for referrals and assessments. The group was intended to help children identify and express emotions surrounding violence, separation, shame guilt and loss. **Intervention setting:** Multi-agency partnership	**Method and process of analysis:** NR **Key themes relevant to this review:** Children: learned that abuse was not their fault, built their self-esteem and were helped to see their lives differently. "It helped me understand why I felt how I did about what happened (M, 15)". The positive, relaxed group atmosphere, together with the structured curriculum encouraged interaction and made it easy to build trust. Children learned to recognize their emotions, by learning language to talk about their feelings. Children had a better understanding of safety planning, but in the future this needs to be discussed with mothers and more individually tailored. "… If like mum and dad are fighting and all that, I've got to go close by a friend or auntie or something or call the police (M, 9)". Mothers: resources helped them understand child behaviour, and by using Cedar language they were able to defuse tense situations at home where previously there would have been an abusive response. "Cedar helped put an end to the 'conspiracy of silence' around domestic abuse in the family". For facilitators, the majority rated the outcomes for the participants as positive. They suggested that Cedar was able to create a	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in finding? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Children and young people who had behavioural, emotional and social difficulties as a consequence of their experience of domestic abuse	**Limitations identified by author:** NR **Limitations identified by review team:** No description of how the interview participants were chosen, nor how the interviews were conducted. No description of how the interviews were analysed **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** Scottish Government

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
		and adolescent mental health services (NHS), 12 women's aid, and 24 other voluntary sector organisations with a domestic abuse, sexual abuse or single parent focus.		positive group environment for children and young people; they gained a greater understanding of domestic abuse and greater knowledge of safe behaviour. Facilitators: Although broadly positive, there was less certainty regarding behavioural changes.		

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Whiteside-Mansell, L., Bradley, R., McKelvey, L., & Lopez, M. **Year:** 2009 **Citation:** Centre-based Early Head Start and children exposed to family conflict. *Early Education & Development, 20*(6), 942-957. **Country of study:** USA **Aim of study:** To examine if attending the Early Head Start centre-based child care during the first 3 years of life protects children from the expected negative impact of witnessing family conflict with respect to maladaptive and aggressive behaviour at the end of the programme (age 3) and before starting school (age 5) **Study design:** Randomized controlled trial	**Source population(s):** Impoverished children referred to Early Head Start at four centre-based model sites. No specific locations described **Eligible population(s):** NR **Selected population(s):** NR **Excluded population(s):** NR **Sample characteristics:** Control group: *Sex*: 51% male; *Ethnicity:* 36% Black, 28% Hispanic, 7% other race; *Mean income as percentage of poverty line for family:* 66%. Intervention group: 54% male; *Ethnicity*: 39% Black, 26% Hispanic, 4% other race; *Mean income as percentage of poverty line for family:* 67% **Setting:** Child care	**Method of allocation:** Random assignment (no further details) **Intervention(s) description:** Early Head Start is a non-parental child care for low-income families. It has a child to staff ratio of 4-1 and a maximum group size of 8 children. Staff members have a Child Development Associate credential. "Children receive more individualized care and attention from qualified caregivers". The paper does not describe the length of the intervention or how frequently children attended the programme. **Control/comparison(s) description:** Comparison children were located in centre based sites with a "similar demographic profile", but no further details are provided. **Sample size(s):** Total n=610; Intervention n=305; Control n=305 **Baseline comparisons:** Groups did not differ on key demographics **Study sufficiently powered:** NR	**Primary outcomes:** Child aggression was measured by the *Child Behaviour Checklist*, a 19 item tool reflecting problems with aggressing (e.g. child has temper tantrums, child hits others), Cronbach's alpha 0.88 (3 years) and 0.89 (5 years). **Secondary outcomes:** Emotional regulation was measured by the *Leiter-R Examiner Rating Scales* (at age 5) which assess affective and emotional self-regulatory aspects of performance in challenging tasks, Cronbach's alpha 0.93 for emotional regulation subscale **Follow up periods:** At end of programme (3 years old) and 2 years later (5 years old) **Methods of analysis:** Regression analyses using full information maximum likelihood estimation	**Who is the target of the intervention?** Impoverished children exposed to family conflict **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity factors in finding?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** At age three follow-up, there was a significant treatment effect such that children in the intervention group had lower aggression (beta=-0.53, $p<0.05$). There was also a significant treatment x family conflict interaction term; further examination of this interaction showed a positive link between family conflict and aggressive behaviour for the comparison group (unstandardized beta=5.7, $p<0.05$) but no link between family conflict and aggressive behaviour in the intervention group (beta=1.55, $p>0.05$). R-square for model=0.25 (25% of variation in child aggression could be explained by model). At age five follow-up, the treatment effect was no longer significant. Aggression was still positively related to family conflict, but did not differ significantly between the treatment and control (EHS service did not moderate the impact at 5 years). **Secondary outcomes:** No significant impacts on emotional regulation **Attrition details:** By age three, 159 had incomplete data, and by age five, 165 had incomplete data. By age five (compared to age three),	**Limitations identified by author:** Reliance on maternal report for outcome measures. There was a lack of convergence at age 3 and 5 for mother-reported and assessor-evaluated child behaviour. **Limitations identified by review team:** Did not report recruitment or randomization procedures. Does not discuss lack of significant findings at age 5 in discussion **Evidence gaps and/or recommendations for future research:** The aspects of high quality care that are particularly effective needs further examination. **Source of funding:** US Administration on

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Quality score: [+] **External validity:** [+]					Hispanics, younger mothers, and less educated mothers were more likely to be missing data. There were no differences in the pattern of missing data for child gender, family structure, poverty level, maternal depression, level of family conflict or child temperament.	Children, Youth, and Families (ACYF)

Table 67. Research Question 5 (Partnerships) Evidence Tables

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Allen, N. E. **Year:** 2005 **Citation:** A multi-level analysis of community coordinating councils. *American Journal of Community Psychology, 35*(1/2), 49-63. **Country of study:** USA **Aim of study:** To examine what elements of council climate and structure explained variation in the perceived effectiveness of these settings in meeting their objectives **Study design:** Cross-sectional study **Quality score:** [+]	**Source population(s):** Council members of DV coordinating councils **Eligible population(s):** 44 councils in the state **Selected population(s):** 43 councils. Overall return rate was 35% (individual council return rates ranged from 14%-75%). Return rate was 42% for sporadic participants and 51% for regular participants. **Excluded population(s):** NR **Sample characteristics:** *Council size*: 8-116 members; *Mean council age:* 5 years, range=7 months-16 years; *Key informant position:* 56% present or former chair, 27% coordinator, 12% long-term member; *Average number of stakeholder groups represented:* 11, range=5-17; *Average number of*	**Method of allocation:** N/A **Intervention(s) description:** The focus of each DV coordinating council varied (e.g. public education, criminal justice), but overall were aimed at: improving practices and policies for institutional responses to DV, improving communication and cooperation between systems, and enhancing public awareness and responsiveness to DV. **Control/comparison/s description:** N/A **Sample size(s):** Surveys from 511 council members. Key informant interviews with leaders from 41 (out of 43) coordinating councils **Baseline comparisons:** Age of committee was included as a covariate in all analyses **Study sufficiently powered:** The author specifically states that council level data is underpowered.	**Primary outcomes:** Mail survey of members and one hour telephone interviews with key informants. The author produced her own instruments which were developed with two DV professionals, and tested. Setting climate was measured by a 6-item conflict resolution scale (Cronbach's alpha=0.78) that identified tactics used for conflicts, 4 items for presence of a shared mission (Cronbach's alpha=0.89) for agreement on DV issues, and 5 items for shared power in decision making (Cronbach's alpha=0.88) degree of inclusion of all members. Council leadership was measured by the *Coalition Effectiveness Inventory Self-Assessment Tool* (Cronbach's alpha=0.94) for management skills, and 15 item Council Effectiveness (Cronbach's alpha=0.96) for the perception of goal accomplishment. Council membership was determined by interview, one for total council membership and one for actual active participants. Council structure was assessed with the Coalition Effectiveness Inventory Self-Assessment Tool for formalizing of structures. Council Goals and Accomplishments (Cronbach's alpha=0.97) asked for a 6 point completion on 12 items. **Secondary outcomes:** NR **Follow up periods:** N/A **Methods of analysis:** Individual level analysis. Aggregate scores were	**Who is the target of the intervention ?** No **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Councils implemented an average of 7.34 of 18 noted formal structures. 100% of councils used regular meetings, 97% meeting by agenda, 92% formal meeting minutes, 85% subcommittees, 76% written mission statement, 63% written goals, 34% formalized decision making protocol, 32% organizational chart, 29% written by-laws, 15% deadline accountability, and 5% member accountability procedures. Council effectiveness (SD): 4.35 (0.5). Councils were viewed as significantly less effective ($p<0.001$) at achieving long term goals than intermediate goals. In the final model, leadership ($p<0.003$) and the breadth of active membership ($p<0.001$) were significant predictors of perceived council effectiveness at the council level. Shared power in decision-making trended towards significance ($p<0.03$). Conflict resolution was not related to perceived council effectiveness.	**Limitations identified by author:** Small sample size at council level. Highly collinear variables. Response bias. Leadership personalities. Different partnership types may have different effectiveness. **Limitations identified by review team:** Limited number of variables measured **Evidence gaps and/or recommendations for future research**: More research on different factors for internal and external effectiveness **Source of funding:** Michigan State University, Michigan Domestic Violence Prevention and

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]	*active stakeholder groups:* 9, range=3-14 **Setting:** Urban and rural community coordinating councils for DV		calculated for each council. Hierarchical linear modeling and standard regression analysis. Multi-level modeling. One-tailed tests		**Secondary outcomes:** N/A **Attrition details:** N/A	Treatment Board (MDVPTB), and U.S. Department of Justice

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Allen, N. E., Watt, K. A., & Hess, J. Z. **Year:** 2008 **Citation:** A qualitative study of the activities and outcomes of domestic violence coordinating councils. *American Journal of Community Psychology, 41*, 63-73. **Country of study:** USA **Quality score:** [+]	**What was/were the research question(s)?** To investigate the particular activities and proximal outcomes of 41 domestic violence coordinating councils. What characterized the activities of these councils and what outcomes were these councils well-positioned to achieve? **Theoretical approach:** Content analysis, inductive generation of themes **How were the data collected?** Semi-structured 90-minute interviews	**What population was the sample recruited from? How were they recruited?** One key informant per council was contacted by mail and telephone **How many participants were recruited?** 41 of 45 coordinating councils of one US state **Inclusion and exclusion criteria:** Tried to have all participants have at least 1 year council experience - 2 did not **Population demographics:** Council data: *Mean council size (SD):* 39 (25); *Mean council age:* 64 months, range=7-192 months; *Council membership:* 100% local DV programs, 100% law enforcement, 88% prosecuting attorney's office, 88% batterer intervention programs, 80% district court, 78% health care organizations, 60% legal aid, 59% mental health services, 58% social service agencies, 51% child protective services, 46% religious organizations, 42% circuit court, 39% educational institutions, 15% local businesses, 29% formal DV survivor representative; *Mean yearly funding (SD):* $9,447 ($20,240); *Paid staff:* 12 councils. Key informants: *Position:*56% present or former chair, 27% coordinator; *Membership:* 56% DV shelter, 20% prosecuting attorney, 7% justice system victim advocates, 7% directors, 5% law enforcement, 2% probation officers, 2% community organizations	**Description of intervention(s):** Council activity outcomes **Intervention setting:** Community coordinating councils for DV	**Method and process of analysis:** Content analysis, one author, identified 25 themes. All authors collaborated on second theme coding of 11 categories. Second and third author coded the transcripts. Coded present or absent. All coding discrepancies were resolved by consensus. Final themes: 6 primary activities and 3 outcomes **Key themes relevant to this review:** 81% cited knowledge promotion. The results were members were more aware of each other's roles. "feel like it's helped me understand more about their programme and why they're not doing all the things I thought they should do for our clients. I think part of that has been people are just really more aware of what the limitations of other agencies are" 71% referenced fostering relationships, from breaking stereotypes to new linkages. "I can really call on elected officials, the police. They're approachable; they're not as defensive." Institutionalized change was mentioned by 93%. New policies, protocols, and new positions have been created. Councils were not necessarily the primary venues for change, but ''backdrops'' for community change (61%). Activities: 85% discussing issues, 51% sharing information, 85% identifying weaknesses in the system's response, 95% providing training for key stakeholders, 73% engaging in public/community education, and 90% lobbying key stakeholders who are not council members.	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Leaders of the councils	**Limitations identified by author:** Self-report. Specific questions on activities may have impacted report. Data from only one informant. Lack of individual council feedback **Limitations identified by review team:** Interview schedule. Lack of ethics. Limited data on informants **Evidence gaps and/or recommendations for future research:** Future research on council effectiveness should focus on the achievement of proximal outcomes, consider the multiple pathways by which proximal outcomes lead to distal outcomes (or fail to do so), and evaluate council effectiveness in the unique contexts in which they operate. **Source of funding:** Michigan State University, the Michigan Domestic Violence Prevention and Treatment Board (MDVPTB), U.S. Department of Justice

