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Appendices

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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 Committee criteria

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Appendix 1

Previous systematic reviews of partner violence screening

Review authors and date	Number of databases searched (census date)	Types of studies reviewed	Number of papers	Findings
Waalen *et al.*, 2000[3]	3 (Jan 1999)	Studies reporting barriers to screening, and interventions to change provider behaviours related to screening	24	Barriers to screening are similar across health-care settings (e.g. lack of DV education/time/effective interventions, fear of offending patient). Studies evaluating interventions to increase screening found those limited to education had no significant effect on screening or identification rates. However, most interventions incorporating strategies in addition to education (e.g. providing specific screening questions) were associated with significant increases in identification
Ramsay *et al.*, 2002[1,2]	3 (Feb 2001)	Studies of interventions initiated in health-care settings, women's and health professionals' attitudes to screening	20	Screening increases the identification of abused women, and many women do not object to being asked. However, the majority of health professionals do not agree with screening women in health-care settings. Insufficient evidence to show if screening and subsequent interventions lead to improved outcomes for abused women, and no study investigated whether it may cause harm
Wathen and Macmillan, 2003[4] (Canadian Task Force)	5 (Dec 2002)	Studies of interventions initiated in primary care; had to be applicable to Canadian clinical practice	22 studies	Screening instruments exist to identify women experiencing partner violence. No comparative studies examining effectiveness of screening for improved women-outcomes (as opposed to abuse identification). No high-quality evidence evaluating effectiveness of shelters to reduce violence, but for women spending at least one night there is fair evidence that advocacy/counselling services decrease re-abuse and improve quality of life. Benefits of other interventions unclear, primarily because of a lack of suitably designed research measuring appropriate outcomes. In most cases, the potential harms of interventions are not assessed
Nelson *et al.*, 2004[5] (US Preventive Services Task Force)	6 (Dec 2002)	Studies of effectiveness of screening tools and interventions (for DV and elder abuse); had to be applicable to US clinical practice	18	No trials of effectiveness of screening in reducing harm have been published. Several screening instruments have been developed, some with fair to good reliability and validity, but none evaluated against measurable violence or health outcomes. Few intervention studies conducted; those existing focus on pregnant women; study limitations restrict their interpretation

Appendix 2

Mapping of selected NSC criteria onto analytic framework for research on partner violence screening

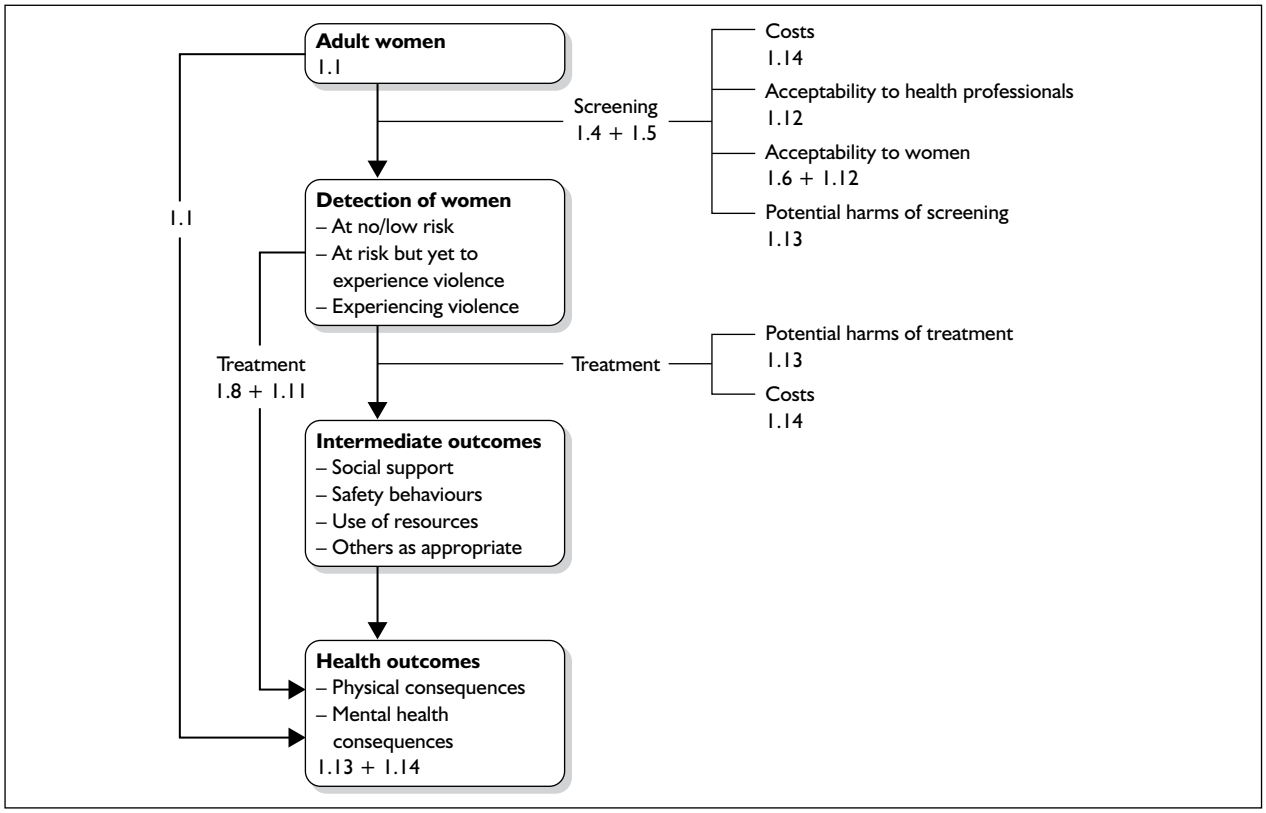

Figure 4 *Adapted from Macmillan et al., 2001.*[18]

Appendix 3

Quality appraisal

Appendix 3.1: Biases measured by quality assessment of diagnostic accuracy studies (QUADAS)

Bias	Explanation
Spectrum bias	Are the results from the sample generalisable to the population? If not, then we cannot generalise to other populations
Selection criteria	Clear inclusion/exclusion criteria
Reference standard	What is the strength of the gold standard? If it cannot effectively distinguish cases and non-cases, this will influence diagnostic accuracy data
Disease progress	Whether index and comparator were collected at the same point in time. If not, then disease status may change between administrations of tools
Partial verification	Have all of the participants received confirmation of disease status with the gold standard? If not, a biased estimate of diagnostic accuracy may occur
Differential verification	Were the index tool results compared to different comparators? If so, they may only be suitable in certain contexts, thus impacting on diagnostic accuracy
Incorporation	Was the index tool used to inform the final diagnosis? If so, this may increase agreement between the index and comparator. Furthermore, if the index and comparator are administered as one tool, this may increase multi-colinearity
Test execution	To ensure both tools were given under the same conditions and for ease of replication. Different administration procedures may affect diagnostic accuracy
Blind analysis	If tools are subjective, knowledge of one tool may influence and bias the outcome of the other tool
Interpretation	The availability of clinical data may influence the interpretation of test outcomes, particularly if the tool requires a degree of subjectivity
Indeterminate results	Were these reported? If not, they may be correlated to the disease and can influence interpretation of results
Study withdrawals	If a systematic dropout has occurred, test performance may be biased

Appendix 3.2: Quality appraisal of primary studies (US Preventative Task Force)

The United States Preventative Services Task Force (USPSTF) quality appraisal framework[34,216] was used to assess the primary studies in this review. The USPSTF tool rates both internal and external validity. Quality of execution of the study is rated on a three-point scale (good, fair or poor), based on the following design-specific criteria:

- for randomised controlled trials, there must be adequate randomisation and consideration of confounders
- for other study designs, consideration of other potential confounders must be reported
- all studies need to maintain comparable groups and no greater loss to follow-up than 20%
- all measurements must be equal, reliable and valid
- definition of interventions must be clear
- all important outcomes should be considered or a good match of outcomes to goals
- analysis is either intention to treat for RCTs, or statistical adjustments are made for confounders if other study designs are used.

Study design is also rated on a three-point scale (greatest, moderate and least). Prospective studies with parallel controls are rated greatest suitability; all retrospective studies or multiple assessment before-and-after studies without parallel controls are given a moderate rating; and single before-and-after measurements and no parallel control, or case studies and series designs are rated as least suitability.

The strength of evidence of each study is then considered with the following criteria:

- quality of execution of the study

Table 9 *Quality of execution and study design (adapted from Harris* et al.*, 2001[34] and Briss* et al.*, 2004[216])*

Definition	Grade
Quality of execution	
A study (including meta-analyses or systematic reviews) that meets all design-specific criteria[a] well	Good
A study (including meta-analyses or systematic reviews) that does not meet (or it is not clear that it meets) at least one design-specific criterion[a] but has no known 'fatal flaw', i.e. any or all of the following problems may occur, without the limitations noted in the 'poor' category below: generally comparable groups are assembled initially, but some question remains about whether some (although not major) differences occurred in follow-up; measurement instruments are acceptable (although not the best) and generally applied equally; some but not all important outcomes are considered; and researchers account for some but not all potential confounders	Fair
A study (including meta-analyses or systematic reviews) that has at least one design-specific[a] 'fatal flaw', or four lesser flaws. Fatal flaws are: groups assembled initially are not close to being comparable or are not maintained throughout the study; unreliable or invalid measurement instruments are used or are not applied at all equally among groups; and key confounders are given little or no attention or a number, i.e. criteria 2, 4 or 7.[34]	Poor
Study design	
Prospective study with parallel controls	Greatest
All retrospective studies (e.g. historical controls), or multiple assessment before-and-after studies without parallel controls	Moderate
Single before-and-after measurements and no parallel control, or case studies and series	Least

a The design-specific criteria are:
For randomised controlled trials (RCTs): adequate randomisation, including concealment and whether potential confounders were distributed equally among groups.
For other studies: consideration of potential confounders.
Maintenance of comparable groups (includes crossovers, adherence, contamination).
No important differential loss to follow-up or overall high loss to follow-up (> 20%).
Measurements: equal, reliable, and valid.
Clear definition of interventions.
All important outcomes considered or good match of outcomes to goals.
In analysis, intention-to-treat analysis for RCTs, or adjustment for potential confounders for other studies.

- suitability of study design
- number of studies that fulfilled minimum suitability and quality criteria
- size and consistency of reported effects.

The combination of these factors determined the final score for evidence of effectiveness for each category of interventions: strong, sufficient or insufficient, in accordance with *Table 10*, adapted from the US Task Force on Community Preventive Services.[216]

Table 10 *Strength of the evidence*

Design suitability (D) (greatest, moderate, least)	Execution (E) (good, fair, poor)	Number of studies satisfying both D and E	Consistent direction of effect of these studies?	Effect size[a]	Evidence of effectiveness
Greatest	Good	At least 2	Yes	Sufficient	Strong
Greatest/moderate	Good	At least 5	Yes	Sufficient	
Greatest	Good/fair	At least 5	Yes	Sufficient	
Greatest	Good	1	Not applicable	Sufficient	Sufficient
Greatest	Good/fair	At least 3	Yes	Sufficient	
Greatest/moderate	Good/fair	At least 5	Yes	Sufficient	
Poor execution or least quality design		Too few studies	Inconsistent	Small	Insufficient

a < 0.2 = small, < 0.5 = sufficient, > 0.5 = large.

Appendix 3.3: Quality appraisal (Jadad score)

Randomised controlled trials were also given a Jadad score using a modified version of the Jadad criteria.[35] The Jadad score was calculated using the five items in *Table 11*. Four of the items are indications of good quality, and each counts as one point towards an overall quality score. The other item indicates poor quality, and a point is subtracted if its criteria are met. The range of possible scores is 0–4.

TABLE 11 *Jadad score calculation*

Item	Score
Was the study described as randomised (this includes words such as randomly, random and randomisation)?	0/1
Was the method used to generate the sequence of randomisation described and appropriate (table of random numbers, computer-generated, etc.)?	0/1
Was there a description of withdrawals and dropouts?	0/1
Deduct one point if the method used to generate the sequence of randomisation was described and it was inappropriate (patients were allocated alternately, or according to date of birth, hospital number, etc.).	0/–1
Blinded assessment of outcomes	0/1
Total (out of 4)	4

Appendix 4

Prevalence and health impact studies

Appendix 4.1: Characteristics, results and quality scores of studies of prevalence

Study	Population	Geographical location	Sample size (women)	Type of sampling
Carrado, 1996[39]	General population	Great Britain	971	Community
Dominy and Radford, 1996[37]	Women in Surrey	Southeast England	484	Community
Finney, 2006[38]	General population	England and Wales	24,498 men and women	Community
Mirrlees-Black and Byron, 1999[40]	General population	England and Wales	6098	Community
Walby and Allen, 2004[36]	General population	England and Wales	12,226	Community
Coid *et al.,* 2003[54]	Women attending GP	London, urban, England	1207	Clinical
Richardson *et al.,* 2002[41]	As above	As above	As above	As above
Bacchus et al., 2004[42]	Pregnant women	South London, England	892	Clinical
Bacchus *et al.*, 2004[44]	Pregnant women	London, urban, England	200	Clinical
Mezey *et al.,* 2005[43]	As above	As above	As above	As above
Bowen *et al.*, 2005[45]	Pregnant women and postpartum	Southwest England	Start: 14,541 End: 7591	Clinical
Johnson *et al.,* 2003[46]	Pregnant women	North England	475	Clinical
Boyle and Todd, 2003[47]	Women in emergency departments	Cambridge, England	Not reported Men and women = 256	Clinical
Sethi *et al.,* 2004[48]	Women in emergency departments	Inner city, urban, England	198	Clinical

Definition of IPV	Lifetime prevalence (%)	One-year prevalence (%)	Age group(s) (%)	Marital status (%)	Quality score (STROBE) total 22
Physical	13	5	Not reported	Not reported	19
Physical, emotional, sexual, psychological	31	Not reported	Not reported	Not reported	12
Physical, emotional, financial, threats	25.4[a]	4.7	Not reported	Not reported	11
Sexual assault	22.7	2.7			
Physical	22.7	4.2	Not reported	Not reported	17
Physical, emotional, financial, threats	25.9[b]	6.0	Not reported	Married: 2	19
				Single: 6.9	
Sexual assault	16.6	2.1		Divorced/separated: 14.5	
				Stable relationship: 6.2	
Sexual	24	Not reported	Not reported	Not reported	17
Physical, sexual	41	17	Not reported	Married: 14	21
				Single: 17	
				Divorced/separated: 28	
				Stable relationship: 16	
Physical, sexual, emotional	13	6.4	Not reported	Not reported	19
Physical, sexual, psychological	23.5	Not reported	Not reported	Not reported	20
As above	As above	As above	As above	Married: 38.3	20
				Single: 61.7	
Physical, sexual, emotional	Not reported	11	Not reported	Not reported	20
Physical, sexual, emotional	17	Not reported	< 16: 1	Married: 30	15
			16–20: 11	Single: 31	
			21–25: 25	Divorced/separated: 11	
			26–30: 40	Stable relationship: 28	
			> 30: 29		
Physical, sexual, emotional	22.1	Not reported	Not reported	Not reported	20
Physical	34.8	6.1	18–29: 30.0	Not reported	20
			30–39: 44.7		
			40–49: 35.7		
			> 49: 35.1		

continued

Study	Population	Geographical location	Sample size (women)	Type of sampling
Wright and Kariya, 1997[50]	Women attending a Scottish A&E department	Scotland	46	Clinical
John *et al.*, 2004[51]	Gynaecology patients	North England	825	Clinical
Keeling, 2004[52]	Women attending pregnancy counselling	Northwest England	312	Clinical
Keeling and Birch, 2004[53]	Women attending family planning clinics	Not reported	292	Clinical

a The figures reported here are those recalculated by Finney (and presented in Table A.5 of that report)[38] so as to enable comparisons with the 2001 findings.[36]
b The figures reported here are those presented by Finney (and presented in Table A.5 of that report).[38]

Definition of IPV	Lifetime prevalence (%)	One-year prevalence (%)	Age group(s) (%)	Marital status (%)	Quality score (STROBE) total 22
Physical	Not reported	41 in 2 months	Not reported	Not reported	16
Physical	21	4	< 20: 4 21–30: 26 31–40: 39 41–50: 23 51–60: 5 > 60: 3	Married: 37 Single: 16 Divorced/separated: 13 Stable relationship: 31	17
Physical, emotional	35.1	19.5	Not reported	Not reported	18
Physical, sexual, emotional, financial	34.9	14	16–24: 32.4 25–29: 30.4 30–34: 38.3 35–39: 45.2 40–44: 24.0 45–49: 55.6 > 50: 18.2	Not reported	19

Appendix 4.2: Sensitivity analysis of prevalence studies

Setting	Studies ordered by quality score (figures in bold) and grouped by setting	Frequency of partner violence (%)	Definition
General population	Carrado, 1996[39] **19**	Prevalence: 13 One-year prevalence: 5	Physical
	Walby and Allen, 2004[36] **19**	Prevalence: 25.9 One-year prevalence: 6	Physical, emotional, financial, threats
	Mirrlees-Black and Byron, 1999[40] **17**	Prevalence: 22.7 One-year prevalence: 4.2	Physical
	Dominy and Radford, 1996[37] **12**	Prevalence: 31	Physical, emotional, sexual, psychological
	Finney, 2006 [38] **11**	Prevalence: 25.4 One-year prevalence: 4.7	Physical, emotional, financial, threats
Clinical population	Richardson *et al*., 2002[41] **21**	Prevalence: 41 One-year prevalence: 17	Physical, sexual
	Mezey *et al*., 2005[43] **20**	Prevalence: 23.5	Physical, sexual, psychological
	Bowen *et al*., 2005[45] **20**	18 weeks' gestation to 33 months' postnatal prevalence: 11	Physical, emotional, sexual
	Boyle and Todd, 2003[47] **20**	Prevalence: 22.1	Physical, emotional, sexual
	Sethi *et al*., 2004[48] **20**	Prevalence: 34.8 One-year prevalence: 6.1	Physical
	Bacchus *et al*., 2004[42] **19**	Prevalence: 13 One-year prevalence: 6.4	Physical, emotional, sexual
	Keeling and Birch, 2004[53] **19**	Prevalence: 34.9 One-year prevalence: 14	Physical, emotional, sexual, financial
	Keeling, 2004[52] **18**	Prevalence: 35.1 One-year prevalence: 19.5	Physical, emotional
	Coid *et al*., 2003[54] **17**	Prevalence: 24	Sexual
	John *et al*., 2004[51] **17**	Prevalence: 21 One-year prevalence: 4	Physical
	Wright and Kariya, 1997[50] **16**	Two-month prevalence: 41	Physical
	Johnson *et al*., 2003[46] **15**	Prevalence: 17	Physical, emotional, sexual

Definition	Studies ordered by quality score (figures in bold) and grouped by definition	Frequency of partner violence (%)	Setting
Physical	Sethi *et al*., 2004[48] **20**	Prevalence: 34.8 One-year prevalence: 6.1	A&E
	Carrado, 1996[39] **19**	Prevalence: 13	General population
	Mirrlees-Black and Byron, 1999[40] **17**	Prevalence: 22.7 One-year prevalence: 4.2	General population
	John *et al*., 2004[51] **17**	Prevalence: 21 One-year prevalence: 4	Gynaecology patients
	Wright and Kariya, 1997[50] **16**	Prevalence: 41	Assault victims in a Scottish A&E department
Physical, sexual	Richardson *et al*., 2002[41] **21**	Prevalence: 41 One-year prevalence: 17	Women attending GPs
	Walby and Allen, 2004[36] **19**	Prevalence: 45 One-year prevalence: 13	General population
Physical, sexual, emotional	Boyle and Todd, 2003[47] **20**	Prevalence: 22.1	A&E department
	Bowen *et al*., 2005[45] **20**	18 weeks' gestation to 33 months' postnatal prevalence: 11	Pregnant women
	Mezey *et al*., 2005[43] **20**	Prevalence: 23.5	Pregnant women
	Bacchus *et al*., 2004[44] **19**	Prevalence: 13 One-year prevalence: 6.4	Pregnant women
	Johnson *et al*., 2003[46] **15**	Prevalence: 17	Pregnant women
Sexual	Coid *et al*., 2003[54] **17**	Prevalence: 24	Women attending GPs
Physical, emotional	Keeling and Birch, 2004[53] **18**	Prevalence: 35.1 One-year prevalence: 19.5	Women attending pregnancy counselling
Physical, sexual, emotional, financial	Keeling, 2004[52] **19**	Prevalence: 34.9 One-year prevalence: 14	Women attending family planning clinics

Appendix 4.3: Characteristics and quality scores of systematic reviews of health impact

Review author(s)/ date	Review question	Dates of search	Inclusion criteria
Boy and Salihu, 2004[62]	To examine the evidence on the association between physical and emotional abuse and pregnancy outcomes	Not reported	Peer-reviewed, research-based studies Population at least five women Pertained to IPV Included pregnant participants Included outcomes data on at least one of the following: birthweight, preterm birth, perinatal mortality, maternal mortality, stillbirth and adverse pregnancy outcomes Studies must be available to the reviewers
Campbell *et al*., 2000[61]	To examine nursing research related to IPV and women's reproductive health	Focused on research published since 1995	Published, nursing research Focused on reproductive health
Golding, 1999[57]	To review literature on battering as a risk factor for mental health problems	Not reported	Studies that inferred mental health problems using clinical interviews, chart reviews, standardised survey interviews, and symptom checklists
Jasinski, 2004[60]	To synthesize the interdisciplinary empirical research on pregnancy-related violence	1996–2004	Focus of the review was primarily on research conducted with samples from the USA
Jones *et al*., 2001[58]	To analyse data from literature based on studies of battered women to determine (1) the correlation of domestic violence and PTSD; (2) the best treatment strategies for PTSD; and (3) the evidence of PTSD treatment effectiveness with battered women	1991–2000	Research-based articles published in the past 10 years Reports on domestic violence, PTSD, domestic violence/treatment/intervention, domestic violence and mental health, cultural differences and domestic violence, domestic violence and welfare reform, and domestic violence and undocumented women
Murphy *et al*., 2001[64]	To determine the strength of association between low birthweight (LBW) and physical, sexual or emotional abuse during pregnancy	MEDLINE (1966–1999), CINAHL (1982–1997)	Published studies measuring pregnancy outcomes Case–control or cohort studies English abstract Focused on women abused during pregnancy or pregnant women living in a relationship that was abusive in the past, or both. Studies were chosen regardless of the relationship of the perpetrator to the victim, if they included clear definitions of physical, sexual or emotional abuse, or some combination of these, and examined the outcome of mean or low birthweight
Nasir and Hyder, 2003[63]	To estimate the magnitude and prevalence of domestic violence during pregnancy in the developing world, to explore the risk factors associated with such behaviour, and to examine the impact on adverse pregnancy outcomes	Not reported	Not reported

Exclusion criteria	No. of primary studies	Total number of participants	Meta-analysis conducted?	Quality score
	30	Not reported	No	Poor
	17 (2 qualitative, 2 quantitative with qualitative element)	8311	No	Poor
Non-English language papers	18 – Depression	1420 – Depression	Yes	Good
Studies exclusively of abuse during pregnancy	13 – Suicidality 11 – PTSD 10 – Alcohol abuse 4 – Drug abuse	2492 – Suicidality 817 – PTSD 1195 – Alcohol abuse 2057 – Drug abuse		
Studies included in the review by Gazmararian *et al.*, 1996[847]	17 on prevalence of pregnancy-related violence and 16 on consequences of pregnancy-related violence	Not reported	No	Poor
Studies that are 'empirically weak'	43	17,243	No	Poor
	8 in the meta-analysis	16,519	Yes	Good
	9 in total 3 describing adverse pregnancy outcomes	Not reported	No	Poor

continued

Review author(s)/ date	Review question	Dates of search	Inclusion criteria
Stith *et al*., 2004[70]	To identify risk factors most strongly related to intimate partner physical abuse perpetration and victimisation	1980–2000	Study must examine the relationship between the identified risk factor and intimate partner violence Must include distinct data on physical violence Must include the quantitative data necessary for the calculation of at least one effect size Sample size must be greater than 20 Sample must include heterosexual married and/or cohabiting couples Each study must use an original sample
Impact on children's health			
Attala *et al*., 1995[68]	To examine the effects on children of witnessing domestic violence	1974–1995	Primary research published in refereed journals in the last two decades Focused on children (0–18 years) who had witnessed domestic violence
Bair-Merritt *et al*., 2006[66]	To examine the association between childhood IPV exposure and physical health	1966–2003	No language restriction Trials investigating postneonatal physical health outcomes related to exposure to IPV
Buehler *et al*., 1997[65]	To examine whether interparental conflict is associated with internalising and externalising problems in children aged 5–18 years	Not reported Manual search of 10 relevant journals was conducted for the last 15 years	Published and non-published studies Sample needed to include married or divorced families who had children somewhere between the ages of 5 and18 years Target child must be a product of the marriage of focus Published in English Study must have statistical data available to calculate an effect size. Reports of non-significant findings were included
Kitzmann *et al*., 2003[67]	To examine the psychosocial outcomes of children exposed to interparental violence	Not reported	Dissertations were included Studies reported empirical data Studies examined the effects of witnessing interadult physical aggression in the home Study reported on psychosocial outcomes, including psychological, emotional and behavioural, social and academic Study examined the association between interadult physical aggression and child psychosocial outcomes either in (1) correlational or multiple regression analyses or (2) group comparisons, in which a group of child witnesses was compared with one or more control groups Study sample restricted to children. Adolescent samples that included 19-year-olds were included if most of the sample was 18 or younger, but college samples of 19-year-olds were excluded Published in 2000 or earlier Reported in English
Kolbo *et al*., 1996[69]	To examine the initial effect of witnessing domestic violence on children's functioning	Not reported	Not reported

Exclusion criteria	No. of primary studies	Total number of participants	Meta-analysis conducted?	Quality score
Unpublished master's theses and dissertations Studies on dating violence	94 in total 6 for depression 11 for alcohol use	899 for depression 7084 for alcohol use	Yes	Medium
	14 3 of these were qualitative, and one had qualitative components	912 children and their parents	No	Poor
Studies without a contemporaneous control Studies including direct trauma from a parent to the child Studies that included sibling violence, and did not have a strict definition of IPV	22	Not reported	No	Medium
Data on stepfamilies	68	Not reported	Yes	Medium
Case studies, qualitative studies Studies examining the effects of witnessing verbal aggression, parent–sibling violence or community violence Studies with outcomes relating to physical health, intelligence, parenting competence and general family functioning Studies with group formation based on a dimension other than exposure to domestic violence	118	Not reported	Yes	Medium
	29	2626	No	Poor

Appendix 5

Screening tool studies

Appendix 5.1: Summary of partner violence screening tools included in the review

The tools are divided into three sections: the first describes all the instruments used as comparators; the second section describes all the index tools; and the third section describes those tools used as both index tools and comparators.

Tools used as comparators

Abuse Risk Inventory (ARI)

This is a 25-item self-report measure using a four-point Likert scale ranging from 'rarely or never' to 'always'. A score of 50 or higher suggests the respondent may be in an abusive situation or at risk for abuse. The ARI has demonstrated a reliability of 0.91.[217]

Composite Abuse Scale (CAS)

The CAS consists of 30 items taken from the Conflict Tactics Scale (CTS), Measures of Wife Abuse, Inventory of Spouse Abuse and the Psychological Maltreatment of Women Inventory, and is designed to assess physical, emotional and sexual abuse. The tool has four dimensions: severe combined abuse, emotional abuse, physical abuse and harassment. Hegarty *et al.*[218] report an internal reliability (Cronbach's alpha) of 0.90 or more for each subscale, and all item–total score correlations of 0.6 or above. When compared with the CTS, concurrent validity between the subscales of each tool ranged from $r = 0.46$ to 0.91. The psychometric validation is further supported by Hegarty *et al.*[219]

Conflict Tactics Scale (CTS)

This 19-item scale assesses abuse within the past year. Answered on a seven-point frequency scale (never, once, twice, 3–5 times, 6–10 times, 11–20 times, > 20 times), the items range in severity from 'low in coerciveness' to 'physical violence', total scores ranging from 15 to 105. Three subscales measure verbal reasoning (three items, alpha = 0.69), verbal aggression (seven items, alpha = 0.84), and violence (nine items, alpha = 0.93).[220]

Conflict Tactics Scale – Revised (CTS2)

Based on the CTS, the CTS2 includes more items for the three subscales and has two extra subscales (sexual coercion and physical injury from assault), totalling 78 items encompassing five subscales (each question is asked twice, one for the respondent and the other for the respondent's partner). Other alterations include improving certain items, such as changing 'his/her' or 'him/her' to 'my partner', utilising an improved distinction between minor and severe acts, simplifying the answering format, and interspersing the order of items to reduce answering in response sets. Good internal consistency was found across all five subscales (alphas for negotiation = 0.86; psychological aggression = 0.79; physical assault = 0.86; sexual coercion = 0.87 and injury = 0.95).[221]

Danger Assessment Scale (DAS)

Used to assess an abused women's potential for homicide, this tool consists of 14 dichotomous items. No time reference is given in the instructions, although some items do specifically refer to the past year. Campbell[222] demonstrated a good reliability of 0.71 and moderate to strong construct validity when DAS was compared with the CTS ($r = 0.43$, $p < 0.000$) and the severity of injury scale adapted from Berk *et al.*[223] ($r = 0.50$, $p < 0.000$).

Index of Spousal Abuse (ISA)

The ISA has 30 questions, which can be administered in written or oral formats. It assesses for physical (ISA-P, 11 items, alpha = 0.91) and non-physical (ISA-NP, 19 items, alpha = 0.93) abuse, using a Likert scale of 1 (never) to 5 (very frequently). Items are weighted, summed and standardised for each scale, then a complex weighted calculation is required to tally a score. Scores range from 0 to 100, the higher scores representing more severe abuse. Cut-scores are 25 for non-physical abuse and 10 for physical abuse.[224] Hudson[225] developed a modified version of the ISA-P, which consisted of 15 items, demonstrating a Cronbach's alpha of 0.93.

Index tools

Abuse Assessment Screen (AAS)

This five-item tool assesses sexual coercion and emotional and physical abuse. Questions refer to time periods (lifetime, preceding 12 months and pregnancy period), severity, perpetrator and body sites. The majority of questions are asked in a yes/no format; positive answers are explored further with multiple-choice options and frequency. The AAS was developed by Parker and McFarlane.[226] Two validation papers currently exist for the AAS, by McFarlane *et al.*[89] (included in this review) and Soeken *et al*.[227]

Behavioural Risk Factor Surveillance Survey (BRFSS)

This is a five-item tool using a yes/no response scale. The questions focus on women's exposure to physical violence, forced intercourse, sexual contact without intercourse, fear because of a partner's anger or threats and put-downs, name-calling or controlling behaviour. Typically, the respondent is asked if they have ever experienced any of the IPV types listed, although the questions can be modified to ask about their most recent partner. A single affirmative answer is indicative of 'any abuse'; affirmative answers for the other questions are indicative of physical, sexual or psychological abuse. These questions are included in a larger questionnaire used in a population survey in the USA.[228]

Hurt, Insulted, Threatened with harm and Screamed at (HITS)

Originally developed from a family physician focus group study,[229] HITS contains four questions: (1) 'How often does your partner physically hurt you?' (2) 'How often does your partner insult you or talk down to you?' (3) 'How often does your partner threaten you with harm?' and (4) 'How often does your partner scream or curse at you?' Women answer each of these questions using a five-point scale from 1 (never) to 5 (frequently). Answers were summed to form an interval scale of the total HITS score, ranging from 4 to 20; a cut-score of 10 suggests abuse.