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Banks, D., Dutch, N., & Wang, K. **Year:** 2008 **Citation:** Collaborative efforts to improve system response to families who are experiencing child maltreatment and domestic violence. *Journal of Interpersonal Violence, 23*(7), 876-902. **Country of study:** USA **Aim of study:** Research questions were: How did the collaborations organize and plan their work? Did the collaborative bodies reflect the Greenbook guidance? What facilitators and obstacles were most salient to the work? How were they addressed? What activities did the collaborations plan to implement policy and practice change	**Source population(s):** A diverse group of communities, varying in population, culture, and geography. Some of the sites were racially homogeneous, and others were ethnically and culturally diverse. **Eligible population(s):** 6 demonstration sites **Selected population(s):** 78% response rate at baseline, 58% response at follow-up. 8-12 stakeholders interviewed at each site during annual visit by evaluation team **Excluded population(s):** One site excluded **Sample characteristics:** Site: Populations described as varying, some	**Method of allocation:** N/A **Intervention(s) description:** In 1999, the National Council of Juvenile and Family Court Judges published *Effective Intervention in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice,* which provided a collaborative roadmap for child welfare systems, dependency courts, and domestic violence service providers (DVSPs) with the principles of promoting safety and well-being for all victims of family violence, holding batterers accountable, and structuring responses to families that are dealing with the co-occurrence of DV and child maltreatment. The Greenbook emphasizes a collaborative foundation led by child protective services agencies, DVSPs, dependency courts, and community members. Programme goals were conducting collaborative case management	**Primary outcomes:** Scales of (1=not at all, 5=very much) on facilitators and obstacles to collaboration, from key informant during annual review (see also Banks, 2008). Analysis of members list for courts, DV services, child welfare, and other systems participation. 8-12 stakeholders at each site were interviewed annually for 6 years. Activity grids reviewed. Key informants were interviewed annually for 6 years, and completed a survey. Site visit interviews emphasized various aspects of the collaborative process: the first site visit focused on engaging partners and establishing the collaborative body; midway focused on the transition from planning to implementation; and interviews conducted toward the end focused on the impact of the collaborative work and the shift to sustainability activities. All site visit interviews addressed the facilitators and obstacles critical to the collaborative work.	**Who is the target of the intervention ?** Key stakeholders in the Greenbook project **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** One site started out with 203 members and reduced over time. Sites 1 and 6 built their collaborations during the planning phase and then reduced their membership during implementation. Site 3 had a steady number of collaborative members. The average number of collaborative members per site=60. One fifth of the membership were DVSPs; one fifth the child welfare system; and between one fifth and one third by the court system. Court membership on the collaboration increased over time. Involvement from batterer intervention providers increased, involvement from survivors and former clients decreased. Scores (SD) were 2.6 (0.8) involvement of senior management; 2.8 (0.7) community collaboration; 3.1 (0.7) project support; 3.1 (0.5) resource commitment; 3.1 (0.6) stakeholder awareness of co-occurring DV and child violence; 3.2 (0.5) senior manager identification of problem. Over time, stakeholders were significantly less likely to agree that existence and accessibility of data were an obstacle: (t(140)=2.312,p=0.022). Stakeholders were significantly more likely to agree that the following were obstacles at follow-up: lack of resources (t(143)=-3.133, p=0.002); burnout of participants (t(143)=-4.258, p=0.000); conflicting organizational cultures (t(144)=-2.086, p=0.039); lack of leadership buy-in (t(143)=-1.946, p=0.054); and lack of accountability (t(116)=-2.505, p=0.014). Stakeholders were significantly less likely to agree that the involvement of key agencies and groups was a facilitator at follow-up (t(143)=2.147, p=0.033). Institutional empathy: understanding the context of how other systems operate. "Also for setting	**Limitations identified by author:** NR **Limitations identified by review team:** Pre-established categories for reporting. High attrition rate at follow-up. Lack of direct quotes. Possible pre-determination of themes. Informants' demographic information not reported **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** Grant No. 2000-MU-MU-0014 to ICF International (formerly, Caliber Associates)

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
in the three primary systems? **Study design:** Mixed methods (before and after study/qualitative study) **Quality score:** [+] **External validity:** [+]	racially homogeneous and others ethnically and culturally diverse. Organization: *Size*: 30% 1-20, 16% 21-100, 45% 100+. Interviewees: *Prior collaboration leadership:* 41%-46%. *Prior collaboration participation:* 72%-76% **Setting:** Court, DV services, or child welfare. Urban vs. rural setting not reported	activities; designing new data procedures and utilizing those data; and facilitating community and parent participation in the planning, implementation, and assessment of the evaluation process. Demonstration initiative funding was not intended for service delivery. **Control/comparison(s) description:** N/A **Sample size(s):** Baseline n=86; Follow-up n=62 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Secondary outcomes:** NR **Follow up periods:** 6 years **Methods of analysis:** Descriptive analysis. T-tests for baseline and follow-up facilitators and obstacles. Activity grids and interviews were coded and used as a cross-check. Compared interviews with activity grids of collaborative activities, produced annually by the site, and reviewed by the project directors. Thematic coding was used (but appears to be pre-established categories).		realistic expectations for systems change in the various partner organizations. Stakeholders reported that they would have benefited from a better understanding of how each system worked early in the demonstration period. This understanding at the planning stage would have helped them to realistically plan and implement policy and practice change in those systems" (p 894). Power: Power was an ongoing obstacle in all the demonstration sites. Effective leadership: One stakeholder noted that leaders should also know "'who the champions of the initiative are' within each system and should use them effectively." (p. 895) Reaching out to the community: One stakeholder remarked that the collaboration sometimes "got ahead of the community" and that the initiative should be "driven by the community, not the other way around" (p. 895). Needs assessments: Developing a logic model and conducting safety audits. Stakeholders noted that "the logic model process engaged the entire...committee in one direction" and "was huge in helping them to get more focused and move forward" (p. 896) Most stakeholders reported during in person interviews that the maintenance of collaborative relationships was the most important part of the work and required the most attention. (p. 894) **Secondary outcomes:** N/A **Attrition details:** 78% response rate at baseline, 58% response at follow-up	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Banks, D., Landsverk, J., & Wang, K. **Year:** 2008 **Citation:** Changing policy and practice in the child welfare system through collaborative efforts to identify and respond effectively to family violence. *Journal of Interpersonal Violence, 23*(7), 903-932. **Country of study:** USA **Aim of study:** To examine system change activities in child welfare agencies in the Greenbook project **Study design:** Mixed methods (before and after study/qualitative study) **Quality score:** [+]	**Source population(s):** Child welfare agencies **Eligible population(s):** Greenbook demonstration sites **Selected population(s):** 5 of 6 sites participated. Response rate: average 37%, range 21%-55%. Qualitative data was from child welfare agency leaders, board members, research partners, and agency staff. 8-12 stakeholders interviewed at each site **Excluded population(s):** 1 of 5 sites used a random, stratified sample **Sample characteristics:** NR **Setting:** Child	**Method of allocation:** One site random stratified by division and care worker language. Case files randomly selected at 25% of all substantiated child maltreatment cases, maximum sample size of 150. Survey announced at staff meeting followed by surveys mailed to potential participants. Repeat announcements made at staff meetings **Intervention(s) description:** Greenbook Project not described here **Control/comparison(s) description:** N/A **Sample size(s):** Caseworker survey: Baseline n=81; Follow-up n=135. Case Abstraction: Baseline n=616; 2 years n=642; 4 years n=562 **Baseline comparisons:** NR **Study sufficiently powered:** Yes. Significance level of 0.05 for 75 cases	**Primary outcomes:** Activity grids for case referrals and interagency working, one set of data from caseworker surveys, one from case file review. 6 years of annual interviews by "national evaluation team" and activity grids which catalogued all collaborative activities. These cumulative grids were updated with input from project directors during each site visit. **Secondary outcomes:** NR **Follow up periods:** 2 years from baseline for caseworker survey. 2 years and 4 years for case files **Methods of analysis:** Pearson chi-square. Descriptive analysis. Three significance tests over time. One site excluded from analysis due to lack of follow-up data. Small sample size precluded significance testing of information-sharing. Cross-sectional, not individual case worker	**Who is the target of the intervention?** Child protection case workers and agencies working on cases involving DV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** *Survey*: Agency works closely with DV service providers significantly increased from 66% to 83% (p=0.005) but only one site had significant change. Agreement that agencies trained staff to understand, identify and respond to DV increased significantly between baseline (58%) and follow up (75%) (p=0.007). Training in DV for child welfare agency caseworkers was implemented in all sites. While all sites implemented screening tools for DV at intake, stakeholders noted that these were not routinely used. Staff who responded that their agency had written guidelines for reporting of DV to DV service providers increased significantly from baseline (68%) to follow-up (84%) (p=0.008). There was also a significant increase in agreement that their agency shares resources with DV service providers from baseline (55%) to follow-up (71%) (p=0.027). Stakeholders noted how the Greenbrook principles helped define and increase the value and role of co-located advocates. Agency includes DV in case conferences not significant, increased from 56% to 68%. *Case Files:* A significant increase in referrals for DV from Time 1 to Time 3 (35% to 65%; $\chi 2=19.770$, df=1, p=0.000), with large site variability in baseline and follow-up values. Batterer referrals increased significantly from 29% to 45% at Time 2 ($\chi^2=7.550$, df=1, p=0.006) and 53% at Time 3 ($\chi^2=13.228$, df=1, p=0.000). *Interviews:* Multidisciplinary case reviews implemented so that agencies more likely to work with DV service providers, and activities reported: quarterly staff meeting with DV and batterer programme providers, severe case management, frontline worker for information coordination. One site failed to establish multidisciplinary team. The problems were differing expectations, the child agency's delay in implementation, and differing policy	**Limitations identified by author:** Timing of data collection. Disconnect between data. Limited follow-up period **Limitations identified by review team:** Very low response rate to survey. Cases sampled varied greatly between sites **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]	welfare services. Rural vs. urban not reported		over time. Interviews and activity grids analysed thematically for vehicles for system change, challenges, and extent of implementation. Grids coded by activity target and type for analysis across sites		implementation processes. Case discussion was limited by confidentiality procedures of the DV partner. This site has answered with cross-trainings on confidentiality. One site added a DV advocate meeting with the parent during the child's interview. **Secondary outcomes:** N/A **Attrition details:** Cross-sectional reporting, case workers not followed forward in time	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Bennett, L. W. & O'Brien, P. **Year:** 2010 **Citation:** The effects of violence acuity and door to service. *Journal of Social Work Practice in the Addictions, 10*(2), 139-157. **Country of study:** USA **Aim of study:** To answer these questions: In dual service settings, are different "doors" to service associated with different outcomes of service? Do women who are abstinent prior to the onset of DV services	**Source population(s):** Women in two states seeking resources/services for DV **Eligible population(s):** NR **Selected population(s):** Non-random sample **Excluded population(s):** NR **Sample characteristics:** The numbers of participants entering each door were: IPV door, 32 women (25%); substance abuse (SA) door, 53 women (41%); and integrated SA/IPV agency door, 43 women (34%). Substance abuse: 68 (57%) were abstinent at baseline. Total	**Method of allocation:** A non-random sample of women was recruited **Intervention(s) description:** In 2001 two state agencies, the Office of Alcoholism and Substance Abuse (OASA) and the Bureau of Violence Prevention and Intervention (BVPI), established a demonstration project to implement and evaluate coordinated and integrated services for women affected by both substance use and IPV. BVPI and OASA selected agencies on the basis of variable geographic location in the state and diversity of clientele. Agencies were also selected to show contrasts in client population (rural and urban) and differences in how services were staged (integrated SA and DV services within agency vs. coordinated services with a partnering agency). In all four settings, the services provided were either oriented to SA (assessment, referral for detoxification, intensive outpatient treatment, toxicology, 12-step groups, individual and group counselling, linkage to methadone maintenance, relapse prevention, and recreation) or oriented to DV prevention (24-hour crisis response; shelter; case management; psycho-education; advocacy or protection orders; transportation; children's programme; and individual, group, or mother–child counselling). All clients were screened for the cross-problem at the participating agencies. In the coordinated model,	**Primary outcomes:** Door to service was defined as the source of referral to the demonstration project, which was either an IPV agency, a SA agency, or an agency providing both SA and IPV services. Substance use days (SUD) was the woman's report of the total number of days in the past month (30 days) when she had used any psychoactive drugs, alcohol, or both. To measure acuity of violence, the most recent episode of IPV was originally coded as still occurring, less than 1 year ago (but it has stopped), 1 to 5 years ago, 6 to 10 years ago, or more than 10 years ago. For this article, acuity was defined as experiencing IPV in the past 12 months. The *Women's Experience of Battering (WEB)* is a 10-item scale created by asking about chronic experiences of battering and the psychological terror associated with IPV. Possible scores on the WEB are between 10 and 60. A lower score on the WEB indicates more perceived vulnerability to the effects of IPV. Cronbach's alpha for the WEB was 0.99 in the original study and 0.95 in this sample. The *Domestic Violence Self-Efficacy (DVSE)* is an 8-item index of	**Who is the target of the intervention?** Women seeking a variety of DV resources **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Yes. See description of	**Primary outcomes:** Participant Characteristics: Only one variable correlated with the outcomes—probation or parole status had a significant relationship with DVSE, WEB, and SUD. Women who were on probation or parole had higher levels of DV self-efficacy ($t(126)=3.26$, $p<0.001$), less fear of battering ($t(121)=4.70$, $p<0.001$), and used substances less frequently ($t(112.9)=2.66$, $p<0.01$) than women who were not on probation or parole. Different Doors Outcome: Women arriving through the three service doors differed at baseline ($F(2,123)=6.89$, $p<0.001$) in their experience of battering, but did not differ in WEB scores at follow-up. Results for DVSE outcome mirrored the WEB outcome results. The three groups differed in DVSE at baseline ($F(2,127)=3.90$, $p<0.05$). Women coming through the IPV door had significantly lower DVSE ($M=25.79$, $SD=7.11$) than women coming through either the SA door ($M=29.31$, $SD=6.90$) or the integrated IPV/SA door ($M=29.77$, $SD=5.94$). However, differences at baseline by service door disappeared when probation or parole status was controlled, and there were no differences in DVSE at follow-up. Past month SUD at baseline differed by service door ($F(2,128)=4.80$, $p<0.01$), with women entering the IPV door using substances significantly more often at baseline ($M=8.94$ days, $SD=11.23$) than women entering either the SA door ($M=4.21$, $SD=8.28$) or the SA/IPV integrated door ($M=2.81$, $SD=7.27$). At follow-up all differences in SUD by door were no longer significant after controlling for SUD at baseline and for probation or parole status. Abstinence and Outcome: Using ANCOVA, no difference in WEB by abstinence at either baseline or follow-up, and consideration of probation or parole status did not influence the null findings; the only predictor of a woman's WEB score at follow-up was her WEB score at baseline; women's experience of battering is independent of their abstinence status. Abstinence at admission appeared to have	**Limitations identified by author:** No comparison group. Small sample size. The WEB outcomes in particular are troubling because cannot determine if the increase in fear of battering from baseline to follow-up is methodological or substantive. The situation beyond the initial screening did not permit using event-based measures in addition to a contextual measure. Self-reports prone to various biases **Limitations identified by review**

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
show greater improvement in self-efficacy or vulnerability to battering than women who are drinking or drugging prior to programme admission? How does proximity of violence impact programme outcomes? **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	of 61 women (52.1%) were the acute victims of IPV at the time they were admitted to services. *Mean age:* 35.21; *Race:* 38% African American, 42% European-non Hispanic; *Mean education (years):* 11.92; *Employed full time:* 17%; *Living arrangement past 30 days:* 71% independent or with someone else, 15% hospital/treatment/incarceration, 9% shelter **Setting:** Urban and rural. Variable (see intervention description)	the DV and SA agency collaborated to provide services to a mutual client. Counsellors administered SA screens to women entering through IPV programs and IPV screens to women entering SA treatment. Women who met the criteria of either screen were invited to participate in the demonstration programme and in the research. Staff members interviewed participants at the onset of service delivery (baseline) and the researchers interviewed participants 4 to 6 months after baseline (follow-up). Telephone follow-up interviews were administered by trained interviewers. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=255; Intervention n=128; Lost to follow-up n=127 **Baseline comparisons:** Women in the sample had less fear associated with battering, higher levels of DV self-efficacy, and fewer substance use days in the past month than women who were unavailable for follow-up (data not provided). **Study sufficiently powered:** NR	self-confidence in managing abuse-related difficulties, solving problems, and helping oneself. Possible scores on the DVSE are between 8 and 40. A higher score on the DVSE indicates the woman experiences herself as more capable of handling the effects of IPV. Cronbach's alpha for the DVSE was 0.86 in a previous study with a sample of 575 IPV service consumers, and 0.85 for the 128 women in the current sample. Participants provided information on age, ethnicity, education, employment, living situation, psychiatric treatment history, arrest history, number of children living with them, probation or parole status, and child protection service status. **Secondary outcomes:** N/A **Follow up periods:** 4 to 6 months after baseline **Methods of analysis:** ANCOVAs	intervention and primary findings	no effect on women's fear of battering, but abstinence at admission might have a positive impact on DVSE. Acuity of Violence and Outcome: Women who experienced IPV in the past year had higher scores at baseline for DVSE (M=27.39, SD=7.7) than women whose abuse was more remote (M=30.23, SD=5.87), but the significance of this difference disappeared after controlling for probation or parole status. Baseline WEB and SUD did not differ by acuity of IPV. At follow-up, ANCOVAs of the three outcomes did not differ by acuity of violence after controlling for the baseline values of the outcomes and probation or parole status. Considering all these results, the elapsed time between the most recent episode of IPV and programme admission did not appear to be a factor in key outcomes. When considering criminal justice involvement, women in this demonstration project, on average, increased their self-efficacy and perceived vulnerability to battering while decreasing their frequency of substance use, regardless of how remote their most recent episode of abuse was. The finding that there was no relationship between the acuity of the domestic abuse episode and either IPV or SA outcomes further supports the continued trend toward adopting a trauma-informed model in settings where co-occurring IPV and SA will be encountered, which will be most settings where women are seen. **Secondary outcomes:** N/A **Attrition details:** The 127 who were lost to follow-up did not differ from those who remained in the study in terms of age, race, education, employment, psychiatric history, or criminal justice status. Lost to follow-up: 50%	**team:** Very high attrition rate (may indicate study was not faithfully implemented) **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Coll, K. M., Stewart, R. A., Morse, R., & Moe, A. **Year:** 2010 **Citation:** The value of coordinated services with court-referred clients and their families: An outcome study. *Child Welfare, 89*(1), 61-79. **Country of study:** USA **Aim of study:** To assess the effectiveness of a coordinated, collaborative approach to services for parents involved in the legal system because of DV and child protection issues **Study design:** Before and after study **Quality score:** [+] **External validity:** [-]	**Source population(s):** Court-referred individuals who experienced family violence **Eligible population(s):** Court-referred individuals who experienced family violence in a metropolitan county in a state in the US Rocky Mountain region **Selected population(s):** NR **Excluded population(s):** NR **Sample characteristics:** *Referral reason:* 13 families (25%) referred due to substantiated report of child maltreatment and DV, 40 families (75%) referred due to concerns that the children were at risk of child maltreatment and DV; *Ethnicity:* 90% White, 8% Hispanic; *Education:* 15% not completed high school, 30% high school	**Method of allocation:** N/A **Intervention(s) description:** The intervention aimed to build collaborative relationships among child protection workers, service providers, and courts. A central feature of this programme was a case coordinator who worked with the families to guide them through the court system, coordinate treatment services, and provide financial assistance for payment for court-ordered services. The case coordinator was responsible for client intake and assessment, pre- and post-test administration, case management and case coordination, treatment progress and completion monitoring, maintenance of direct contact with families, coordination and facilitation of multidisciplinary team (MDT) meetings with treatment providers and other community members, assistance in developing treatment plans, developing and maintaining policies and procedures for programme operation, developing data forms and information sharing agreements, performing research functions, developing evaluation tools, completing quarterly reports, and following up on evaluation activities with families. The case coordinator proposed service or treatment recommendations to enhance family functioning, provide alternatives for resolving issues, and improve parent and child safety (i.e., parent education and evaluations for DV and substance abuse). Based on	**Primary outcomes:** The *Intimacy, Conflict, and Parenting—Family Functioning Scale (ICPS-FFS)* was used to measure family functioning. The ICPS-FFS is a 30-item client self-report tool with items measured on a six-point agreement scale (alphas for subscales range from 0.68 to 0.92). The *North Carolina Family Assessment Scale (NCFAS)* measured family functioning and child well-being. The NCFAS is a family functioning and child well-being measurement focusing on five domains: environment, social support, family/caregiver characteristics, family interactions, and child well-being. Cronbach's alpha ranged from 0.71 to 0.94. For the construct validity component, relationships were statistically supported, with concurrent validity correlations ranging from 0.26 to 0.71. The *Spousal Assault Risk Assessment (SARA)* is a 10-item clinical checklist of risk factors for spousal assault. The SARA rates imminent risk of violence toward a partner and toward others as low, low to moderate, moderate, moderate to high, or high. SARA ratings significantly discriminated between offenders with and offenders without a history of spousal violence, and between	**Who is the target of the intervention?** Families dealing with domestic abuse and child-protection issues **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Overall results indicate that having a single case coordinator who collaborated across service providers was particularly effective with court-referred clients and their families for increasing family intimacy and child well-being and for decreasing family danger and conflict. Results from the ICPS-FFS indicate that participants noticeably gained in all three areas of family functioning measured (all p's<0.0001): intimacy (mean pre-score=37.5, post=60.8), conflict (mean pre-score=39.7, post=24.9; reduction in score indicates less conflict), and parenting (mean pre-score=25.8, post=38.8). Results from the NCFAS indicate that all areas (environment, parent capabilities, family interactions, family safety, child well-being) as viewed by the clinician improved significantly (all p's<0.001). For the SARA, both total scores and critical (imminent danger) scores significantly decreased (by an average of 7.3 points and 2.6 points, respectively;	**Limitations identified by author:** No comparison group **Limitations identified by review team:** High proportion of non-completers **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** Rocky Mountain Quality Improvement Centre

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	graduates, 12% GED, 32% some college, 4% bachelor's degree; *DV history:* 68% had history of past DV, 77% had a criminal record, 90% reported DV in their past, 44% had past involvement with child protection; *Reported mental health problems:* 35%; *Reported being childhood victims of abuse:* 33%; *Substance abuse/dependence at intake:* 76%; *Employed:* 62%; *Annual income:* 37% less than $10,060; 24% $10,061-20,560, 13% $20,561-24,060, 27% >$24,060; *Average number of children:* 2.6 **Setting:** Urban court-based programme	these recommendations, the family court judge ordered evaluations (substance abuse, DV, mental health, child at risk, etc.) for clients. Participants then completed the recommended or court-ordered evaluations, and the case coordinator worked with the treatment planning team (which included the family) to develop the family's comprehensive treatment plan. The treatment planning team consisted of the case coordinator, family court services staff, CPS staff from the Department of Health and Welfare, county probation, the family (together or separate, depending on safety concerns or condition and terms of court orders), and advocates (i.e., court advocates, psychosocial rehabilitation workers, individual counsellors) involved in the family's case. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=53 families (92 adult programme participants). However, in most instances, only 48 or fewer participants completed both pre- and post-measures. **Baseline comparisons:** N/A **Study sufficiently powered:** NR	recidivistic and non-recidivistic spousal assaulters. SARA ratings showed good convergent and discriminant validity with respect to other measures related to risk for general and violent criminality. The *Garrity and Baris Parental Conflict Scale (G&B-PCS)* classifies parental conflict as minimal, mild, moderate, moderately severe, or severe conflict. The scale describes a couple's style of conflict resolution and their ability to cooperate, and assesses an environment's danger for children. The G&B-PCS has not been examined for validity and reliability. These measures were administered pre- and post-intervention. As an incentive to complete the post-tests, $50 gift certificates to the local mall were offered after completing the interview and paperwork. **Secondary outcomes:** NR **Follow up periods:** 6 months to 1 year **Methods of analysis:** T-tests		p's<0.0001). G&B-PCS results indicate significant gains for the participant group in moving from severe or moderately severe parental conflict to moderate, mild, or minimal conflict. **Secondary outcomes:** N/A **Attrition details:** 93 people participated, but in most instances, only 48 or fewer participants completed both pre- and post-measures. Reasons for dropping out included transportation difficulties, financial difficulties, further legal problems, and/or other crises. Demographically, there were no differences between those who completed post-measures and those who did not. Analysis of pre-test scores suggests that non-completers may have been at greater risk than completers.	

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Donovan, C., Griffiths, S., & Groves, N. **Year:** 2010 **Citation:** *Evaluation of early intervention models for change in domestic violence: Northern Rock Foundation Domestic Violence Abuse Intervention Project.* Northern Rock Foundation **Country of study:** UK **Quality score:** [+]	**What was/were the research question(s)?** To explore the development and working of multi-agency (MA) operations (one of several questions in the report) **Theoretical approach:** NR **How were the data collected?** 6 monthly interviews and observations of boards over the 3 year project. Frontline staff were asked: what MA working was/should be, what MA working relationships were like currently, had the Project had an impact on MA working relationships, hopes and fears for the new Project, impact of rurality on DV and services, awareness of own agency's role in the new Project, challenges and solutions, and new developments. Senior management added the progress of Project, involvement of senior management of partner agencies,	**What population was the sample recruited from? How were they recruited?** Interviews with frontline staff and senior managers **How many participants were recruited?** Interviews: *Letgo*: 55 interviews with senior management, 52 frontline staff. *Safer Families*: 98 senior management, 72 frontline staff. Observations: *Safer Families*: 15 partnership, 16 steering group. *Letgo*: 21 management, 5 steering. **Inclusion and exclusion criteria:** Only senior management and frontline staff were interviewed. **Population demographics:** NR	**Description of intervention(s):** Both projects provided tailored, one-to-one support to victim/survivors, both one-to-one and group work for children and voluntary perpetrator programmes. Independent Domestic Violence Advisors (IDVAs) undertook a risk assessment, offered safety planning and undertook an assessment of need, the outcome of which resulted in referrals to, and acting as an advocate with, appropriate partner agencies. Contact with victim/survivors varied in frequency and type depending on need. IDVAs also provided emotional and practical support and undertook regular reviews of victim/survivors' risk. **Intervention**	**Method and process of analysis:** Conceptualized a two stage model with a development phase and an operational phase **Key themes relevant to this review:** *Pre-existing partnership relations*: Letgo was a new programme, a fresh slate: "It's all the agencies that are involved with a family... working together to share information and look together at what can be done to improve the situation for the children and families" p.71. Safer Families was a pre-existing programme that added DV to its mandate, and had pre-existing tensions, and other issues were prioritized over DV. "I think it's important on an inter-agency basis that we manage the professional tensions carefully, that can sometimes develop, particularly...between the interface, between child protection work and domestic violence." p. 72. *Bid participation:* Letgo had a long-time chair driving bid for project, and senior management involved in DV. Police heavily involved. Wide-buy-in with discussion of shared benefits. Health not well represented. For Safer Families, the chair who submitted the bid left before the project, and the new director was out for a long term leave with the chair post vacant twice. Bid driven by small group, and other agencies resented being left out of the bid process. Some key partners, including children services, did not honour their commitments to the partnership. Less involvement of senior management. *Project management:* Letgo had strong lines of communication with lead agency. There developed increasingly difficult working relationships within Safer Families, between Safer Families and the lead agency, and between the lead agency and the Gateshead Council. A mid-project evaluation led to staff reductions. *Staff:* Safer Families identified a need for more lead-in time for staff recruitment. *Outcome data collection:* Safer Families stopped data collection after mid-project changes, and Letgo did not have	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Women and children survivors of DV, and the perpetrators	**Limitations identified by author:** NR **Limitations identified by review team:** Most information presented as narrative overview. Lack of demographic data on informants **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** Northern Rock Foundation

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
	future sustainability, and lessons learned. Observed strategic boards and steering groups.		**setting:** Multipartner agencies. Safer Families more urban, and Letgo rural	a systematic data collection process. *Communication:* Safer Families: many partnership staff not aware of new services, and information sharing was weak with the housing partner. "It does depend on different people and some are very good and they will tell you the background and everything. But others are like 'They're only housing. Why do they need to know?" pp.78-79. Staff felt partnerships not supportive. Letgo had a new housing advocate who had role problems, and requested regular meetings with programme manager. *Power:* In both projects, police questioned the professional experience of partners. In Letgo, the probation officer prevented the project from attending a conference. There was a lack of senior management participation in Safer Families. The lead agency was deemed to lack authority because it was in the voluntary sector. "even giving a voluntary sector agency lots of money doesn't necessarily give the voluntary sector agency lots of power" p. 82. Other agencies felt threatened because the project was perceived either as 'taking over' their area or as a threat to their funding. "It's about learning that they aren't the only people" p. 85. Letgo used a strategy of inclusion for the agencies. *Resources:* Both projects faced challenges securing the commitment from children's services of a dedicated social worker. Staff turnover and absences were also identified as a concern in both projects. For rural Letgo, there was a widely held belief that rurality promoted good MA working due as a response to the scarcity of resources, and that rurality resulted in a more stable workforce with a low staff turnover.		