Ongoing Violence Assessment Tool (OVAT)

Developed by Weiss *et al.*,[230,231] the OVAT consists of four questions measuring both physical and non-physical violence. Based on the ISA, three questions are answered using true/false responses, the other uses a five-point Likert response from 1 (never) to 5 (very frequently). The OVAT takes 1 minute or less to administer and can be scored immediately.

Partner Violence Screen (PVS)

Using a yes/no response, three brief questions ask about two dimensions, one item on physical violence within the past year, and two items on safety. Measuring safety is believed to be a short-term measure of risk for further violence and need for counselling.[232,233]

Perinatal Self-Administered Inventory (PSAI)

Developed as an intake measure to be used on the first obstetric appointment, this tool consists of several components including substance use, pregnancy complaints, pregnancy history, personal medical and family histories, genetic history and psychosocial history. It is under the latter section that questions of current mental or physical abuse and mental and physical abuse as a child are asked. If a yes is given to any question, the nurse probes further for more detailed information which is recorded on the form.[90]

Slapped, Threatened or Thrown (STaT)

This is a brief three-question tool using a yes/no response.[234] The questions are 'Have you ever been in a relationship where a) your partner has pushed or slapped you; b) your partner threatened you with violence; c) your partner has thrown, broken or punched things?' The total of affirmative responses is summed; respondents scoring 1 or above are considered positive for domestic abuse.

Tools used as both a comparator and index

Woman Abuse Screening Tool (WAST)

The WAST is an eight-item questionnaire that was originally developed for use in a general practice setting. Women respond on a three-point response set, then the answers are summed to form an interval scale. Brown *et al.*[235] report a coefficient alpha estimated at 0.95 revealing good reliability. Regarding construct validity, the evidence is again supportive. Corrected item–total correlations ranged from $r = 0.81$ to 0.89 ($p < 0.001$), individual WAST items were highly correlated with the ARI ($r = 0.80$ to 0.85, $p < 0.001$), and overall ARI and WAST scores were also highly correlated, at $r = 0.96$, $p < 0.00$.

Women's Experience with Battering Scale (WEB)

The WEB is a 10-item tool that measures battering by characterising women's perceptions of their vulnerability to physical and psychological danger or loss of control in relationships. A six-point Likert

scale of 1 (strongly agree) to 6 (strongly disagree) is used for this tool. Smith *et al.*[236] reported that the WEB has moderate to good construct validity when compared with the physical violence subscale of the CTS ($r = 0.71$, $p < 0.0001$) and psychological abuse (ISA-NP) ($r = 0.88$, $p < 0.0001$), as well as other measures such as belief in a just world, self-esteem, marital satisfaction, locus of control, depression, anxiety, perceived health status, injury, chronic pain and number of visits to a physician or hospital. Good reliability has been shown for the WEB, with a Cronbach's alpha of 0.93.

Appendix 5.2: Summary of partner violence screening tools not included in the review

Below are lists of various tools used to identify domestic abuse. The studies that utilised these tools were excluded from the review as they did not fulfil the validation study criteria, that is: either the tool comprised 13 items or more; an inappropriate comparator was used, such as a clinical interview; or a comparator was absent. This is not an exhaustive list of *all* the tools used from *all* of the excluded studies, because many studies were excluded for other reasons such as including males in the sample or using a non-health-care sample.

Stand-alone tools

Abuse Assessment Questionnaire (AAQ)

Consisting of six items, this tools screens for physical and sexual abuse during the past year. Comparison of this tool with a clinical interview showed this tool to have good diagnostic accuracy. The overall sensitivity and specificity varied from 85.7% to 95.8% and from 89.7% to 99.6% respectively. The overall positive and negative predictive value varied from 91.9% to 97.7% and 97.05 to 99.3% respectively.[237]

Abuse Assessment Screen-Disability (AAS-D)

This four-item tool is designed to detect abuse towards women with physical disabilities. The first two questions of the AAS-D are taken directly from the Abuse Assessment Scale (AAS).[226] The other two questions are: 'Within the last year, has anyone prevented you from using a wheelchair, cane, respirator, or other assistive devices?' and 'Within the last year, has anyone you depend on refused to help you with an important personal need, such as taking your medicine, getting to the bathroom, getting out of bed, bathing, getting dressed, or getting food or drink?' The items are answered using yes or no.[238]

Dartmouth COOP Charts – the Relationship Chart

The charts consist of picture and word questions developed for general health screening. The Relationship Chart evaluates intimate partner violence with the following question: 'During the past four weeks, how often have problems in your household led to: insulting or swearing? yelling? threatening? hitting and pushing?' The chart is scored on a Likert scale of 1 – 'none of the time' – to 5 – 'all of the time'.[239]

Intimate Partner Violence (IPV) Assessment Icon Form

Based on the five-item Abuse Assessment Scale (AAS),[226] each of the questions is present in both written and pictorial format, thus an individual can complete the tool regardless of their literacy level. Inter-rater reliability and criterion-related validity of the tool have been found to be adequate for literate and semiliterate participants.[240]

Life History Calendar of Domestic Violence (LHC-DV)

Based on the assumption that personally experienced events that are thematically similar and/or sequentially proximal are stored together, the recall of easily accessible information helps the recall of more detailed, associated events. This tool involves a semistructured interview format to elicit memorable and/or easily recalled information of a personal nature, such as places of residence, family members and occupational history. The information elicited is laid out in a calendar format. This information is then used as a memory aid to elicit information about domestic violence victimisation. The interview obtains information on the occurrence and timing of not only domestic violence but also events that affect the relationship between domestic violence and women's well-being. The interview takes approximately 40–60 minutes to administer, with an additional 20–30 minutes if the interviewer asks about health and sociodemographic characteristics.[241]

Partner Abuse Scale: Physical (PASPH) and Partner Abuse Scale: Non-Physical (PASNP)

These instruments were designed to measure self-reports of physical and non-physical partner abuse.[225] Each questionnaire consists of 25 questions, which are scored on a seven-point Likert scale ranging from 'never' to 'all the

time'. The raw scores for each questionnaire are rescaled into scaled scores, which range from 0 (never abused) to a maximum score of 100. Attala *et al.*[242] report good reliability for both of these questionnaires (Cronbach's alpha: PASPH = 0.97 and PASNP = 0.98).

Partner Violence Interview (PVI)

This instrument is a 26-item structured assessment, adapted from the CTS,[243] which asks subjects to report on the various levels of violence that they have experienced or perpetrated in their lifetime. The measure asks about physical and sexual abuse and takes approximately 25 minutes to complete. The tool focuses on three separate areas – violence inflicted by current partners (current partner scale); violence inflicted by previous partners (ex-partner scale); and violence inflicted by a subject towards a partner (towards partner scale). Re-test reliability ranged from 0.70 to 0.85 for ex-partner and current partner scales respectively. Internal consistency was assessed using Kuder–Richardson formula 20 (KR-20) and ranged from 0.78 to 0.93 across the three scales.[244]

Psychological Maltreatment of Women Inventory (PMWI)

This is a 58-item instrument designed to measure the level of psychological maltreatment of women by their male partners in intimate relationships. Two subscales are used in this tool, Dominance-Isolation and Emotional-Verbal. Questions are answered on a five-point Likert scale ranging from never (1) to very frequently (5). Good construct validity has been shown between this tool and the ISA (non-physical subscale $r = 0.89–0.94$; physical subscale $r = 0.78–0.85$) and CTS ($r = 0.64–0.68$).[245]

Psychological Maltreatment of Women Inventory – Short Version (PMWI-Short)

This is a 14-item version of the above tool. The subscales and items are scored in the same way. Good construct validity has been shown between the short version and the ISA (non-physical subscale $r = 0.88–0.90$; physical subscale $r = 0.80–0.86$) and CTS ($r = 0.65–0.68$) although the correlations tend to be slightly lower.[246]

Severity of Violence Against Women Scales (SVAW)

This is a 46-item tool designed to measure threats of violence, acts of violence and sexual aggression. Respondents answer on a four-point Likert scale to indicate how often the specified behaviour has occurred. Threats of violence are scored as symbolic, mild, moderate or serious, whereas acts of violence are scored as mild, minor, moderate or serious. This tool also detects sexual aggression. Good reliability has been shown for this tool, with values ranging from 0.89 to 0.96.[247]

Trauma Questionnaire (TQ)

This is a 10-item self-report questionnaire that assesses a women's history of childhood and adult sexual trauma, sexual harassment and domestic violence, and measures her desire for mental health help. Comparison of this tool with a clinical interview revealed good to excellent k values (0.41–0.88) with no systematic bias.[248]

Victimisation Assessment Tool (VAT)

The purpose of this tool is to ascertain the level of trauma a subject has experienced due to domestic violence. The interviewer asks various screening questions about any abuse that may have occurred, then the interviewer scores the reported abuse on a five-point Likert scale, ranging from 1 – 'no experience of physical violence or abuse', to 5 – 'life-threatening or prolonged violence/abuse with very severe physical and or emotional trauma'. This tool has shown average to good internal consistency (kappa), ranging from 94.7 for experiences of child physical abuse to 57.5 for being mugged.[249]

Wife Abuse Inventory (WAI)

This is a three-page questionnaire, page one consisting of 17 items that ask about biographical data on the respondent and their partner.[250] Pages two and three contain the 34 scale items, which ask about family management and abuse. This tool has been shown to have high internal consistency: for coefficient alpha, 0.90 and for split halves, 0.90.[251]

Hospital screening tools/screening protocols/flowcharts/intake questionnaires

Department of Emergency Medicine, West Virginia University Domestic Violence Screening Questionnaire

This questionnaire was developed as an extremely brief screening tool for domestic violence in a university-affiliated emergency department. There are nine questions answered in a yes/no fashion. The questionnaire focuses on physical and emotional abuse and safety.[252]

Domestic Violence Screen used in four Los Angeles hospitals

A screening tool consisting of five questions that ask about physical and emotional abuse was developed in order to identify victims of domestic abuse. This tool also asks questions about the

nature of the injury, if advice/referral was given and if mandatory reports were completed.[253]

Flowchart Domestic Violence Questioning
This study used a flowchart to screen women for domestic violence. The first step requires obtaining consent to ask some questions about domestic violence. If consent is given, a short paragraph is then read to the women describing physical, emotional and sexual abuse, and asking if the individual has ever experienced any of these. If a positive response is given, the woman is then asked if she would like to talk about it. The flowchart details various organisations and leaflets to give to anyone who discloses abuse.[254]

IPV Questionnaire, Karachi
This questionnaire was designed to screen for physical, verbal and sexual abuse during pregnancy or marital life. The screen consisted of 14 questions and took approximately 40 minutes to administer in an interview format.[255]

Kentucky Paediatric Practice Screen
Two screens were used in this study. The first was a six-item screen that included the following questions: 'Are you in a relationship now or have you ever been in a relationship in which you have been harmed or felt afraid of your partner?' and 'Are you afraid of your current partner?'. The second screen consisted of a 72-item general intake questionnaire that included one DV-related question: 'Are you or your child being hurt, hit, or frightened by anyone in your house?'. No psychometric or diagnostic accuracy data were presented for this screen.[256]

Magee-Women's Hospital Outpatients Obstetrics and Gynaecology Clinic Screening Form
Used as a screen during prenatal visits. The domestic violence-related questions were: 'Have you had any partner(s) or family members who have been abusive to you throughout your lifetime?'. 'Are you currently in a relationship in which you are physically hurt, threatened, or made to feel afraid?' and 'Are you safe?'. No psychometric or diagnostic accuracy data were presented for this screen.[257]

Maternity Social Support Scale – The Royal Brisbane and Women's Hospital
Used as part of the registration process, all new obstetric patients were asked to complete the six-item self-report questionnaire. Two of the questions relate to domestic violence: 'I feel controlled by my husband/partner' and 'There is conflict with my husband/partner'. Respondents answer on a five-point Likert scale ranging from never (1) to always (5). A score of 3 or more on either of these questions indicates a case of abuse.[258]

Paediatric Safety Questionnaire
This questionnaire consists of ten questions, four of which relate to domestic violence. These questions are: 'Do you feel safe in your current relationship with your partner?', 'Have you been hit, kicked, punched, or otherwise hurt by a partner within the last year?', 'Is there a partner from a previous relationship who is making you feel unsafe now?' and 'Within the past year, has a partner repeatedly used words, yelled, or screamed at you in a way that frightened you, threatened you, put you down, or made you feel rejected?'. Responses to these questions were rated on a five-point Likert scale ranging from 'strongly agree' to 'strongly disagree'.[259]

Queensland Health's Domestic Violence Initiative Form
This questionnaire consists of six questions, which ask about threats of abuse, physical and psychological abuse, and, if an affirmative response has been given, whether the respondent would like any help. All the questions are answered in a yes/no format, and one or more affirmative responses indicate a case of abuse.[258]

Social History Questionnaire
Four abuse assessment questions were added to one of the general intake questions of health centres in Texas. The questions focus on physical and sexual abuse and are answered with a yes/no response.[260]

Sutherland Hospital ED Domestic Violence Screen
As part of a domestic violence screening pilot, all women presenting to the emergency department were asked the following three abuse questions: 'Within the last 12 months, have you ever been hit, slapped, kicked, or other ways hurt by your partner or ex-partner?', 'Are you frightened of your partner or ex-partner?' and 'Are you safe to go home when you leave here?'.[261]

The Mount Sinai Hospital Risk Screening Questionnaire
This is a 20-item questionnaire that is used to screen new patients for risk of domestic violence. The questions focus mainly on emotional and psychological abuse and the health consequences of such abuse. The first five questions are scored as yes/no responses, the rest of the questions are scored on a three-, four- or five-point Likert scale

to indicate the degree to which the respondents worry about specific behaviours, the frequency with which they experienced specific risk phenomena or the extent to which they agree with statements. A positive response on any of the items indicates the individual to be 'at risk' of abuse.[262]

Two-Question Abuse Screen

Women entering an emergency department with vaginal bleeding were asked the following abuse screening question: 'Have you ever been hit, slapped, kicked, or otherwise physically hurt by your male partner?'. Women who answered 'yes' were then asked 'Have you ever been forced to have sexual activities?'.[263]

Universal Violence Prevention Screening Protocol

This measure includes five questions related to intimate partner violence for the previous 12 months and the past month. Each question is answered with a yes/no response, an affirmative answer indicating abuse.[264]

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Appendix 5.3: Characteristics of included screening tool studies

Study details	Study design	Number of participants	Participants
Bonomi *et al.*, 2006[87]	**Index tool:** Women's Experience with Battering (WEB) **Comparator tool:** Behavioural Risk Factor Surveillance Survey (BRFSS) **Inclusion criteria:** Women enrolled for at least 3 years in a Group Health Cooperative (GHC) in Washington State, aged 18–64 years **Exclusion criteria:** Women who had never been in an intimate partner relationship, or who resided outside Washington State **Sample:** Abused and non-abused women **Type of study:** Validation study **Setting:** USA Telephone survey of randomly selected women **Tool presentation:** WAST was administered first by doctor, then a researcher administered ARI. The format has not been stated	**Eligible:** 2504 **Declining:** 0 **Recruited:** 2504	**Age (mean, SD, range):** 46.2, 11.6, not stated **Ethnicity:** White: 82.7% Hispanic: 4% **SES:** < $25,000: 10.9% $25,000–50,000: 28.2% $50,000–75,000: 26.5% > $75,000: 34.5%
Brown *et al.*,2000[91]	**Index tool:** Woman Abuse Screening Tool (WAST) **Comparator tool:** Abuse Risk Inventory (ARI)	**Eligible:** 399 patients; 44 physicians	**Age (mean, SD, range):** 46.2; not stated; 18–86

continued

Study details	Study design	Number of participants	Participants
	Inclusion criteria: Using a stratified random sampling frame, 20 physicians needed to be selected from 400 in London, Ontario, Canada. Women needed to be 18 or older, attending for a periodic health examination, for prenatal care or acute symptoms of illness, be English speaking, unaccompanied by another person, currently involved in an intimate relationship (married or common law) and they had to consider the attending physician as their primary care physician **Exclusion criteria:** Not stated **Sample:** Abused and non-abused women **Type of study:** Validation study **Setting:** Canada Family practice site **Tool presentation:** WAST was administered first by a doctor, then a researcher administered ARI. The format has not been stated	**Declining:** 92 patients; 24 physicians **Recruited:** 307 patients; 20 physicians	**Ethnicity:** White: 97.6% **SES:** > $30,000: 58.7%
Brown *et al.*, 2001[93]	**Index tool:** Women Abuse Screening Tool (WAST) WAST-Short (WAST-S) **Comparator tool:** Abuse Risk Inventory (ARI) **Inclusion criteria:** 18 years of age (not adhered to). In a couple relationship for the last 12 months **Exclusion criteria:** Not stated **Sample:** Abused and non-abused women **Type of study:** Validation study	**Eligible:** Not stated **Declining:** Not stated **Recruited:** 4625 abused 21 non-abused	**Age (mean, SD, range):** Abused mean: 35.6 Abused range: 17–58 Non-abused mean: 37.8 Non-abused range: 27–54 SD not stated **Ethnicity:** Not stated **SES:** > Can$30,000: 15%/94.7% Abused:15% Non-abused: 94.7%

Study details	Study design	Number of participants	Participants
	Setting: France Refuge and private homes **Tool presentation:** Tools presented in an interview (suggested) by both researchers and refuge workers		
Chen *et al.*, 2005[81]	**Index tool:** Hurts, Insults, Threatens and Screams (HITS) **Comparator tool:** Index of Spouse Abuse – Physical (ISA-P) Woman Abuse Screening Tool (WAST) English and Spanish versions of both index and comparator were used **Inclusion criteria:** Women attending an urban family practice site who were 18 years or older and were currently involved in an ongoing relationship **Exclusion criteria:** Not stated **Sample:** Abused and non-abused women, predominantly Hispanic **Type of study:** Validation study **Setting:** USA Urban family practice site **Tool presentation:** Single structured interview with trained medical students	**Eligible:** 386 **Declining:** 128 refused; 56 did not complete questionnaire due to long waiting period for a private room **Recruited:** 202	**Age (mean, SD, range):** 35.8 (SD and range not stated) **Ethnicity:** Total (%) English/Spanish/Non-Hisp white/Non-Hisp black/Non-Hisp other/Hispanic 20.3/36.3/NA/6.4/11.5/NA Spoken language (%) English/Spanish/Non-Hisp white/Non-Hisp black/Non-Hisp other/ Hispanic 1/1.8/NA/72.3/50.4/100 **SES:** Income (mean $) Spanish: 10,757 English: 14,142

continued

Study details	Study design	Number of participants	Participants
Coker *et al.*, 2001[79]	**Index tool:** Women's Experience with Battering Scale (WEB) **Comparator tool:** Index of Spouse Abuse – Physical (ISA-P) **Inclusion criteria:** Women seeking medical care in one of two university-associated family practice clinics, aged between 18 and 65 and who were insured by a managed care organisation and/or Medicaid and had ever been in an intimate sexual relationship with a man for a least 3 months **Exclusion criteria:** Women whose partners would not leave them alone were not recruited **Sample:** Abused and non-abused women **Type of study:** Validation study **Setting:** USA Two university-associated family practice clinics **Tool presentation:** Tools given in an interview and followed up with a telephone survey by trained graduates	**Eligible:** 1503 **Declining:** 174 refused 97 did not complete health assessment interview 80 had missing data on several response variables **Recruited:** 1152	**Age (mean, SD, range):** Not stated **Ethnicity:** African American: 62% White: 38% **SES:** Not stated
Connelly *et al.*, 2000[92]	**Index tool:** Single question hospital screen 'Are you in a relationship in which you have been threatened, scared or hurt by someone?' If yes, whom? **Comparator tool:** Conflict Tactics Scale (CTS) **Inclusion criteria:** Mothers giving birth between Feb 1996 and Mar 1997 who participated in a randomised clinical trial of paraprofessional home visitation services. High-risk mothers were identified 24 hours after birth using 15-item screen Furthermore, participants had to be English- or Spanish-speaking, not active to child protective services and referenced 'baby's father' for the CTS	**Eligible:** Not stated **Declining:** Not stated **Recruited:** 436	**Age (mean, SD, range):** 23.4, 6.2, 14–42 46% were 21 years or younger **Ethnicity:** Hispanic: 40% African American: 23% Caucasian: 27% Asian, Pacific Islander, Native American/other: 9%

Study details	Study design	Number of participants	Participants
	Exclusion criteria: Not stated **Sample:** Abused and non-abused women **Type of study:** Validation study, part of a larger clinical trial **Setting:** Not entirely clear where tools were administered, i.e. at hospital or home visit **Tool presentation:** Single question was embedded in admission protocol, CTS was administered as an interview by a trained paraprofessional interviewer		**SES:** Not stated
Ernst *et al.*, 2004[80]	**Index tool:** Ongoing Violence Assessment Tool (OVAT) **Comparator tool:** Index of Spouse Abuse (ISA) **Inclusion criteria:** English-speaking patients entering emergency department and completing both the OVAT and ISA **Exclusion criteria:** Under the age of 18, had no current partner, had an altered mental state, had an underlying psychiatric diagnosis, were too ill to participate or drug or alcohol intoxicated **Sample:** Abused and non-abused women **Type of study:** Validation study	**Eligible:** 362 **Declining:** 46 10 did not complete forms **Recruited:** 306	**Age (mean, SD, range):** 34, 10, range not stated (includes males) **Ethnicity:** Caucasian: 49% African American: 16% Hispanic: 20% Asian or other: 15% (this includes males) **SES:** Not stated

continued

Study details	Study design	Number of participants	Participants
	Setting: USA A&E department **Tool presentation:** Self-complete questionnaire administered by a researcher		
Feldhaus *et al.*, 1997[84]	**Index tool:** Partner Violence Screen (PVS) **Comparator tool:** Index of Spouse Abuse (ISA) Conflict Tactics Scale (CTS) **Inclusion criteria:** Non-critical, English-speaking women presenting to one of two urban emergency departments **Exclusion criteria:** Under the age of 18, had an altered mental status or primary psychiatric disorder **Sample:** Abused and non-abused women **Type of study:** Validation study **Setting:** USATwo urban, hospital-based A&E departments **Tool presentation:** First researcher administered verbal PVS, then the written self-completed ISA Second researcher administered the verbal CTS and four further questions	**Eligible:** 426 **Declining:** 47 Another 57 missed due to heavy volume of patients **Recruited:** 322	**Age (mean, SD, range):** 36, 16, range not stated **Ethnicity:** Black: 19% White: 45% Hispanic: 30% Other: 6% **SES:** < $15,000: 64%
MacMillan *et al.*, 2006[85]	**Index tool:** Partner Violence Screen (PVS); Woman Abuse Screening Tool (WAST) **Comparator tool:** Composite Abuse Scale (CAS)	**Eligible:** 2602 **Declining:** 141	**Age (mean, SD, range):** 37.1, 11.9, not stated **Ethnicity:** Born in Canada:

Study details	Study design	Number of participants	Participants
	Inclusion criteria: All women presenting for an appointment at the included sites (EDs, family practices or women's health clinics), aged 18–64 years, at a site for their own health-care visit, able to separate themselves from individuals who accompanied them, able to speak and read English, were not too ill to participate and could provide informed consent **Exclusion criteria:** Not stated **Sample:** Abused and non-abused women **Type of study:** Validation study: primary aim was to test presentation effects of tools **Setting:** Canada, Ontario: 2×ED; 2 ×Family practices; 2×Women's health clinics **Tool presentation:** This study looked at one of three presentation methods: Computer-based self-complete method: PVS and WAST (randomly ordered) on table computer followed by CAS and demographics on paper. Written self-complete method: demographics, PVS, WAST (both randomly ordered) then CAS on paper Face-to-face interview with health-care provider: used one of two indexes (randomly selected), then gave written version of demographics and CAS	**Recruited:** 2461	87.4% **SES:** < $24,000: 17.6%Woman was the main source of income, wages or salary: 57.8%
McFarlane *et al.*, 1992[89]	**Index tool:** Abuse Assessment Screen (AAS) **Comparator tool:** Conflict Tactics Scale (CTS); Index of Spouse Abuse (ISA); Danger Assessment Screen (DAS) **Inclusion criteria:** Women entering one of two perinatal clinics	**Eligible:** 691 **Declining:** 0 **Recruited:** 691	**Age (mean, SD, range):** Age ranged from 13 to 30+ years 13 to 19 years: 31% 20 to 29 years: 57% > 30 years: 12%

continued

Study details	Study design	Number of participants	Participants
	Sample: Abused and non-abused women **Type of study:** Validation study **Setting:** USA Two perinatal clinics **Tool presentation:** Self-report questionnaires administered by primary care provider		**Ethnicity:** Black: 39%White: 27%Hispanic: 34% **SES:** Below poverty level (not stated): 95%
Paranjape *et al.*, 2006[86]	**Index tool:** Slapped, Threatened or Thrown (STaT) **Comparator tool:** Index of Spousal Abuse (ISA) **Inclusion criteria:** Women aged 18–65 years, English speaking, and seen a medical provider within the centre on that day **Exclusion criteria:** Patients who could not be interviewed alone **Sample:** Abused and non-abused women **Type of study:** Validation study **Setting:** USA Urgent care centre in an inner city hospital that provides primary care **Tool presentation:** Single interview questionnaire administered by half-trained interviewers	**Eligible:** 324 **Declining:** 84 **Recruited:** 240	**Age (mean, SD, range):** 38, 10, not stated **Ethnicity:** African American: 91.3% **SES:** Median monthly income: $800

Study details	Study design	Number of participants	Participants
Peralta and Fleming, 2003[88]	**Index tool:** One question: 'Do you feel safe at home?' **Comparator tool:** Modified Conflict Tactics Scale (CTS) (6 items) **Inclusion criteria:** All women within the waiting room of the urban family practice clinic in Madison, Wisconsin, who were English-speaking and aged between 18 and 36 years **Exclusion criteria:** Non-English speakers **Sample:** Abused and non-abused women **Type of study:** Validation study **Setting:** USA, urban family practice clinic **Tool presentation:** Self-report questionnaire administered by researchers	**Eligible:** **Declining:** 12% **Recruited:** 399	**Age (mean, SD, range):** Mean and SD not stated; range 18–36 **Ethnicity:** Abuse status (%)Abused/non-abusedBlack: 44.2/55.8White: 43.9/56.1Other: 45.2/54.8 **SES:** Not stated
Reichenheim and Moraes, 2003[83]	**Index tool:** Abuse Assessment Screen (AAS) **Comparator tool:** Revised Conflict Tactics Scale (CTS2) **Inclusion criteria:** Case of premature birth within 6-month period. Given birth within 24 hours; interviews conducted in first 48 hours postpartum	**Eligible:** 3800 **Declining:** 3; 23 excluded **Recruited:** 748; 233 abused, 515 non-abused	**Age (mean, SD, range):** 23.9, 6.5, range not stated **Ethnicity:** Brazilian **SES:** Median monthly income per capita of US$96.7 (95%CI 26.5–346.4)

continued

Study details	Study design	Number of participants	Participants
	Exclusion criteria: Diabetes mellitus, systematic arterial hypertension, or given birth to neonates with severe congenital malformations, infections associated with prematurity, or twins **Sample:** Abused and non-abused women **Type of study:** Validation study **Setting:** Brazil, Rio de Janeiro, three public sector maternity wards **Tool presentation:** Interview questionnaire administered by five trained interviewers		
Sagrestano *et al.*, 2002[90]	**Index tool:** Perinatal Self-Administered Inventory (PSAI): contains two questions on DV **Comparator tool:** Conflict Tactics Scale (CTS) **Inclusion criteria:** Women in a waiting room of a women's care centre scheduled for routine prenatal care **Exclusion criteria:** Less than 20 weeks pregnant; were accompanied by small children who could not leave the waiting room with another relative; did not speak English or Spanish **Sample:** Abused and non-abused women **Type of study:** Validation study	**Eligible:** 196 **Declining:** 0 **Recruited:** 196, but only 166 entered into analysis	**Age (mean, SD, range):** 25.7, 6.0, 14–41 **Ethnicity:** African American: 48%Hispanic: 46%White or other: 6% **SES:** Median annual income was $10,000–20,000 49.4% earned less than$10,000

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Study details	Study design	Number of participants	Participants
Sherin *et al.*, 1998[82]	**Setting:** Mid-Western USA, university-affiliated women's care centre **Tool presentation:** Interview conducted by researcher **Index tool:** 'Hurts, Insults, Threatens and Screams at her' (HITS) **Comparator tool:** Conflict Tactics Scale (CTS) **Inclusion criteria:** Phase 1: Female patients of the Family Practice Centre of Christ Hospital Medical Centre (Advocate) who attended between April and June 1996, were aged 21 or over and had lived with the same partner for at least 12 monthsPhase 2: Self-identified victims of domestic violence at either a crisis shelter or ER **Exclusion criteria:** Not stated **Sample:** Abused and non-abused women **Type of study:** Validation study **Setting:** USA, phase 1: Family practice centre; phase 2: DV crisis shelter and an emergency room **Tool presentation:** Phase 1: Nurses administered self-report questionnaires Phase 2: Staff at the shelter/agency staff working in the emergency room administered self-report questionnaires	**Eligible:** Not stated **Declining:** Not stated **Recruited:** Phase 1: 160 Phase 2: 99 (54 from crisis shelter; 45 from emergency room)	**Age (mean, SD, range):** Not stated **Ethnicity:** Not stated **SES:** Not stated

SES, socioeconomic status.