Appendix O

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Ernst, J. S. & Smith, C. A. **Year:** 2012 **Citation:** Assessment in adult protective services: Do multidisciplinary teams make a difference? *Journal of Gerontological Social Work, 55*(1), 21-38. **Country of study:** USA **Aim of study:** To compare differences in outcomes in adult protective cases between a nurse/social worker team and a lone social worker **Study design:** Before and after study **Quality score:** [+] **External validity:** [-]	**Source population(s):** Adults 65 and older investigated following abuse allegations in 2 counties **Eligible population(s):** Reported cases **Selected population(s):** Reported cases **Excluded population(s):** To avoid differences in Hispanics between the two counties, only Caucasians and African Americans were used for analysis. One county had a significantly higher prevalence of African Americans ($p<0.01$), but no further adjustments made **Sample characteristics:** *Gender:* 64% female; *Mean age:* 80.5 years old; *Ethnicity:* 77% Caucasian, 23% African American **Setting:** Urban adult protective services	**Method of allocation:** Secondary data analysis of two counties, one using a social worker and nurse team, and one using a lone social worker **Intervention(s) description:** One county used a MA level social worker and a registered nurse to conduct initial investigations of elder abuse. **Control/comparison(s) description:** Standard single social worker investigation of abuse **Sample size(s):** Initial subsample of 1200 cases, with exclusion n=869 **Baseline comparisons:** Without Hispanic population, two counties matched for race and SES **Study sufficiently powered:** 18 months of cases examined	**Primary outcomes:** Case assessment for risk reduction of physical abuse, neglect and self-neglect, exploitation, physical environment, and social environment. Outcomes recorded in 3 categories, none to low risk, medium risk, and high risk. Risk calculated by subtracting case closing score from initial score. Cases with no initial risks excluded from analysis **Secondary outcomes:** Cost assessment **Follow up periods:** Standard case closure - varied **Methods of analysis:** Chi-square and t-tests	**Who is the target of the intervention?** Elders over 65 who are in the adult protective services caseload **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The team case management had significantly improved risk reduction in every category but exploitation. Team significantly reduced physical abuse by mean difference of 0.48 ($t=3.813$, $df=41$, $p<0.001$), neglect by 0.38 ($t=7.177$, $df=818$, $p<0.001$), social environment by 0.19 ($t=2.390$, $df=484$, $p=0.017$), and physical environment by 0.32 ($t=3.908$, $df=721$, $p<0.001$). No significant differences in case recidivism **Secondary outcomes:** No cost differences **Attrition details:** N/A	**Limitations identified by author:** No information on team members influence on case disposition, worker experience, initial risk scores higher in team county **Limitations identified by review team:** Elimination of Hispanic cases (14% of population of team county). No report of disposition of Asian cases, 13% in team county **Evidence gaps and/or recommendations for future research**: Explore whether there are specific situations in which a MDT approach is not only more effective, but also achieves cost effectiveness **Source of funding:** John A. Hartford Foundation Social Work Faculty Scholars Programme

Appendix O

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Giacomazzi, A. L. & Smithey, M. **Year:** 2001 **Citation:** Community policing and family violence against women: Lessons learned from a multiagency collaborative. *Police Quarterly, 4*(1), 99-122. **Country of study:** USA **Quality score:** [+]	**What was/were the research question(s)?** What was the collaborative process for a multi-agency project? **Theoretical approach:** NR **How were the data collected?** Focus groups conducted by study authors with two student recorders. Questions were on mission, process of collaboration, barriers, and reasons for their agency's involvement in the Commission. The authors reviewed meeting notes and documents for data on commission meetings, meeting attendance, and agency participation.	**What population was the sample recruited from? How were they recruited?** Phase 1 (planning stage) used arandom sample of 19 agencies. Phase 2 used a random sample of 18 agencies. **How many participants were recruited?** Phase 1: 14 selected, 11 actually participated. Phase 2: 18 selected and participated **Inclusion and exclusion criteria:** NR **Population demographics:** Phase 1: *Gender*: 7 women, 4 men; *Position*: 2 probation officers, 1 policeman, 1 private security officer, 2 nonprofit advocates, 2 human services, 1 educator, 1 court administrator, 1 military, 1 legal aid; *Average participation in Commission*: 7 meetings. Phase 2: *Gender:* 15 women, 3 men; *Position:* 4 court, 4 law enforcement, 4 private social services, 1 educator, 3 public non-profit social services, 2 private sector	**Description of intervention(s):** Local police department used a grant to establish Domestic Violence Prevention Commission to reduce family violence. The partnership was a multi-level collaborative public-private partnership with the police composed of the city, district and county attorney's offices; adult and juvenile probation and parole offices; military; school district; judges; municipal, county, and state legal aid; battered women's shelter; YMCA; transitional living centre; clergy; and other volunteer services with 88 distinct organizations. The Commission reported formal recommendations. The initial project was police family violence training. The planning phase had 22 meetings with an average of 36 attendees. Phase 2 involved the setup of 10 subcommittees, and held 8 meetings with an average attendance of 30. **Intervention setting:** Commission meetings	**Method and process of analysis:** Focus groups and archival research. Two focus groups at end of planning, and 2 focus groups 1 year in implementation **Key themes relevant to this review:** Self-Interest as a motivation to participate: turfism. Identified as an extreme and continuing problem in phase 2. Turfism was seen by all participants as a barrier to collaboration. "Turfness is almost palpable. It is entrenched...the agencies are still only cordial, with all clutching to their territory" p. 112. Leadership and dominance: phase 1 concern about police as originators, and differences between preventive activities and police responses. "No one here is really looking at prevention, just punishment" p. 113. A proposed police checklist was never implemented due to police resistance. Phase 2 found a lack of leadership. Organizational ambiguity resulting in unclear expectations. Outcome was a waning interest in the Commission. "During Phase 1 you knew what was expected and the dates of the meetings...this is not the case in Phase 2" p. 114. Absence of key players in the implementation phase "top-level involvement by key agencies seems to be missing from the Commission" p. 115. Marginalization of non-law enforcement members.	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Participating agencies	**Limitations identified by author:** Small number of focus group participants. Inherent biases from focus groups **Limitations identified by review team:** Lack of description of analysis process when feedback is critical. No participant feedback. No ethics information. A few quotes of participants used term "turfism" - not a commonly used phrase, which suggests the possibility that the critical term was "fed" to the participants in a leading way **Evidence gaps and/or recommendations for future research:** More work on collaborative process **Source of funding:** National Institute of Justice (USDOJ)

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Laing, L., Irwin, J., & Toivonen, C. **Year:** 2012 **Citation:** Across the divide: Using research to enhance collaboration between mental health and domestic violence services. *Australian Social Work, 65*(1), 120-135. **Country of study:** Australia **Quality score:** [+]	**What was/were the research question(s)?** What factors contributed to enhanced collaboration and what are the benefits of this for women who experience both DV and mental health issues? **Theoretical approach:** Action research **How were the data collected?** Over 12 months the research team collected data at monthly working group meetings including: reflective memos; records of action research meetings and actions; training programme agendas, attendance numbers and designations; documents developed through the process (e.g., the service agreement); and case studies of client impact. Brief telephone interviews were conducted with action research participants by	**What population was the sample recruited from? How were they recruited?** Working group consisted of DV workers based in refuges and community-based outreach services (e.g. community workers, social workers and psychologists), and mental health practitioners from inpatient, crisis and outpatient teams (e.g. nurses, OT, social workers and psychologists). All participants worked in a fast growing, multicultural area in Sydney. All participants had been invited to join the working group after participating in a previous focus group. **How many participants were recruited?** Total interviews n=27 **Inclusion and exclusion criteria:** NR **Population demographics:** 9 mental health workers and 7 DV workers at Time 1 (6 months or midway through the research) and 6 mental health and 5 DV workers at Time 2 (12 months, the end of the	**Description of intervention(s):** The working group met monthly to generate initiatives aimed at developing and improving collaboration between the mental health and DV sectors. As part of an action research project, this included trying these initiatives, reflecting on and evaluating the outcomes, and, based on this, refining the initiatives and trying them. The starting point for improving collaborative practices was the barriers and enhancers of collaboration that had been identified in the earlier focus groups. Two priorities were identified: the enhancing of communication and the development of a service agreement. The working group initially prioritized improving communication and encouraged the sharing of the knowledge and skills of each sector, which lead to a series of joint training seminars. Another priority	**Method and process of analysis:** Interviews were coded and analysed thematically. The data were interrogated to identify similarities and differences in the two sectors. **Key themes relevant to this review:** Aspects that facilitated collaboration: *Commitments that build trust and a shared sense of purpose* (e.g. "The commitment from management has made it a lot easier... without his commitment it would have been quite hard to work well with the mental health sector," "...we're not the only ones here interested in this, they're just as interested as we are.' And then we started to work together a lot better."); B*uilding personal relationships* (e.g. "it breaks down that view of seeing the mental health sector as an immovable system that goes against what we are trying to do. It certainly makes joint work a lot more possible"); *Developing "Institutional Empathy"*(e.g. "All services have respect for what the other services are trying to do but understanding if they cannot offer help, then we are learning to accept that and not blaming the other service."); *From leadership to ownership* (e.g. "The University has appeared to take a neutral stand point as to who was doing it wrong or right before the collaboration work, so their input has helped an enormous lot in the project's success.") MH practitioners identified many	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Mental health and DV workers	**Limitations identified by author:** NR **Limitations identified by review team:** Little information about participants by occupation, little detail about data analysis. **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** Australian Research Council Linkage Grant

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
	members of the research team who were not facilitating the research group.	action research)	identified by the working group was to promote broader institutional change by embedding practice changes within formal agreements so that changes in practice were maintained even with personnel changes. To do this, at each monthly meeting the group reviewed joint cases that highlighted aspects of practice that needed to be addressed to improve collaboration. From these systemic discussions, the core elements of a formal service agreement were generated. **Intervention setting:** Mental health and DV sectors	changes in their practice that would benefit women experiencing DV (e.g. "Before when we did an assessment and there was some issues of domestic violence, the clinician was more inclined to think that it was part of the mental illness," "I am more aware of DV issues and my colleagues have raised issues about clients and I have informed them of DV services that they can refer their clients to.") The working group implemented a number of actions to achieve their two key strategies (e.g. a formal service agreement was developed between the MH service and the three DV services). Additionally, with support of MH colleagues the DV workers successfully lobbied for funding a new specialist DV-MH outreach worker position.		

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Penhale, B., Perkins, N., Pinkney, L., Reid, D., Hussein, S., & Manthorpe, J. **Year:** 2007 **Citation:** *Partnership and regulation in adult protection: The effectiveness of multi-agency working and the regulatory framework in Adult Protection. Final Report.* **Country of study:** UK **Quality score:** [+]	**What was/were the research question(s)?** To examine the prevalence and understand the process of partnership working in adult protection; identify strengths, barriers, an disadvantages of a multi-agency approach; and examine perceptions on regulation in this area **Theoretical approach:** NR **How were the data collected?** This was a mixed-methods evaluation. In phase one, questionnaires were sent to all 172 Councils with Social Services Responsibilities (CSSRs) in England and Wales, asking about the structure and functioning of the adult protection arrangements in each CSSR, as well as respondents' perceptions of the strengths, barriers, and disadvantages of working in the partnerships. Phase	**What population was the sample recruited from? How were they recruited?** For phase one, the questionnaire was sent to all 172 CSSRs, and the final analytic sample was 133 CSSRs (60% of surveys were filled out by adult protection coordinators, 39% by a manager with adult protection responsibility, and one respondent did not give details of their role). In phase two, a purposive sample of 26 local authorities was chosen to represent a range of geography, local authority type, deprivation/affluence status, assessed performance and history of adult protection working. From this sample of local authorities, researchers interviewed 32 senior social services managers with job titles such as Assistant Director, Service Manager, and Head of Service. They also interviewed a purposive sample of social service workers selected to cover a range of practice teams working with adults (older adults, learning disabilities, mental health, physical disabilities, and hospital-based social workers). The main job titles of participants were social worker, senior social worker, care manager, team leader, and senior practitioner. A focus group	**Description of intervention(s):** In 2000, the Department of Health issued *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, and the National Assembly for Wales issued *In Safe Hands: Implementing adult protection procedures in Wales* (a similar document also focusing on adult protection). Note that "adult protection" encompasses a broad range of victims and types of abuse, focusing on vulnerable adults (e.g. those with disabilities, elders, etc.) and so these documents are not specific to DV. Local authority social services departments were required to take the lead role in co-ordinating multi-agency responses to adult protection at local level. However, they did not receive any additional resources to fund implementation or ongoing work. The main features of such a multi-agency approach were:	**Method and process of analysis:** For the phase one questionnaire, simple descriptive statistics for quantitative questions and thematic analysis of open-ended questions were conducted. For interviews and focus group data in phases two and three, qualitative analyses were conducted using Nvivo and a framework analysis approach. **Key themes relevant to this review:** The benefits of partnership working included: information sharing; sharing of skills, knowledge, and expertise; the fostering of shared decision-making, shared ownership and shared responsibility amongst agencies, particularly in the areas of drawing up joint procedures and strategies; and co-ordination of responses (with associated reduction in duplication of work) and incorporation of different agency perspectives. Barriers included: some lack of commitment to partnership working; agencies not providing the resources required (financial or human resources) with little evidence of joint-funding arrangements; lack of clarity about the roles and responsibilities of each agency; insufficient information sharing; different priorities in relation to adult protection amongst agencies; and delays in decision making at both strategic and operational levels, which were often linked to differing priorities between agencies. The respondents identified four major	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** People providing services or otherwise engaged in the response to address abuse of vulnerable adults	**Limitations identified by author:** NR **Limitations identified by review team:** The scope of the guidelines is very broad and so results may not be directly transferable to the issue of DV. Many measures were subjective, the bulk of which were from the service provider side rather than the client side (and the client side feedback was noticeably less positive). Some details of methodology (e.g. evaluation instruments used) were missing. **Evidence gaps and/or recommendations for future research:** Explore perspectives from a representative sample of service users, families, carers and representatives of

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
	two involved data collection from a few stakeholder groups: Face-to-face interviews were conducted with social services staff at the senior management, middle management, and operational levels. Focus group discussions were held with members of the multi-agency adult protection committees (APCs), using a topic guide which included an adapted version of the partnership assessment tool (PAT), originally developed as a tool to assess the 'health' of multiorganisational partnerships. Discussions were recorded and transcribed for analysis. Phase three of the research involved semi-structured interviews and focus groups with a range of service users, carers and relatives, including representatives from service user groups and support organizations.	was also held in each of the 26 selected local authorities, with a total of 271 participants attending, all of whom were members of the local APC. The authors report that a total of 260 interviews were completed in phase two, though it is not clear what the specific numbers are for the remaining interviewee groups (which included adult protection coordinators, training staff, policy managers, and legal officers). In phase three, 22 interviews and 19 focus groups were conducted in 16 areas (most of which differed from the areas sampled in phase two) with a snowball sample of service users, carers and relatives, and representatives from service user groups and support organizations. The sample was chosen to represent a range of "vulnerable adults" and their supporters. **How many participants were recruited?** See information in population and sample selection **Inclusion and exclusion criteria:** NR **Population demographics:** NR	providing elements of an inter-agency framework; a multi-agency management committee (or adult protection committee); a clear definition of the roles and responsibilities of each agency; developing an inter-agency policy with regard to policies and principles; procedures to be put in place for the reception of and responding to referrals relating to adult protection concerns; joint protocols for issues such as sharing of information in adult protection matters; contract monitoring for independent providers; systems to be put in place to monitor the effectiveness of adult protection work; training strategies concerning adult protection to be developed for relevant staff groups. **Intervention setting:** NR	inhibitors to their work: the lack of adequate resources (human and financial) for adult protection work; the lack of specific legislation to protect vulnerable adults; a concern that some agencies do not view the 'No Secrets' / 'In Safe Hands' guidance as a 'must do' but a 'may do' and in some ways as optional; and uncertain commitment from all agencies at local levels to undertake adult protection work and participate fully in partnership working. Data from the PAT showed a near unanimous view that the partnership approach acted as a conduit for new ideas; led to better policy making; added credibility to policy; assisted with the implementation of policy and knitted networks together. Conversely, respondents were largely divided as to whether partnership working created unrealistic expectations among partners; suits providers rather than consumers of public services; could create an established way of conducting business and confers status on partners who are not reflective of their constituency. Feedback from service users, families, carers and representatives of independent organizations in phase three was generally less positive regarding the actual experiences with adult protection.		independent organizations to confirm or disconfirm findings from phase three of this study **Source of funding:** Department of Health "Modernising Adult Social Care Initiative"

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Robinson, A. L. **Year:** 2003 **Citation:** *The Cardiff Women's Safety Unit: A Multi-Agency Approach to Domestic Violence.* Cardiff University. **Country of study:** UK **Aim of study:** To evaluate the Women's Safety Unit (WSU), in part to examine multi-agency working relationships **Study design:** Cross-sectional study **Quality score:** [+] **External validity:** [+]	**Source population(s):** 19 prosecutors and case records of 222 women **Eligible population(s):** N/A **Selected population(s):** 192 cases and 12 prosecutors **Excluded population(s):** 30 cases excluded for lack of data **Sample characteristics:** *Mean age:* 40; *Ethnicity:* 9 White British, 2 European, 1 no answer; *Average work experience:* 11 years; *Average time at current unit:* 7 years; *Specialization in DV:* 4 prior, 2 current; *Prior DV education:* "half"; *DV case experience:* nine 500+ cases, two 100-500 cases, 1 <100 cases **Setting:** Social services agency. Urban vs. rural	**Method of allocation:** N/A **Intervention(s) description:** The aim of the WSU is to facilitate inter-agency co-operation to provide victims with a seamless response to their cases. The goals are increasing the proportion of victims willing to seek help, increasing the proportion of cases resulting in arrest, charges and convictions, providing more appropriate and adequate services to victims, and reducing the level of repeat victimisation. It has provided multi-agency training for 1182 personnel. The WSU is staffed by one Operational Manager, two Support Workers, one Seconded Police Officer, and one Administrator. The Seconded Police Officer provides criminal justice information and case follow-up, attends pretrial reviews, and WSU staff attended court with 60 clients. The WSU has developed protocols with the South Wales Police and the Crown Prosecution Service in Cardiff. Added referral form to police report and faxing them to WSU office for response in 2 working days. Created a risk assessment form for use with a Multi-Agency Risk Assessment Conference and the creation of safety plans. **Control/comparison(s)**	**Primary outcomes:** 6 page survey created with input from 2 Senior Crown Prosecutors for their experience of prosecuting DV cases, their attitudes towards these cases, their working relationships with other agencies in the community, and their perception of the factors that influence case outcomes. 10 point scale for importance of multi-agency for case review. Created 25-point scale for "social capital" based on ratings of contact, trust, understanding, cooperation, and empathy **Secondary outcomes:** Case review for number and agency for referrals made and referrals received by WSU **Follow up periods:** N/A **Methods of analysis:** Noted that unable to give mean scores for social capital to other agencies due to lack of	**Who is the target of the intervention?** Women who experience DV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No, but strong statement of need for future work with diverse populations in the conclusion. **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** Multi-agency as important to case resolution scored 7.5 out of 10, but there was no consensus as scores were 2, 3, 6, 7, 8, and 10. The WSU earned the most points for addressing the needs of DV victims. Police are viewed as the most effective at reducing and identifying cases of DV, and deterring future offending. The WSU is viewed as the most effective at addressing the needs of victims. The CPS is perceived to be effective at deterring offenders from committing future violence. Only 5 respondents completed a question on inter-agency relationships, and the WSU was the largest at 12 relationships, followed by police at 6. WSU had highest rating for social capital at 24.5, court 23.2, and police 18.2. **Secondary outcomes:** Referrals made: 83 to Homesafe Agency, 53 counselling, 48 police, 4 housing, 29 National Society for the Prevention of Cruelty to Children, 19 Crown Prosecutor, 13 Social Services, 13 Women's Aid, plus 11 other agencies or services. 78% of clients referred to another agency, and 18% of clients' children referred to another agency. Average client received 2 referrals: 65 one referral, 48 two referrals, 39 three referrals, 12 four to nine referrals, and 8 women received 10+.	**Limitations identified by author:** Perhaps respondents were reluctant to list people (and/or agencies) with whom they have poor relationships. **Limitations identified by review team:** Very low response rate, and survey not conducted on the dominant referral agencies. More of a description than an analysis **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** NR

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	setting not specified	**description:** N/A **Sample size(s):** 19 prosecutors, 12 answered survey (63%), but 2 were missing data. Referral data from 192 women's case records **Baseline comparisons:** N/A **Study sufficiently powered:** NR	data. Tallies of Likert scales		Referrals received: 21 different agencies or groups have made referrals to WSU. 118 by the police, 29 "other", 21 Crown Prosecutor, 10 health visitors, 6 Women's Aid, 5 housing agencies, 4 Probation, 3 Social Services, and one from multiple agencies. **Attrition details:** 2 of 12 surveys returned had "substantial portion" of missing answers.	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Robinson, A. L. **Year:** 2006 **Citation:** Reducing repeat victimization among high-risk victims of domestic violence: The benefits of a coordinated community response in Cardiff, Wales. *Violence Against Women, 12*, 761-788. **Country of study:** UK **Aim of study:** To examine the functioning and impact of Multi-Agency Risk Assessment Conferences (MARACs), as well as risk factors for experiencing DV **Study design:** Cross-sectional study **Quality score:** [+] **External validity:** [+]	**Source population(s):** MARACs in Cardiff and the victims discussed at the MARACs **Eligible population(s):** NR, but it appears that the eligible population could have been all MARACs in Cardiff **Selected population(s):** NR **Excluded population(s):** For analysis of revictimization data, there were 164 cases discussed in MARACs during the study period, but the final sample was 146 because: 10 were involved in more than one MARAC, so only their first MARAC was included; 4 male victims were excluded because the couple had a history of DV but the male happened to be the victim for the MARAC-triggering incident; 2 were excluded because their files couldn't be found.	**Method of allocation:** N/A **Intervention(s) description:** MARACs occur fortnightly (formerly monthly) and provide a forum for sharing information and taking actions to reduce future harm to high-risk victims and their children. At the meetings, the circumstances of individual victims (all women) are discussed, and plans are created to help promote their safety. To hold a MARAC, high-risk victims are identified through a regular analysis of police risk indicator forms and/or a participant agency representative bringing forward cases which they deem to be high risk. In practice, roughly 15 people attended the MARACs. The following agencies were consistently represented: police, probation, social services, the WSU, health, and housing. Much of the work associated with MARACs is administrative in nature and was performed in addition to people's everyday workloads. **Control/comparison(s) description:** N/A **Sample size(s):** Number of MARACs not reported. See	**Primary outcomes:** Observations of six monthly MARAC meetings. Key informant interviews were conducted as part of the process evaluation with representatives from the following agencies: police (n=3), probation (n=1), Women's Safety Unit (WSU) (n=1), social services (n=1), housing and homelessness (n=2), health (n=1), and Women's Aid (n=1). Police incident and police call-out data for the 6-month sample of MARAC victims (n=146 women) were used to assess violence level and risk factors. Semi-structured interviews with 27 women were conducted at 6-months to assess quality of life, safety, and security. **Secondary outcomes:** NR **Follow up periods:** The evaluation spanned six months, so follow-up time from the initial DV incident ranged from 1-6 months. **Methods of analysis:** Mixed methods study. Limited details on data analysis provided	**Who is the target of the intervention?** The "intervention" of a MARAC is targeted at those working with victims of DV. Ultimately, MARACs are intended to impact outcomes for the DV victims. **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Substance use was a risk factor for DV	**Primary outcomes:** Respondents viewed the main output of the MARACs as sharing information. This was viewed as the key ingredient necessary to provide high-risk victims of DV (and their children) the assistance they require from many agencies to be safe. Sharing information means that gaps in knowledge are filled so that agencies have a more holistic idea of what is happening in a particular victim's life or in a particular household (e.g. "Some agencies may have snippets of info that on their own don't raise any particular concern, it's only when the jigsaw of info is pieced together that the risk factors begin to be understood."). Another benefit was that MARACs enabled key contacts in agencies to be identified. Respondents felt that effective multi-agency work required agencies to be able to share confidential information with each other. Limitations of MARACs included the dependence of MARACs on the cooperation of the victim, and the administrative burden placed on participants of MARACs. The majority of MARAC victims did not have any additional DV complaints on file at the end of the evaluation period (79%) and did not have any police call-outs for DV (70%). However, follow-up interviews with a subsample of victims indicate that there may have been more DV present than would be indicated solely by police records; based on interview data,	**Limitations identified by author:** Lack of a comparison group. Limited follow-up time for revictimization rates. Sample only included very-high risk victims **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research**: Conduct similar research with a broader range of victims, not just those at very high risk. Explore changes in victims' risk levels over time, particularly so that one can identify those who are not considered high-risk (and so, not captured by the MARACs) but whose risk of future violence may escalate

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	Sample characteristics: Victims: *Mean age:* 29; *Ethnicity:* 86% White Euro; *Children in household:* 71%; *Employment status:* 27% employed, 47% unemployed, 16% other, 9% unknown; *Percent with previous complaints for DV on record:* 77%. Offenders: *Mean age:* 33; *Ethnicity:* 77% White Euro; *Employment status:* 26% employed, 52% unemployed, 7% other, 21% unknown; *Relationship to victim at time of offense:* 14% spouse, 10% ex-spouse, 39% partner, 36% ex-partner, 1% mother. **Setting:** NR	description of outcome measures for sample sizes by data source **Baseline comparisons:** N/A **Study sufficiently powered:** N/A			the author estimate that 4/10 women were revictimized during the 6-month study period rather than 3/10, as indicated by police data. **Secondary outcomes:** N/A. Note that some analyses are excluded from this data extraction because they are not relevant to this topic/question. For example, the correlation matrix identifying risk factors for DV offenses provides valuable information for one of the study's purposes (identifying risk factors in the Wales context), but does not speak to what makes an effective partnership to address DV. **Attrition details:** N/A	quickly **Source of funding:** Safer Cardiff