Appendix 5.4: Results of included screening tool studies

		Outcomes	
Study	**Evaluated tools**	**Prevalence**	**Reliability**
Bonomi *et al.*, 2006[87]	**Index tool:** Women's Experience with Battering (WEB) **Comparator Tool:** Behavioural Risk Factor Surveillance Survey (BRFSS)	WEB: 7% BRFSS: 14.7%	Not stated
Brown *et al.*, 2000[91]	**Index:** Woman Abuse Screening Tool (WAST) **Comparator:** Abuse Risk Inventory (ARI)	Period: WAST: 8.5%	Coefficient alpha 0.75
Brown *et al.*, 2001[93]	**Index:** Women Abuse Screening Tool (WAST) and WAST-Short (WAST-S) **Comparator:** Abuse Risk Inventory (ARI)	Not stated	Coefficient alpha 0.95
Chen *et al.*, 2005[81]	**Index:** HITS (English and Spanish versions) **Comparator:** Index of Spouse Abuse – Physical (ISA-P); Woman Abuse Screening Tool (WAST) (English and Spanish versions)	ISA-P: 5.4% WAST: 9.9% ISA-P or WAST: 10.9%	**Presentation effects of instruments:** English language: interviews were of similar reliability, regardless of tool order Spanish language: HITS and WAST then ISA-P scored higher reliability (Cronbach's alpha 0.71) than ISA-P then HITS and WAST (Cronbach's alpha 0.49)* Presentation method not significantly associated with total scores of any tool after controlling for demographics Presentation effects for Spanish version of HITS did not change construct validity or accuracy of the Spanish version of HITS ($p > 0.05$) **Cronbach's alpha:** English HITS: 0.76 English ISA-P: 0.80 English WAST: 0.78 Spanish HITS: 0.61* Spanish ISA-P: 0.77 Spanish WAST: 0.80 Overall HITS: 0.71 Overall ISA-P: 0.78 Overall WAST: 0.78 *Reliability varies depending upon presentation of tools
Coker *et al.*, 2001[79]	**Index:** Women's Experience with Battering Scale (WEB) **Comparator:** Index of Spouse Abuse-Physical (ISA-P)	Period: WEB:19.8%; ISA-P: 11%	Cohen's kappa: 0.60

Concurrent validity	Construct validity (diagnostic accuracy) Comparison	Sen	Spe	PPV	NPV	LR+	LR–	DOR
Not stated	BRFSS any	72.4	89.7	34.4	97.7	7.0	0.3	22.8
	BRFSS sexual	21.3	99.4	72.5	94.4	35.3	0.8	44.6
	BRFSS physical	42	94.7	37.1	95.6	7.9	0.6	12.8
	Fear due to threats	48.3	96.5	50.9	96.1	13.7	0.5	25.9
	Controlling behaviour	64.9	94.3	46.1	97.3	11.4	0.4	30.8
Correlation between WAST and ARI: $r = 0.69$, $p = 0.01$	Not stated							
Not stated	Not stated							
Correlations (r) between English HITS & ISA-P= 0.76 English HITS & WAST= 0.75 Spanish HITS & ISA-P= 0.81 Spanish HITS & WAST= 0.81 Overall HITS & ISA-P= 0.77 Overall HITS & WAST= 0.76 ($p < 0.001$ for all correlations)	HITS							
	English	86	99	86	99	90.7	0.1	
	Spanish	100	86	45	100	7.3	0.0	
Correlation between WEB and ISA-P: $r = 0.67$	WEB	85.9	91.1	51.6	98.3	9.7	0.2	64.4

continued

		Outcomes	
Study	**Evaluated tools**	**Prevalence**	**Reliability**
Connelly *et al.*, 2000[92]	**Index:** Single-question hospital screen: 'Are you in a relationship in which you have been threatened, scared or hurt by someone? If yes, whom?' **Comparator:** Conflict Tactics Scale (CTS)	Single question: 4% CTS: 18.6%	Not stated
Ernst *et al.*, 2004[80]	**Index:** Ongoing Violence Assessment Tool (OVAT) **Comparator:** Index of Spouse Abuse (ISA)	OVAT: 33% ISA: 21%	Cronbach's alpha = 0.6* kappa = 0.58 (95% CI 0.53–0.63)* *Based on male and female data
Feldhaus *et al.*, 1997[84]	**Index:** Partner Violence Screen (PVS) **Comparator:** Index of Spouse Abuse (ISA); Conflict Tactics Scale (CTS)	Current PVS : 29.5% (95% CI: 24.6–34.8%) ISA : 24.3% (95% CI: 19.2–30.1%) CTS: 27.4%* (95% CI: 21.7–33.6%) *Of the 36 women with only a previous relationship and no current partner, prevalence was 43%	Not stated
MacMillan *et al.*, 2006[85]	**Index tool:** Partner Violence Screen (PVS); Woman Abuse Screening Tool (WAST) **Comparator tool:** Composite Abuse Scale (CAS)	CAS: 10.3% Presentation (95% CI) Computerised: PVS: 11.2% (8.8–13.5) WAST: 10.1% (7.9–12.3) Face-to-face: PVS: 8.7% (5.9–11.4) WAST: 10.5% (7.5–13.4) Written: PVS: 11.2% (9.0–13.3) WAST: 7.0% (5.3–8.8)	Not stated
McFarlane *et al.*, 1992[89]	**Index:** Abuse Assessment Screen (AAS) **Comparator:** Conflict Tactics Scale (CTS); Index of Spouse Abuse (ISA); Danger Assessment Screen (DAS)	ASS: Physical and sexual violence Within last year 26% During pregnancy 17% Combined 55%	Not stated

Concurrent validity	Construct validity (diagnostic accuracy)							
	Comparison	**Sen**	**Spe**	**PPV**	**NPV**	**LR+**	**LR–**	**DOR**
Not stated	Not stated							
Inter-item correlation of 0.38 (variance 0.03)* *Based on male and female data	OVAT	85.7	83.1	56.8	95.7	5.1	0.2	29.8
Not stated	PVS vs ISA							
	Physical violence (1 PVS question)	53.2	89.1	61.1	85.6	4.9	0.5	9.2
	Safety (2 PVS questions)	48.4	87.6	55.6	84.1	3.9	0.6	6.6
	Combined	64.5	80.3	51.3	87.6	3.3	0.4	7.4
	PVS vs CTS							
	Physical violence (1 PVS question)	68.2	94.6	82.7	88.8	12.6	0.3	37.2
	Safety (2 PVS questions)	39.7	87.4	54.4	79.4	3.2	0.7	4.6
	Combined	71.4	84.4	63.4	88.7	4.6	0.3	13.5
Not stated	PVS	49.2	93.7	55.3	94.2			
	WAST	47.0	95.6	47.0	94.0			
	Overall accuracy of PVS= 89.2% Overall accuracy of WAST= 90.6%							
Not stated	Not stated							

continued

		Outcomes	
Study	**Evaluated tools**	**Prevalence**	**Reliability**
Paranjape *et al*., 2006[86]	**Index Tool:** Slapped, Threatened or Thrown (STaT) **Comparator Tool:** Index of Spousal Abuse (ISA)	ISA Most recent relationship 32.9% Current IPV 15.4%	Not stated
Peralta and Fleming (2003)[88]	**Index:** One question: 'Do you feel safe at home?' **Comparator:** Modified Conflict Tactics Scale (CTS) (6 items)	Period (90 days) CTS: 44.3%	Not stated
Reichenheim and Moraes, 2003[83]	**Index:** Abuse Assessment Screen (AAS) **Comparator:** Revised Conflicts Tactics Scales (CTS2)	ASS : 6.7% (95% CI: 5–8.7) CTS2 : Minor : 18.4% (95% CI: 15.7–21.4) Major: 7.6% (95% CI: 5.8–9.8) Overall: 18.9% (95% CI: 16.2–22.0)	Not stated
Sagrestano *et al*., 2002[90]	**Index:** Perinatal Self-Administered Inventory (PSAI): contains two questions on DV **Comparator:** Conflict Tactics Scale (CTS)	CTS: Verbal aggression: 84.3%, 17% experienced violence in past year During the current pregnancy, verbal abuse: 68.1%, violence 13.3%	Not stated

Concurrent validity	Construct validity (diagnostic accuracy) Comparison	Sen	Spe	PPV	NPV	LR+	LR–	DOR
Not stated	STaT scores							
	≥ 1	94.9	36.6	42.3	93.6			
	≥ 2	84.8	54.0	47.5	87.9			
	3	62.0	65.8	47.0	77.9			
Not stated	'Do you feel safe at home?'							
	Any violence	8.8	95.8	62.5	56.8	2.1	1.0	1.9
	Mainly physical violence with some psychological violence	15.0	94.7	25.0	90.5	2.9	0.9	3.2
	Mainly psychological violence with some physical violence	8.8	95.9	62.5	57.6	2.2	1.0	2.3
Not stated	AAS vs CTS2							
	Minor cases (5 items of CTS2)	31.9	99.0	88.0	13.5	31.9	0.7	46.2
	Severe cases (7 items of CTS2)	61.4	97.8	70.0	0.0	27.9	0.4	71.6
	Both (all 12 items on CTS2)	31.7	99.2	90.0	13.9	39.6	0.7	57.4
Correlations	Not stated							
PSAI: 'Are you experiencing severe conflicts with anyone in your home?' and • Standard scale: negative interactions with baby's father $r = 0.16$ ($p = 0.035$) • Standard scale: verbal aggression (CTS) $r = 0.10$ ($p > 0.05$) PSAI: 'Are you suffering mental or physical abuse now?' and • Standard scale: verbal aggression (CTS) $r = 0.03$ ($p > 0.05$) • Standard scale: violence (CTS) $r = -0.05$ ($p > 0.05$)								

continued

		Outcomes	
Study	**Evaluated tools**	**Prevalence**	**Reliability**
Sherin *et al.*, 1998[82]	**Index:** 'Hurts, Insults, Threatens and Screams at her' (HITS) **Comparator:** Conflict Tactics Scale (CTS)	Not stated	HITS Cronbach's alpha: 0.80 Presentation effects: Median HITS score was 5 for those who completed it first and second, $z = 23$, $p > 0.05$ Median CTS score was 19.64 for first completers, 20 for second time completers, $z = 0.26$, $p > 0.05$

DOR, diagnostic odds ratio; LR−, negative likelihood ratio; LR+, positive likelihood ratio; NPV, negative predictive value; PPV, positive predictive value; Sen, sensitivity; Spe, specificity.

	Construct validity (diagnostic accuracy)							
Concurrent validity	**Comparison**	**Sen**	**Spe**	**PPV**	**NPV**	**LR+**	**LR–**	**DOR**
Correlation of HITS and CTS: $r = 0.85$ Subscores – physical violence: $r = 0.8$; verbal violence: $r = 0.81$	HITS (simulated data from statistical modelling using cut scores to differentiate cases and non-cases)	96	91	87	97			

Appendix 5.5: Assessment of quality of screening tool studies

	Assessment criteria[a]													
Study	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
Bonomi *et al.*, 2006[87]	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes
Brown *et al.*, 2000[91]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No
Chen *et al.*, 2005[81]	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes
Coker *et al.*, 2001[79]	No	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	No	No	Yes	Yes	Yes
Connelly *et al.*, 2000[92]	No	Yes	No	No	Yes	Yes	Yes	No	No	No	No	Yes	No	No
Ernst *et al.*, 2004[80]	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	No	No	Yes	Yes	No
Feldhaus *et al.*, 1997[84]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
MacMillan *et al.*, 2006[85]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No	Yes
McFarlane, *et al.*,1992[89]	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No
Paranjape *et al.*, 2006[86]	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes
Peralta and Fleming, 2003[88]	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No	No	Yes	No	Yes
Reichenheim and Moraes, 2003[83]	Yes	Unclear	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes
Sagrestano *et al.*, 2002[90]	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	No	No	Yes	Yes	Yes
Sherin *et al.*, 1998[82]	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	No

a Assessment criteria:
1: Spectrum of patients representative?
2: Inclusion criteria stated?
3: Efficient reference standard?
4: Time period short enough between administered tools?
5: Whole/random selection of sample verified with reference standard?
6: All participants receive the same reference standard?
7: Reference standard independent of index tool? (did not form part of reference standard)
8: Enough detail to replicate execution of index tool?
9: Enough detail to replicate execution of reference standard?
10: Blind analysis of index tool?
11: Blind analysis of reference standard?
12: Same clinical data available when interpreted as would be available in practice?
13: Uninterpretable/intermediate results presented?
14: Withdrawals from the study explained?

Appendix 5.6: Bias in screening tool studies

Study	Bias	Decreasing quality
[a]Feldhaus *et al*., 1997[84]	Blind analysis	
[a]Chen *et al*., 2005[81]	Blind analysis	
	Incorporation bias	
Brown *et al*., 2000[91]	Blind analysis	
	Withdrawals	
[a]MacMillan *et al*., 2006[85]	Blind analysis	
	Uninterpretable results	
[a]Paranjape *et al*., 2006[86]	Blind analysis	
	Incorporation bias	
[a]Bonomi *et al*., 2006[87]	Blind analysis	
	Reference standard	
	Interpretation bias	
[a]Reichenheim and Moraes, 2003[83]	Spectrum bias[b]	
	Blind analysis	
	Incorporation bias	
[a]Coker *et al*., 2001[79]	Spectrum bias	
	Blind analysis	
	Incorporation bias[b]	
McFarlane *et al*., 1992[89]	Spectrum bias	
	Withdrawals	
	Blind analysis	
Sagrestano *et al*., 2002[90]	Reference standard	
	Blind analysis	
	Incorporation bias	
Sherin *et al*., 1998[82]	Reference standard	
	Withdrawals	
	Blind analysis	
[a]Peralta and Fleming, 2003[88]	Reference standard	
	Blind analysis	
	Indeterminable results	
	Incorporation bias	
[a]Ernst *et al*., 2004[80]	Spectrum bias[b]	
	Blind analysis	
	Test execution[b]	
	Withdrawals	
Connelly *et al*., 2000[92]	Spectrum bias	
	Test execution	
	Reference standard	
	Blind analysis	
	Indeterminate results	
	Withdrawals	
	Disease progression bias	

a Studies with completely reported diagnostic accuracy data.
b Scored unclear on QUADAS.

Appendix 6

Acceptability of screening studies to women

Appendix 6.1: Characteristics of qualitative studies and quality scores

Study details	Study design	Number of participants	Participants	Quality score (CASP total)
Bacchus *et al*., 2002[119]	Sample: abused and non-abused women Interview setting: women's houses and general practitioner's surgeries Data collection: semistructured interviews	Approached: 781 Recruited: 717: 32 interviewed Response rate (%): 91.8	Age (mean, SD, range): Not stated Ethnicity (%): Not stated	33
Belknap and Sayeed, 2003[95]	Sample: abused women Interview setting: home or at the agency Data collection: open-ended questions	Approached: 7 Recruited: 7 Response rate (%): 100	Age (mean, SD, range): 30 (19–38) Ethnicity (%): Mexican American: 100 No SD stated	21
Chang *et al*., 2003[265]	Sample: abused women Interview setting: locations where women attended their support groups Data collection: semistructured focus group interviews	Approached: not stated Recruited: 41 Response rate (%): not stated	Age (mean, SD, range): 30 (19–38) Ethnicity (%): White: 29.3 Black: 34.1 Latino: 36.6 No SD stated	30
Chang *et al*., 2005[99]	Sample: abused women Interview setting: shelter, women's hospital, general internal medicine clinic Data collection: semistructured interviews	Approached: not stated Recruited: 21 Response rate (%): not stated	Age (mean, SD, range): 44.2 (22–62) Ethnicity (%): White: 81 Black: 19	34
Chang *et al*., 2005[98]	Sample: abused women Interview setting: locations where women attended their support groups Data collection: focus groups	Approached: not stated Recruited: 41 Response rate (%): not stated	Age (mean, SD, range): 37 (22–77) Ethnicity (%): White: 29.2 Black: 34.1 Latina: 36.6	34
Dowd *et al*., 2002[120]	Sample: abused and non-abused women Interview setting: non-clinical meeting room of hospital property Data collection: focus groups	Approached: not stated Recruited: 59 Response rate (%): not stated	Age (mean, SD, range): 37 (22–77) Ethnicity (%): White: 32.2 African American: 33.9 Latina: 33.9	27
Hathaway *et al*., 2002[97]	Sample: abused women Interview setting: hospital or heart clinic where customer received advocacy service, except for two phone interviews Data collection: semistructured interviews	Approached: 186 Recruited: 138; 49 interviewed Response rate (%): 74.2	Age (mean, SD, range): 21–81 Ethnicity (%): White: 51 Latina: 35 Asian: 6 Other: 8	20

Study details	Study design	Number of participants	Participants	Quality score (CASP total)
Lutenbacher *et al.*, 2003[266]	Sample: abused women Interview setting: living room area of a nursing school Data collection: focus groups	Approached: 40 Recruited: 24 Response rate (%): 60	Age (mean, SD, range): 35 (21–51) Ethnicity (%): White: 67 African American: 20	27
Lutz, 2005[100]	Sample: abused women Interview setting: private safe place Data collection: in-depth, open-ended interviews	Approached: not stated Recruited: 12 Response rate (%): not stated	Age (mean, SD, range): 29.7 (18–43) Ethnicity (%): White: 50 Black: 33.3 Arab American: 16.7	27
Stenson *et al.*, 2001[96]	Sample: abused and non-abused women Interview setting: private examination room in antenatal clinic Data collection: one open-ended question	Approached: 1074 Recruited: 879 Response rate (%): 82	Age (mean, SD, range): Not stated Ethnicity (%): Not stated	32
Taket *et al.*, 2004[211]	Sample: abused women Interview setting: privately Minority Birmingham: refuges Salford: Salford Women's Aid Wakefield: S&S, GP practice Data collection: interviews	Approached: 697 Recruited: 44 Response rate (%): not stated	Age (mean, SD, range): 18–68 Ethnicity (%): Minority Birmingham: 13.9 Salford: 3.9 Wakefield: 2.3	32
Zeitler *et al.*, 2006[115]	Sample: abused women Interview setting: family planning clinic Data collection: one open-ended question	Approached: 697 Recruited: 372, 120 interviewed Response rate (%): 53.4	Age (mean, SD, range): 15–24 Ethnicity (%): White: 22 Black: 31 Hispanic: 30 Asian: 11 Other: 6	31
Zink and Jacobson, 2003[267]	Sample: abused women Interview setting: women from shelter: private room; women from support group: the interviewer's room or private room outside the support group location Data collection: focus groups	Approached: not stated Recruited: 32 Response rate (%): not stated	Age (mean, SD, range): 32 (18–45) Ethnicity (%): White: 50 African American: 50	32
Zink *et al.*, 2004[268]	Sample: abused women Interview setting: privately Data collection: interviews	Approached: not stated Recruited: 32 Response rate (%): not stated	Age (mean, SD, range): 32 (18–45) Ethnicity (%): White: 50 African American: 50	27

S&S, Support and Survival.

Appendix 6.2: Characteristics of quantitative (survey) studies

Study details	Study design	Number of participants	Participants
Bair-Merritt *et al.*, 2006[108]	Inclusion criteria: Female caregivers, aged 18 and older or emancipated minors if they were not accompanied by another adult, if the child or children with them were all younger than 3 years and if their child was not critically ill, as determined by a physician Exclusion criteria: Not stated Sample: Abused and non-abused women Type of study: Cross-sectional survey	Approached: 281, 139 in the pre-group and 142 in the post-group Recruited: 269;133 in the pre-group and 136 in the post-group Response rate (%): 96	Age (mean, SD, range): 28.6 ±8.7 in the pre-group 28.5 ±9.9 in the post-group Ethnicity (%): Pre-group: White: 22 Black: 77 Other: 1 Post group: White: 18 Black: 79 White: 18 Asian: 3 Other: 0
Brzank *et al.*, 2002[269]	Inclusion criteria: Female A&E outpatients between 18 and 60 years of age Exclusion criteria: Excluded were those patients who could not be approached due to the severity of their injury or condition, danger of infection, intoxication, mental confusion, language barriers or where the interview could not take place in a secure environment without escort Sample: Abused and non-abused women Type of study: Cross-sectional survey: self-report	Approached: 1557 Recruited: 806 Response rate (%): 70	Age (mean, SD, range): 18–60 years (no mean or SD) Ethnicity: Not stated
Caralis and Musialowski, 1997[109]	Inclusion criteria: All female patients who came daily during the 4-hour time blocks of the clinic Exclusion criteria: Not stated Sample: Abused and non-abused women Type of study: Cross-sectional survey	Approached: 516 Recruited: 406 Response rate (%): 78.7	Age (mean, SD, range): 50.4 ±16 Ethnicity (%): White: 57 Black: 26 Hispanic: 17

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Study details	Study design	Number of participants	Participants
Friedman *et al.*, 1992[110]	Inclusion criteria: Not stated Exclusion criteria: Age less than 18, inability to understand the English language, and unwillingness to give consent Sample: Abused and non-abused women Type of study: Cross-sectional survey	Approached: Not stated Recruited: 164 Response rate (%): Not stated	Age (mean, SD, range): < 50: 52% > 50: 48% Ethnicity (%): White: 55 Black: 30 Hispanic: 6 Caribbean: 4 Other: 5
Glass *et al.*, 2001[105]	Inclusion criteria: All women > 18 years who were attending an ED on selected shifts; not to ill to respond; English or Spanish speaking Exclusion criteria: Not stated Sample: Abused and non-abused women Type of study: Cross-sectional survey- self report	Approached: 4641 Recruited: 3455 Response rate (%): 74	Age (mean, SD, range): 18–65 years (no mean or SD) Ethnicity: Not stated
Gielen *et al.*, 2000[111]	Inclusion criteria: Women were selected for the mailing if they were between the ages of 21 and 55 years at the time of the recruitment and had been enrolled continuously in the HMO from 1995 through 1997 Exclusion criteria: Not stated Sample: Abused and non-abused women Type of study: Case–control study	Approached: 442 Recruited: 406 Response rate (%): 87.4 – cases 90.9 – controls	Age (mean, SD, range): 21–55 years (no mean or SD) Ethnicity (%): White: 53.4
Hurley *et al.*, 2005[103]	Inclusion criteria: Subjects included non-critically ill patients, aged 16–95 years, who presented to the ED during specified data collection time frames. All potentially eligible patients in the waiting room were approached individually during these time frames Exclusion criteria: Subjects who refused or were in distress were not included Sample: Abused and non-abused women Type of study: Self-report survey	Approached: 304 women Recruited: 304 women Response rate (%): 100	Age (mean, SD, range): 16–95 years (39.4) Ethnicity: Not stated

continued

Study details	Study design	Number of participants	Participants
McCaw *et al.*, 2001[101]	Inclusion criteria: Health plan members were eligible to participate in the study if they were female, aged 18–60 years, and had a medical visit designated 'routine' by the clinician in the internal medicine or obstetrics/gynaecology departments Exclusion criteria: Not stated Sample: Abused and non-abused women Type of study: Cross-sectional survey following an intervention	Approached: Not clear Recruited: 397 (190 pre- and 207 post-intervention) Response rate (%): Not clear	Age (mean, SD, range): 18–60 years Ethnicity (pre-intervention) (%): White: 32.6 Black: 43.6 Hispanic: 12.7 Asian: 4.4 Other: 6.6
McDonnell *et al.*,2006[112]	Inclusion criteria: Not stated Exclusion criteria: Not stated Sample: Abused and non-abused women Type of study: Verbal questionnaire	Approached: 481 women Recruited: 478 women Response rate (%): 99.4	Age (mean, SD, range): Not stated Ethnicity: Not stated
McNutt *et al.*, 1999[113]	Inclusion criteria: 18–44 years old, had an obstetric, gynaecology, general physical or other extended examination between 15 March and 25 April 1996; spoke English; were determined by nursing staff to be physically capable of participating; were unaccompanied in the examination room by anyone over the age of 3 years Exclusion criteria: Not stated Sample: PCT (abused and non-abused) patients, DV programme patients and shelter residents Type of study: Cross-sectional survey, self-report and interview	Approached: 124 Recruited: 161 at PCT Response rate (%): 64.5 PCT95.5 for DV programme 100 for shelter residents	Age (mean, SD, range): 18–45+ years Ethnicity (%): White: 47 Black: 33 Other: 20
Newman *et al.*, 2005[114]	Inclusion criteria: All English- and Spanish-speaking women who brought their children for emergency care between the hours of 7PM and 3AM, Sundays to Fridays Exclusion criteria: Women who did not speak English or Spanish, were accompanied into the treatment rooms with a male partner, or had a child with illness and injury managed in the resuscitation area Sample: Abused and non-abused women Type of study: Cross-sectional survey	Approached: 781 Recruited: 451 Response rate (%): 97.83	Age (mean, SD, range): 32 ± 10 years Ethnicity (%): White: 25 Black: 29 Hispanic: 42 Other: 3 Unknown: 0.2

Study details	Study design	Number of participants	Participants
Renker and Tonkin, 2006[102]	Inclusion criteria: Given birth within last 72 hours; be in satisfactory condition; speak and read English; 18 years or older; capable of giving informed consent, delivered infant in a stable condition Exclusion criteria: Not stated Sample: Abused and non-abused women Type of study: Cross-sectional survey using anonymous computer-based self-report	Approached: 1069 Recruited: 519 Response rate (%): 48.55	Age (mean, SD, range): Not stated Ethnicity (%): White: 73 Black: 20 American Indian/Alaskan Native: 2.8 Asian: 1 Native Hawaiian/Pacific Islander: 0.4 Mixed race: 1.8 No response: 1.2
Richardson *et al.*, 2002[41]	Inclusion criteria: Women were eligible to participate if they were registered with the practice, were over 15 years old, and were able to read English, Turkish, or Bengali (the three languages in which the questionnaire was available) Exclusion criteria: Those who were holding an infant or who were too unwell to complete the questionnaire were ineligible Sample: Abused and non-abused women Type of study: Self-administered questionnaire survey. Review of medical records	Approached: 2192 Recruited: 1207 Response rate (%): 55	Age (mean, SD, range): 16–45+ (39.4) years Ethnicity (%): White British: 41 Irish: 4 Other: 9 Black African: 6 British: 8 Caribbean: 10 Other: 1 Asian Bagladeshi: 1 Indian: 3 Pakistani: 1 Turkish: 7 Other: 10

continued

Study details	Study design	Number of participants	Participants
Romito *et al.*, 2004[107]	Inclusion criteria: All women over 17 years of age attending one of six family practice sites Exclusion criteria: If patient was too ill or confused Sample: Abused and non-abused women Type of study: Cross-sectional survey, self-report	Approached: 542 Recruited: 426 Response rate (%): 78.6	Age (mean, SD, range): 17–85 years (no mean or SD) Ethnicity: Not stated
Sethi *et al.*, 2004[48]	Inclusion criteria: Women within waiting room on chosen shift Exclusion criteria: Aged under 18 or over 80 years; too ill, distressed, intoxicated or confused to respond to the question or unable to speak English; requiring psychiatric assessment Sample: Abused and non-abused women Type of study: Cross-sectional study, researcher interview	Approached: 228 Recruited: 198 Response rate (%): 86.8	Age (mean, SD, range): 18–80 years (no mean or SD) Ethnicity: Not stated
Zeitler *et al.*, 2006[115]	Inclusion criteria: Adolescent and young adult females aged 15–24 years who presented for family planning services at Planned Parenthood of New York City's Margaret Sanger clinic between April and August 2004 were eligible to participate in this study Exclusion criteria: Not stated Sample: Abused and non-abused women Type of study: A cross-sectional quantitative and qualitative survey	Approached: 697 Recruited: 645 Response rate (%): 92.54	Age (mean, SD, range): 15–24 years (no mean or SD) Ethnicity (%): Hispanic: 33 White: 22 Black: 28 Asian: 12 Other: 5
Webster *et al.*, 2001[116]	Inclusion criteria: Not stated Exclusion criteria: Those who could not read or write English were excluded, unless they had responded to the original questions through an interpreter and an interpreter was available to assist with the evaluation Sample: Abused and non-abused women Type of study: Cross-sectional study	Approached: 1500 Recruited: 1313 Response rate (%): 87.5	Age (mean, SD, range): Not stated Ethnicity (%): Not stated

Study details	Study design	Number of participants	Participants
Weinsheimer *et al.*, 2005[104]	Inclusion criteria: All women aged 18–80 admitted to the Trauma Service were tracked for inclusion. Eligible participants included those who spoke English and were able to read an introductory letter regarding the survey Exclusion criteria: Patients with a head injury or psychiatric disorder precluding informed consent Sample: Abused and non-abused women Type of study: In-person survey	Approached: 105 Recruited: 95 Response rate (%): 90	Age (mean, SD, range): 18–79 (38.9) years Ethnicity (%): White: 37.9 Black: 1.1 Hispanic: 32.6 Native American: 28.4
Witting *et al.*, 2006[117]	Inclusion criteria: The study participants were all English-speaking adults (older than age 18 years) in the hospitals' ED waiting rooms (not hospital employees) Exclusion criteria: Patients too ill to participate Sample: Abused and non-abused women Type of study: A self-administered questionnaire	Approached: 146 Recruited: 146 Response rate (%): 100	Age (mean, SD, range): 37.3 (12.3) Ethnicity (%): Non-white: 60

Appendix 6.3: Results of quantitative studies and quality scores

Author, publication year	Results	Quality score (STROBE total)
Bair-Merritt *et al.*, 2006[108]	The two groups (pre, $n = 133$; post, $n = 136$) did not significantly differ with respect to age, race, education, or personal intimate partner violence history	17
	The post group was less likely to prefer pediatric emergency department intimate partner violence 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 history of intimate partner violence were less likely than women without this history to say that they would disclose intimate partner violence to their pediatric emergency department provider ($p < 0.001$)	
	No difference existed between previously abused and non-abused women with regard to the acceptability of displaying resources or routine screening	
Brzank *et al.*, 2004[269]	Sixty-seven percent of interviewed women considered physicians contact persons after experiencing domestic violence. However, only 8% had ever been asked about domestic violence experiences by their physicians	9
	Thirty-two percent of all interviewees would have wanted to be asked. This number increased to 41% in case of experienced sexual violence, and to 44% in case of experienced physical or emotional violence	
	Sixty-four percent of interviewees think that generally questions about domestic violence experience should be part of the general anamnesis	
Caralis and Musialowski, 1997[109]	Overall, the majority of women (85%) agreed that doctors should, in their practices, routinely screen for abuse (77% of non-abused women and 70% of the abused women), and 50% strongly agreed	16
Friedman *et al.*, 1992[110]	Among the 164 participating patients, routine physical abuse inquiry was favoured by 78% and routine sexual abuse inquiry was favored by 68%	19
	Older patients were more in favour of routine physical abuse inquiry. Age, however, did not influence the desire for routine sexual abuse inquiry	
	Regardless of site, patients with less than a high school education were more in favour of routine inquiry about physical abuse and sexual abuse	
	Eighty percent of those who reported sexual abuse favoured routine physician inquiry about sexual abuse compared with 64% of those who reported never being sexually abused ($p < 0.05$)	
	In regard to physical abuse, patients who reported abuse were just as likely as patients who reported never being abused to volunteer a history of abuse and favour routine inquiry	
Glass *et al.*, 2001[105]	Women who were acutely abused or who were physically or sexually abused in the past year were significantly less likely to agree with either routine screening (80% vs 89%, $p < 0.01$) or mandatory reporting of intimate partner violence (76% vs 90%, $p < 0.01$) than were women who reported a lifetime history of abuse or who reported no intimate partner violence	14
Gielen *et al.*, 2000[111]	Forty-eight percent of the sample agreed that health-care providers should routinely screen all women, with abused women more likely than non-abused women to support this policy (54% vs 42%)	16
	Women thought it would be easier for abused women to get help with screening (86%), although concerns were raised about increased risk of abuse with screening (43%)	
Hurley *et al.*, 2005[103]	The study showed that universal screening of female patients for intimate partner violence was supported by 86% of patients, with no differences in opinion in relation to age or sex. However, from the 304 women participating in the survey, 263 approved universal screening, 32 disapproved and 9 had no opinion	16