Study details	Research parameters	Populations and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Authors: Robinson, A. L. **Year:** 2006 **Citation:** *Advice, Support, Safety & Information (ASSIST): The benefits of providing assistance to victims of domestic abuse in Glasgow.* Cardiff, UK: Cardiff University. **Country of study:** Scotland **Quality score:** [+]	**What was/were the research question(s):** To accurately describe the implementation of ASSIST and its contribution to Glasgow's multi-agency response to domestic abuse, and whether the implementation of ASSIST has impacted upon the working practices of key agencies in the multi-agency partnerships, and if so, whether the changes have been positive **Theoretical approach:** Participatory evaluation which recognizes the expertise of people inside the service being evaluated is designed to reveal the processes and outputs that are important from the perspectives of both the evaluator and the agency. The evaluation is methodology is "meaningful and intuitive" **How were the data collected:** Data collection/ evaluation	**What population was the sample recruited from? How were they recruited?** Key informants from agencies in partnership, selection criteria not reported **How many participants were recruited:** First year survey n=13. First year interviews (face to face and telephone) n=10. Second year interviews (face to face and telephone) n=14 **Inclusion and exclusion criteria:** NR **Population demographics:** First year survey: ASSIST 4; Strathclyde Police,1; Procurator Fiscals Office, 1; Victim Support Scotland. 2; Social Work, 1; Glasgow City Council, 1; Women's Aid, 1; Women's Support Project, 1; Glasgow Violence Against Women Partnership, 1. First year interviews: ASSIST 4;	**Description of intervention:** A pilot specialist Domestic Abuse Court in Glasgow was established to deal with the majority of domestic abuse incidents reported to Strathclyde Police G Division. ASSIST was established to provide these services to victims, with police referrals given with the victim's consent. DV victims are risk assessed and receive a range of services in a 'one-stop-shop' style, there is an enhanced multi-agency response provided to very high-risk victims Multi-Agency Action Planning (MAAPs), and advocacy provided to children. The service provides crisis support and information; support and advocacy throughout the court process and short-term post disposal support to facilitate access to other services (such as drug or alcohol counselling, therapy, housing, etc). ASSIST provides the qualitative information to victims about defendants' pleas, bail conditions and to link this	**Method and process of analysis:** Respondents identified as from CJ (criminal justice) or VS (voluntary sector agency). Weekly Bulletins written by the ASSIST Coordinator, documents, and protocols were reviewed. Not so much an identification of themes as a review of operational and strategic concerns. **Key themes relevant to this review:** Improved services: Police respondents were unambiguous that ASSIST had improved the service afforded to victims of domestic abuse. "Service to victims in the pilot area is better across the board – everyone in this area is far more switched on to the difficulties faced by victims because of ASSIST." Police indicated the importance of criminal justice agencies working with community-based agencies to achieve successful outcomes. "The difference that ASSIST makes is a dual role: 1) individual advocacy for the victim and 2) institutional advocacy for the court." "MAAPs are a cracking idea, and fit in with police NIM and tasking to identify most at risk victims." [also provides outcome evaluation for clients] On a day to day basis, there is a lot of contact between the ASSIST administrator and the Crown Office and Procurator Fiscal Services administrator, and this contributed a great deal to the success of the operational relationship. PF Liaison meetings provide a regular meeting for problem-solving and sharing information, and extremely useful, enabling more in-depth understanding of the operational practicalities in other agencies. Ways to improve performance can be discussed and agreed. One example is the PF indicating that ASSIST reports needed to be more explicit about	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** For this report: partner agencies and institutions	**Limitations identified by author:** NR **Limitations identified by review team:** No ethics reporting. While justice and voluntary staff are identified, no comparison made. No true identification of themes. Interesting methodology, participatory evaluation, but did not differ from standard outsider-researcher based responses **Evidence gaps and/or recommendations for future research:** Strong need for additional resources and to roll out pilot services to the entire community, particularly resources to increase advocacy hours. The workload implications of these new arrangements warrant further investigation **Source of funding:** The Hestia Trust and The Henry Smith Charity provided the funding to carry out

Study details	Research parameters	Populations and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
	took 2 years. Interviews and surveys were conducted during the first and second year with key informants in the multi-agency partnership.	Strathclyde Police,1; Procurator Fiscals Office, 1; Victim Support Scotland. 2; Women's Aid, 1; Glasgow Violence Against Women, 1. Second year interviews: ASSIST 1; Strathclyde Police,1; Sheriffs, 2; VIN, 1; Victim Support Scotland. 1; Social Work, 3; Glasgow City Council, 1; Women's Aid, 1; Women's Support Project, 1	information to the Risk Assessment and safety planning being carried out with the victim. Glasgow Community and safety services provides the insitiutional support and sturcture. The service delivery starts address immediate concerns and a possible Intake Review, followed by a risk assessment, and providing information, offering referrals to other agencies. Then there is support for the court process, and up to 12 weeks post-case support. **Intervention setting:** multi-agency partnership [intervention cont] MAAP meetings were conducted for very high risk cases, but the procedure has had a lack of resources. Key agencies are contacted for the meeting, and discuss previous services given and further actions. Responsibility is assigned and follow-ups are made.	special conditions attached to bail. Operational policy and practice has been refined through regular multi-agency meetings, evidence of commitment and good working relationships. "To be an effective partner the multi-agency partnership must 'tick a box' in your own organization… if my organization didn't attach importance to this then I wouldn't be an effective partner – I wouldn't get time to come to meetings, etc. The level of commitment is fairly significant – things get done because each agency is committed." Despite early successes of the pilot, another respondent cautioned against becoming complacent: "The multi-agency approach is performing well, although it must be recognised that all agencies should strive for continuous improvement and not rest on laurels." There was perhaps some early adjustment needed to work issues of ownership and responsibility, and some concern that not enough emphasis on strategy was being undertaken by the partner agencies. These issues appear to have been addressed over time. Strategically, it has been more of a challenge to determine the direction of ASSIST – with some respondents worried that too much attention was being paid to the service provision itself ('ASSI') rather than bringing services together ('ST'). All agencies are agreed that the response to victims of domestic abuse in the pilot area has improved as a result of the new arrangements, and that successful criminal justice outcomes depend on dedicated support agencies like ASSIST bringing the 'victim's voice' to the table.		this research

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Robinson, A. L. & Rowlands, J. **Year:** 2006 **Citation:** *The Dyn Project: Supporting men experiencing domestic abuse. Final Evaluation Report* **Country of study:** UK **Quality score:** [+]	**What was/were the research question(s)?** To identify and understand the services offered, the process of screening referrals, the type of intervention most helpful to specific groups of clients, the impact on clients, benefits and challenges of incorporating services for men and women, and clients' perceptions of the Dyn Project **Theoretical approach:** The evaluation was designed using participatory evaluation. **How were the data collected?** Data for the evaluation were from: 171 case files, 10 case studies, participant observation by one of the authors who was the Dyn Project Coordinator, 4 interviews with Dyn clients, and 7 interviews with practitioners from a range of agencies that have worked with the	**What population was the sample recruited from? How were they recruited?** GBT and heterosexual men in Cardiff and across Wales. No further details provided **How many participants were recruited?** See information on data collection **Inclusion and exclusion criteria:** NR **Population demographics:** *Age:* 5% <20 years old, 29% 21-30, 27% 31-40, 21% 41-50; *Ethnicity:* 79% White European. Where employment status was known, equal proportions were in full-time work as were unemployed. About 1/4 of referrals were for gay male victims of domestic abuse.	**Description of intervention(s):** The Dyn Project provides a safety planning and advocacy service for gay, bisexual, transgender (GBT) and heterosexual men who have experienced domestic abuse. Men in Cardiff can access a 'one-stop-shop' for advice, support, information and referrals to other agencies. This can be done via telephone or via face-to-face appointments. For men living outside of Cardiff, the Dyn Wales /Dyn Cymru Helpline is a confidential listening and advice line operating Monday 9am-12noon, Wednesday 1pm-4pm and Thursday 6pm-9pm. In addition, the Dyn Project has been involved in delivering training to agencies in the local area (including Magistrates, the Crown Prosecution Service, the National Probation Service, health services and voluntary and community groups), as well UK-wide (for example, to CAADA, the NSPCC and Broken Rainbow). Finally, the Dyn Project and Broken Rainbow facilitated the establishment of a UK wide Lesbian, Gay, Bisexual and Transgender (LGBT) Domestic Abuse Forum to help develop networks and the sharing of	**Method and process of analysis:** NR **Key themes relevant to this review:** Interviews with the key informants revealed several strengths of the multi-agency approach. They reported increased information-sharing which meant that better outcomes were possible for the client and some professional suspicion/anxiety was removed about male victims since the Dyn information helped identify true victims (rather than heterosexual perpetrators attempting to present to services as victims). Other strengths cited were: providing a more holistic picture of the amount of men needing services and the types of support they require; challenging misconceptions and increasing attention about male victims of domestic abuse; improving other agencies' awareness and responses to male victims; and providing a specialist service for GBT victims that greatly enhanced the provision afforded to this community. Gay male victims (as opposed to heterosexual male victims) were less likely to recognize or disclose their experiences as abusive, but were more willing to take up services and support from the Dyn project. Of the four GBT clients who were interviewed, 3 perceived the Dyn Project as having reduced the violence and/or threat of violence in their lives, while one	**Did they conduct any aspect of sex, gender or diversity analysis?** Some findings contrasted different sub-categories of Dyn clients (e.g. gay men, heterosexual men with varying histories of DV) and those findings relevant to this review are listed in the "Key themes" section. **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** See main findings **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Men (heterosexual and gay/bisexual/transgender) experiencing domestic abuse in	**Limitations identified by author:** NR **Limitations identified by review team:** Small samples for interviews. Limited info on data analysis **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** Safer Cardiff, the Cardiff Community Safety Partnership, and the Women's Safety Unit

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
	Dyn Project. Comments regarding the multi-agency model were mainly drawn from the last data source (interviews with practitioners, 4 of whom were from voluntary sector agencies and 3 of whom were from criminal justice agencies).		good practice between those working on this issue. One of the guiding principles of the Dyn Project is that work with men who have experienced domestic abuse must take place within a multi-agency setting. This setting must include an Information Sharing Protocol between key agencies to facilitate the screening of counter-allegations so that risk can be reduced and safety increased for men, their former or current partners and any children. **Intervention setting:** The Dyn Project was initially located in the Women's Safety Unit offices, and then moved to Safer Cardiff offices. However, the intervention itself involves contact in a variety of ways including over the phone, internet, and referrals other agencies.	felt that these increased because his partner didn't like the fact he was talking to people in the Dyn Project. All four were satisfied or very satisfied with the Dyn Project. The researchers recommend that programs targeting heterosexual male victims should always be linked to a service for women, because the boundary between victim and perpetrator is often blurred for these men. The Dyn Project was able to provide important information to the women's service organization about men attempting to present as victims, and it also made direct referrals about women who were not currently known to them. Therefore, if properly managed, a project for heterosexual men can provide an extra 'safety net' for women experiencing domestic abuse in any community, while at the same time providing services (however these are taken up or delivered) for heterosexual men who are 'legitimate victims'.	Wales	

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Robinson, A.L. & Tregidga, J. **Year:** 2007 **Citation:** The perceptions of high-risk victims of domestic violence to a coordinated community response in Cardiff, Wales. *Violence Against Women, 13*(11), 1130-1148. **Country of study:** UK **Aim of study:** To determine the levels of revictimization one year after being referred to a Multi-Agency Risk Assessment Conference (MARAC) and the victims' perceptions of the intervention **Study design:** Before and after study **Quality score:** [+] **External validity:** [+]	**Source population(s):** Women referred for DV services **Eligible population(s):** Women referred to the Cardiff MARAC **Selected population(s):** Sampled 22%-28% of DV cases each month for 4 months **Excluded population(s):** No exclusion, but most attempts to contact for the qualitative data collection were made only once for safety concerns **Sample characteristics:** *Mean age:* 29 (half<30); *Household:* 75% one or more children in home; *Ethnic "minority":* 5%; *Employed:* 1 in 3; *DV experiences:* 7 in 10 reported that the perpetrator has alcohol, drug, and/or mental health issues; a criminal record; and is jealous and/or controlling. About 4 in 10 reported injuries, threats to kill them, strangling, and the abuse was becoming worse or more frequent. A significant minority (2 to 3 in 10) revealed that the perpetrator used weapons, had threatened	**Method of allocation:** N/A **Intervention(s) description:** MARACs provide a forum for sharing information across criminal justice, voluntary sector, and statutory agencies to provide action plans to reduce harm to high-risk DV victims and their children. The Women's Safety Unit (WSU) acts as victim's advocate at meetings, and informs the women of actions being taken. The WSU is a community-based advocacy service that aims to increase safety for victims of DV in Cardiff. The unit is effectively a “one-stop shop” that provides advice, specialist counselling services, legal and housing services, referrals to refuge, and target hardening. **Control/comparison(s) description:** N/A **Sample size(s):** Total n=102. Qualitative information n=9 **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** Police DV complaints and records. For qualitative information, interview topics included perceptions of the various agencies, relationships, additional abuse, children, the effect of the abuse on their quality of life, and their opinions as to why they were in their present situation. Scripted interviews averaged 30-45 minutes, and appear to have been conducted either by the advocate's office or by telephone. Interviews with participants often functioned as a counselling session "providing women with the opportunity to talk about their experiences in a way that they had perhaps not been able to do before" (p.1139). The authors discuss difficulties in recruitment, especially the inability to contact potential participants by telephone, safety concerns, difficulty in discussing past abuse. **Secondary outcomes:** NR **Follow up periods:** 1 year **Methods of analysis:** Prevalence. Coding for themes based on interview format	**Who is the target of the intervention?** Women at high risk for DV **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** Only mention of alcohol or drug use by perpetrators as two of several high risk factors for repeat DV	**Primary outcomes:** 74 women reported no further violence at 6 months. At 12 months, 25 of them had filed complaints. At 12 months: 47% no violence, 20% 1 report, 11% 3 reports, and <5% for 4, 5, and 6 or more reports. Police file review showed a possible 5 more women exposed to violence but not officially reported. With this adjustment, 42% no violence at one year follow-up. Findings from the qualitative data: Sharing information: participants knew the agencies were working on their behalf, and saw a benefit in sharing information so the service providers would know the full history. "All the services know about the case history. Everyone seems to be working together. The combination of WSU, Social Services, and welfare has worked." (p.1142). Providing support: participants felt support from several different agencies. "I can’t believe that within a year I’ve had all this support. I’ve dealt with my husband for [the] last 10 years and I coped all on	**Limitations identified by author:** Limitations of police report, conflicts between interview self-report and police data. Measurement concerns for indicators of positive outcomes **Limitations identified by review team:** No comparison statistics on revictimization rates. Very small sample for qualitative portion of the study. Scripted interview provided themes **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** Safer Cardiff

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
	suicide, and there was sexual abuse. The average victim had more than three DV complaints on record. Information on qualitative data sample not provided. **Setting:** Urban vs. rural setting not reported. Multi-agency setting				my own with it. [But now] people seem to bend over backwards to help you." (p.1143). "To be honest, I have been surprised at the amount of support that has been there for me. It is good that all people in different agencies know what is happening." (p. 1143) Continuing challenges: problems with providers was generally directed at one agency, not the MARAC. Problems with information about legal processes, including bail release, and child contact by perpetrator. **Secondary outcomes:** N/A **Attrition details:** N/A	