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Author, publication year	Results	Quality score (STROBE total)
McCaw *et al.*, 2001[101]	The majority of women (80%) felt that clinicians should screen all their women patients for domestic abuseResponses to questions about the appropriateness of clinicians screening all women patients did not reflect a substantial change between the pre- and post-intervention periods	19
McDonnell *et al.*, 2006[112]	Of the 471 women who answered the questions regarding acceptability, 468 (99%) found the questions acceptable and considered that all women should be asked these questions There were no differences in acceptability across age groups and no differences between those who reported abuse and those who did not as to whether these questions were acceptable. The three patients who said the questions were not acceptable did not report any abuse	13
McNutt *et al.*, 1999[113]	When asked if physicians should ask all female patients about intimate partner violence, less than half of all groups (40%), except women in shelters (64%), agreed	16
Newman *et al.*, 2005[114]	When asked if it was appropriate to screen them for intimate partner violence when they sought care for their children, 75% of women stated it was Method of screening: 44% chose direct verbal questioning, 36% written questionnaire, 20% suggested other	16
Renker and Tonkin, 2006[270]	The great majority of women screened by their prenatal care providers (97%, SE 0.01%, $n = 195$) stated that they were not embarrassed, angry, or offended when they were screened for domestic violence There were no differences in acceptability of screening by health-care setting (public compared with private) or income, but women aged younger than 21 years were more likely ($p = 0.018$) than those older than 21 years to say they were embarrassed by the violence questions (13%, SE 0.4%, $n = 4$ compared with 1%, SE 0.2%, $n = 2$), although the small total ($n = 6$) for this subgroup should be noted when interpreting this finding Of the 66 women who reported abuse on the computer self-interview and who were screened during their pregnancies, only 11 (17%, SE 1.5%) women stated that they acknowledged their abuse to their health-care providers. There were no significant differences for this group ($n = 66$) in disclosure by age, race, income, prenatal care setting (public compared with private), or relationship with their neonate's father	16
Richardson *et al.*, 2002[41]	In total, 82 (8%) women reported that they would mind 'in general' if their doctor asked whether they had ever been threatened, hit or hurt by a partner or former partner, with 114 (11%) minding a similar inquiry about forced sexIf the same questions were asked by a practice nurse, 119 (12%) and 136 (13%) women, respectively, said they would mind being asked In total, 202 (20%) women reported that they would mind being asked by their general practitioner about abuse or violence in their relationship if they had come about something else, with 234 (23%) objecting to a nurse asking the same question (3% difference, 1–5%) The acceptability of being asked was not significantly different between women who were and were not currently experiencing domestic violence (data not shown). Overall, 432 (42%) women reported that they would find it easier to discuss these issues with a female doctor and 31 (3%) with a male doctor	19
Romito *et al.*, 2004[107]	Eighty-five per cent of the respondents answered that the family doctor should ask all women about violence, 7% thought he/she should not, and 8% were uncertain Although a higher percentage of women experiencing current violence gave a positive answer than women not experiencing current violence, the association was not significant However, younger women were significantly less likely to think that doctors should ask all patients (data not shown). When asked with whom they would like to talk about violence, if needed (more than one answer was possible): 54% chose the family doctor; 28% a psychologist; 22% other women with the same experience; 9% a social worker and 7% the police (data not shown)	20

continued

Author, publication year	Results	Quality score (STROBE total)
Sethi *et al.*, 2004[48]	When questioned about how often they should be asked about domestic violence in the accident and emergency department, 35% felt that this should be always and 26% felt it should be usually asked, 38% felt it should be seldom asked, and only 1% felt that they should never be askedInterestingly, a higher proportion of women who had been abused (43%) suggested that women should always be asked about experience of domestic violence, compared with 30% among those who had not been abused. Many women justified their answers by commenting on the need for privacy and safety, but felt that it would be acceptable and appropriate to ask direct questions in women presenting with injuries Of those responding, 122 (9%) stated that they were not asked the questions at their first visit, a further 5 (0.4%) indicated that they were probably not asked because their partner was present, and 52 women (4%) stated that they could not remember whether they had been asked about domestic violence or not	18
Zeitler *et al.*, 2006[115]	The vast majority of women responded favorably to the attitude questions about violence screening. Almost 90% said they would not mind being asked When respondents were categorised according to how much they minded being asked about violence, we did not detect differences in race, school enrolment, parity, family violence, or lifetime dating violence experience. However, women aged 15–18 years as compared with women aged 19–21 years were 2.9 times more likely to voice some to much concern with violence screening by a provider (36%, $p < 01$) Willingness to be screened also varied depending on women's violence experiences. Women who were victims of physical violence and women who were victims or perpetrators of sexual violence were most likely to mind being screened Almost 90% of those surveyed felt that universal screening by health-care providers is a 'very good' or 'somewhat good idea'. Women who had experienced physical violence in the last year were significantly less likely ($p < 0.05$) to report that they felt it was a good idea for health-care providers to ask all women about violence, but even so, 80% of this group was in favour of all women being asked Multivariate analyses found three factors to be associated with young women who expressed some concern with violence screening as compared with those who did not report any concern. Those young women who reported severe physical victimisation in the last year, categorised as 'often' as compared with 'none', reported experiencing early sexual abuse and were younger than 19 years were more likely to have some to high levels of concern with screening	19
Webster *et al.*, 2001[116]	Most of the respondents, 1263 (98%), believed it was a good idea to ask women about domestic violence when visiting a hospital. There was no difference in the responses from rural, remote or inner city sites (range 98.6 ± 95.5%, $\chi^2 = 7.38$, df 4, $p = 0.117$) Nor were there differences between sites in terms of how women felt when asked domestic violence questions ($\chi^2 = 8.68$, df 8, $p = 0.37$). Three responses were possible: 1197 (96%) felt OK about being asked, 18 (1%) felt relieved to be able to talk to someone about their problem, and 30 (3%) felt uncomfortable. Twenty-three (77%) of the women who felt uncomfortable, still agreed that it was a good idea to ask about domestic violence When asked about which health-care professionals should screen for domestic violence, multiple responses were possible: 1068 (65%) of the women nominated midwives, 1055 (64%) nominated general practitioners, 809 (49%) selected social workers and 771 (47%) selected hospital doctors. Only 42 (2%) thought no one should ask. A number of women wrote comments such as 'anyone who cares should ask' When analysed by hospital, respondents from the remote area site were less likely to select the hospital midwife ($\chi^2 = 17.2$, df 4, $p = 0.002$) or the general practitioner ($\chi^2 = 18.2$, df 4, $p = 0.001$) than those from either rural or city hospitals Of those responding, 122 (9%) stated that they were not asked the questions at their first visit, a further 5 (0.4%) indicated that they were probably not asked because their partner was present, and 52 women (4%) stated that they could not remember whether they had been asked about domestic violence or not	16

Author, publication year	Results	Quality score (STROBE total)
Weinsheimer *et al.*, 2005[104]	Although 18% of women thought screening infringed on their privacy, the overwhelming majority (> 90%) felt that it was appropriate to ask about intimate partner violence and that women should be asked about it when in the health-care setting Nearly all (93%) of the 44 women who reported a history of IPV thought a trauma centre health-care provider could assist them with a safety plan, but about one in four abused women thought reporting would increase their chances of further harm	19
Witting *et al.*, 2006[117]	Visitors and providers supported screening, with increasing prevalence as the scenarios increased in severity, with visitors showing a fivefold increase for the high-risk (86%) versus the low-risk (17%) scenario. Although providers showed greater support for the goal of intimate partner violence screening than visitors, the tendency to screen in practice was lower; actually, estimates of screening practice were similar to the proportion of visitors expecting screening in each scenario. As the scenarios increased in severity, the differences between providers and visitors decreased The majority of visitors and providers felt that a physician, rather than a nurse, should have the primary responsibility for intimate partner violence screening, with visitors expressing this view almost 50% more frequently than providers Neither group felt that the gender of the screener was important Among visitors, those with lower educational attainment supported ED IPV screening more frequently than those with higher education	15

PCT, primary care trust.

Appendix 7

Interventions after disclosure of partner violence

Appendix 7.1: Characteristics of intervention studies

Author(s), publication year	Setting	Inclusion criteria	Intervention
Advocacy studies			
Bybee and Sullivan, 2005[130] RCT	USA DV shelter	Abused women who stayed at least one night in refuge and intended to stay in area for at least 3 months post-refuge	Individual advocacy to help women leaving a DV refuge to devise safety plan and access community resources: 4–6 hours planned contact per week for first 10 weeks after leaving refuge, actually provided mean 7 hours per week contact **Control care:** Standard shelter services provided to all residents, and then usual after-refuge care (if any)

Data monitoring periods	Primary outcome measures	Number of participants	Participants
Baseline, and 10 weeks, 6, 12, 18, 24 months post-intervention, and 3-year post-intervention follow-up for the original sample	Validated: Abuse (CTS – modified) Psychological abuse (IPA, developed for study) Resources (EOR and DOR) Depression (CES-D) Locus of control (IPC) Fear and anxiety (RAST) Self-efficacy (developed for study) Non-validated: Independence from assailant 3–year follow-up: Abuse (CTS – modified) Quality of life Social support Resources (DOR)	***n* eligible:** 157 ***n* participants:** 146 ***n* completing intervention:** 141 (97% of recruited) Intervention: 71 Control: 70 ***n* completing follow-up (% of participants):** 6 months 131 (90% of recruited; 93% of intervention group who completed 3+ sessions and all control group)	**Age range:** 17–61 Mean = 28 (Not stated if any between-group differences) **Ethnic origin:** 42% African American 46% White 7% Latina 2% Asian American 3% other (Not stated if any between-group differences) **SES:** 61% unemployed 81% receive government aid 64% educated to high-school level 34% some college education (Not stated if any between-group differences) **Features of abuse:** Severe abuse occurring once a month or less **Relationship with abuser (at study entry):** 77% married or cohabiting and living with assailant 6% involved but not living with assailant 15% single, divorced, separated

continued

Author(s), publication year	Setting	Inclusion criteria	Intervention
Constantino *et al.*, 2005[122] RCT	USA DV shelter	None stated explicitly but women were first-time residents of a DV shelter, no explicit definition of abuse but talks about abuse being the intentional violence or controlling behaviour of a current or ex-intimate partner (and in this study the perpetrator being male)	A social support intervention provided by a trained nurse to provide resources and include information on resources, time to access resources, and an environment in which to chat with a counsellor and friends. Based on theory that there are four separate functions of social support: belonging, evaluation, self-esteem, and tangible support (BEST). Belonging was generated through listening and responding to other abused women. Evaluation or appraisal was incorporated into sessions by helping women to see themselves as others do. Self-esteem was promoted by focusing on each woman's strengths and accomplishments in surviving IPV. Tangible support included discussion of resources in the community. 90-minutes sessions, once a week for 8 weeks **Control care:** The control group gathered in a room with the principal investigator for a free-flowing chat session with no structure. They also continued to receive the standard shelter services provided to all residents

Data monitoring periods	Primary outcome measures	Number of participants	Participants
Baseline and immediate post-intervention	Validated: Social support (ISEL) Distress (BSI) Health-care utilisation (HSQ)	***n* eligible:** Not stated ***n* participants:** 30 ***n* completing intervention:** 24 (80% of recruited) ***n* completing follow-up (% of participants):** Not applicable, no post-intervention follow-up	**Age range:** 28–43 Mean = 35 (n/s between-group differences) **Ethnic origin:** 71% White 29% Black (n/s between-group differences) **SES:** Income 58% < $10,000 17% $10,000–19,999 21% $20,000–29,999 4% > $30,000 Education 12% junior high 67% high school 4% trade school 17% degree (n/s between group differences) **Features of abuse:** No explicit definition but talks about abuse being the intentional violence or controlling behaviour of a current or ex-intimate partner (and in this study the perpetrator being male) **Relationship with abuser (at study entry):** 17% married 21% divorced 17% separated 4% widowed 21% cohabiting 21% single

continued

Author(s), publication year	Setting	Inclusion criteria	Intervention
McFarlane *et al.*, 2006[123] RCT	USA Two primary care public health clinics and two women, infants, and children clinics (WICs)	Women aged 18–44 years, English or Spanish speaking, identified by nurse as physically or sexually abused by an intimate partner within last 12 months (AAS)	A nurse case management intervention empowering abused women by increasing independence/control, based on Dutton's empowerment model: focus on protection/safety, enhanced choice-making/problem-solving. An underlying feature of the model is that each woman knows what is best for her and her children, and the nurse is simply facilitating this (by listening, encouraging discussion), giving anticipatory guidance, and guided referrals tailored to the woman's individual needs. All project nurses received a 40-hour training programme. Case management sessions lasted for 20 minutes, on average **Control care:** A referral card listing a safety plan and sources for IPV services. No counselling, education, referrals or other services were offered

Data monitoring periods	Primary outcome measures	Number of participants	Participants
Baseline, 6, 12, 18 and 24 months	Validated measures: Abuse (SVAWS) Homicide risk (DAS) Harassment at work (EHQ) Non-validated: Resource use (CRC) Use of safety behaviours	***n* eligible:** 433 ***n* participants:** 360 Intervention: 180 Control: 180 ***n* completing intervention:** Not applicable, one-off session?? ***n* completing follow-up (% of participants):** 319 (89% of recruited)	**Age range:** Intervention Mean = 30 Control Mean = 31 Significant difference ($p = 0.003$) (n/s between-group differences) **Ethnic origin:** Intervention 9% White 22% Black 67% Hispanic 1% other Control 15% White 33% Black 52% Hispanic ($p = 0.01$) **SES:** Income 31% < $5000 21% $5000–10,000 31% $10,000–20,000 17% > $20,000 Education 49% < High school 29% High school grad 22% > High school (n/s between-group differences) **Features of abuse:** Physical sexual abuse **Relationship with abuser (at study entry):** 65% Current spouse 5% Former spouse 16% Current boyfriend 14% Former boyfriend

continued

Author(s), publication year	Setting	Inclusion criteria	Intervention
Sullivan et *al.*, 2002[124] RCT	USA Community – working in the family's home	Females had to have at least one child aged 7–11 living with them, intended to stay in the area for 8 months, with at least one of their children aged 7–11 required to participate; mother had to have experienced some type of physical violence from an intimate partner or ex-partner in the previous 4 months	Intervention to improve well-being in mothers and self-confidence in children, and to serve as a protective factor against continued violence. Three components: (1) a trained paraprofessional helped mothers generate, mobilise and access community resources; (2) similar advocacy for the children; (3) children attended a 10-week support and education group. Intervention was based on the needs of the individual mother and child, but all advocates were instructed to focus on actively assisting mothers and children to access resources and take children to a 10-week support and education group All advocacy had five phases: assessment, implementation, monitoring, secondary implementation, and termination, also tried to ensure that advocate no longer needed after 16 weeks. Details about child intervention not reported here. Intervention lasted 16 weeks, families saw advocates for a mean 9 hours per week (median 8, SD = 2.5), averaging 5 hours with children and an additional 3 hours with the women **Control care:** Does not give any information about the control group women

Data monitoring periods	Primary outcome measures	Number of participants	Participants
Baseline, immediate post-intervention, 4 months post-intervention	Validated: Abuse (IPA, CTS – modified) Depression (CES-D) Self-esteem (RSEI) Non-validated: Quality of life Social support Child measures not included here	***n* eligible:** Not stated ***n* participants:** 80 (cannot calculate response rate) Breakdown by group not stated ***n* completing intervention:** Not stated ***n* completing follow-up (% of participants):** 76 (95% of recruited) Breakdown by group not stated	**Age range:** Mean = 31 (77% < 35 years) (Not stated if any between-group differences) **Ethnic origin:** 49% Non-Hispanic white 39% African American 5% Hispanic/Latina 5% Multiracial 1% Asian 1% Native American (Not stated if any between-group differences) **SES:** Income Mean income $1200 per month, 88% receiving government aid Employment 44% employed (Not stated if any between-group differences) **Features of abuse:** Physical abuse (in last 4 months) **Relationship with abuser (at study entry):** 79% no longer involved with abuser 14% living with abuser 7% involved with abuser but not living together

continued

Author(s), publication year	Setting	Inclusion criteria	Intervention
Tiwari *et al.*, 2005[121] RCT	Hong Kong Public hospital antenatal clinic	Pregnant women aged 18+ years, < 30 weeks' gestation, attending first antenatal appointment, identified as physically, psychologically or sexually abused by an intimate partner within last 12 months	Intervention based on an empowerment protocol to enhance abused women's independence and control: safety advice, choice-making, problem-solving. Some items in the protocol were modified to ensure cultural congruence. A component of empathic understanding, derived from client-centred therapy, was also added. Empathic understanding emphasised the need to take in and accept the woman's perceptions and feelings. It was designed to help women positively value themselves and their own feelings. Session lasted about 30 minutes, women given a reinforcing brochure at end **Control care:** Standard care: a wallet-sized card with information on community resources, including shelter hotlines, law enforcement, social services and non-government organisations
Support group studies			
Fry and Barker, 2002[139] Case–control study	USA DV shelter	Not reported	'Tell Us Your Story' sessions: each woman narrated a story about six salient events that she had experienced in the last 4–6 months. Group facilitator offered encouragement, directed questions, and steered the contents. Sessions ranged from 30 to 90 minutes **Control care:** Women attended information-giving support groups at women's shelters

Data monitoring periods	Primary outcome measures	Number of participants	Participants
Baseline and 6 weeks post-delivery	Validated (although not for telephone administration): Abuse (CTS – modified) Depression (EPDS) Quality of life (SF36)	***n* eligible:** 117 ***n* participants:** 110 ***n* completing intervention:** Not applicable, one-off session ***n* completing follow-up (% of participants):** 106 (96% of recruited women)	**Age range:** Intervention mean = 30 Control mean = 31 (No information on group differences, but look non-significant) **Ethnic origin:** All Chinese **SES:** Income (HK$11,000 average wage): Intervention 13% < $10,000 28% $10,000–20,000 55% > $20,000 Control 19% < $10,000 39% $10,000–20,000 37% > $20,000 (No information on group differences, but control group look to be somewhat poorer) **Features of abuse:** Physical, sexual or psychological abuse **Relationship with abuser (at study entry)** All women stayed with their partners for the pre- and post-test period
Baseline and post-intervention (at 4 months)	Validated: Abuse (ISA, modified) Depression (BDI) Self-esteem (SES) Non-validated: Fry's 25-item measure of Global and Domain-Specific Efficacy Scale, the Ego-strength scale	***n* eligible:** Not reported ***n* participants:** 39 Intervention: 21 Controls: 18 ***n* completing intervention:** Not applicable, one-off session ***n* completing follow-up (% of participants):** 38 (97.4% of recruited women)	**Age range:** Not reported **Ethnic origin:** Not reported **SES:** Not reported **Features of abuse:** Intervention group 'had experienced abuse in the previous 6 months or so' Control group not reported **Relationship with abuser (at study entry):** Not reported

continued

Author(s), publication year	Setting	Inclusion criteria	Intervention
Psychological intervention studies			
Arinero and Crespo, 2004[151] Case–control study	Spain Intervention conducted in a health-care setting Women were referred from social services, counsellors and the judiciary	Women aged over 18 years presenting with at least one post-traumatic symptom but not meeting the diagnostic criteria for PTSD at least a month after the first abusive episode. Women were excluded if they were alcohol or drug users or if they did not speak Castellano	The intervention included psychoeducation, breathing control techniques, self-esteem improvement procedures, cognitive therapy, problem-solving, communication skills training, as well as specific strategies for relapse prevention **Control care:** Waiting list

Data monitoring periods	Primary outcome measures	Number of participants	Participants
Baseline, 1, 3 and 6 months	Validated: Depression (BDI) Self-esteem (Rosenberg scale) Post-traumatic stress symptoms (post-traumatic cognitions inventory) Scale of maladaptation	***n* eligible:** 17 ***n* participants:** 17 Intervention: 12 Controls: 5 ***n* completing intervention:** 12 Intervention women completed ***n* completing follow-up (% of participants):** 17 Intervention: 12 Controls: 5	**Age range:** Intervention Mean = 47.33 (SD = 8.15) Control Mean = 38.8 (SD = 9.81) **Ethnic origin:** Not reported **SES:** Income 50% of the intervention group were economically dependent on their partner Education Intervention: 8.3% had not completed primary education 58.3% completed primary education 25% completed secondary education 8.3% had a university degree Control: 40% had not completed primary education 40% completed primary education 0% completed secondary education 20% had a university degree **Features of abuse:** Intervention: 16.7% psychological 66.7% physical and psychological 16.7% physical, psychological and sexual Control: 20% psychological 80% physical and psychological 0% physical, psychological and sexual **Relationship with abuser (at study entry):** Intervention: 58.3% had denounced partner 25% had left home Control: 60% had denounced partner 80% had left home

continued

Author(s), publication year	Setting	Inclusion criteria	Intervention
Cruz and Sanchez, 2006[152] Before-and-after study	Mexico Community	Women who had completed at least six grades of elementary education, lived with a problem-drinker spouse and suffered some degree of marital abuse or neglect. Women were excluded if they had been referred to psychiatric treatment due to depression, or if they were dependent on alcohol or participating in support groups during the study or receiving psychological or psychiatric treatment	Group cognitive behavioural therapy to promote self-esteem, coping strategies and assertiveness: three main components: (1) identifying and correcting cognitive biases and defective information; (2) establishing emotional regulation strategies; and (3) acquiring assertive interpersonal skills. Women received 18 150-minute weekly group sessions
Gilbert *et al.*, 2006[150] RCT	USA Methadone Maintenance Treatment Programs (MMTPs)	Women aged 18 or older currently enrolled in an outpatient MMTP, who reported using any illicit drug in the past 90 days and reported physical aggression, sexual coercion, injury-related abuse or severe psychological IPV by an intimate partner in the past 90 days. Women were excluded if they had a cognitive impairment that would prevent comprehension of the assessment or intervention or did not speak and understand English at a conversational level	A relapse prevention and relationship safety intervention to help women reduce drug use and IPV: 11 2-hour group sessions and 1 individual session. Sessions were held twice weekly for 6 weeks. Women attended a mean of 11 out of 12 sessions, half of the women attended all 12 sessions and the remaining half attended between 9 and 11 sessions **Control care:** An informational session was provided for the control group and consisted of a 1-hour didactic presentation of a wide range of local community services that women in MMTPs can access, tips on help-seeking, and a comprehensive directory of local IPV-related services

Data monitoring periods	Primary outcome measures	Number of participants	Participants
Baseline, 3, 6 and 18 months	Validated: Assertion (Assertion Inventory) Self-esteem (Self-esteem inventory) Non-validated: Coping (The Birmingham coping inventory)	***n* eligible:** 18 ***n* participants:** 18 ***n* completing intervention:** 18 ***n* completing follow-up (% of participants):** 18 at 3- and 6-month follow-ups 15 (83%) at 18 months	**Age range:** 25–50 **Ethnic origin:** Not reported **SES** Ranged from low to middle Education – ranged from completing elementary school to college education **Features of abuse:** Not reported **Relationship with abuser (at study entry)** All women were still living with the abuser
Baseline and 3-month follow-up	Validated: Abuse (CTS2) Depression (BSI) Drug and alcohol use (Drug and alcohol use behaviour questionnaire) Non-validated: Sexual risk behaviour (SRBQ) PTSD (PTSD Checklist-Civilian)	***n* eligible:** 40 ***n* participants:** 34 ***n* completing intervention:** 31 ***n* completing follow-up (% of participants):** 31 (91%)	**Age range:** Mean 41.8 years (SD = 6.6) **Ethnic origin:** 59.3% Latina 20.6% White 15.6% African American **SES:** Education: 54.5% graduated from high school Employment: 21.8% were currently employed **Features of abuse:** Physical aggression, sexual coercion, injury-related abuse or severe psychological IPV 63% of the intervention group and 44% of the control group had experienced severe physical or sexual abuse **Relationship with abuser (at study entry):** Not reported

continued

Author(s), publication year	Setting	Inclusion criteria	Intervention
Koopman *et al*., 2005[142] RCT	USA Community	Women over 18 years, who had experienced IPV. Able to converse and write in English and living in conditions that the women judged as safe from abuse.	Individual expressive writing sessions used to write about the most stressful events of a woman's life, exploring her deepest emotions and feelings **Control care:** Neutral writing task. Women wrote as objectively as possible about their daily schedule, and how they used their time

Data monitoring periods	Primary outcome measures	Number of participants	Participants
Baseline and post-intervention (at 4 months)	Validated: Pain (Bodily Pain Scale of the SF36 Health Survey) Depression (BDI) PTSD (PCL-S)	***n* eligible:** Not reported ***n* participants:** 59 Not known how many in each group ***n* completing intervention:** Not applicable, one-off session ***n* completing follow-up (% of participants):** 47 (80% of recruited women)	**Age range:** 21–56 Mean = 36.5 (SD = 8.9) (No between-group differences) **Ethnic origin:** White/European American 68%, Latina/Hispanic 13%, Middle Eastern 6%, African American 6%, Asian American 2% and other 4% (No between-group differences) **SES:** 43% of the women were employed full-time, with an additional 21% employed part time and 36% not employed. No between-group differences 60% of the sample reported a household income under US$40,000. No between-group differences Education ranged from high school to completing graduate school, a median had completed some college. Intervention women completed more years (16.8 years) than controls (mean 14.8 years), but not related to the outcome measures. **Features of abuse:** Abuse was 'quite severe': 83% had been slapped, hit or punched, 79% had been pushed or shoved, 50% had been choked, 46% had been kicked, 46% had been raped and 16% had been threatened with a weapon **Relationship with abuser (at study entry):** Not living with abuser. On average, women had left abuser 5 years earlier.

continued

Author(s), publication year	Setting	Inclusion criteria	Intervention
Labrador *et al.*, 2006[144] Case–control study	Spain University and centres where women were contacted Women were referred from the municipal centre for women, judges of the first instance, women's counsellors for women's housing and victim support centres	Women who had experienced domestic violence and who were diagnosed with chronic post-traumatic stress disorder according to the 'DSM-IV-TR' criteria. Women were excluded if they had a previous diagnosis of a mental disorder, were likely to commit suicide, misused drugs or alcohol. or were already receiving therapy for the problem	The intervention group was split in half, the first group (GE-1) received (1) self-evaluation and problem-solving, (2) breathing control, (3) exposure therapy (which involved recalling past events and confronting flashbacks), and (4) cognitive therapy. The second group (GE-2) received (1) self-evaluation and problem-solving, (2) breathing control, (3) cognitive therapy and (4) exposure therapy (in that order). There were eight sessions of 60 minutes, delivered weekly **Control care:** Waiting list

Data monitoring periods	Primary outcome measures	Number of participants	Participants
Baseline and post-test (2 months after the start of the intervention)	Validated: Depression (BDI) Self-esteem (Rosenberg scale) Scale of maladaptation Post-traumatic Cognition Inventory	***n* eligible:** Not reported ***n* participants:** 20 (10 intervention, 10 control) ***n* completing intervention:** 18 (8 intervention, 10 control) ***n* completing follow-up (% of participants):** Not applicable: 80% had post-treatment data, no follow-up was conducted after post-treatment	**Age range:** 19–50 years Mean 35 **Ethnic origin:** Not reported **SES:** Education Intervention: 0% Primary not completed 40% Primary completed 50% Secondary 10% University Control: 20% Primary not completed 50% Primary completed 30% Secondary 0% University Employment Intervention: 50% Service sector 30% Administrative sector 10% Housewife 10% Unemployed Control: 60% Service sector 0% Administrative sector 10% Housewife 30% Unemployed Class Intervention: 40% Medium-low 60% Medium Control: 100% Medium-low **Features of abuse:** Median length of abuse 7.6 years 15% Physical 10% Psychological 35% Harassment 40% Needed medical attention **Relationship with abuser (at study entry):** Not reported

continued

Author(s), publication year	Setting	Inclusion criteria	Intervention
Reed and Enright, 2006[143] RCT	USA Not reported Women were all self-selecting volunteers: 10% responded to recruitment flyers (posted in domestic abuse resource centres) and 90% responded to newspaper advertisements	Women between the ages of 25 and 55 who had experienced spousal psychological abuse but not physical abuse and who had been permanently separated for at least 2 years. Women were excluded if they were currently involved in an abusive relationship, had a history of childhood physical abuse, or had a significant ongoing psychiatric illness, such as suicidal ideation or psychosis	Forgiveness therapy based on the Enright forgiveness process model. Participants determined the time spent on each forgiveness topic. Sessions were held weekly and the mean treatment time (one 1-hour session per week) was 7.95 months (SD = 2.61), with a minimum of 5 months and a maximum of 12 months. There was no prescheduled number of sessions, therapy ended when the woman reported the work was complete **Control care:** Alternative treatment (AT): participants engaged in 1-hour weekly participant-initiated discussion of current life concerns (considering the impact of past abuse) and in intervener-facilitated therapeutic discussions about the validity of anger regarding the injustice of past abuse, present strategies for healthy assertive choices, and interpersonal relationship skills. Participants determined the time spent on each participant-initiated concern. The AT was designed and delivered to match as closely as possible the basic elements of the therapy approach (anger, validation with mourning, assertiveness strategies, and interpersonal skills)
Children's studies			
Ducharme *et al.*, 2000[166] Parallel group study	Canada Women's homes Mother–child dyads were referred from child welfare agencies, school boards, women's shelters and other social service agencies as well as directly from potential participants	Women had experienced family violence and had children aged 3–10 with severe behaviour problems.	The intervention aimed to improve parent–child cooperation through the use of 'errorless compliance training', a success-based, non-coercive intervention involving the hierarchical introduction of more demanding parental requests at a gradual pace, which lasted between 14 and 28 weeks **Control care:** Delayed treatment

Data monitoring periods	Primary outcome measures	Number of participants	Participants
Baseline, post-test and follow-up (the length of the follow-up period was not reported).	Validated: Forgiveness (EFI) Self-esteem (CSEI) Anxiety (STAI) Depression (BDI-II) Environmental mastery (Environmental Mastery Scale) Finding meaning in suffering (Reed Finding Meaning in Suffering Scale) Post-traumatic stress (DSM-IV criteria checklist) Non-validated: Role of the abuse in women's lives (story measure)	***n* eligible:** Not reported ***n* participants:** 20 (10 intervention, 10 control) ***n* completing intervention:** 20 (10 intervention, 10 control) ***n* completing follow-up (% of participants):** 20 (10 intervention, 10 control) 100%	**Age range:** 32–54 years Mean 44.95 (SD = 7.01) **Ethnic origin:** 90% European American 5% Hispanic American 5% Native American **SES:** Education – 20% had a high-school diploma or general equivalency diploma, 30% had some college education or an associate's degree, 20% were college graduates, 15% had some postgraduate degrees Employment – 15% were unemployed, 25% had part-time employment, 60% had full-time employment. **Features of abuse:** Psychological abuse without physical abuse. All women had experienced serious emotional abuse. **Relationship with abuser (at study entry)** Participants had been divorced or separated for at least 2 years from their partner.
Request compliance was observed throughout treatment. All other outcomes were baseline and follow-up (6 months) only	Validated: Child behaviour (CBCL) Parental stress (PSI) Non-validated: Compliance probability checklist Observational measures of compliance	***n* eligible:** Not reported ***n* participants:** 22 families (22 mothers, not stated how many children) Not stated how many were in intervention and control groups ***n* completing intervention:** 9 mothers (and their 15 children) ***n* completing follow-up (% of participants):** 9 mothers (and their 15 children) 41%	**Age range:** 21–56 Mean = 36.5 (SD = 8.9) (No between-group differences) **Ethnic origin:** Not reported **SES:** All mothers were receiving welfare assistance. All had received some high-school education, but only one had some college education. **Features of abuse:** Mean Conflict Tactics Scale score represented a minimum of 38.6 physically aggressive acts and 77.7 verbally aggressive episodes **Relationship with abuser (at study entry):** Women were no longer living with the abuser

continued

Author(s), publication year	Setting	Inclusion criteria	Intervention
Jouriles *et al.*, 2001[162] McDonald *et al.*, 2006 (24-month follow-up)[163] RCT	USA DV shelter/ women's homes	Preliminary requirements: mothers had to (1) report the occurrence of at least one physically violent act from a male partner during the previous 12 months and (2) have at least one child in the 4–9-year-old range who met *DSM-IV* criteria for oppositional defiant disorder or conduct disorder. For families in which more than one child met initial eligibility criteria, the youngest child to do so was selected as the target child Post-shelter requirements: (1) mother and target child had to be living together; (2) they had to be in a residence in which the former partner was not a member of the household; (3) the residence had to be within 50 miles of the shelter; and (4) the residence had to be safe enough for project staff to visit	Two components: (1) provided mothers and children with social and instrumental support and mothers with problem-solving skills; and (2) taught mothers to use certain child management skills designed to help reduce their children's conduct problems. Students served as mentors for the children. Therapists and mentors provided emotional support to the women during their transition from the shelter and helped them obtain physical resources and social support. The intervention was designed to include weekly sessions of 1–1.5 hours and began after shelter departure and continued for up to 8 months **Control care:** Families were contacted monthly either in person or by telephone. Families were encouraged to use existing community or shelter services. With the exception of immediate safety concerns, the families in the comparison condition received no clinical services through the programme or from the therapists, other than referrals and the tangible goods

Data monitoring periods	Primary outcome measures	Number of participants	Participants
Assessment sessions lasted 2–3 hours and consisted of mother's completion of questionnaires and a videotaped 45-minute family interaction. Assessments were repeated every 4 months resulting in a total of five assessments over a 16-month period.	Validated: Child behaviour (CBCL) Mother's psychological distress (SCL-90-R) Recurrence of abuse (CTS) Child's oppositional defiant disorder and conduct disorder symptoms (*DSM-IV* diagnostic criteria) Children's happiness/ social relationships (Gesten's Health Resources Inventory) Maternal aggression towards children (CTS-R) Non-validated: Child management skills Contact with partner	***n* eligible:** 73 Post-shelter eligibility 40 ***n* participants:** 36 (18 intervention, 18 control) ***n* completing intervention:** 31 ***n* completing follow-up (% of participants):** 31, 86% at 8-month follow-up 32, 83% at 24-month follow-up	**Age range:** Mother's mean: 27.97 (SD = 4.90) (24-month follow-up mean 28.7, SD = 4.9) Children's mean: 5.67 (SD = 1.88) (24-month follow-up mean 5.5, SD = 1.7) **Ethnic origin:** 11 African American, 10 Caucasian, 12 Latino, 1 Asian American, and 2 other 24-month follow-up: 9 Caucasian, 11 African American, 8 Latino, 1 Asian American and 1 other **SES:** All participants were on low income: mothers reported a mean pre-shelter income of $7500 (SD = $7100) and 89% reported receiving some form of public financial assistance during the year prior to their shelter residence Mother's education: mean 11.03 years, SD 2.19 24-month follow-up: All of the families could accurately be described as living in poverty: mothers reported a mean pre-shelter annual income of $7100 (SD = $6130), with 64% having received some form of financial assistance during the year prior to shelter entry. Immediately after shelter departure, 84% were receiving public assistance. Over the course of the 24-month follow-up period 13% were unemployed the whole time. **Features of abuse:** Mean number of acts of violence perpetrated toward the women during the year prior to coming to the shelter was estimated at 68.38 (SD = 53.65) **Relationship with abuser (at study entry):** Women were not living with the abuser

continued

Author(s), publication year	Setting	Inclusion criteria	Intervention
Lieberman *et al.*, 2005[160] Lieberman *et al*., 2006[161] RCT	USA Not reported	Child–mother dyads were recruited if the child was 3 to 5 years old, had been exposed to marital violence as confirmed by mother's report on the Conflict Tactics Scale 2, and the perpetrator was not living at home	Child–parent psychotherapy (CPP): weekly joint child–parent sessions were interspersed with individual sessions with the mother. The intervention aimed to change maladaptive behaviours and support developmentally appropriate interactions. The treatment group attended a mean of 32.09 CPP sessions (SD 15.20)

Data monitoring periods	Primary outcome measures	Number of participants	Participants
Dyads were assessed at intake, 6 months into treatment, at the conclusion of 12 months' treatment, and 6 months post-treatment. The Symptoms Checklist-90 Revised was the only mother-related measure administered at 6 months' follow-up	Validated: Child behaviour (CBCL) Children's traumatic stress disorder (semistructured interview for diagnostic classification DC: 0–3 for clinicians) Mother's stress (life stressor checklist-revised) Psychiatric symptoms (Symptoms Checklist-90 Revised) Mother's PTSD, re-experiencing, avoidance and hyperarousal symptoms (CAPS)	***n* eligible:** Not reported ***n* participants:** 75 children and their mothers **2006 paper:** 42 were in the intervention group and 33 in the control group ***n* completing intervention:** 65 (87% of recruited) ***n* completing follow-up (% of participants):** **2006 paper:** 6-month follow-up: 50 (27 in the intervention group and 23 in the comparison), 67%	**Age range:** 3–5 years Mean: 4.06 (SD = 0.82) Mothers' ages not reported **Ethnic origin:** Children: 38.7% had mixed ethnicity (predominantly Latino/white) and the rest were 28% Latino, 14.7% African American, 9.3% White, 6.7% Asian and 2.6% Other Mothers: 37.3% Latina, 24% white, 14.7% African American, 10.7% Asian, and the rest were mixed or other ethnicities **SES:** Mean monthly family income was $1817 (SD = $1460; range $417–$8333). Public assistance was received by 23% of the families and 41% had incomes below the federal poverty level according to the Department of Health and Human Services Guidelines. Mean duration of maternal education was 12.51 years (SD = 3.96). **Features of abuse:** Not reported **Relationship with abuser (at study entry):** Women were not living with their abusers at the start of the study. However, 17% of mothers either returned to their violent partners or entered a new violent relationship during the study

continued

Author(s), publication year	Setting	Inclusion criteria	Intervention
McFarlane *et al*., 2005 (baseline and 1-year follow-up)[165] McFarlane *et al.*, 2005 (2-year follow-up)[164] RCT	USA Two primary care public health clinics and two women, infants, and children clinics (WICs)	Women aged 18–44 years, English or Spanish speaking, identified by nurse as physically or sexually abused by an intimate partner (including girlfriends and ex-girlfriends) within last 12 months (AAS). Women had a child aged 18 months to 18 years who lived with them	A nurse case management intervention empowering abused women by increasing independence/control, based on Dutton's empowerment model: focus on protection/safety, enhanced choice-making/problem-solving. An underlying feature of the model is that each woman knows what is best for her and her children, and the nurse is simply facilitating this (by listening, encouraging discussion), giving anticipatory guidance, and guided referrals tailored to the woman's individual needs. All project nurses received a 40-hour training programme. Case management sessions lasted for 20 minutes, on average **Control care:** A referral card listing a safety plan and sources for IPV services. No counselling, education, referrals or other services were offered

Data monitoring periods	Primary outcome measures	Number of participants	Participants
Baseline, 6, 12, 18 and 24 months	Validated measures: Child behaviour (CBCL)	***n* eligible:** 360 ***n* participants:** 258 ***n* completing intervention:** Not applicable, one-off session?? ***n* completing follow-up (% of participants):** 12-month follow-up: 80% 24-month follow-up: 233 90%	**Age range:** Intervention: Mean = 30 Control: Mean = 31 Significant difference $p = 0.003$ (n/s between-group differences) **Ethnic origin:** 67% of the children were Hispanic, 26% African American, 7% Caucasian **SES:** Income: 31% < $5000 21% $5000–10,000 31% $10,000–20,000 17% > $20,000 Education: 49% < high school 29% high-school graduate 22% > high school (n/s between-group differences) **Features of abuse:** Physical sexual abuse **Relationship with abuser (at study entry):** 65% current spouse 5% former spouse 16% current boyfriend 14% former boyfriend

continued

Author(s), publication year	Setting	Inclusion criteria	Intervention
Sullivan et *al.*, 2002[124] RCT	USA Community – working in the family's home	Females had to have at least one child aged 7–11 years living with them, intended to stay in the area for 8 months, and at least one of their children aged 7–11 was required to participate; mother had to have experienced some type of physical violence from an intimate partner or ex-partner in the previous 4 months	Intervention to improve well-being in mothers and self-confidence in children, and to serve as a protective factor against continued violence. Three components: (1) a trained paraprofessional helped mothers generate, mobilise, and access community resources; (2) similar advocacy for the children; (3) children attended a 10-week support and education group. Intervention was based on the needs of the individual mother and child, but all advocates instructed to focus on actively assisting mothers and children to access resources and take children to a 10-week support and education group. All advocacy had five phases: assessment, implementation, monitoring, secondary implementation, and termination, and also tried to ensure that the advocate was no longer needed after 16 weeks. Intervention lasted 16 weeks, families saw advocates for a mean 9 hours week (median 8, SD = 2.5), averaging 5 hours with children and an additional 3 hours with the women **Control care:** No information about the control group women

BDI, Beck Depression Inventory; BSI, Brief Symptom Inventory; CBCL, Child Behaviour Checklist: CES-D, Center for Epidemiologic Studies Depression Scale.

Data monitoring periods	Primary outcome measures	Number of participants	Participants
Baseline, immediate post-intervention, 4 months post-intervention	Validated: Abuse (IPA, CTS – modified) Depression (CES-D) Self-esteem (RSEI) Child's self-competence (self-perception profile for children) Non-validated: Quality of life Social support Child's contact with assailant Child's witnessing abuse (mother's responses) Assailant's abuse of child (average of emotional abuse of child, injury of child and overall abuse of child)	***n* eligible:** Not reported ***n* participants:** 80 Breakdown by group not stated ***n* completing intervention:** Not reported ***n* completing follow-up (% of participants):** 76 (95% of recruited) Breakdown by group not stated	**Age range:** Mean = 31 (77% < 35 years) Children ranged from 6.5 to 11 years, with the mean at 8.3 **Ethnic origin:** 49% Non-Hispanic white 39% African American 5% Hispanic/Latina 5% Multiracial 1% Asian 1% Native American Children: 44% were African American, 40% were non-Hispanic white, 10% were multiracial, 5% were Hispanic and 1% were Asian (Not stated if any between-group differences) **SES:** Income: Mean income $1200 per month, 88% receiving government aid Employment: 44% employed (Not stated if any between-group differences) **Features of abuse:** Physical abuse (in last 4 months) **Relationship with abuser (at study entry):** 79% no longer involved with abuser 14% living with abuser 7% involved with abuser but not living together

Appendix 7.2: Results of intervention studies and quality scores

Author(s), publication year	Outcomes including any multivariate analysis/adjustment for confounders	Quality scores (USPSTF, Jadad)
Advocacy studies		
Bybee and Sullivan, 2005[130]	These results are based on the findings as reported in the 2005 paper (3-year follow-up of the original sample recruited in 1992)	Fair, Greatest
	Contact with original assailant: 19% still involved with the man and 50% had had contact in last 6 months. No data by condition	Jadad 1
	Assault by perpetrator over last year: 19% ($n = 23$). Of these, 65% ($n = 15$) were still in a relationship with the man. Mean severity of assaults = 2.00 (severe abuse occurring once a month or less). No data about if there was any condition effect	
	Harassment and intimidation over last 6 months: 22% no longer reported such behaviour. No significant condition effects	
	New relationships: 81% had new relationship some time over the 3 years. 19% ($n = 23$) of the total sample had been assaulted by new partner in last 6 months. Mean severity of assaults = 2.13 (severe abuse occurring once a month or less). No data about if any condition effect	
	Condition effects at 3 years	
	MANOVA (physical abuse, quality of life, social support, difficulty accessing resources) was significant, $p = 0.089$ (alpha had been set at > 0.10 to avoid type II errors), suggesting that there were modest overall differences between conditions at 3 years	
	Univariate one-way ANOVAs also conducted and two attained significance: quality of life ($p = 0.058$), social support ($p = 0.016$); the two non-significant findings related to physical abuse ($p = 0.18$) and DOR ($p = 0.13$)	
	(Race was also added into a second analysis, but there was no main effect for race or any interaction with condition)	
	Physical abuse at 3-year follow-up and change from 2-year follow-up	
	36% ($n = 44$) experienced some level of physical abuse by a partner or ex-partner during past 6 months	
	28% ($n = 34$) experienced severe physical abuse by a partner or ex-partner during past 6 months	
	These percentages were similar to those at 2-year follow-up, but there was a correlation of only 0.53, so some women improved whereas others became re-abused. Only 53% ($n = 66$) of the women reported no abuse at either 2- or 3-year follow-up	
	There was a slight increase for women in advocacy intervention (up from 31% to 36%) and a slight decline in the control group (down from 43.55% to 35.5%), but these changes did not differ significantly by condition ($p = 0.44$)	
	Continued abuse risk predicted by: prior abuse (last 6 months), difficulties accessing resources, problems with state welfare system, social contacts making life more difficult	
	Reduced risk predicted by: being employed, higher quality of life, social contacts providing practical help or available to talk	

Author(s), publication year	Outcomes including any multivariate analysis/adjustment for confounders	Quality scores (USPSTF, Jadad)
Constantino *et al.*, 2005[122]	**Social support (ISEL)**	Fair, Greatest
	Total score: A trend towards significance ($p = 0.060$). Control group pre- to post-intervention means 19.54 to 29.00. Intervention group pre- to post-intervention means 20.64 to 21.91	Jadad 2
	Belonging subscale: Intervention group had a statistically significantly greater improvement post-treatment than control group ($p = 0.016$). Control group pre- to post-intervention means of 4.54 to 7.54. Intervention group pre- to post-intervention means of 6.00 to 4.82	
	Tangible subscale: A trend towards significance ($p = 0.084$). Control group pre- to post-intervention means 4.31 to 7.23. Intervention group pre- to post-intervention means 4.82 to 5.55	
	Appraisal subscale: no trend found	
	Self-esteem subscale: no trend found	
	Psychological distress (BSI): Intervention group had statistically significantly greater improvement ($p = 0.013$). Control group pre- to post-intervention means of 152.15 to 108.38. Intervention group pre- to post- means of 159.73 to 151.36	
	Health-care utilisation (HSQ): Intervention group showed statistically significant less health-care utilisation ($p = 0.032$). Control group pre- to post-intervention means of 0.82 to 0.21. Intervention group showed pre- to post- means of 0.36 to 0.29	
McFarlane *et al.*, 2006[123]	For a like-with-like analysis, combined 6 and 12 months, and 18 and 24 months'	Fair, Greatest
	Main finding is that there was no effect for the intervention; all outcomes improved over time, regardless of group allocation:	Jadad 2
	Both groups reported significantly ($p < 0.001$) fewer threats of abuse, assaults, danger risks for homicide, events of work harassment	
	Both groups reported significantly ($p < 0.001$) more safety behaviours but community resource use declined	
	Subgroup analyses – abuse scores were stratified into tertiles; again there was no differential effect of the intervention (no statistics reported)	
	Adverse effects: none reported by study participants	

continued

Author(s), publication year	Outcomes including any multivariate analysis/adjustment for confounders	Quality scores (USPSTF, Jadad)
Sullivan *et al.*, 2002[124]	Analysis based on 76/78 (97.5%) as missing follow-up data imputed	Fair, Greatest
	Abuse (no effect): For intervention women, mean abuse steeply declined from baseline to post-intervention and then remained relatively stable when tested again at 4 months' follow-up; for control group women, there was a less steep decline from baseline to post-intervention, but this then increased until they were very similar to the intervention women at 4 months' follow-up (quadratic relationship, $p < 0.05$)	Jadad 2
	Well-being (no significant effect): Effect of intervention on mothers' overall general well-being (quality of life, social support, depression, self-esteem) over time was marginally significant ($p < 0.08$)	
	Quality of life (no significant effect): mean increased from baseline to 4 months' follow-up for intervention women, whereas it slightly decreased for control group women (linear relationship, $p < 0.10$)	
	Social support (no effect): mean increased from baseline to post-intervention but reverted to baseline at 4 months' follow-up for intervention women, whereas it worsened from baseline to post-intervention but reverted to baseline at 4 months' follow-up for control group women (quadratic relationship, $p < 0.10$)	
	Depression: mean declined from baseline to 4 months' follow-up for intervention women, whereas it slightly increased for control group women (linear relationship, $p < 0.05$)	
	Self-esteem: mean increased from baseline to 4 months' follow-up for intervention women, whereas it stayed the same for control group women (linear relationship, $p < 0.05$)	
Tiwari *et al.*, 2005[121]	The analysis was conducted on an 'intention-to-treat' basis. In addition, a per-protocol analysis was conducted on the 106 participants who completed. There were no differences when comparing the results of the two analyses. N.B. It is not reported if they tested for baseline differences between groups for outcome measures and demographic measures, although – with the possible exception of income and there being more sexual abuse in the control group at baseline – the baseline outcome measures look very similar	Good, Greatest Jadad 4
	Abuse (CTS): Following the intervention, the experimental group reported significantly less psychological abuse (mean difference 1.1, 95% CI –2.2 to 0.04, $p<0.05$) and less minor physical violence (mean difference –1.0, 95% CI –1.8 to 0.17, $p<0.05$. Severe abuse and sexual abuse did not differ between groups	
	Quality of life (SF36): Following the intervention, the experimental group had significantly higher physical functioning (mean difference 10, 95% CI 2.5–18, $p < 0.05$) and significantly improved scores on the role limitation measures for both physical (mean difference 19, 95% CI 1.5–37, $p < 0.05$) and emotional problems (mean difference 28, 95% CI 9–47, $p < 0.05$). There was, however, more bodily pain reported in this group. General health, vitality, social functioning, and mental health did not differ between groups	
	Depression (EPDS): Significantly fewer women in the intervention group had postnatal depression at follow-up. Twenty-five controls scored ≥10 compared with nine interventions (RR 0.36, 95% CI 0.15–0.88)	
	Adverse events: At follow-up, women asked if the frequency of violence had increased since the last interview, and if so, whether it was the result of their taking part in this study. No adverse events were reported by the women in the experimental or control group as a result of receiving the intervention or standard care	

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Author(s), publication year	Outcomes including any multivariate analysis/adjustment for confounders	Quality scores (USPSTF, Jadad)
Support group studies		
Fry and Barker, 2002[139]	Main finding is that there was no effect for the intervention; all outcomes improved over time, regardless of group allocation:	Poor, Greatest
	Depression: Both the intervention group and the control group experienced significant reductions in depression ($p < 0.001$), but the reductions in the intervention group were greater	Jadad not applicable
	Ego Strength Scale: Both the intervention group and the control group experienced significant improvements in the ability to share feelings, feelings of personal adequacy, and a sense of reality (measured by the Ego Strength Scale) ($p < 0.001$), but the improvements in the intervention group were greater	
	Self-efficacy: Both the intervention group and the control group experienced significant improvements in global self-efficacy scores ($p < 0.001$), but the improvements in the intervention group were much greater	
	Self-esteem: Both the intervention group and the control group experienced significant improvements in self-esteem scores ($p < 0.001$), but the improvements in the intervention group were greater	
Psychological intervention studies		
Arinero and Crespo, 2004[151]	Main finding is that there was a significant decrease in post-traumatic and depressive symptoms and an improvement in adaptation levels, which was maintained at 6-month follow-up. There were no significant improvements in self-esteem	Poor, Greatest
	Depression: There were significant decreases in depression for the intervention group post-treatment ($p \leq 0.01$), the authors state this was still significant at 6 months but no data were presented. The effect size post-treatment was 0.95 and at the 1-month follow-up it was 0.66, but effect sizes for the 3- and 6-month follow-ups were not presented	Jadad not applicable
	Self-esteem: There was a small increase in self-esteem for both the intervention and control groups but this was not significant at any time point	
	Maladaptation: The intervention group had significant decreases in scores on the global scale of maladaptation post-treatment ($p \leq 0.01$), at 1- and 3-month follow-ups ($p \leq 0.05$), and at 6-month follow-up ($p \leq 0.01$). The effect size at post-treatment was 1, and at 6-month follow-up it was 1.26	
	PTSD: The intervention group had significant decreases on the avoidance subscale, which were maintained at 6-month follow-up ($p \leq 0.01$), with an effect size of 1.12. Decreases on the hyperarousal subscale were significant at 1- and 3-month follow-up ($p \leq 0.05$), but not the 6-month follow-up. Decreases on the re-experiencing subscale were significant only at the 1-month follow-up ($p \leq 0.05$). The intervention group had decreases in the total post-traumatic thoughts scale but this only reached significance at the 6-month follow-up ($p \leq 0.01$). The effect size for total post-traumatic thoughts at post-treatment was 0.36, and at 6-month follow-up it was 0.53	

continued

Author(s), publication year	Outcomes including any multivariate analysis/adjustment for confounders	Quality scores (USPSTF, Jadad)
Cruz and Sanchez, 2006[152]	**Self-esteem:** Increases in self-esteem were significant at all three follow-up periods (3, 6 and 18 months), but there were no significant changes from pre-test to immediate post-test **Coping strategies:** Differences were statistically significant from pre-test to all three follow-ups. Non-significant differences were obtained from pre-test to post-test **Assertiveness:** The likelihood to act showed statistically significant increases from both pre-test to follow-ups 1 and 2 along with pre-test to 2, but no significant changes were found between pre- and post-test, or at the third follow-up Degree of discomfort differences from pre-test to follow-up 2 revealed only a marginal significance ($p < 0.10$). Differences from pre-test to immediate post-test and follow-ups 1 and 3 showed non-significant statistical differences	Poor, Moderate Jadad not applicable
Gilbert *et al.*, 2006[150]	**Abuse:** Women in the intervention group were 7.1 times more likely than women in the information group to report a decrease in experiencing minor physical, sexual and/or injurious IPV in the past 90 days at the follow-up assessment ($p = 0.05$) Women in the intervention group were more likely than women in the information group to report a decrease in both minor psychological IPV (OR = 5.3, $p = 0.03$) and severe psychological IPV (OR = 6.07, $p = 0.03$) Women in the intervention group were 5.3 times more likely than women in the information group to report a decrease in experiencing any physical, sexual and/or injurious IPV at the 3-month follow-up assessment, but this was not significant ($p = 0.10$) Compared to women in the information group, women receiving the intervention were also 7.1 times more likely to report a decrease in experiencing severe physical IPV, but this was not significant ($p = 0.07$) No significant differences were found between women in the intervention and information groups with respect to sexual IPV or injurious IPV outcomes **Substance use:** Women in the intervention group were 3.3 times more likely than women in the control group to report a decrease in any drug use in the past 90 days at follow-up, but the difference was not significant ($p = 0.08$) Women in the intervention group were more likely to report a decrease in binge drinking and crack cocaine use, but the difference was not significant No significant differences were found between the groups with respect to their heroin or marijuana use at follow-up **Depression:** Women in the intervention group were 5.7 times more likely than women assigned to the control group to report a decrease in their level of depression at 3 months' follow-up ($p = 0.01$) **PTSD:** Women in the intervention group were 4.6 times more likely than women assigned to the control group to report a decrease in avoidance PTSD symptoms, but the difference was not significant ($p = 0.06$). No significant differences were found between women in the intervention and control groups with respect to changes in their hyperarousal or re-experiencing PTSD symptoms at the 3-month follow-up	Fair, Greatest Jadad 2

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Author(s), publication year	Outcomes including any multivariate analysis/adjustment for confounders	Quality scores (USPSTF, Jadad)
	Sexual HIV risk behaviour: Women in the intervention group were 6.1 times more likely than women in the control group to report a decrease in having sex while high on illicit drugs ($p = 0.04$). Women in the intervention group were also more likely than the control group to report a decrease in having multiple sex partners, but the difference was not significant at a 95% level (OR = 2.77, $p = 0.09$) No significant differences were found between groups with respect to changes in the number and proportion of protected sexual acts at the 3-month follow-up **Adverse events:** None of the potential adverse events identified by the authors or other adverse events were detected	
Koopman *et al.*, 2005[142]	**Depression and PTSD:** At baseline, 40% of women reported significant levels of pain, 53% met criteria for likely PTSD, and 40% met screening criteria for clinical depression Intervention group had reduced depression at follow-up [difference scores intervention group mean −5.8 (10.3), control group mean −2.6 (6.7)]. The mean difference score for PTSD in the treatment group was −6.6 (10.3) and in the control group −6.2 (12.4). The mean difference score for bodily pain in the treatment group was 0.1 (1.7) and in the control group 0.3 (2.7) Women who were more severely depressed at baseline and allocated to the intervention fared significantly better in terms of follow-up depression scores when compared with their similarly baseline depressed control counterparts (interaction $p = 0.05$) Paradoxically, the reverse was true for bodily pain; here women in greater pain at baseline benefited more if allocated to the control condition (interaction $p < 0.05$) There was no group×time interaction for PTSD **Adverse effects:** None, as the safety net of referral to the clinical psychologist was not needed	Fair, Greatest Jadad 3
Labrador *et al.*, 2006[144]	**Depression:** The intervention group had reductions in their mean level of depression from 23.63 (7.17) pre-treatment to 11.13 (9.17) post-treatment. The control group's mean level of depression pre-treatment was 29.8 (10.92) and post-treatment it was 30.2 (12.14). An ANOVA (2×2) showed that along with the significant time effect there was also a significant condition effect ($p < 0.05$) **Self-esteem:** The intervention group showed increases in their mean level of self-esteem from 24 (4.1) pre-treatment to 30.13 (3.6) post-treatment. The control group's mean level of self-esteem pre-treatment was 23.6 (4.81) and post-treatment it was 22 (3.62). An ANOVA (2×2) showed that along with the significant time effect there was also a significant condition effect ($p < 0.05$) **Maladaptation** The intervention group showed reductions in their mean level of maladaptation from 20.38 (4.5) pre-treatment to 12.73 (7.17) post-treatment. The control group's mean level of maladaptation pre-treatment was 21.4 (5.12) and post-treatment it was 21.7 (6.03). An ANOVA (2×2) showed that along with the significant time effect there was also a significant condition effect ($p < 0.05$)	Fair, Greatest Jadad not applicable

continued

Author(s), publication year	Outcomes including any multivariate analysis/adjustment for confounders	Quality scores (USPSTF, Jadad)
	PTSD: The intervention group experienced reductions in their mean level of PTSD on the inventory of post-traumatic cognitions from 14.64 (3.16) pre-treatment to 9.62 (3.59) post-treatment. The control group's mean level of PTSD on the inventory of post-traumatic cognitions pre-treatment was 14.38 (3.66) and post-treatment it was 14.19 (3.86). An ANOVA (2×2) showed that there was no significant condition effect ($p > 0.05$). There was a significant condition effect on one item of the inventory of post-traumatic cognitions on which the intervention group displayed reductions: negative cognitions ($p < 0.05$)	
Reed and Enright, 2006[143]	**Comparison of mean change from pre-test to post-test:**	Fair, Greatest
	Statistical significance was demonstrated on all the dependent variables, with the exception of state anxiety	Jadad 2
	Women in the intervention group demonstrated a significantly greater increase in forgiving the former abusive partner ($p < 0.001$), in self-esteem ($p < 0.05$), in environmental mastery (everyday decisions; $p < 0.05$), in finding meaning in suffering (moral decisions; $p < 0.05$) and in new stories (survivor status; $p < 0.01$)	
	The intervention group also demonstrated a significantly greater reduction in trait anxiety ($p < 0.05$), depression ($p < 0.05$), in post-traumatic stress symptoms ($p < 0.05$), and in old stories (victim status; $p < 0.001$)	
	There was within-group statistical significance (in the intervention group from pre-test to post-test) for improvements in state anxiety scores ($p < 0.05$)	
	Comparison of mean change from pre-test to post-test and from pre-test to follow-up for intervention women:	
	The intervention group had significant improvements in self-esteem, state anxiety and trait anxiety between post-test and follow-up ($p < 0.05$)	
	The improvements experienced by the intervention group on forgiveness, depression, environmental mastery (everyday decisions), finding meaning in suffering (moral decisions) and in new stories (survivor status) were maintained at follow-up	
Children's studies		
Ducharme *et al.*, 2000[166]	N.B. The results reported are across groups, i.e. interventions and controls combined – presumably with the latter having received the intervention (so only a before-and-after analysis)	Fair, Greatest
	Compliance	Jadad not applicable
	Baseline: high compliance for level I requests (89.4%) graduating downwards to 36.9% for level 4 requests	
	Treatment (progressive difficulty of requests):	
	Level 1 requests: high compliance (86.9%), similar to baseline	
	Level 2 requests: high compliance (86.6%), an increase of 12% over baseline	