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Sharp, C., Jones, G., Netto, G., & Humphreys, C. **Year:** 2011 **Citation:** *We Thought They Didn't See: Cedar in Scotland - Children and Mothers Experiencing Domestic Abuse Recovery Evaluation Report.* Edinburgh: Scottish Womens Aid. **Country of study:** Scotland **Quality score:** [+]	**What was/were the research question(s)?** To assess the impact of the partnership working model of delivery amongst practitioners including effective referral arrangements, co-facilitation of groupwork and the wider impact on inter-agency working and any changes in practice relating to domestic abuse. Also considers the effectiveness of national partnership structures **Theoretical approach:** Action research **How were the data collected?** An evaluation team acted as 'critical friends' to the pilots, ensuring that the review of evidence was systematic. Local Advisory Groups (LAGs) recorded briefing notes from meetings indicating any uncertainties or contradictions. Data also came from 3 Exchange Events,	**What population was the sample recruited from? How were they recruited?** *Interview and web survey:* Six coordinators and 68 co-facilitators. *Exchange Events:* #1 no details provided, evaluation framework; #2 had 40 attendees from pilot sites, national partnership, and government; #3 had 60 attendees, Cedar Graduates, Coordinators, Co-facilitators, the National Partnership, the Scottish Government and third sector agencies and local authorities from other areas of Scotland. **How many participants were recruited?** 73 responses to a web survey from 53 individuals (85% response rate) **Inclusion and exclusion criteria:** Participation in the co-facilitation was voluntary **Population demographics:** Co-facilitators: *Gender:*	**Description of intervention(s):** Multi-agency professional learning and practice integration is one of the programme's 5 guiding principles, with the goal of improving joint working and agencies' responses when supporting children and young people affected by domestic abuse. The goal was improving joint working and agencies' responses when supporting children and young people affected by domestic abuse. The 12-week group programme was delivered to children and mothers by the group coordinators in partnership with co-facilitators from partner agencies. Two Cedar coordinators managed, co-ordinated, and acted as a 'single point' for referrals and assessments. Multi-agency LAGs were established in each pilot area with the Cedar coordinators, their managers, and a small number of staff from key partner agencies. Many of these partner agencies made referrals and provided staff to co-facilitate groups. LAGs	**Method and process of analysis:** Reviewing the multiple sources with an action inquiry process **Key themes relevant to this review:** The pilot was able to train those from generalist agencies to work with domestic abuse recovery. Cedar provided some professionals with new skills, particularly groupwork skills, and other insights on theory, language, practical ideas, and knowledge of resources. Some providers did not believe the referrals did not reach a threshold for intervention. There could be 'ambivalence' in some agencies because the programme was not seen as their function, and in a tight financial and regulatory climate may influence perceived priorities for services. An important lesson was to clarify the expectations of partner agencies that make referrals to avoid omission or duplication of efforts. The positioning of Cedar in the multi-agency process raised issues about communication and confidentiality. Cedar worked best within a local context where there were clear policies and partnership strategies. A noticeable shift occurred over the pilot period as there was more involvement from staff employed by non-social work local authority departments. Facilitators: found the programme to be an opportunity to engage more fully with other agencies, and continue professional development. The vast majority reported they developed their knowledge of the impact of domestic abuse on children. "I've changed my own input. I'm more sensitive about the way I put things. I'm more aware of how	**Did they conduct any aspect of sex, gender or diversity analysis?** Yes, see diversity findings below **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** More men were recruited as co-facilitators. Overall, the vast majority were not from minority ethnic groups. **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Staff in all partner agencies	**Limitations identified by author:** As a pilot, the volume of groups completed was well below the original targets. The coordinators' role in leading groups and the underestimation of the workload limited the capacity of the pilot programme. More relationships with specialist agencies **Limitations identified by review team:** Lack of information on method of analysis. Disjointed reporting of results. No ethics for the interviews and web surveys **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** Scottish Government

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
	notes from the LAG and National Partnership meetings, 3 web surveys of all coordinators and co-facilitators, and five telephone interviews with selected co-facilitators.	24% men, 76% women; *Agency affiliation:* 5 local authority, 16 social work, 6 education, 1 police, 4 child and adolescent mental health services (NHS), 12 women's aid, and 24 other voluntary sector organisations with a domestic abuse, sexual abuse or single parent focus. Most were in non-supervisory or management positions; *Facilitators' previous experience:* 7% little groupwork, 51% some groupwork, 41% extensive groupwork; 2% little women's DV, 48% some women's DV, and 50% extensive women's DV; 10% little children's DV, 49% some children's DV, and 41% extensive children's DV	usually met about every six weeks. About two-thirds of staff attended pre-programme training. **Intervention setting:** Multi-agency partnership	some young people would take what I say. I'm more confident [in my wider work]. Before I used to think what they needed was a formal service ... professional response - now I'm more child-focused ... think about what would connect with the young people, use their language and ask their opinions." Most co-facilitators reported greater communication and sharing of knowledge between agencies and greater awareness of resources and other agencies.		

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Stanley, N., Miller, P., Foster, H. R., & Thomson, G. **Year:** 2011 **Citation:** Children's experiences of domestic violence: Developing an integrated response from police and child protection services. *Journal of Interpersonal Violence, 26*(12), 2372-2391. **Country of study:** UK **Aim of study:** To examine the interface between the police and child protection services in responding to DV incidents including tools, approaches, and challenges of implementation **Study design:** Cross-sectional	**Source population(s):** All children exposed to DV in the districts **Eligible population(s):** 251 incident reports of adult DV with children in the household **Selected population(s):** 184 cases in final analysis **Excluded population(s):** Records from ongoing prosecutions not available, and 12 multiple notification records excluded **Sample characteristics:** For the interviews: *Department:* 18 police officers, 6 DV advocates, 9 supervising officers, 13 children's social workers, 2 children's social service administrators, and 10 managers; *Gender:* children's social workers were "predominately female" and there were 5 female police officers; *Mean years of experience:* 10, range=18 months-30 years **Setting:** Mixed urban	**Method of allocation:** All DV cases with children during one month collected from two districts **Intervention(s) description:** Since 2002, police were required to notify children's social services for all DV incidents where there were children in the household. National guidance does not stipulate what information should be included in notification forms sent to children's social services; this is determined at the local level. **Control/comparison(s) description:** N/A **Sample size(s):** 251 DV reports with children. 58 interviews. 57 surveys (a 35% response rate) **Baseline comparisons:** N/A **Study sufficiently powered:** NR	**Primary outcomes:** Data extracted from key police databases and files from children's social services were entered into spreadsheets, coded, and analysed. Qualitative data were from 58 individual interviews. Participants were asked to describe and comment on the processes for recording and transferring information between the police and children's social services and to identify the strengths and weaknesses of current systems for collaboration. A short postal survey was sent to the chairs of all local Safeguarding Children's Boards. Interview data were analysed with NVivo, and the surveys were reviewed manually. It appears there were 2 waves of interviews, January 2007 and 2009 **Secondary outcomes:** Case outcomes at children's social services **Follow up periods:** 21 months **Methods of analysis:** Retrospective analysis of police and social service records over 21 months	**Who is the target of the intervention?** Police and child social service workers **Did they conduct any aspect of sex, gender or diversity analysis?** Yes, see below **Do they report sex, gender or diversity based factors in findings?** Authors note the difference in female gender prevalence between social workers and police officers **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** 19% of the reports had inconsistencies between information included in notifications and that in the original police reports. 25 police notifications did not report children's exposure to DV when it was in the police report. Only 19% of police records had narrative descriptions. Discrepancies in the identifying details for children and families were found in 40% of notifications. The qualitative data showed that social workers were aware that very few notified cases received a service and a number commented that too many notified incidents involved verbal altercations that they did not consider warranted their service's attention: "we wouldn't accept a notification [or] referral from another agency on that basis" and "I would say the Police need to have a filtering process," Social workers described difficulties in contacting both specialist DV and frontline officers outside the setting of formal statutory meetings such as child protection case conferences. Both police officers and social workers considered that interprofessional training could enhance understanding of each other's roles. Police officers commented that they had limited understanding of what social workers did with the information that they sent them and of social work roles and tasks generally. Practitioners from both services suggested shadowing. The survey revealed that social services was a partner in all the models reported, and the police a partner in all but two of 30 examples.	**Limitations identified by author:** Under-reporting of DV to police. The amount of information varied **Limitations identified by review team:** Quantitative measures may not add much to the research, except perhaps for under-reporting by police (25 of 184 cases). From the qualitative portion of the study: Very low response rate, and much of the paper taken up with "models" proposed by the survey. Lack of themes **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** NSPCC

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
study **Quality score:** [+] **External validity:** [+]	and rural. Police and children's social services				Health and education services were cited as participating partners in about half the approaches reported. **Secondary outcomes:** Only 15% of the families notified to children's social services received a social work assessment or intervention. Notifications triggered a new social work intervention in only 5% of cases, and 10% had an open case. 60% received no further action. **Attrition details:** 22% of original sample due to lack of records	

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Steel, N., Blakeborough, L., & Nicholas, S. **Year:** 2011 **Citation:** *Supporting high-risk victims of domestic violence: A review of Multi-Agency Risk Assessment Conferences (MARACs).* **Country of study:** UK **Quality score:** [+]	**What was/were the research question(s)?** To improve understanding of how MARACs worked and potential areas of development, including considering the case for putting MARACs on a statutory basis **Theoretical approach:** Qualitative research findings were based on "an analytical approach similar to grounded theory" **How were the data collected?** Literature review. Performance monitoring data from 208 MARACs. Quality assurance assessment data from 83 MARACs. National survey of MARAC Chairs, MARAC/DV coordinators and Independent Domestic Violence Advisers/specialist domestic abuse support services (at least one response was received from over 90% of known MARACs). Structured interviews with 13 members of the	**What population was the sample recruited from? How were they recruited?** See information on data collection **How many participants were recruited?** Varied by data source. See information on data collection **Inclusion and exclusion criteria:** NR **Population demographics:** NR	**Description of intervention(s):** MARACs are multi-agency meetings where statutory and voluntary agency representatives share information about high-risk victims of domestic abuse in order to produce a co-ordinated action plan to increase victim safety. The agencies that attend MARACs vary but are likely to include, for example: the Police, Probation, IDVAs, Children's Services, health and housing. At the time of writing, there were approximately 250 MARACs in operation across England and Wales. Co-ordinated Action Against Domestic Abuse (CAADA), a national charity, has developed a set of ten guidance principles for MARACs, as well as tools and guidance to help MARACs put these principles into practice (e.g. a "typical" meeting should last half a day and discuss around 15 to 20 high-risk cases with a very brief and	**Method and process of analysis:** Mixed methods evaluation. See information on data collection for data sources. Some analyses were carried out by an external research company while others were carried out by the research team for this study. Thematic analysis of qualitative data **Key themes relevant to this review:** Existing research indicates that MARACs (and IDVAs) have the potential to improve victim safety and reduce re-victimisation and therefore may be a highly cost-effective measure, though a more robust evaluation would be required to strengthen these findings. The three areas which NMSG interviewees perceived as core to a MARACs' effectiveness are enhanced information sharing; appropriate agency representation; and the role of the IDVA in representing and engaging the victim in the process. Factors which were seen as supporting effective practice included having: strong partnership links (including a commitment from agencies to tackle DV in general); strong leadership (through the MARAC chair); good co-ordination (through a MARAC co-ordinator); and the availability of training and induction. The majority of survey respondents felt the MARAC they attend was either "very effective" or "fairly effective" at improving the outcomes for DV victims in their area. There was general agreement with best practice guidelines suggesting that, as a minimum, there are six core agencies which should regularly attend MARACs: police, probation, IDVAs, housing, children	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** People working in a variety of disciplines relevant to DV	**Limitations identified by author:** Possible bias in some data sources which could limit generalisability of findings (e.g. the survey targeted specific MARAC roles, small sample size for qualitative interviews, quality assurance assessment data available only for those who opted to collect it) **Limitations identified by review team:** N/A **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** NR

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
	National MARAC Steering Group (NMSG). Structured interviews with 47 representatives from a range of agencies involved in four purposefully selected case study sites. Data were collected from Sep 2010 to Jan 2011.		focused information sharing process). **Intervention setting:** NR	services, and health. Potential areas for future development of MARACs included: increasing the number of non-police referrals, improving representation of key agencies at meetings, increasing clarity around how MARACs and other multi-agency procedures working with victims of domestic abuse (i.e. safeguarding children and vulnerable adult procedures) interlink, developing links between MARACs and services which are aimed at addressing the perpetrators' behaviour, improved monitoring of MARACs, ensuring MARACs are reflective of the communities they serve, and ongoing training at the local and national level. Many stakeholders felt it would be beneficial to place MARACs on a statutory footing. Key perceived advantages of placing MARACs on a statutory footing included: better agency representation; stronger accountability; and improved continuity and consistency. Where disadvantages were perceived these included: increased bureaucracy, greater burden on agencies, and concern that victim's views may be lost or victim engagement would decline.		