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Author(s), publication year	Outcomes including any multivariate analysis/adjustment for confounders	Quality scores (USPSTF, Jadad)
	Level 3 requests: high compliance (85.7%), an increase of 25% over baseline Level 4 requests: high compliance (86.1%), an increase of 49% over baseline Follow-up for level 4 requests: high compliance (82.9% at 1 month, 89.1% at 3 months, 81.2% at 6 months) Across all children mean compliance to phase 1 requests was 86.9% (similar to the high compliance levels demonstrated to level 1 requests in baseline). Mean compliance across all children in phase 2 was 86.6% (an increase of 12 percentage points over baseline). Mean compliance to level 3 requests was 85.7% (an increase of 25 percentage points over baseline levels). In phase 4 the mean compliance score across all children was 86.1% (an increase of 49 percentage points over baseline). Mean compliance across all children for 1-month follow-up was 82.9%, for 3-month follow-up 89.1%, and for 6-month follow-up was 81.2% **Generalisation** Comparable with treatment data Level 3 requests: high compliance (91%), an increase of 30% over baseline Level 4 requests: high compliance (85%), an increase of 47% over baseline **Maternal responses** Mothers rated their children significantly more cooperative after treatment. There were also significant improvements in maternal perceptions of externalising, internalising, and total behaviour problems and significant positive change on the Parent Characteristics and Child Characteristics scales. Effect sizes (represented by both *r* and BSED statistics) showed that all changes in maternal perception were substantial ($p < 0.05$) **Maternal perception of externalising, internalising and total behaviour problems (measured by the CBCL):** Internal problems decreased from a mean of 16.85 pre-treatment to a mean of 9.92 post-treatment with an effect size of 0.58 External problems decreased from a mean of 22.08 pre-treatment to a mean of 14.54 post-treatment with an effect size of 0.58 Total problems decreased from a mean of 62.00 pre-treatment to a mean of 37.32 post-treatment with an effect size of 0.70 **Maternal responses on the Parent Characteristics and Child Characteristics scales:** Child characteristic scores decreased from a mean of 137.20 pre-treatment to a mean of 112.73 post-treatment with an effect size of 0.55, and parent characteristic scores decreased from a mean of 173.27 pre-treatment to a mean of 152.00 post-treatment with an effect size of 0.67	

continued

Author(s), publication year	Outcomes including any multivariate analysis/adjustment for confounders	Quality scores (USPSTF, Jadad)
	Maternal perception of the child's compliance to specific requests: Scores on the compliance probability checklist decreased from a mean of 312.83 pre-treatment to a mean of 215.75 post-treatment with an effect size of 0.91 **Consumer satisfaction:** The mean satisfaction score was 4.4 for the programme and 4.8 for the therapist (out of 5)	
Jouriles *et al.*, 2001[162] McDonald *et al.*, 2006 (24-month follow-up)[163]	**Externalising problems CBCL:** Intervention group: Baseline mean 66.28, SD 10.00; 4-month mean 58.69, SD 9.41; 8-month mean 57.00, SD 11.10; 12-month mean 54.80, SD 12.95; 16-month mean 49.79, SD 9.17 Control group: Baseline mean 65.56, SD 9.13; 4-month mean 61.61, SD 12.01; 8-month mean 60.11, SD 10.81; 12-month mean 55.47, SD 10.39; 16-month mean 58.59, SD 13.62 Externalising problems improved in both groups, but at a faster rate in the intervention group At the fifth assessment (16 months) the intervention group's mean level of externalising problems did not differ from the mean of the normative population, suggesting the results were clinically significant. The mean level of externalising problems in the control group continued to differ significantly from the mean of the normative population **Internalizing problems CBCL:** Intervention group: Baseline mean 62.28, SD 8.94; 4-month mean 53.06, SD 9.38; 8-month mean 52.07, SD 9.71; 12-month mean 53.20, SD 9.79; 16-month mean 48.07, SD 7.98 Control group: Baseline mean 58.72, SD 11.96; 4-month mean 55.06, SD 12.35; 8-month mean 55.41, SD 10.43; 12-month mean 50.94, SD 9.28; 16-month mean 51.59, SD 9.66 Children's internalising problems diminished over time, with similar rates of change in both groups **Child management skills:** Intervention group: Baseline mean 3.58, SD 0.53; 4-month mean 4.03, SD 0.40; 8-month mean 4.04, SD 0.34; 12-month mean 4.02, SD 0.36; 16-month mean 3.88, SD 0.39 Control group: Baseline mean 3.75, SD 0.43; 4-month mean 3.67, SD 0.54; 8-month mean 3.80, SD 0.47; 12-month mean 3.66, SD 0.38; 16-month mean 3.83, SD 0.41 There was a significantly higher mean level of child management skills at assessment 3 (8 months) in the intervention group and the intervention group improved faster than the control group	Fair, Greatest Jadad 1

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Author(s), publication year	Outcomes including any multivariate analysis/adjustment for confounders	Quality scores (USPSTF, Jadad)
	Mother's psychological distress, SCL-90-GSI: Intervention group: Baseline mean 67.78, SD 8.85; 4-month mean 59.94, SD 13.66; 8-month mean 53.40, SD 12.55; 12-month mean 58.87, SD 14.27; 16-month mean 52.38, SD 8.15 Control group: Baseline mean 67.44, SD 9.49; 4-month mean 64.28, SD 11.17; 8-month mean 59.83, SD 11.08; 12-month mean 54.00, SD 13.74; 16-month mean 55.94, SD 11.31 The mothers' psychological distress diminished over time but there was no significant difference between the comparison and intervention groups **Recurrent abuse:** Intervention group 31% reported yes Comparison group 44% reported yes Chi-squared test shows no significant difference between groups Mean number of moves was 3.7 (SD = 1.7, mode = 3); no difference between groups Mean number of job changes was 1.8 (SD = 1.7, mode = 0); no difference between groups Results at 24 months' follow-up: **Reductions in conduct problems:** At baseline all the children met *DSM-IV* criteria for either oppositional defiant disorder or conduct disorder. Two years after the termination of services 2 of the 13 children (15%) in the intervention group and 9 of the 17 children (53%) in the control group were classified as meeting *DSM-IV* criteria for either oppositional defiant disorder or conduct disorder ($p < 0.05$) Two of the 13 children (15%) in the intervention group and 9 of the 17 children (53%) in the control group were reported to have externalising problems at clinical levels 2 years after the end of treatment ($p < 0.05$) In 12 of the 17 (71%) families in the control group, the child was reported to be at clinical levels of conduct problems (using CBCL data) at either the 8-month or 24-month follow-up. In contrast, in only 4 of the 13 (31%) families in the intervention group was the child reported to be at clinical levels at one of these assessment points. These differences are statistically significant ($p < 0.05$) Mean CBCL externalising scale scores for children in the intervention and control groups did not differ significantly from one another at the 24-month follow-up; however, the *t*-test was rerun without an outlier from the intervention group and this new analysis showed a significant difference: intervention group mean = 52.1, SD = 8.4; control group mean = 60.0, SD = 14.7 ($p = 0.05$)	

continued

Author(s), publication year	Outcomes including any multivariate analysis/adjustment for confounders	Quality scores (USPSTF, Jadad)
	Internalising problems and happiness/social relationships: Mean levels of internalising problems did not differ significantly between the intervention and control groups at the 24-month follow-up. However, there were differences in the proportion of children in each group exhibiting clinical levels of internalising problems. In the control group 35% of the children were reported to exhibit clinical levels of internalising problems compared with 0% in the intervention group ($p < 0.05$) A comparison of children's happiness/social relationships scale scores revealed a significant difference between the intervention group (M = 3.9, SD = 0.8) and the control group (M = 3.5, SD = 0.8) ($p < 0.05$) **Maternal aggression towards children:** Twenty-three percent of the mothers in the intervention group and 53% of the mothers in the comparison group returned to their partners, this difference was not found to be significant ($p < 0.10$). There was not a significant association between child conduct problems at the outset of the study (first assessment) and mother's return to partner over the course of the study, nor was there a significant association between mother's return to partner and children's conduct problems at the 24-month follow-up **Recurrence of physical violence:** In the intervention group 38% reported recurrence of violence and in the control group 47% reported recurrence of violence. This difference was not significant. Recurrence of violence was not found to be associated with the mother's return to partners N.B. There are some discrepancies within the text and table as to the significance of a mother's return to her partner and children's happiness/social relationships. In the text, a mother's return to partner has a significance level of $p < 0.10$, but the table says $p < 0.05$. Children's happiness/social relationships does not appear to be significant in the table, but is significant ($p < 0.05$) in the text	
Lieberman *et al.*, 2005[160] Lieberman *et al.*, 2006[161]	**Child functioning:** At intake, there was no group difference, with 50% ($n = 18$) of the CPP group and 39% ($n = 11$) of the comparison group meeting criteria for TSD. At post-test there was a statistically significant group difference ($p<0.01$) with 6% ($n = 2$) of children in the CPP group and 36% ($n = 10$) children in the comparison group meeting criteria for TSD There was a significant group×time interaction for the total number of TSD symptoms ($p < 0.001$). Follow-up analyses indicated that the CPP group had a significant intake post test reduction in the number of TSD symptoms ($p < 0.001$), whereas the comparison group did not Analyses of CBCL total scores showed a significant group×time interaction ($p < 0.05$) with follow-up analyses revealing that only the CPP group evidenced significant intake-post-test reductions ($p < 0.01$). Analyses were repeated with only the children who completed the CBCL at intake and post-test (to examine whether error was introduced because some children completed the CBCL 2–3 at intake and the CBCL 4–18 at post-test). These analyses also resulted in a significant interaction effect ($p < 0.05$), with follow-up analyses confirming that only the CPP group showed significant reductions in behaviour problems ($p < 0.01$). There were no significant age effects when the original analyses with the TSD and CBCL were repeated using age as a covariate	Fair, Greatest Jadad 2

Author(s), publication year	Outcomes including any multivariate analysis/adjustment for confounders	Quality scores (USPSTF, Jadad)
	Maternal symptoms: The CAPS scores revealed a significant group×time interaction for avoidance ($p < 0.05$). Follow-up analyses showed significant intake-outcome reductions in avoidant symptoms for the CPP group only ($p < 0.001$). For total CAPS scores and the GSI there were significant main effects for time ($p < 0.001$) and trends for group×time ($p = 0.07$) For total CAPS scores both the CPP and comparison groups showed significant intake-outcome reductions (CPP $p < 0.001$; comparison $p < 0.05$). The interaction was not significant. For GSI scores, the CPP group showed statistically significant reductions ($p < 0.001$) whereas the comparison group showed a trend in this direction ($p = 0.06$) Re-experiencing and hyperarousal showed significant effects for time (re-experiencing $p < 0.001$, hyperarousal $p < 0.001$) but not group×time (re-experiencing p = NS, hyperarousal p = NS) **Clinical significance** of treatment effects on maternal symptoms (determined by examining the percentage of mothers in each group who were diagnosed with PTSD): At intake, there was no group difference, with 47% ($n = 16$) of the CPP group and 46% ($n = 12$) of the comparison group meeting PTSD criteria At outcome there was a decline in PTSD diagnosis for mothers in both groups, with 12% ($n = 4$) of CPP mothers and 27% ($n = 7$) of comparison mothers meeting criteria for PTSD. This difference was not statistically significant **Key results and explanations at 6-month follow-up:** **Child functioning:** For completers analysis and ITT analysis, there were significant group×time interactions. Further analyses showed that the intervention group had significant reductions in CBCL Total Behaviour Problem scores (completer $p < 0.001$; ITT $p < 0.001$). The reduction was not significant for the control group **Maternal symptoms:** For completers analysis and ITT analysis, there were significant group×time interactions. Further analyses showed that the intervention group improved significantly on distress scores (GSI), but the control group did not ($p < 0.001$); ITT analyses showed only a significant main effect for time ($p < 0.001$) The immediate post-intervention analyses showed that mothers in both the CPP and the control groups had declined in the severity of their global symptoms. Although there was not a significant group×time interaction immediately after treatment completion, the decline in symptom severity was statistically significant only for the CPP mothers, with the control group showing a trend in that direction The follow-up assessment revealed a significant symptom decline only for the CPP mothers, with no comparable movement in the control group. The finding suggests that mothers in the CPP group continued to improve after the termination of treatment, whereas the control group did not	Fair, Greatest Jadad 3

continued

Author(s), publication year	Outcomes including any multivariate analysis/adjustment for confounders	Quality scores (USPSTF, Jadad)
McFarlane *et al.*, 2005 (baseline and 1-year follow-up)[165] McFarlane *et al.*, 2005 (2-year follow-up)[164]	Main finding is that there was no effect for the intervention; outcomes improved over time, regardless of group allocation **Other analyses:** When study children were compared with a clinically referred sample, there were few differences re baseline scores, but by 24 months' the majority (stratified by age and gender for 6+) had scores significantly less than the referred norms, but this did not differ by allocation arm. The scores of the children aged 5 and under improved the most, the scores of teenagers improved the least (with their internal behaviour scores never significantly differing from scores of clinically referred youth). So, this too shows only the positive effect of time (not the intervention) This analysis takes no account of allocation group. When study children's scores were dichotomised into what would be referral and non-referral categories at entry and at 24 months', approximately 30% of the young children (18 months–5 years) had moved out of the clinical range by the end of the study, less pronounced improvements were found for ages 6–18 years, and 41% remained in the clinical range for referral in terms of their internal behaviours at 24 months' **One-year follow-up paper:** Both groups of children improved significantly on CBCL scores from intake to 1 year, irrespective of which treatment protocol their mothers received Normative scores, for both the clinically referred and non-referred samples of children, were obtained from the CBCL manual. At intake, most scores of children from the abused women were not significantly different from the scores of clinically referred children. However, at 1 year, with the exception of internal behaviour scores for girls aged 12–18, all scores of children from treated abused mothers were significantly lower than the scores of non-referred children. Additionally, at intake, all scores of children from the abused women were significantly higher than those of the non-referred children. At 1 year, only scores for boys aged 6–11 years and girls aged 12–18 years remained significantly higher than the scores of non-referred children.	

Author(s), publication year	Outcomes including any multivariate analysis/adjustment for confounders	Quality scores (USPSTF, Jadad)
Sullivan *et al.*, 2002[124]	**Well-being** (MANCOVA) Effect of intervention on mothers' overall **general well-being** (quality of life, social support, depression, self-esteem) over time was marginally significant ($p < 0.08$) The following are ANOVA analyses on individual outcomes: **Abuse:** For intervention women, mean abuse steeply declined from baseline to post-intervention and then remained relatively stable when tested again at 4 months' follow-up; for control group women, there was a less steep decline from baseline to post-intervention, but this then increased until they were very similar to the intervention women at 4 months' follow-up (quadratic relationship, $p < 0.05$) **Assailant's overall abuse of child:** Mean scale scores were 1.44 (SD = 0.90) at pre-intervention and 0.66 (SD = 0.63) at 4-month follow-up; individual scores ranged from 0.00 (indicating no abuse experienced during the time interval) to 4.96 **Child's witnessing abuse:** Mean scale scores were 1.51 (SD = 0.85) at pre-intervention and 0.51 (SD = 0.73) at 4-month follow-up; individual scores ranged from 0.00 (indicating no witnessing of abuse during the time period) to 3.39 **Child's contact with assailant:** Although the conditions did not differ on contact at baseline, by the 4-month follow-up, significantly fewer children in the intervention group were in daily contact with their mother's assailant (11.1% vs 27.3%) **Child's self-competence:** Pre-intervention mean scale scores were given, but no post-intervention scores were given in the text, and the means and SDs were not given by group. Table 1 in the paper gives means by group and post-intervention and 4-month follow-up, but no SDs **Mother's quality of life:** Mean increased from baseline to 4 months' follow-up for intervention women, whereas it slightly decreased for control group women (linear relationship, $p < 0.10$) **Mother's social support:** Mean increased from baseline to post-intervention but reverted to baseline at 4-month follow-up for intervention women, whereas it worsened baseline to post-intervention but reverted to baseline at 4-month follow-up for control group women (quadratic relationship, $p < 0.10$) **Mother's depression:** Mean declined from baseline to 4 months' follow-up for intervention women, whereas it slightly increased for control group women (linear relationship, $p < 0.05$) **Mother's self-esteem:** Mean increased from baseline to 4 months' follow-up for intervention women, whereas it stayed the same for control group women (linear relationship, $p < 0.05$)	Fair, Greatest Jadad 2

Appendix 7.3: USPSTF assessment of execution of intervention studies

Type of intervention	Author(s), publication year	RCTs: adequate randomisation (other designs: consideration of potential confounders; if no consideration of any confounders, score as poor)	Maintenance of comparable groups (includes crossovers, adherence, contamination) (if baselines not matched, score paper as poor, if contamination only, score as fair)	No important differential loss to follow-up or overall high loss to follow-up (> 20%)
Advocacy	Constantino *et al*., 2005[122]	No	No	Yes
	McFarlane *et al*., 2006[123]	No	No	Yes
	Sullivan *et al*., 2002[124]	No	No	Yes
	Tiwari *et al*., 2005[121]	Yes	Yes	Yes
	Advocacy total 'yes' out of 4	1	1	4
Support groups	Fry and Barker, 2002[139]	Not applicable	No	Yes
Individual psychological interventions	Koopman *et al*., 2005[142]	No	No	Yes
	Labrador *et al*., 2006[144]	No	No	Yes
	Reed and Enright, 2006[143]	No	Yes	Yes
	Individual psychological total 'yes' out of 3	0	1	3
Group psychological interventions	Arinero and Crespo, 2004[151]	No	No	Yes
	Cruz and Sanchez, 2006[152]	Not applicable	Not applicable	Yes
	Gilbert *et al*., 2006[150]	Yes	Yes	Yes
	Group psychological total 'yes' out of 3	1	1	3

Measurements: equal, reliable and valid (if measurements so poor as to be unacceptable, score study as poor)	**Clear definition of interventions (individualised interventions allowed if within a structured format)**	**All important outcomes considered or good match of outcomes to goals**	**RCT: intention-to-treat analysis (other designs: adjustment for potential confounders)**	**Quality rating (see Appendix 3)**	**Statistics**
Yes	Yes	Yes	No ITT	Fair Greatest	No effect sizes given
Yes	Yes	Yes	No ITT	Fair Greatest	No effect sizes given
Mixed CTS is poor, others are fine	Yes	Yes	No ITT	Fair Greatest	No effect sizes given
Yes	Yes	Yes	Yes	Good Greatest	No effect sizes given
4	4	4	1	–	–
No Cronbach's alpha given	Yes	Yes	No	Poor Greatest	No effect sizes given
Yes	Yes	Yes	No ITT	Fair Greatest	No effect sizes given
Yes	Yes	Yes	Yes	Poor Greatest	No effect sizes given
Yes	Yes	Yes	Yes	Fair Greatest	No effect sizes given
3	3	3	2	–	–
Yes	Yes	Yes	No	Poor Greatest	Gives effect sizes
Yes	Yes	Yes	No	Poor Moderate	No effect sizes given
No data on reliability	Yes	Yes	No ITT	Fair Greatest	No effect sizes given
2	3	3	0	–	–

continued

Type of intervention	Author(s), publication year	RCTs: adequate randomisation (other designs: consideration of potential confounders; if no consideration of any confounders, score as poor)	Maintenance of comparable groups (includes crossovers, adherence, contamination) (if baselines not matched, score paper as poor, if contamination only, score as fair)	No important differential loss to follow-up or overall high loss to follow-up (> 20%)
Interventions with children	Ducharme *et al*., 2000[166]	Not applicable	Yes	No (59%)
	Jouriles *et al*., 2001[162]	No	Yes	Yes
	Lieberman *et al*., 2006;[161] Lieberman *et al*., 2005[160]	No details on randomisation	Yes	Yes
	McFarlane *et al*., 2005;[165] McFarlane *et al*., 2005[164]	No	No	Yes
	Sullivan *et al*., 2002[124]	No	No	Yes
	Interventions with children total 'yes' out of 5	0	3	4

Measurements: equal, reliable and valid (if measurements so poor as to be unacceptable, score study as poor)	**Clear definition of interventions (individualised interventions allowed if within a structured format)**	**All important outcomes considered or good match of outcomes to goals**	**RCT: intention-to-treat analysis (other designs: adjustment for potential confounders)**	**Quality rating (see Appendix 3)**	**Statistics**
No data on reliability	Yes	Yes	No	Poor Least	Gives effect sizes
Yes	Yes	Yes	No ITT	Fair Greatest	No effect sizes given
Yes	Yes	Yes	Yes	Fair Greatest	No effect sizes given
Yes	Yes	Yes	No ITT	Fair Greatest	No effect sizes given
Yes	Yes	Yes	No ITT	Fair Greatest	No effect sizes given
4	5	5	1	–	–

Appendix 7.4: Jadad score for intervention studies

Jadad score calculation											
Item	**Score**	**Constantino *et al.*, 2005[122]**	**Jouriles *et al.*, 2001[162]**	**Lieberman *et al.*, 2005,[160] 2006[161]**	**Gilbert *et al.*, 2006[150]**	**Reed and Enright, 2006[143]**	**Koopman *et al.*, 2005[142]**	**Bybee and Sullivan, 2005[130]**	**Tiwari *et al.*, 2005[121]**	**Sullivan *et al.*, 2002[124]**	**McFarlane *et al.*, 2006[123]**
Was the study described as randomised (this includes words such as randomly, random, and randomisation)?	0/1	1	1	1	1	1	1	1	1	1	1
Was the method used to generate the sequence of randomisation described and appropriate (table of random numbers, computer-generated, etc.)?	0/1	1	0	0	1	0	0	1	1	0	1
Was there a description of withdrawals and dropouts (need demographic data or use of ITT)?	0/1	0	0	1	0	1	1	1	1	0	0
SUBPOINT: Deduct one point if the method used to generate the sequence of randomisation was described and it was inappropriate (patients were allocated alternately, or according to date of birth, hospital number, etc.)	0/–1	0	0	0	0	0	0	0	0	0	0
Blinded assessment of outcomes	0/1	0	0	1	0	0	1	1	1	1	0
Total (out of 4)	4	2	1	3	2	2	3	4	4	2	2

Jadad score calculation									
Item	**Score**	**Kubany et *al.*, 2004[146]**	**Kubany et *al.*, 2003[145]**	**Mancoske et *al.*, 1994[147]**	**Melendez et *al.*, 2003[156]**	**McFarlane et *al.*, 2004[136]**	**McFarlane et *al.*, 2000[134]**	**Sullivan and Bybee, 1999[126]**	**Sullivan and Davidson, 1991[129]**
Was the study described as randomised (this includes words such as randomly, random, and randomisation)?	0/1	1	1	1	1	1	1	1	1
Was the method used to generate the sequence of randomisation described and appropriate (table of random numbers, computer-generated, etc.)?	0/1	0	0	0	0	0	0	1	0
Was there a description of withdrawals and dropouts (need demographic data or use of ITT)?	0/1	1	1	0	1	1	1	1	0
SUBPOINT: Deduct one point if the method used to generate the sequence of randomisation was described and it was inappropriate (patients were allocated alternately, or according to date of birth, hospital number, etc.)	0/–1	0	0	0	0	0	0	0	0
Blinded assessment of outcomes	0/1	0	0	0	1	– 1	– 1	1	0
Total (out of 4)	4	2	2	1	3	1	1	4	1

Appendix 7.5: Sensitivity analysis for intervention studies

Studies ranked by effect size (largest first)	Setting	Intervention	Studies ranked by quality (best first)
PTSD			
Labrador *et al*., 2006[144] Post-test 1.23 **Large**	Spain Targeted at women with PTSD who were referred from women's centre, judges, counsellors and victim support centres	Individual psychological intervention Exposure and cognitive therapy	Koopman *et al.*, 2005[142] Fair, Greatest Jadad 3
Reed and Enright, 2006[143] Post-test 2.33 **Large**	Urban USA Responded to flyers	Individual Psychological (forgiveness therapy)	Lieberman *et al.*, 2005,[160] 2006[161] Fair, Greatest Jadad 3
Kubany *et al*., 2003,[145] 2004[146] Immediate post-therapy 2003 paper 0.90 **Large** 2004 paper 0.33 **Small**	Targeted at women with PTSD	Individual psychological intervention Cognitive behavioural therapy (CBT)	Kubany *et al.*, 2003,[145] 2004[146] Fair, Greatest Jadad 2
Lieberman *et al*., 2005,[160] 2006[161] Post-test 0.41 **Small**	USA Not reported	Child–parent psychotherapy (CPP)	Reed and Enright, 2006[143] Fair, Greatest Jadad 2
Koopman *et al*., 2005[142] 4-month follow-up 0.10 **Small**	USA Community	Individual Psychological (expressive writing)	Labrador *et al.*, 2006[144] Fair, Greatest Jadad not applicable
Depression			
Labrador *et al*., 2006[144] Post-test 1.77 **Large**	Spain Targeted at women with PTSD who were referred from women's centre, judges, counsellors and victim support centres.	Individual psychological intervention Exposure and cognitive therapy	Sullivan and Bybee, 1999[126] Fair, Greatest Jadad 4
Reed and Enright, 2006[143] 1.55 **Large**	Urban USA Responded to flyers	Individual Psychological (forgiveness therapy)	Koopman *et al.*, 2005[142] Fair, Greatest Jadad 3
Kubany *et al*., 2003,[145] 2004[146] Immediate post-therapy 2003 paper 0.42 **Small** 2004 paper 0.25 **Small**	Targeted at women with PTSD	Individual psychological intervention CBT	Kubany *et al.*, 2003,[145] 2004[146] Fair, Greatest Jadad 2
Sullivan and Bybee, 1999[126] 10 weeks post-intervention 0.29 **Small**	USA Women exiting shelters	Advocacy 10 weeks community advocacy	Reed and Enright, 2006[143] Fair, Greatest Jadad 2

Studies ranked by effect size (largest first)	Setting	Intervention	Studies ranked by quality (best first)
Koopman *et al*., 2005[142] 4-month follow-up 0.16 **Small**	USA Community	Individual Psychological (expressive writing)	Labrador *et al.,* 2006[144] Fair, Greatest Jadad not applicable
Self-esteem			
Labrador *et al*., 2006[144] Post-test 2.25 **Large**	Spain Targeted at women with PTSD who were referred from women's centre, judges, counsellors and victim support centres	Individual psychological intervention Exposure and cognitive therapy	Kubany *et al.,* 2003,[145] 2004[146] Fair, Greatest Jadad 2
Reed and Enright, 2006[143] Post-test 1.81 **Large**	Urban USA Responded to flyers	Individual Psychological (forgiveness therapy)	Reed and Enright, 2006[143] Fair, Greatest Jadad 2
Cox and Stoltenberg, 1991[153] Post-test Intervention group 1 and control: 0.11 **Small** Intervention group 2 and control: 0.88 **Large**	New shelter residents	Group psychological intervention including CBT, skills-building and problem-solving	Labrador *et al.,* 2006[144] Fair, Greatest Jadad not applicable
Kubany *et al*., 2003,[145] 2004[146] Immediate post-therapy 2003 paper 0.48 **Small** 2004 paper 0.10 **Small**	Targeted at women with PTSD	Individual psychological intervention CBT	Cox and Stoltenberg, 1991[153] Poor, Greatest Jadad not applicable
Physical abuse			
Tiwari *et al*., 2005[121] Minor physical abuse 6 weeks post-delivery 0.48 **Small** Severe physical abuse 6 weeks post-delivery 0.09 **Small**	Hong Kong Public hospital antenatal clinic	Advocacy	Tiwari *et al.,* 2005[121] Good, Greatest Jadad 4
Sullivan and Bybee, 1999[126] 10 weeks post-intervention 0.26 **Small**	USA Women exiting shelters	Advocacy 10 weeks community advocacy	Sullivan and Bybee, 1999[126] Fair, Greatest Jadad 4
McFarlane *et al*., 2006[123] *12-month follow-up:* Assault 0.07 **Small** Danger risk for homicide 0.03 **Small** *24-month follow-up:* Assault 0.02 **Small** Danger risk for homicide 0.09 **Small**	USA Two primary care public health clinics and two women, infants and children clinics (WICs)	Advocacy	McFarlane *et al*., 2006[123] Fair, Greatest Jadad 2

Appendix 8

Morbidity and mortality outcomes of screening studies

Appendix 8.1: Characteristics of studies

Study details	Study design	Intervention	Number of participants	Participants
Coyer *et al.*, 2006[170]	**Inclusion criteria:** Women aged 18 or older who attended the rural health-care clinic **Exclusion criteria:** Not stated **Setting:** USA, rural health-care clinic **Target group of intervention:** Nurses **Design:** Before-and-after **Sampling time frame:** 12 months pre-intervention and 12 months post-intervention **Data source:** Medical notes	**Framework:** Not stated **Programme:** Discussion with nursing staff identified a need for improving their knowledge of local community resources. Due to staff interest, two local agencies that support women in violent situations in-serviced the members of the clinic in order to provide background information, local statistics, resources available and the processes of referrals. Policies on how to manage patients giving a 'yes' response to 'Is anyone hurting you?' were developed **Duration and frequency:** Not stated **Comparison care:** Usual pre-intervention care	Pre-intervention: 1690 Post-intervention: 859	Only given for those identified as abused post-intervention **Age:** Mean 45.5, range 27–57 **Ethnicity:** White: 4; Hispanic: 2 **SES:** Not stated **Scope of abuse:** Abuse. Screening question was 'Is anyone hurting you?'
Harwell *et al.*, 1998[168]	**Inclusion criteria:** Not stated **Exclusion criteria:** Not stated **Setting:** USA; four community health centres **Target group of intervention:** Physicians/nurses/social workers/psychologists **Design:** Before/after, historical controls **Sampling time frame:** 6 months pre- and 6 months post-intervention **Data source:** Medical records	**Framework:** trauma theory, RADAR **Programme:** Training/support package for health providers to increase referrals, included step-by-step and 'where to turn for help' pocket guides **Duration and frequency:** Single session of 3–6 hours didactic training (video presentation) for all staff, with tailored follow-up training for some staff **Comparison care:** Usual pre-RADAR management	Intervention: 255 Comparison: 251	**Age:** Mean = 30 (no significant differences between groups) **Ethnicity:** 52% Latina; 47% African American; 1% other (no significant differences between groups) **SES:** 97% public health insurance (no significant differences between groups) **Scope of abuse:** Physical and emotional abuse

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Study details	Study design	Intervention	Number of participants	Participants
McCaw *et al.*, 2001[101]	**Inclusion criteria:** Not stated **Exclusion criteria:** Not stated **Setting:** USA HMO **Target group of intervention:** Nurses, medical assistants, physical therapists, receptionists **Design:** Before/after, historical controls **Sampling time frame:** 12 months pre- and 9 months post-intervention **Data source:** Medical records	**Framework:** Systems model approach, with links to the community **Programme:** Several brief training and information sessions for clinical staff, receptionists; sought improved links with community services, informed patients about domestic violence (mailings, materials in waiting room) and services, provided clinicians with information and prompts, employing on-site domestic violence specialist **Duration and frequency:** 'Several brief training and information sessions' **Comparison care:** Usual pre-intervention management	Not stated	**Age:** Not stated, but of local HMO patient population, about 25% aged 20–60 **Ethnicity:** Not stated, but of local HMO patient population: white 45%; African American 22%; Latino 15%; Asian 16%; other 2% **SES:** Not stated, but of local HMO patient population Income: < $25 000 – 37%; $25,000–50,000 – 34%; > $50 000 – 29% Education: 92% high-school graduates **Scope of abuse:** Implies that women asked about physical and emotional abuse (and maybe sexual)
Ramsden and Bonner, 2002[173]	**Inclusion criteria:** All women over 16 years of age presenting to the ED **Exclusion criteria:** Not stated **Setting:** Australia; Emergency Department (AED) **Target group of intervention:** AED staff **Design:** Before/after, historical controls **Sampling time frame:** 3 months pre-intervention, no time span stated for post-intervention study period **Data source:** Medical records	**Framework:** Not stated **Programme:** Training on domestic violence, screening protocols and referral pathway. Resources on local services and contact numbers were provided **Duration and frequency:** Not stated **Comparison care:** Usual pre-intervention care	245 screened in intervention group. No other details	**Age:** Not stated **Ethnicity:** Not stated, but catchment area predominantly Anglo-Saxon, 25% born in non-English-speaking countries, 0.7% indigenous Australians **SES:** Not stated, but catchment area ranged from affluent to very low income **Scope of abuse:** Not stated, but two of the three screening questions refer to physical abuse

continued

Study details	Study design	Intervention	Number of participants	Participants
Shepard *et al.*, 1999[174]	**Inclusion criteria:** Women who received home visits from county PHNs as part of a maternal and child health home visiting programme **Exclusion criteria:** Not stated **Setting:** USA; homes of women **Target group of intervention:** Social workers (public health nurses) **Design:** Before/after, historical controls **Sampling time frame:** pre-intervention 12 months preceding; post-intervention subsequent 12 and 24 months **Data source:** Medical records	**Framework:** Duluth feminist model **Programme:** Use of protocol to increase referrals (to refuge/women's group, arranging transport to refuge/safe housing) and information giving (booklet on abuse, information on community resources, calling police/seeking protection order) **Duration and frequency:** Not stated **Comparison care:** Usual pre-protocol management	Intervention: 814 (52% with documented DV assessment) Comparison: 546	**Age:** > 50% aged 21–30 **Ethnicity:** Not stated **SES:** Not stated but many likely to be on low incomes **Scope of abuse:** Physical abuse
Thompson *et al.*, 2000[169]	**Inclusion criteria:** Members of adult care team in primary care clinics at least half time Medical records of cases of DV between current or former intimate partners or parent or adult child; aged > 18 years; continuously enrolled at one of the clinics throughout study period; at least one clinic visit for one of four 'sentinel' diagnoses (depression, physical injury, pelvic pain or physical examination) **Exclusion criteria:** Paediatricians or receptionists or any clinical staff not based in the 5 practices **Setting:** USA. Five primary care clinics of Group Health Cooperative (a large HMO)	**Framework:** Precede/proceed **Programme:** Focuses on changing practitioner predisposing factors, (knowledge, beliefs, barriers and attitudes), enabling factors (environmental and infrastructure processes supporting the intervention) and reinforcing factors (i.e. the use of feedback) **Duration and frequency:** Two separate half-day training sessions and four educational sessions. Opinion leaders attended three extra training sessions. System support included posters in waiting areas, cue cards for care providers, and screening questionnaires and newsletters for the clinical teams were all supplied	Health-care providers 179: *Intervention site:* Pre-intervention: 1590 Post-intervention: 1372 *Comparison site:* Pre-intervention: 2205 Post-intervention: 2020	No demographic information stated for medical records

Study details	Study design	Intervention	Number of participants	Participants
	Target group of intervention: Physicians, nurse practitioners, physician assistants, registered nurses, licensed practical nurses and medical assistants **Design:** Randomised controlled trial **Sampling time frame:** Baseline and 6 months post-intervention (staff asked about their responses to abused women in the previous 3 months) **Data source:** Staff self-reports	**Comparison care:** Usual pre-intervention management		
Ulbrich and Stockdale, 2002[172]	**Inclusion criteria:** Not stated **Exclusion criteria:** Not stated **Setting:** USA. Four rural family planning clinics **Target group of intervention:** All staff, but results relate only to nurse practitioners (NPs) and registered nurses **Design:** Before/after, historical controls **Sampling time frame:** Baseline and 6 months post-intervention (staff asked about their responses to abused women in the previous 3 months) **Data source:** Staff self-reports	**Framework:** RADAR **Programme:** Didactic training with RADAR pocket cue cards, plus a learning module, a presentation by DV advocacy programme, use of a screening/referral protocol; on-site advocate provided 1 day per week at one clinic, in others an advocate on-site as needed by women with crises, otherwise off-site **Duration and frequency:** Initial session (duration not known), with additional training and support over 2 years (also 5-hour quarterly meetings attended by one NP and DV Coordinator from each clinic, and 1-hour workshops every 6 months) **Comparison care:** Usual pre-intervention management	Staff: 40	**Age:** Majority of attending women were aged 15–34 **Ethnicity:** Not stated, but in three of the four clinics, the catchment area was 90% white **SES:** In three clinics, 55% of the attending women were at or below poverty level; other clinic not stated **Scope of abuse:** Physical and sexual abuse

continued

Study details	Study design	Intervention	Number of participants	Participants
Wiist and McFarlane, 1999[171]	**Inclusion criteria:** For medical records, all prenatal patients identified at first visit as abused in year prior to or since pregnancy, perpetrator likely to be partner but not necessarily **Exclusion criteria:** Not stated **Setting:** US antenatal clinics **Target group of intervention:** Nurses, physicians, nutritionists, counsellors, clerical staff **Design:** Before/after, parallel groups **Sampling time frame:** Baseline, 3 and 12 months (total 15 months) post-intervention **Data source:** Medical records	**Framework:** Not stated **Programme:** Use of 'Mardi of Dimes' protocol to increase referrals **Duration and frequency:** Single session of 90 minutes didactic training, additional weekly visits from nurse-trainer to provide support/instruct new staff **Comparison care:** Usual care, no protocol management	Pre-protocol: 540 (both groups) Post-protocol: intervention 360; comparison 180	**Age:** Pre-protocol not stated (both groups) Post-protocol 60% aged 20–29 (both groups) **Ethnicity:** Pre-protocol at least 97% Latina (both groups) Post-protocol 96% Latina (both groups) **SES:** Pre-protocol not stated (both groups) Post-protocol 97% income < $20,000 (both groups) **Scope of abuse:** Not stated, but screening tool includes questions on physical and sexual abuse

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Appendix 8.2: Results of studies and quality scores

Study details	Number identified as abused	Outcomes including any multivariate analysis/adjustment for confounders	Quality score (USPSTF)
Coyer *et al.*, 2006[170]	6	Identification of DV • Pre-intervention: No records had any notation of abuse • Post-intervention: 6 women had notation of abuse in medical records (2 answered yes to screening question, 4 discussed abuse with nurse during routine physical exam) • Referral • Pre-intervention: No one was referred to DV-related services • Post-intervention: 5 referrals to violence shelters, local or national abuse hotline numbers, or local drug treatment facility No statistics were stated	Poor, Moderate
Harwell *et al.*, 1998[168]	Intervention: 13 confirmed abuse; 14 suspected abuse Comparison: 5 confirmed abuse; 5 suspected abuse	DV screening performed Baseline 5%, 25% after training RR = 1.87 (95% CI = 1.61–2.16) • DV suspected • Baseline 2%, 6% after training • RR = 1.49 (95% CI = 1.13–1.99) DV confirmed • Baseline 2%, 5% after training • RR = 1.49 (95% CI = 1.08–1.97) DV abuse assessment completed • Baseline 2%, 4% after training • RR = 1.34 (95% CI = 0.93–1.94)	Poor, Moderate

continued

<table>
<tr><th>Study details</th><th>Number identified as abused</th><th>Outcomes including any multivariate analysis/adjustment for confounders</th><th>Quality score (USPSTF)</th></tr>
<tr><td></td><td></td><td>Safety assessment completed
• Baseline 5%, 17% after training
• RR = 1.65 (95% CI = 1.39–1.97)
Abused women referred to community health centre staff
• Baseline 2%, 4% after training
• RR = 1.44 (95% CI = 1.02–2.03)
Abused women referred to outside agency
• Baseline 0%, 4% after training
• RR = 1.81 (95% CI = 1.45–2.28)
Two predictors for screening during the intervention period were having more than one clinic visit (OR = 1.56, 95% CI = 1.12–3.41) and being married (OR = 0.62, 95% CI = 0.40–0.92)</td><td></td></tr>
<tr><td>McCaw et al., 2001[101]</td><td>Not stated</td><td>Referrals to a DV specialist
• Increase in number of referrals after the intervention (but no referral rates or statistical analysis)
• n = 51 pre-intervention, n = 134 post-intervention
• Number of referrals increased across departments, as did self-referrals
<table>
<tr><th></th><th>Baseline</th><th>Post intervention</th></tr>
<tr><td>Medicine</td><td>25</td><td>46</td></tr>
<tr><td>Obstetrics/gynaecology</td><td>8</td><td>25</td></tr>
<tr><td>Psychiatry</td><td>4</td><td>24</td></tr>
<tr><td>AED</td><td>3</td><td>14</td></tr>
<tr><td>Social services</td><td>2</td><td>7</td></tr>
<tr><td>Unknown</td><td>7</td><td>0</td></tr>
<tr><td>Self-referrals</td><td>7</td><td>18</td></tr>
</table></td><td>Poor, Moderate</td></tr>
</table>

DOI: 10.3310/hta13160

Study details	Number identified as abused	Outcomes including any multivariate analysis/adjustment for confounders	Quality score (USPSTF)
Ramsden and Bonner, 2002[173]	Intervention: 36 Comparison: not known	Referrals to a social worker or police • $n = 8$ (0.31%) pre-intervention (but not reported how many women were identified as abused) • $n = 14$ (0.6%) post-intervention (out of 36 women identified as abused) • Authors report that referrals doubled after the intervention (but no referral rates or statistical analysis)	Poor, Moderate
Shepard *et al.*, 1999[174]	Intervention: 41 Comparison: 31	Percentage of women identified as experiencing domestic violence • Baseline 5.7%, 9% at 12 months ($p > 0.05$), 9.2% at 24 months ($p > 0.05$) • Re-analysis controlling for age did not reach significance ($p > 0.05$) Percentage of women referred directly to domestic violence services • Baseline 3%, 13% at 12 months ($p = 0.20$), 17% at 24 months ($p = 0.10$) • Re-analysis controlling for age did not reach significance ($p > 0.05$) Percentage of women given information • Baseline 0.03%, 74% at 12 months ($p < 0.001$), 78% at 24 months ($p < 0.001$) • Re-analysis controlling for age reached significance ($p < 0.001$)	Poor, Moderate
Thompson *et al.*, 2000[169]	Intervention: pre-intervention 25: post-intervention 35 Comparison: pre-intervention 29; post-intervention 30	Identification of DV victims • At the intervention site, 25 (2.3%) at baseline, 35 (4.0%) at 9-month follow-up, OR = 1.5, 95% CI = 0.73–3.17 • At the comparison site, 29 (1.9%) at baseline, 30 (2.2%) at 9-month follow-up Proxy measures for DV – case findings by diagnosis • Depression 2.8% baseline, 2.5% at 9-month follow-up, OR = 0.71, 95% CI = 0.22–2.25 • Injury 0.8% baseline, 1.3% at 9-month follow-up, OR = 1.4, 95% CI = 0.31–6.33 • Pelvic pain 3.8% baseline, 8.4% at 9-month follow-up, OR = 3.8, 95% CI = 1.1–12.5	Fair, Greatest Jadad score 3

continued

<table>
<tr><th>Study details</th><th>Number identified as abused</th><th>Outcomes including any multivariate analysis/adjustment for confounders</th><th>Quality score (USPSTF)</th></tr>
<tr><td></td><td></td><td>• Physical examination 0.4% at baseline, 1.6% at 9-month follow-up, OR = 2.7, 95% CI = 0.13–54.7
• Recorded quality of assistance ‘good or excellent’ 66.7% at baseline, 63.6% at 9-month follow-up, OR = 0.96, 95% CI = 0.17–5.4</td><td></td></tr>
<tr><td>Ulbrich and Stockdale, 2002[172]</td><td>Not measured</td><td>Self-reported referrals to community-based domestic violence advocacy programmes in last 3 months (%)
<table>
<tr><td></td><td>Pre-training</td><td>6-month follow-up</td></tr>
<tr><td>Less than once a month</td><td>46.7</td><td>42.9</td></tr>
<tr><td>1 to 3 times per month</td><td>53.3</td><td>35.7</td></tr>
<tr><td>Once a week</td><td>0.0</td><td>21.4</td></tr>
</table>
Frequency of discussing domestic violence with patients in past 3 months (%)
<table>
<tr><td></td><td>Pre-training</td><td>6-month follow-up</td></tr>
<tr><td>Less than once a month</td><td>50.0</td><td>21.4</td></tr>
<tr><td>1 to 3 times per month</td><td>31.3</td><td>7.1</td></tr>
<tr><td>Once a week</td><td>18.8</td><td>57.1</td></tr>
</table>
Only descriptive statistics given due to small sample sizes</td><td>Poor, Moderate</td></tr>
<tr><td>Wiist and McFarlane, 1999[171]</td><td>Intervention: 29 (26 post-protocol and 3 pre-protocol)

Comparison: 1 (0 post-protocol and 1 pre-protocol)</td><td>Women identified as abused
• Significantly higher at intervention sites post-intervention compared with before (7.2% vs 0.8%; $p < 0.0001$)
• Women were seven times more likely to be identified as abused post-intervention (OR = 6.8; 95% CI = 2.4–19.6)

Referrals

Pre-protocol:
• No referrals documented at intervention or comparison clinics

Post-protocol:
• Comparison: 0 (0%) identified cases referred at 3 or 12 months
• Intervention: 6 (67%) identified cases referred at 3 months; 9 (53%) identified cases referred at 12 months</td><td>Poor, Moderate</td></tr>
</table>

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Appendix 8.3: USPSTF assessment of execution of studies

Author(s), publication year	RCTs: adequate randomisation; other designs: consideration of potential confounders (if no consideration of any confounders, score as poor)	Maintenance of comparable groups (includes crossovers, adherence, contamination) (if baselines not matched, score paper as poor, if contamination only, score as fair)	No important differential loss to follow-up or overall high loss to follow-up (> 20%)	Measurements: equal, reliable and valid (if measurements so poor as to be unacceptable, score study as poor)	Clear definition of interventions (individualised interventions allowed if within a structured format)	All important outcomes considered or good match of outcomes to goals	RCT: intention-to-treat analysis; other designs: adjustment for potential confounders	Quality rating (see Appendix 3)	Statistics
Coyer *et al.*, 2006[170]	No	Yes	n/a	Yes	Yes	Yes	No	Poor Moderate	No statistics
Harwell *et al.*, 1998[168]	No	Yes	n/a	No	Yes	Yes	No (only age)	Poor Moderate	Correct paired analysis not used No effect size
McCaw *et al.*, 2001[101]	No	Yes (historical control)	No	Yes	Yes	Yes	No	Poor Moderate	No effect size
Ramsden and Bonner, 2002[173]	No	No	n/a	No	No	Yes	No	Poor Moderate	No statistics
Shepard *et al.*, 1999[174]	No	Yes	n/a	Yes	No	Yes	Yes	Poor Moderate	No effect size
Thompson *et al.*, 2000[169]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Fair Greatest	No effect size
Ulbrich and Stockdale, 2002[172]	No	No	Yes	No	Yes	Yes	Yes	Poor Moderate	No statistics
Wiist and McFarlane, 1999[171]	No	No	Yes	No	No	Yes	Yes	Poor Moderate	No effect size
Heath-care training total 'yes' out of 10	1	4	2/5	4	5	8	9	–	–

Appendix 9

Studies of acceptability of screening to health-care professionals

Appendix 9.1: Characteristics of qualitative studies and quality scores

Study details	Study design	Number of participants	Participants	Quality score (CASP)
Dowd *et al.*, 2002[120]	Focus groups	Approached: Not stated Recruited: 38 Response rate (%): Not stated	Age (mean, SD, range): Not stated Gender: Female – physicians, 10; nurses, 19 HCP training/expertise: physicians, 17; nurses, 21	27
Edin and Högberg, 2002[175]	Qualitative interviews + questionnaires	Approached: 18 (qualitative interviews) and 51 (questionnaires) Recruited: 5 (qualitative interviews) and 42 (questionnaires) Response rate (%): 27.77 (qualitative interviews) and 82 (questionnaires)	Age (mean, SD, range): Not stated Gender (%): Female, 100 HCP training/expertise: Midwives	37
Hindin, 2006[182]	Open-ended questions	Approached: 150 Recruited: 8 Response rate (%): Not stated	Age (mean, SD, range): 41 (30–56) Gender (%): Female, 100 HCP training/expertise: Certified nurse-midwives	33
Loughlin *et al.*, 2000[180]	In-depth interviews	Approached: Not stated Recruited: 13 Response rate (%): Not stated	Age (mean, SD, range): Not stated Gender (%): Not stated HCP training/expertise: Emergency department staff, 13 medical staff, 2 nursing staff, 10 administrator, 1	35
McCosker *et al.*, 2005[179]	Focus groups	Approached: Not stated Recruited: Not stated Response rate (%): Not stated	Age (mean, SD, range): Not stated Gender (%): Not stated HCP training/expertise: Midwives	31
Mezey *et al.*, 2003[177]	Focus groups and semistructured interviews	Approached: Not stated Recruited: 28 Response rate (%): Not stated	Age (mean, SD, range): Not stated Gender (%): Female, 100 HCP training/expertise: Midwives	31
Minsky-Kelly *et al.*, 2005[181]	Focus groups	Approached: Not stated Recruited: 39 Response rate (%): Not stated	Age (mean, SD, range): 42 Gender (%): Female, 15 HCP training/expertise (%): Nurses, 80; mental health service providers, 20	32
Price *et al.*, 2005[183]	Individual and focus group interviews	Approached: Not stated Recruited: 34 Response rate (%): Not stated	Age (mean, SD, range): Not stated Gender (%): Female, 100 HCP training/expertise: Midwives	19

Study details	Study design	Number of participants	Participants	Quality score (CASP)
Stenson *et al.*, 2005[176]	Focus groups	Approached: 28 Recruited: 21 Response rate (%): 75	Age (mean, SD, range): 42–62 (54) Gender (%): Female, 100 HCP training/expertise: Midwives	31
Taket *et al.*, 2004[211]	Qualitative interviews	Approached: Not stated Recruited: 124 Response rate (%): Not stated	Age (mean, SD, range): Not stated Gender (%): Not stated HCP training/expertise (%): Project staff, 8; key stakeholders, 32; Womens' aid outreach workers, 3; Victim Support volunteers, 3 health service staff, 78	32
Taylor *et al.*, 2006[178]	Focus groups and individual semistructured telephone interviews	Approached: 38 for focus groups; 30 for interviews Recruited: 28 for focus groups; 8 for interviews Response rate (%): 73.7% focus groups; 26.6% interviews	Age (mean, SD, range): Not stated Gender (%): Not stated HCP training/expertise: Physicians who provide obstetric care	31

Appendix 9.2: Characteristics of quantitative (survey) studies

Study details	Study design	Number of participants	Nature of participants
Bair-Merritt *et al.*, 2004[184]	Inclusion criteria: Not stated Exclusion criteria: Not stated Type of study: Cross-sectional survey	Approached: 194 Recruited: 127 Response rate (%): 68	Age (mean, SD, range, %): < 30: 43 30–34: 51 35–40: 2 Ethnicity (%): White: 73 Black: 3 East Asian/Pacific Islander: 9 South Asian: 5 Hispanic American: 8 Other: 2 HCP gender (%): Female, 68 HCP training/expertise (%): Free-standing children's hospital, 38 Paediatric programme in a university-based hospital, 36 Paediatric programme in a community-based general hospital, 22
Bair-Merritt *et al.*, 2006[185]	Inclusion criteria: Not stated Exclusion criteria: Not stated Type of study: Cross-sectional questionnaire	Approached: 158 Recruited: 151 Response rate (%): 96	Age (mean, SD, range,%): Physicians: 31.5; Nurses: 32.5; Other: 31.5 Ethnicity (%): White: 77 Black: 8 Asian: 12 Other: 3 HCP gender (%): Physicians: Female 26%, male 18% Nurses: Female 30%, male 6% Other: Female 14%, male 6% HCP training/expertise (%): Physicians, 30; Nurses, 53; Paramedics, 10; Other, 7

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Study details	Study design	Number of participants	Nature of participants
Baig *et al.*, 2006[186]	Inclusion criteria: Residents across six residency programmes Exclusion criteria: Not stated Type of study: Self-report online questionnaire	Approached: 309 Recruited: 167 Response rate (%): 54	Age (mean, SD, range, %): Not stated Ethnicity (%): Minority, 20 HCP gender (%): Female, 60 HCP training/expertise (%): Internal medicine, 42; Obs./Gyn., 8; Paediatrics, 13; Emergency medicine,16; Family medicine, 9; Medicine/paediatrics, 13
Baird, 2005[187]	Inclusion criteria: Not stated Exclusion criteria: Not stated Type of study: Cross-sectional survey	Approached: 39 Recruited: 29 Response rate (%): 76	Age (mean, SD, range): Not stated Ethnicity (%): Not stated HCP gender (%): Not stated HCP training/expertise (%): Midwives
Barnett, 2005[188]	Inclusion criteria: Not stated Exclusion criteria: Not stated Type of study: Cross-sectional survey	Approached: 236 Recruited: 132 Response rate (%): 55.9	Age (mean, SD, range): Not stated Ethnicity (%): Not stated HCP gender (%): Not stated HCP training/expertise (%): Midwives
Ellis, 1999[189]	Inclusion criteria: Not stated Exclusion criteria: Not stated Type of study: Cross-sectional survey	Approached: 101 Recruited: 40 Response rate (%): 39.6	Age (mean, SD, range): 24–59 years (mean = 39) Ethnicity (%): Not stated HCP gender (%): Female, 92.5 HCP training/expertise (%): Nurses, by total years in nursing: 1–9: 32.5 10–19: 60 20–29: 5 30–39: 2.5 Educational backgrounds: High school diplomas: 17.5 Associate's degrees: 27.5 Bachelor's degrees: 40 Master's degrees: 15

continued

Study details	Study design	Number of participants	Nature of participants
Fikree *et al.*, 2004[190]	Inclusion criteria: Eligibility criteria were determined by area of residence, enrolment in obstetrics residency training, and work experience Exclusion criteria: Not meeting the inclusion criteria Type of study: Self-report questionnaire	Approached: 100 Recruited: 100 Response rate (%): 100	Age (mean, SD, range): Not stated Ethnicity (%): Not stated HCP gender (%): Not stated HCP training/expertise (%): 100 obstetricians: 48 seniors; 29 juniors; 23 trainees
Friedman *et al.*, 1992[110]	Inclusion criteria: Not stated Exclusion criteria: Age less than 18, inability to understand the English language, and unwillingness to give consent Type of study: Cross-sectional survey	Approached: 15 from Boston City Hospital and 18 from Lahey Clinic Recruited: 11 from Boston City Hospital and 16 from Lahey Clinic Response rate (%): 73 for Boston City Hospital and 89 for Lahey Clinic	Age (mean, SD, range): Not stated Ethnicity (%): Not stated HCP gender (%): Not stated HCP training/expertise (%): Primary care attending physicians
Goff *et al.*, 2001[191]	Inclusion criteria: Participants' names were selected from the Texas State Board of Medical Examiners, and the American Academy of Nurse Practitioners. No explicit inclusion criteria stated Exclusion criteria: Not stated	Approached: Physicians in primary care specialties (emergency medicine, psychiatry, family practice, general practice, gynaecology, internal medicine, obstetrics/ gynaecology): 345 General dentists: 177 Nurse practitioners: 84 Total: 606 Recruited: Physicians in primary care specialties: 315 General dentists: 170 Nurse practitioners: 76 Total: 561	Age (mean, SD, range): Not stated Ethnicity (pre-intervention) (%): Not stated

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Study details	Study design	Number of participants	Nature of participants
	Type of study: Cross-sectional survey	Response rate (%): Physicians in primary care specialties: 27.3 General dentists: 43.5 Nurse practitioners: 43.4 Total: 34.4 NOTE: figures (p. 42) do not add up – values come to 221 (114%), which is not what is stated!	HCP gender (%): Nurse practitioners, F: 91 Physicians, F: 27 Dentists, F: 8 HCP training/expertise (%): Years in practice: range 1–49, mean 16.7 years
Knapp *et al.*, 2006[271]	Inclusion criteria: Not stated Exclusion criteria: Not stated Type of study: Self-administered questionnaire	Approached (pre, post, follow-up): Not stated Recruited (pre, post, follow-up): 79/87/48 Attending physician: 20/17/17 Nurse: 42/48/18 Social worker: 14/16/12 Response rate (%) (pre, post, follow-up): Attending physician: 25.3/19.5/35.4 Nurse: 53.2/55.2/37.5 Social worker: 17.4/19.8/25.0	Age (mean, SD, range) (pre, post, follow-up): 36.8/32.9/33.5 Ethnicity (pre-intervention) (%): Not stated HCP gender (%) (pre, post, follow-up): F: 89.5/88.5/83.3 HCP training/expertise (%) (pre, post, follow-up): Attending physician: 25.3/19.5/35.4 Nurse: 53.2/55.2/37.5 Social worker: 17.4/19.8/25.0
Lazenbatt *et al.*, 2005[192]	Inclusion criteria: Not stated	Approached: 861	Age (mean, SD, range): 20–25: 1.4 26–30: 9 31–35: 29.5 36–40: 27.7 41–45: 16.2 46–50: 10.5 51–55: 5.1 56–60: 0.4 61–65: 0.2

continued

Study details	Study design	Number of participants	Nature of participants
	Exclusion criteria: Exclusion of midwives who were on maternity leave, career break or long-term sick leave Type of study: Self-report postal questionnaire	Recruited: 488 Response rate (%): 57	Ethnicity (%): Not stated HCP gender (%): Female, 95 HCP training/expertise (%): Hospital midwives: 80 Community midwives: 20
Nayak, 2000[193]	Inclusion criteria: Students from 4th (preclinical), 5th and 6th (clinical) years at a medical faculty in the year 1996–1997 Exclusion criteria: Not stated Type of study: Cross-sectional survey	Approached: 192 Recruited: 106 Response rate (%): 66.24	Age (mean, SD, range): Year 4: 21.53 (1.42) Year 5: 23.31 (1.33) Year 6: 24.50 (1.04) Ethnicity: Kuwaiti nationals of Arab descent Gender (%): Female, 57.8 HCP training/expertise : Medical students
Nicolaidis *et al.*, 2005[194]	Inclusion criteria: Not stated Exclusion criteria: Not stated Type of study: Cross-sectional survey	Approached: 90 practices Recruited: 31 practices; 278 HCP Response rate (%): 34.4 practicest	Age (mean, SD, range): Not stated Ethnicity (%): Not stated Gender (%): Female, 91 HCP training/expertise: 123 (62%) had prior IPV training Professional role: Primary care providers: 25 Medical support staff: 44 Administrative staff: 20 Other employees: 8 Unknown: 3 Medical specialty (providers only): Family medicine: 46 Internal medicine: 27 Obstetrics/gynaecology: 17 Other: 10
Price and Baird, 2003[195]	Inclusion criteria: Not stated Exclusion criteria: Not stated Type of study: Audit questionnaire	Approached: 250 Recruited: 126 Response rate (%): 50.4	Age (mean, SD, range): Not stated Ethnicity (%): Not stated Gender (%): Not stated HCP training/expertise (%): Midwives

Study details	Study design	Number of participants	Nature of participants
Richardson *et al.*, 2001[196]	Inclusion criteria: Not stated Exclusion criteria: Not stated Type of study: Anonymous questionnaire survey	Approached: 700 Recruited: 401 Response rate (%): 57.3	Age (mean, SD, range): Not stated Ethnicity (%): Not stated Gender: Higher proportion of women GPs than national average F: More women HCP training/expertise (%): GP, 48.6; nurses, 27.9; health visitors, 23.5
Roelens *et al.*, 2006[197]	Inclusion criteria: All members of the Flemish College of Obstetricians and Gynaecologists – Board Certified Exclusion criteria: Not stated Type of study: Self-report questionnaire	Approached: 478 Recruited: 249 Response rate (%): 52.1	Age (mean, SD, range): 43.5 (37.0; 52.8) Ethnicity: Not stated Gender (%): Female, 30.8 HCP training/expertise (%): Public hospital: 24.2 Private hospital: 65.9 University hospital: 17.0
Salmon *et al.*, 2006[198]	Inclusion criteria: Not stated Exclusion criteria: Not stated Type of study: Pre-, post- and follow-up survey	Approached: 79 Recruited: 70 Response rate (%): 89	Age (mean, SD, range): 14.8 (9.6) Ethnicity: Not stated Gender (%): Female, 100 HCP training/expertise (%): Diploma: 43 Certificate: 39 Degree: 12 Master's: 5
Shye *et al.*, 2004[199]	Inclusion criteria: Not stated Exclusion criteria: Not stated Type of study: Survey questionnaire	Approached: 273 Recruited: 203 Response rate (%): 74.4%	Age (mean, SD, range): Not stated Ethnicity (%): Not stated Gender (%): Not stated HCP training/expertise (%): Subjects included all internal medicine, GPs, health appraisal, paediatric and Obs/Gyn physicians, physician assistants and nurse practitioners in the HMO's main metropolitan area

Appendix 9.3: Results and quality scores of quantitative studies

Author, publication year	Results	Quality scores (STROBE)
Bair-Merritt *et al.*, 2004[184]	Ninety-three percent of chief residents felt that paediatricians should screen for domestic violence, but only 21% screen every patient Seventy-one percent agreed or strongly agreed that paediatricians do not screen secondary to lack of training	15
Bair-Merritt *et al.*, 2006[185]	Most providers (65%) responded definitively yes or probably yes when asked if, in addition to the posters, paediatric emergency department health-care professionals should screen for intimate partner violence Age, gender and role in the emergency department did not affect opinions about screening Screening appropriate: total: 97/149; men: 31/44; women: 66/105; OR = 1.41 (0.66–3.01)	17
Baig *et al.*, 2006[186]	One hundred and eight residents thought domestic violence screening was 'very important', 51 'somewhat important', five 'neutral', one 'low importance', and zero 'not important'. In total, 95.2% of residents felt that domestic violence screening is important Resident characteristics, such as gender, year in residency and personal history of abuse, were not independently associated with importance placed on screening or on stated intention to screen for domestic violence Residents who had taken care of a domestic violence victim were more likely to report that domestic violence screening was very important than those who thought they had never taken care of a domestic violence victim In the multivariate logistic regressions, emergency medicine residents remained less likely to report domestic violence screening as being important than Obs/Gyn residents Some paediatric residents did not screen because of privacy concerns and thus may miss domestic violence among their adolescent patients. Residents reported lack of time, personal discomfort and forgetting to ask as personal barriers to domestic violence screening. Although residents stated no or poor training in domestic violence as a barrier, training in residency was not independently associated with priority placed either on screening or on stated intention to screen	18
Baird, 2005[187]	Only 52% of respondents felt it was the midwife's role routinely to enquire about domestic violence; 38% were unsure, whereas 10% felt there was no role for the midwife When asked 'Do you believe that a midwife enquiring about domestic violence may offend a pregnant woman', 68% responded 'Yes', whereas 21% were unsure and 11% responded 'No'	11
Barnett, 2005[188]	Sixty-six percent thought that midwives should ask women about domestic violence. However, a quarter were unconvinced and a further 7.1% believed that it was inappropriate The majority said that it should be a multidisciplinary task with general practitioners and health visitors (who would know the whole family) asking routinely about domestic violence Midwives' experience of abuse and comments (20% experienced personal abuse) Midwives felt strongly (91.7%) that robust referral systems should be in place before they ask women about domestic violence and feared that if this was not the case then questioning could in fact make a woman's situation worse	13