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
Author(s): Whetstone, T.S. **Year:** 2001 **Citation:** Measuring the impact of a domestic violence coordinated response team. *Policing: An International Journal of Police Strategies & Management, 24*(3), 371-398. **Country of study:** USA **Aim of study:** To examine the efficacy of a pilot project which teamed police officers with victim advocates as first responders to 911 calls for DV cases **Study design:** Mixed methods (before and after study/qualitative study) **Quality score:** [+]	**Source population(s):** People in intimate partner relationships who make DV calls **Eligible population(s):** People in intimate partner relationships who made DV calls in the districts under study **Selected population(s):** People involved in IP DV calls who had complete data **Excluded population(s):** Disputants who were siblings, parent and child, or in any other non-intimate relationship **Sample characteristics:** Based on call data, victims in the two districts were predominantly White with 17-20% African Americans. Women	**Method of allocation:** N/A **Intervention(s) description:** The project teamed specialized uniformed police officers and victim advocates as first responders/follow-up investigators to intimate partner DV cases in the district. This domestic violence coordinated response team (DVU) initially consisted of three victim advocates drawn from a social service provider, a director, and unit secretary, two patrol officers and one sergeant from the police department, one probation/parole officer, and one correctional officer. All agency representatives shared a one-room office. The programme required victim advocates to respond with assigned uniformed officers to DV 911 calls and any follow-up visits. Both advocates and officers were specifically selected and trained to provide enhanced service at the time of the 911 response. The advocates were specially trained in victim support, counselling and accessing service providers. The police officers were trained to enhance their investigative procedures and interview skills, and to improve the conduct of comprehensive crime scene and follow-up investigations. The inclusion of probation/parole and corrections officers gave the unit the ability to conduct greater surveillance and supervision of perpetrators. **Control/comparison(s)**	**Primary outcomes:** Data on all DV calls for both the treatment district and the comparison district were collected for the year preceding the intervention and the 18 month life of the pilot project (for a total of 30 months) in one month increments. Data were drawn from the mainframe database of police report records, police radio dispatch records, a computer system in the office of the courts, and unit records. Quantitative measures from this data included: number of DV CFS (which includes DV involving non-intimate-partner relationship as well as calls which were misclassified), number of IPV incidents (i.e. those which could have been under the purview of the DV team in this pilot), and number of DV perpetrators that were arrested. Various ratios were calculated from these variables (e.g. number of arrests/number of IP incidents). Additional data were drawn from exit surveys completed by clients, which included a series of statements using a Likert scale where 1=strongly disagree and 5=strongly agree. A series of interviews was	**Who is the target of the intervention?** Victims of intimate partner DV, including both men and women **Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No	**Primary outcomes:** The specialized DV unit performed significantly better than the comparison district. Cases initiated by the specialized unit resulted in higher arrest, prosecution and conviction rates. The mean gain in # of arrests/# of IP incidents was 11% in the treatment district vs. 4% in the comparison district ($p<0.05$). In post-test-only comparisons, the treatment district had significantly higher arrests and prosecutions (mean=33% vs. 28%, $p<0.05$), higher conviction rate as a percentage of intimate DV cases (mean=6% vs. 1%, $p<0.001$), and greater percentages of DV victims receiving medical attention (mean=15% vs. 10%, $p<0.05$). Data from the exit survey show that victims had high satisfaction with the DVU's work (mean=4.73 out of 5, with 5 being the best score), liked having the victim advocate there to help (mean=4.77) and felt that police should always have such advocates with them (mean=4.64). From the qualitative interviews, the vast majority of victims/clients were overwhelmingly positive about their experience with the unit. They were pleased with the level of service and	**Limitations identified by author:** There were problems with data access (e.g. incompatible computer systems/formats). Some cases in the comparison district could have "fallen through the cracks". The structure of the unit might not be readily replicated where victim advocacy services are scarce or non-existent. There were several initiatives and a department-wide campaign in the comparison district to improve the response to DV, which could have contaminated the findings. Cases initiated by general assignment patrol officers in the treatment district still often involved follow-up by the DVU, making it harder to assess differences resulting from the DVU alone. **Limitations**

Study details	Population and setting	Method of allocation to intervention/control	Outcome measures and methods of analysis	SGBA	Results	Notes
External validity: [+]	constituted over 80% of the victims of DV. Victim demographics were proportional with the general population within each district (no further details provided). For the exit survey, 13% were male, 74% were Caucasian while 16% were African-American, 51% had a high school diploma/GED, and 36% had at least one or more years of college. The survey respondent demographics reflect the distributions in the population and in the DV cases in this study. **Setting:** Urban and rural. Community (any setting involved in the response to DV calls)	**description:** The comparison district had no analogous unit and conducted business as usual regarding DV calls. It was selected based on the fact that its volume of calls for service (CFS) was second only to the treatment district, it was geographically close to the treatment district, and had similar resident housing and income levels. **Sample size(s):** Data from 4,004 calls were used in quantitative analyses (no breakdown provided for treatment vs. comparison). 45 exit surveys were completed. **Baseline comparisons:** DV activity in the comparison district was significantly different from the treatment district on nearly all measures. There were no statistically significant differences in victim demographic profiles between the two districts at either pre- or post-test. There was a slightly greater number of African Americans in the comparison district, but this was not statistically significant. **Study sufficiently powered:** NR	conducted during and after the pilot with personnel, clients and secondary clients (individuals or government agencies that interacted with either unit personnel or their clients, such as prosecuting attorneys and women's shelters). **Secondary outcomes:** NR **Follow up periods:** Not clear. It appears the post-test was done upon conclusion of the pilot, though the reported study period extends to four months beyond that. **Methods of analysis:** Paired sample t-tests to compare outcome variables from before the intervention to after the intervention. Descriptive statistics from the exit survey		expertise, felt they understood their options better, felt their safety was improved with help from the DVU, and grateful for assistance in preparing for and being supported during court appearances. The majority of victims reported a modest sense of empowerment. Both prosecutors and judges reported better case preparation by the DVU police officers over cases handled exclusively by general assignment police officers. The prosecutors felt that having advocates maintaining contact with the victims in the first two weeks following incidents was crucial. All DVU personnel commented on the ease of communication between team members, which allowed improved inter-agency efficiency. **Secondary outcomes:** N/A **Attrition details:** N/A	**identified by review team:** Though it is understood that the author was limited to the available data, it is still a limitation to use arrests, prosecutions, and convictions as the main outcome variable without addressing potential confounders like pre-intervention levels of prosecutions and convictions, or severity of the crime. **Evidence gaps and/or recommendations for future research**: NR **Source of funding:** NR

Study details	Research parameters	Population(s) and sample selection	Details of intervention	Outcomes and methods of analysis/Results	SGBA	Notes
Author(s): Woodford, M. R. **Year:** 2010 **Citation:** Successful community-government collaborative policy making: A case study of a workgroup to improve income support services to victims of intimate violence. *Journal of Policy Practice, 9*(2), 96-113. **Country of study:** Canada **Quality score:** [+]	**What was/were the research question(s)?** This study aimed to advance understanding of successful community-government collaborative policy making by examining the factors that promoted this outcome in the selected case. **Theoretical approach:** Constant comparative method **How were the data collected?** Semi-structured interviews with workgroup members from community agencies and government departments and agencies, as well as senior officials with the income support department. Interviews retrospectively explored the individual's expectations of and hopes for the workgroup, including any issues of concern entering the group; descriptions of the group's process; experiences as the group carried out its mandate; and reflections about the group's effectiveness and the impact of the policy changes. The author observed a follow-up community consultation session about the implementation of the workgroup's recommendations. Field notes were taken during the observation. More detailed notes were made immediately following the session.	**What population was the sample recruited from? How were they recruited?** The workgroup represented all provincial regions, and government officials included policy personnel, operational managers, and frontline staff. **How many participants were recruited?** The workgroup was limited to 12 individuals representing different parts of the service system working with victims of violence. **Inclusion and exclusion criteria:** NR **Population demographics:** Engagement occurred with three groups of stakeholders: affected community agencies and networks; governmental stakeholders (government of Newfoundland and Labrador [NFLD]); and the host department's executive and minister	**Description of intervention(s):** The 12-member workgroup (representing governmental and nongovernmental sectors, including advocacy groups) was created In response to concerns that income support system redesign efforts were not adequately meeting victims' needs nor promoting violence prevention. The workgroup was asked to recommend ways to improve income support services to victims of IPV. The workgroup carried out its mandate over an eight-month period, occasionally consulting with other community and government stakeholders. Its deliberations resulted in identifying 16 issues and crafting 27 recommendations **Intervention setting:** Workgroup	**Method and process of analysis:** Grounded theory analysis **Key themes relevant to this review:** A number of factors contributed to success: context (support of the host department's leadership, willingness to be measured risk takers); design (group size and composition, focusing on departmental policy issues, engaging other stakeholders); group process (trust, respect, open communication, and equity within the group, purposeful consideration of responsiveness and feasibility); broker role (connecting with policy power-holders).	**Did they conduct any aspect of sex, gender or diversity analysis?** No **Do they report sex, gender or diversity based factors in findings? Did they provide any analysis of these sex, gender and diversity related factors?** No **Did this study examine or discuss links between DV and substance use or issues of trauma?** No **Target of intervention:** Programs and funding and policies relating to DV in Newfoundland	**Limitations identified by author:** Retrospective study as the workgroup had completed its mandate before the study was conducted. Recall bias. Some participants may have been inclined to only discuss particular aspects of the collaborative group given participant bias. **Limitations identified by review team:** Small number of perspectives examined **Evidence gaps and/or recommendations for future research:** It is beneficial to compare the outcomes of collaboration with those of other deliberation based models. **Source of funding:** Social Sciences Humanities Research Council of Canada

Appendix P. Glossary

Advocacy: A form of support that involves assistance with making connections to services, such as referral, care coordination.

Advocacy interventions: Inform, guide and help victims of domestic violence to access a range of services and supports, and ensure their rights and entitlements are achieved.

Batterers/ abusers/ perpetrators: Used interchangeably in this report to refer to those responsible for an act of violence/ abuse. Batterer is typically limited to acts of physical violence/ abuse. Note that in the elder literature, neglect is distinguished from abuse, and therefore the term ‘perpetrator’ may be more appropriate within this context. For simplicity, we have used the word abusers, although if authors use ‘batterer’ or ‘perpetrator’ we have maintained these terms.

Child maltreatment: Child abuse, neglect or violence is experienced directly by child, is not an observer only

Clinical/selective enquiry: Asking selected patients or clients about domestic violence dependent on presentation. Also referred to as “case finding.”

Cognitive behavioural approaches: Help individuals challenge their way of thinking and the way they react to certain situations, and replace maladaptive coping skills/thinking patterns/ feelings/ behaviours with more adaptive ones. A range of concrete techniques are used to support such cognitive and behavioural change.

Coordinated community responses: Integrate the work of batterer intervention programs, the criminal justice system, shelters for battered women, social service agencies, and health services into a community wide anti-violence network.

Counselling/brief interventions: Promote a range of outcomes, such as reducing depression and increasing empowerment among those who have experienced domestic violence, through interventions based on psycho-educational, cognitive-behavioural, and motivational interviewing approaches.

Domestic violence (DV): Violence between family members or between people who are (or who have been) intimate partners. With the scope of this review it also includes intimate relationships between teenagers and abuse of parents by children.

Duluth model: A model developed in the USA for responding in a comprehensive way to domestic violence. Violence is framed as gender based, connected to issues of power and control, and as it applies to perpetrators focuses on men’s accountability for violence/ abuse.

Duration: For the purposes of this review, we arbitrarily divided short term (16 weeks and less) and long term (over 16 weeks) interventions and approaches.

Elder abuse/ elder maltreatment: Elder abuse was defined by Action on Elder Abuse in 1995 as ”a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person.” It is understood to include various forms: physical, verbal, psychological, sexual and financial abuse, as well as neglect. The World Health organization uses the term elder maltreatment to refer to, and be intentionally inclusive of, these forms of abuse and neglect, of people over age 60.

Exposure to violence: Child may observe the violent incident, overhear the violence, witness or be aware of the outcome or effects of the violence, intervene during the incidence of abuse, or be used as “hostages” by the perpetrator of the violence

Independent Domestic Abuse Advisors (IDVAs): Specialist case-workers working primarily with high risk victims from the point of crisis who work independent of any one agency. They offer intensive short to medium term support and mobilize multiple resources for victims by coordinating the response of a wide range of statutory and voluntary agencies.

Indicated prevention intervention: Prevention interventions aimed at those demonstrating initial signs of at-risk behaviours.

Interpersonal violence (IPV): Violence done in the context of close relationships as opposed to by strangers, used interchangeably with domestic violence

Motivational interviewing: A person centred, collaborative approach to counselling (individual or group) that focuses on evoking and strengthening people’s values and ideas for movement towards behavioural change.

Multi component intervention: An intervention that has multiple components, for example a children’s group, and a mother’s group, or a children’s group, and care coordination and safety planning.

Multi-Agency Risk Assessment Conferences (MARAC): Meetings which provide a forum for sharing information and developing actions to reduce harm to high-risk victims of domestic violence and their children.

Older people or elders: Older people are generally defined as people who are over 65 years of age, but some studies used the term to refer to those over 60 years of age.

Parenting intervention: Interventions with the goal of improving parenting, with goals such as reducing parental stress, improving parent-child relationship, increasing parenting efficacy, enhancing parental self acceptance, decreasing child maladaptive behaviour

Primary prevention intervention: Intervening before intimate partner violence has occurred.

Psycho-educational intervention: An approach to service provision that is less intensive than therapeutic interventions, with goals

Refuge: Residential service provided for women and children leaving situations of domestic violence, also referred to as shelter

Routine enquiry: Similar to universal screening, but disclosure is not the only outcome; does not require use of standardized screening tool, flexibility in how the person is asked.

Safety planning: An intervention that supports analysis of one's risk for experiencing violence, identifying warning signs of violence, and developing concrete plans for finding safety for implementation when violence is imminent or is happening.

Secondary prevention intervention: Identifying and intervening with those who are at risk of intimate partner violence.

Selective/ targeted prevention intervention: Prevention interventions aimed at a subgroup of the population that is deemed at risk.

Shelter: Residential service provided for women and children leaving situations of domestic violence, also referred to as refuge.

Single component intervention: An intervention that has one component only, for example a children's group, or a parenting group, or individual counselling, or home visiting, or safety planning.

Skill-building interventions: Include training and educational interventions aimed at improving various skills among victims of abuse (including relaxation, decision making, and financial skills). tertiary prevention intervention- intervening after intimate partner violence is clearly identified and causing harm.

Therapeutic intervention: An approach to service provision that is structured, has a treatment focus, is delivered by professional clinicians, such as psychologists, and is based on a psychological or psychiatric model. Therapeutic interventions may be delivered in an individual or group format. Play therapy is specific form of therapeutic intervention used with young children.

Trauma informed intervention: A flexible, supportive and safety-oriented approach to service provision, whereby service providers work from awareness that it is likely their clients have histories of violence/trauma, yet disclosure is not prerequisite to service admission, and direct treatment of trauma is not the service focus.

Universal prevention intervention: Prevention interventions aimed at whole populations.

Universal screening/ screening: Asking all patients or clients about domestic violence, regardless of presentation. Use standardized tool(s) and disclosure is the outcome.

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