Author, publication year	Results	Quality scores (STROBE)
Ellis, 1999[189]	Although 35 (88%) of the respondents had attended some type of in-service training on domestic violence, only 21 (53%) felt that nurses should screen all women for domestic violence Also, 63% of nurses felt prepared to ask routine questions about domestic violence, 33% felt somewhat prepared and 5% felt not prepared	12
Fikree *et al.*, 2004[190]	Despite encountering physically abused victims during clinical practice, only eight obstetricians mentioned that they had ever received any training on identification or management of victims of domestic abuse. However, most (83%) thought that it was important to receive appropriate training, irrespective of marital status or gender. Interestingly, several obstetricians verbalised the desire of human rights issues training as an important component of a domestic violence screening and management programme Almost half of the respondents were favourably inclined routinely to screen patients. Among the three categories of obstetricians interviewed, junior obstetricians (59%) were more likely to be favourably inclined for routine screening compared with either senior (42%) or trainee (43%) obstetricians Emotional harm (77%), physical harm (60%) and pregnancy complications (49%) suffered by abused women were considered the most common reasons for perceiving routine screening as important However, reasons articulated by those obstetricians who did not consider it important to screen routinely included no solution to the problem (30%), inquiring was an invasion of privacy (19%), and there was not enough time to enquire (9%). All respondents considered it important to inquire about domestic violence upon suspecting abuse	16
Friedman *et al.*, 1992[110]	Among physicians, one-third believed that physical abuse and sexual abuse questions should be asked routinely However, sexual abuse inquiries were never made by 89% at initial visits or by 85% at annual visits. Physical abuse inquiries were never made by 67% at initial visits, or by 60% at annual visits Eighty-one percent believed they could help with problems associated with physical abuse and 74% with sexual abuse	19
Goff *et al.*, 2001[191]	Twenty-five percent of physicians, 2.7% of dentists and 45.5% of nurse practitioners believed that women should be asked as part of routine exam Overall, 20% of the health-care professionals believed women should be screened	16
Knapp *et al.*, 2006[271]	For four statements, there were no measurable changes in attitudes and beliefs between the baseline and both post-training evaluations. These included 'It is inappropriate to ask about IPV in the pediatric setting' (baseline: 4.3, 43% agreed; post-training: 4.3, 70% agreed; 6-month follow-up: 4.6, 65% agreed)	17
Lazenbatt *et al.*, 2005[192]	Fifty-three percent ($n = 254$) felt that every woman should be screened for domestic violence When midwives were asked if they had ever raised the issue of domestic violence with a client, only 28% ($n = 135$) reported to have done so. From the 28% of midwives who reported raising the issue of domestic violence with a client, 45.9% ($n = 62$) reported to have asked a direct question, with 7.4% ($n = 10$) reporting to have asked both a direct and indirect question	16

continued

Author, publication year	Results	Quality scores (STROBE)
Nayak, 2000[193]	Although most of the students (93%) felt that training in issues related to interpersonal violence is necessary, only 25% agreed that patients should be routinely assessed for a history of victimisation	18
Nicolaidis *et al.*, 2005[194]	Majority agreed it is the primary care provider's responsibility to ask about domestic violence when seeing patients for health maintenance visits (66%), chronic pain (56%) or injuries (62%) Fifteen percent agreed with screening for intimate partner violence at every visit	17
Price and Baird, 2003[195]	Fourteen percent of the audit respondents did not believe it was the role of the health-care professionals to screen at all, with an even larger number (39%) feeling that routine screening should not occur within professional practice From the responses it would appear that only a small number of hospital midwives screen routinely, with the majority of those who do screen being community-based midwives When asked who should screen, a wide range of responses was given, from 'any one who is in contact with women to specialists'. A large majority of hospital staff felt that it was the responsibility of the primary health-care team, specifically naming relevant individuals or by responses such as 'any health professional that [sic] has an ongoing relationship with the woman, i.e. a community midwife'	11
Richardson *et al.*, 2001[196]	Thirty-two percent thought that health visitors should routinely ask about domestic violence, 15% thought this for practice nurses, and 14% for general practitioners Practice nurses were significantly less likely than health visitors (or general practitioners) to think that routine enquiry about domestic violence should take place (OR = 0.46, 95% CI = 0.27–0.77, $p = 0.003$). Other predictor variables had no significant effect	15

Author, publication year	Results	Quality scores (STROBE)
Roelens *et al.*, 2006[197]	Agreement with the incentive to screen: In the main survey participants declined universal and systematic screening (69.5%) and also refuted the common view of pregnancy as a window of opportunity to screen (48.6%). Rather, obstetrician/gynaecologists favoured direct questioning of the patient by means of the Abuse Assessment Screen in case of suspected abuse (82.7%) Motivation: Most physicians surveyed considered directed screening (79.6%) although not universal screening (15.2%) as an issue of medical liability Perceived self-efficacy: The preponderance of survey participants felt insufficiently skilled to discuss partner abuse in a straightforward manner and to manage abuse-related issues with putative victims of domestic violence (51.4%). Similarly, physicians surveyed felt insufficiently acquainted with referral practices in case of partner abuse (59.8%) Outcome expectancy: A majority of obstetrician/gynaecologists believed that screening for intimate partner violence may be an effective means to counteract such abusive behaviours (65.4%). Yet, about half of all survey respondents were also convinced that there is a defined lack of referral services and specialised care facilities for women suffering from domestic violence	16
Salmon *et al.*, 2006[198]	At baseline participating community midwives thought that screening for domestic violence is important (88.6%); post-test this proportion increased to 97.5%, and at 6-month follow-up it was 97.3% Agreement on the importance of midwives in such routine enquiry demonstrated a significant increase at post-test (97.6%) compared with baseline (83.6%), but this declined to a non-significant level at follow-up (94.5%) No significant changes were found for views on the role of other health professionals enquiring about domestic violence	17
Shye *et al.*, 2004[199]	Clinicians' opinions about the best approach to screening women for domestic violence exposure showed that 75% would prefer to routinely ask patients at health maintenance visits, 8% would prefer to ask only women who are at high risk, 15% would let a clinician decide who to ask, and 2% would let the woman bring the subject up herself	17

Appendix 10

Cost-effectiveness of screening for partner violence

Appendix 10.1: Summary of data sources and assumptions used in the model

	Literature review	Service use data	Assumption
Intervention unit costs		×	Thirty percent of all programme steering group meetings contributed towards the management of the intervention
Partner violence unit costs	×		Fifty percent of divorce proceedings arising from IPV involve children and property The average stay in a shelter in England and Wales is 6 weeks (information from Refuge) Twenty percent of IPV cases have child-care needs (based on the Women and Equity Unit figures). We assumed that this child care is for 6 weeks Women who are not abused incur civil justice and temporary housing costs. These costs are assumed to be in proportion to the divorce figures between IPV and non-IPV populations Women whose abuse is unidentified have lower costs, because their needs are not recognised or addressed. We assume their criminal justice, civil justice and temporary housing costs are half those for IPV Women undergoing advocacy and/or psychology treatment are assumed to have the same criminal justice costs, etc. as those who have disclosed and are not seeking an intervention Women in medium-term improvement have reduced costs. Their civil justice, temporary housing and mental health costs are the average of no abuse costs and the costs associated with those who have disclosed and are not seeking treatment. Their employment costs are half those of the disclosed – not seeking treatment group. The criminal justice costs are the same as in the abuse unidentified group
Transitional probabilities		×	The rate of recorded assessments must be inflated by 1.25 for intervention practices and by 3.33 for the control practice to get a true rate of assessments, with a standard error of 0.174 and 1 respectively The rate of assessing abused women to rate of assessing non-abused is 1.5 for both the intervention and control practices, with a standard error of 0.125 Fourteen percent experienced abuse in the past year In England and Wales two women die per week from domestic violence
Quality of life	×		Wittenberg *et al*.[272] estimated a quality of life of between 0.58 and 0.63 on a scale of 0 (equivalent to death) and 1 (equivalent to optimal health). We assume a quality of life of 1 when there is no abuse, 0.63 where abuse is ongoing, and 0.65 when women are experiencing medium-term improvement

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Appendix 10.2: Transition probabilities

	Control (standard error)	Intervention (standard error)	Source	Period
No abuse to no abuse	0.997	0.997	Assumption	6-monthly
No abuse to abuse unidentified[a]	0.0027	0.0027	Complementary figure	6-monthly
No abuse to death	0.00029	0.00029	Office of National Statistics all-cause mortality rate[848]	6-monthly
	1	1		
Abuse unidentified to no abuse	0.005	0.005	Assumption	6-monthly
Abuse unidentified to abuse unidentified	0.97143	0.94048	Complementary figure	6-monthly
Abuse unidentified to GP assessment	0.023 (0.016)	0.054 (0.04)	PreDoVe study	Instantaneous
Abuse unidentified to abuse identified (through other means)	0	0	PreDoVe study	6-monthly
Abuse unidentified to death	0.000385	0.000385	Violent deaths[273] and all-cause mortality[848]	6-monthly
	1	1		
GP assessment to abuse identified (true positive)	0.21	0.42	PreDoVe study. Assume control half as effective	Instantaneous
GP assessment to abuse unidentified (false negative)	0.79	0.58	Complementary figure	Instantaneous
	1	1		
Identified to accept referral	0.75	0.95	Assumption	Instantaneous
Identified to decline referral[b]	0.25	0.05	Complementary figure	Instantaneous
	1	1		
Accept referral to advocate	0.67	0.67	PreDoVe study	Instantaneous
Accept referral to psychologist	0.29	0.29	PreDoVe study	Instantaneous
Accept referral to both	0.04	0.04	PreDoVe study	Instantaneous
	1	1		
Advocate to psychologist	0.05	0.05	PreDoVe study	6-monthly
Advocate to medium-term improvement	0.3	0.3	Assumption	6-monthly
Advocate to disclosed – not seeking intervention	0.6496	0.6496	Complementary figure	6-monthly

continued

	Control (standard error)	Intervention (standard error)	Source	Period
Advocate to death	0.000385	0.000385	Violent deaths[273] and all-cause mortality	6-monthly
	1	1		
Psychologist to advocate	0.05	0.05	PreDoVe study	6-monthly
Psychologist to medium-term improvement	0.3	0.3	Assume same impact as advocate	6-monthly
Psychologist to disclosed – not seeking intervention	0.6496	0.6496	Complementary figure	6-monthly
Psychologist to death	0.000385	0.000385	Violent deaths[273] and all-cause mortality	
	1	1		
Both to medium-term improvement	0.3	0.3	Assume same impact as advocate	6-monthly
Both to disclosed – not seeking intervention	0.6996	0.6996	Complementary figure	6-monthly
Both to death	0.000385	0.000385	Violent deaths[273] and all-cause mortality	6-monthly
	1	1		
Disclosed – not seeking intervention to accept referral	0.2	0.2	Assumption	6-monthly
Disclosed – not seeking intervention to IEV	0.7946	0.7946	Complementary	6-monthly
Disclosed – not seeking intervention to no abuse	0.005	0.005	Assume same rate as abuse unidentified to no abuse	6-monthly
Disclosed – not seeking intervention to death	0.000385	0.000385	Violent deaths[273] and all-cause mortality	6-monthly
	1	1		
Medium-term improvement to medium-term improvement	0.59971	0.59971	Complementary	6-monthly
Medium-term improvement to disclosed – not seeking intervention	0.2	0.2	Assumption	6-monthly
Medium-term improvement to no abuse	0.2	0.2	Assumption	6-monthly
Medium-term improvement to death	0.00029	0.00029	All-cause mortality	6-monthly

a PreDoVe trial, i.e. in both the control and intervention practices we assume that the rate of assessing an abused woman, x_a, to the rate of assessing a non-abused woman, x_b, is $x_a = 1.5x_b$, which rearranges to $x_b = 0.66x_a$. So in the control practice the rate of assessment of the non-abused is $x_b = 0.66 \times 4.6\% = 3.036\%$, and in the intervention practices $x_b = 0.66 \times 10.7\% = 7.06\%$. Converting this to a 6-monthly transition using the hazard ratio gives 0.036 for the intervention and 0.0183 for the control. We add these additional assessment costs of the non-abused into the cost-effectiveness ratio (although the transitions do not appear directly in this table).

b Identified to decline referral are classified as disclosed – not seeking intervention.

The 6-monthly transition probability, p, is approximately half the annual transition probability, q. However, our estimates are based on an estimate, where we first calculate the annual hazard rate, r, i.e. $r = (-\log(1-q))/12$ months, and then estimate the 6-monthly transition based on the formula $p = 1 - \exp(-r*6)$.

In Appendix 10.2 we only include the proportion of GP assessment for the abused, because this figure is required to calculate the 6-monthly transitions from abuse unidentified to advocacy and/or psychology services. However, for the non-abused we only need to record these GP assessments in our cost-effectiveness calculations because we assume that the non-abused will not be referred.

Appendix 10.3: Treatment costs in 2005 prices (£ sterling)

	Cost per person	Source
Cost of advocacy	164	PreDoVe
Cost of psychologist	305	PreDoVe
Cost of advocate and psychologist	469	PreDoVe
Administration costs	5	PreDoVe
Use of HARK by doctor or nurse	24	Netten et al[274]

Costs associated with advocacy and/or psychological interventions were collated for each woman in the PreDoVe pilot trial, and averaged across all women in the arm.

Appendix 10.4: Average 6-monthly costs and annual quality-adjusted life years

	Examples of what costs are covered	No abuse	Abuse unidentified	Advocate	IEV	Medium-term improvement
Criminal justice	Violence against a person	0	£436	£873	£873	£436
Civil justice	Injunctions, divorce proceedings, children and property	£18	£93	£185	£186	£101
Employment loss of output	Fatalities, serious wounding	£0	£1628	£1628	£1628	£814
Temporary housing	Shelters, hostel accommodation, local authority housing, friends and family	£111	£379	£757	£757	£434
Social services and child care	Children looked after or in need	£0	£432	£432	£432	£0
Medical services	Family medicine consultations, emergency room visits, health visitor (public health nurse) visits	£0	£164	£164	£164	£0
Mental health		£52	£209	£209	£209	£131
Treatment costs	Advocate's visits	£0	£0	£164	£0	£0
Administration costs	Central administration of the intervention	£0	£0	£5	£5	£0
Total 6-monthly costs		£181	£3340	£4416	£4253	£1916
Annual quality of life		1	0.63	0.63	0.63	0.65

Appendix 10.5: Sensitivity analyses (varying cost and benefit by 25%)

Variable	Base case value	Upper value	Upper value ICER	Lower value	Lower value ICER
ICER	2450				
No abuse to no abuse	0.997	0.999	2078	0.994	2976
No abuse to abuse unidentified	0.003	0.004	2266	0.002	2630
No abuse to GP assessment (intervention)	0.037	0.046	2628	0.028	2284
No abuse to GP assessment (control)	0.018	0.023	2532	0.014	2362
Abuse unidentified to no abuse	0.005	0.006	2728	0.004	2172
Abuse unidentified to abuse unidentified (intervention)	0.941	0.972	1368	0.706	648
Abuse unidentified to abuse unidentified (control)	0.972	0.999	3278	0.941	54
Abuse unidentified to GP assessment (intervention)	0.054	0.068	2420	0.023	1350
Abuse unidentified to GP assessment (control)	0.023	0.054	54	0.017	2780
GP assessment to identified (true positive) (intervention)	0.420	0.525	2372	0.315	2452
GP assessment to identified (true positive) (control)	0.210	0.263	2140	0.158	2726
Identified to accept referral (intervention)	0.950	1.000	1514	0.750	6872
Identified to accept referral (control)	0.750	0.950	3390	0.563	1620
Accept referral to advocate	0.670	0.838	2294	0.503	2604
Accept referral to psychologist	0.290	0.363	2518	0.218	2384
Accept both	0.040	0.050	2476	0.030	2424
Advocate and/or psychologist to disclosed – not seeking intervention (changing both together)	0.650	0.813	41,466	0.488	–8066 (cost saving)
Advocate and/or psychologist to medium-term improvement (changing together)	0.300	0.375	–3594 (cost saving)	0.225	12,872
Disclosed – not seeking intervention to accept referral	0.200	0.250	512	0.150	4936
Disclosed – not seeking intervention to disclosed – not seeking intervention	0.795	0.994	19,324	0.596	–3334 (cost saving)
Disclosed – not seeking intervention to no abuse	0.005	0.006	2024	0.004	2894
Medium-term improvement to medium-term improvement	0.600	0.750	2778	0.450	2286
Medium-term improvement to disclosed – not seeking intervention	0.200	0.250	5286	0.150	–366 (cost saving)
Medium-term improvement to no abuse	0.200	0.250	80	0.150	6426
Discount rate	3.5% for costs and benefits	No discount	1754	5% for costs and benefits	2766

Variable	Base case value	Upper value	Upper value ICER	Lower value	Lower value ICER
Abuse unidentified	0.630	0.680	18,542	0.580	1312
Advocate	0.630	0.680	2192	0.580	2776
Psychologist	0.630	0.680	2322	0.580	2594
Advocate and psychologist	0.630	0.680	2434	0.580	2468
Disclosed – not seeking intervention	0.630	0.680	1690	0.580	4448
Medium-term improvement	0.650	0.700	2208	0.630	2562
HARK (one-off cost of administration)	23.80	47.60	2938	0.000	1962
Advocacy	164	205	2656	123	2246
Psychologist	305	381	2640	229	2262
Extra cost of mental health services when abused	157	196	2164	118	2738
Extra criminal justice cost when abused	873	1091	4636	655	274
Extra civil justice costs when abused	168	210	2870	126	2030
Extra employment costs when abused	1628	2035	–548 (cost saving)	1221	5440
Extra housing costs when abused	646	808	4070	485	830
Extra medical (non-mental health) costs when abused	164	205	2062	123	2846
Extra child-care costs when abused	432	540	1418	324	3482

Appendix 11

Self-appraisal of reviews

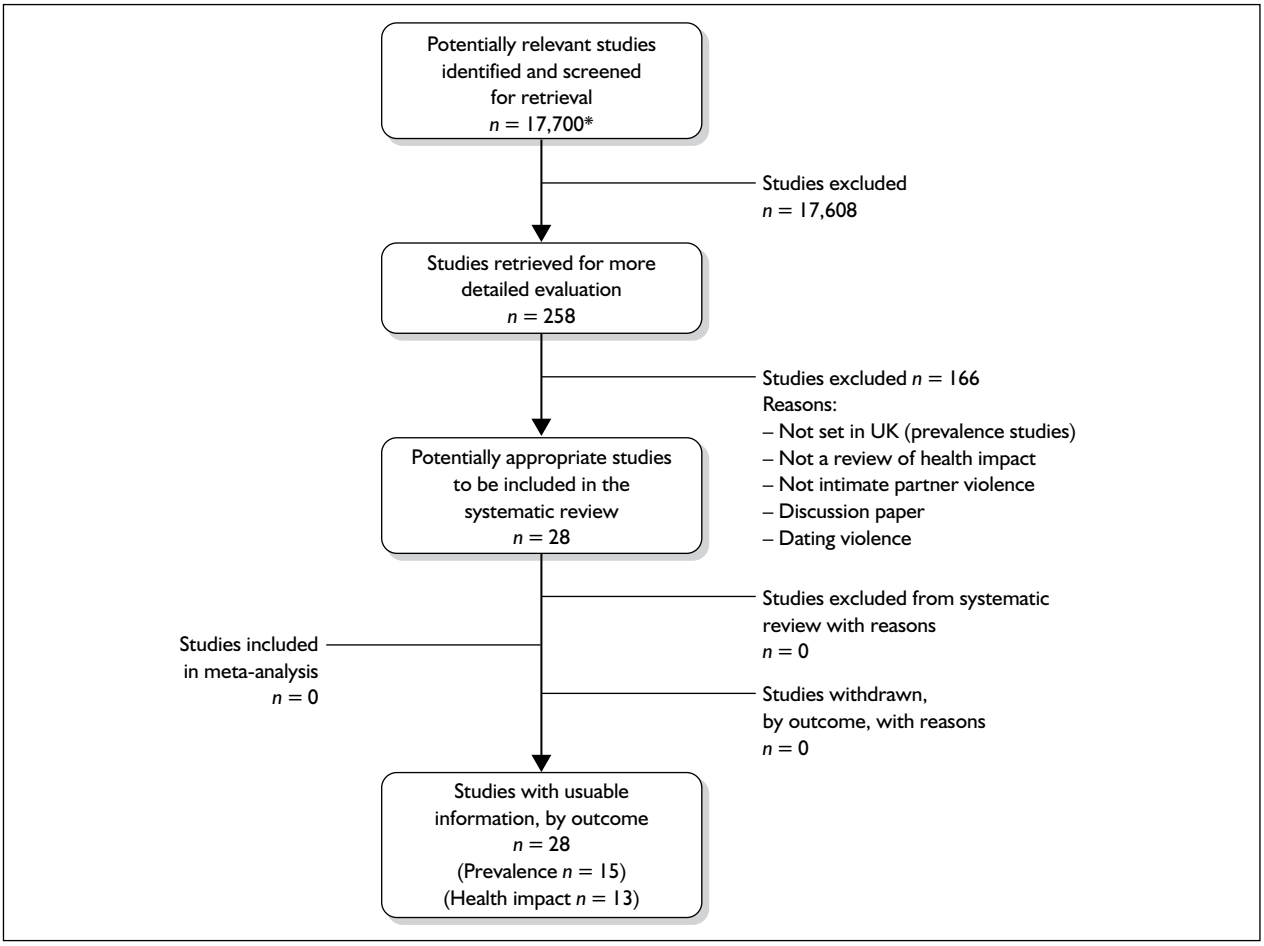
Appendix 11.1: The MOOSE criteria applied to review of prevalence studies

Main heading	Subheading	Done
Reporting of background should include		
	Problem definition	Yes
	Hypothesis statement	Not applicable
	Description of study outcome(s)	Yes
	Type of exposure or intervention used	Not applicable
	Type of study designs used	Yes
	Study populations	Yes
Reporting of search strategy should include		
	Qualifications of searchers (e.g. librarians and investigators)	Yes, although not in the text. The searchers had master's level training that included searching bibliographic databases
	Search strategy, including time period included in the synthesis and keywords	Yes
	Databases and registries searched	Yes
	Effort to include all available studies, including contact with authors	Yes
	Search software used, name and version, including special features used (e.g. explosion)	No
	Use of hand searching (e.g. reference lists of obtained articles)	Yes
	List of citations located and those excluded, including justification	No – the inclusion/exclusion criteria were unambiguous for this review
	Method of addressing articles published in languages other than English	Yes
	Method of handling abstracts and unpublished studies	Excluded
	Description of any contact with authors	Yes
Reporting of methods should include		
	Description of relevance or appropriateness	Yes
	Rationale for the selection and coding of data (e.g. sound clinical principles or convenience)	Yes
	Documentation of how data were classified and coded (e.g. multiple raters, blinding and inter-rater reliability)	Yes (as only a single, unblinded rater, test of inter-rater reliability not applicable)

Main heading	Subheading	Done
	Assessment of confounding (e.g. comparability of cases and controls in studies where appropriate)	Yes
	Assessment of study quality, including blinding of quality assessors; stratification or regression on possible predictors of study results	Yes, but assessor not blinded
	Assessment of heterogeneity	Qualitative
	Description of statistical methods	Not applicable as studies not meta-analysed
	Provision of appropriate tables and graphics	Yes
Reporting of results should include		
	Graphic summarising individual study estimates and overall estimate	Yes, although only included study estimates, not pooled prevalence
	Table giving descriptive information for each study included	Yes
	Results of sensitivity testing (e.g. subgroup analysis)	Yes
	Indication of statistical uncertainty of findings	Yes, although only confidence intervals on included study estimates
Reporting of discussion should include		
	Quantitative assessment of bias (e.g. publication bias)	No
	Justification for exclusion (e.g. exclusion of non-English language citations)	Not applicable – all studies of UK prevalence were included
	Assessment of quality of included studies	Yes
Reporting of conclusions should include		
	Consideration of alternative explanations for observed results	Yes
	Generalisation of the conclusions (i.e. appropriate for the data presented and within the domain of the literature review)	Yes
	Guidelines for future research	Yes
	Disclosure of funding source	Yes

Appendix 11.2: Flow diagram of inclusion/ exclusion for health impact review

This figure* represents the total number of abstracts identified by search string. It is not possible to separate abstracts according to review questions as the search string identified all potentially relevant studies for each review question at the same time. Furthermore, the true number of abstracts is likely to be less than 17,700 because some abstracts were duplicated across databases.



DOI: 10.3310/hta13160

Appendix 11.3: Modified QUORUM statement checklist and flow diagram for screening tool review

QUORUM statement checklist

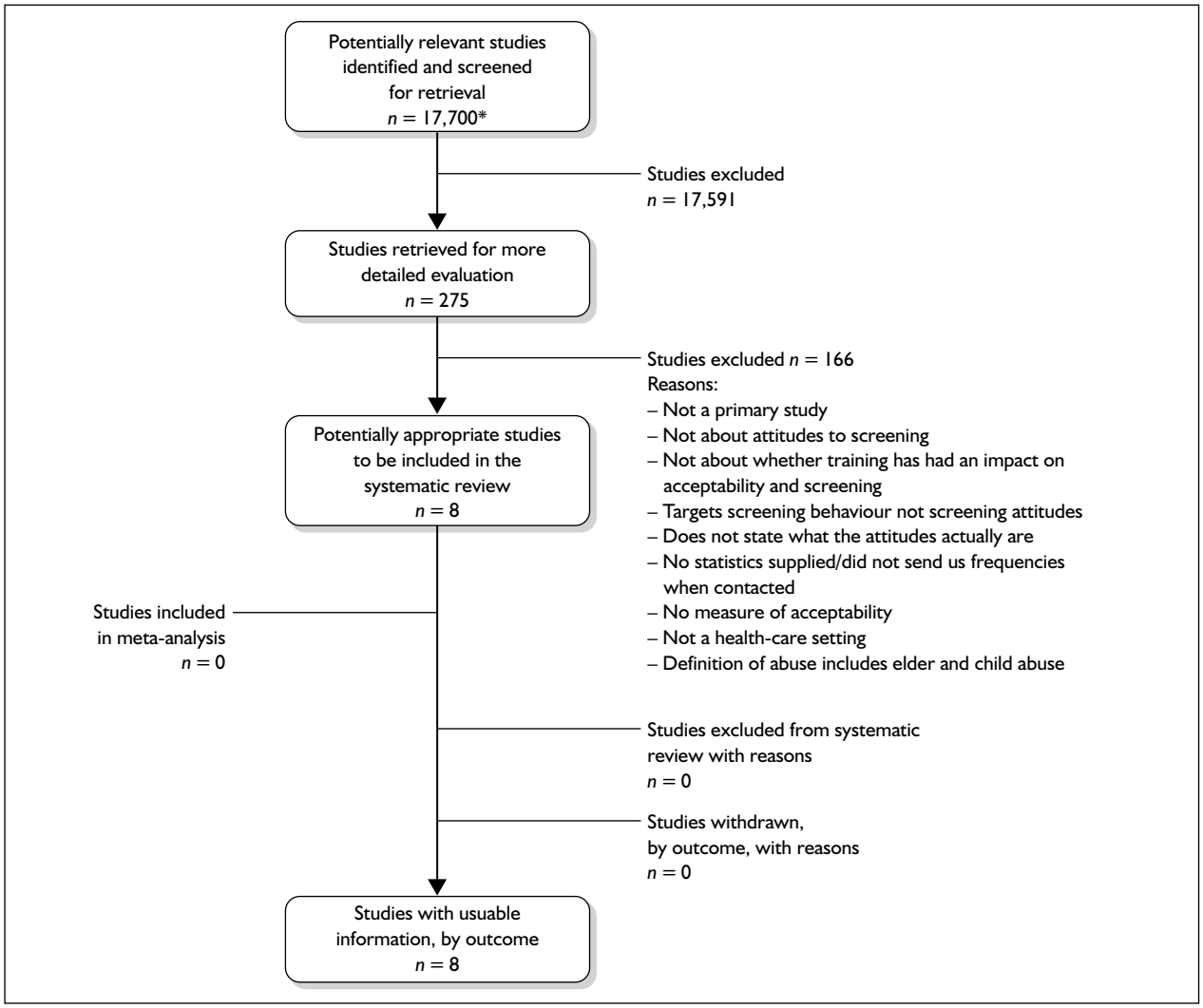
Heading	Subheading	Descriptor	Reported?	Page number
Title		Identify the report as a systematic review	Yes	In report title
Abstract		Use a structured format	Yes	iii–iv
		Describe		
	Objectives	The clinical question explicitly		
	Data sources	The databases (i.e. list) and other information sources		
	Review methods	The selection criteria (i.e. population, intervention, outcome and study design); methods for validity assessment, data abstraction and study characteristics, and quantitative data synthesis in sufficient detail to permit replication		
	Results	Characteristics of the studies included and excluded; qualitative and quantitative findings (i.e. point estimates and confidence intervals); and subgroup analyses		
	Conclusion	The main results		
		Describe		
Introduction		The explicit clinical problem and rationale for review	Yes	1–6
Methods	Searching	The information sources in detail (e.g. databases, registers, personal files, expert informants, agencies, hand-searching), and any restrictions (years considered, publication status, language of publication)	Yes	12
	Selection	The inclusion and exclusion criteria (defining population, intervention, principal outcomes and study design	Yes	8–11

continued

Heading	Subheading	Descriptor	Reported?	Page number
	Validity assessment	The criteria and process used (e.g. masked conditions, quality assessment and their findings)	Yes	15, Appendix 5.4
	Data abstraction	The process or processes used (e.g. completed independently, in duplicate)	Yes	12–13
	Study characteristics	The type of study design, participants' characteristics, details of intervention, outcome definitions and how clinical heterogeneity was assessed	Yes	8–11, 13
	Data synthesis	The principal measures of effect (e.g. relative risk), method of combining results (statistical testing and confidence intervals), handling of missing data; how statistical heterogeneity was assessed; a rationale for any *a priori* sensitivity and subgroup analyses and any assessment of publication bias	Yes	13
Results	Trial flow	Provide a meta-analysis profile summarising trial flow (see figure)	Yes	
	Study characteristics	Present descriptive data for each study (e.g. age, sample size, intervention, dose, duration, follow-up period)	Yes	29–33, Appendix 5.2
	Quantitative data synthesis	Report agreement on the selection and validity assessment; present simple summary results	Yes	33–36, Appendices 5.3 and 5.4
Discussion		Summarise key findings; discuss clinical inferences based on internal and external validity; interpret the results in light of the totality of available evidence; describe potential biases in the review process (e.g. publication bias); and suggest a future research agenda	Yes	36–37, 73–77

QUORUM statement flow diagram

This figure* represents the total number of abstracts identified by search string. It is not possible to separate abstracts according to review questions as the search string identified all potentially relevant studies for each review question at the same time. Furthermore, the true number of abstracts is likely to be less than 17,700 because some abstracts were duplicated across databases.



Appendix 11.4: Modified QUORUM statement checklist and flow diagram for acceptability of screening to women review

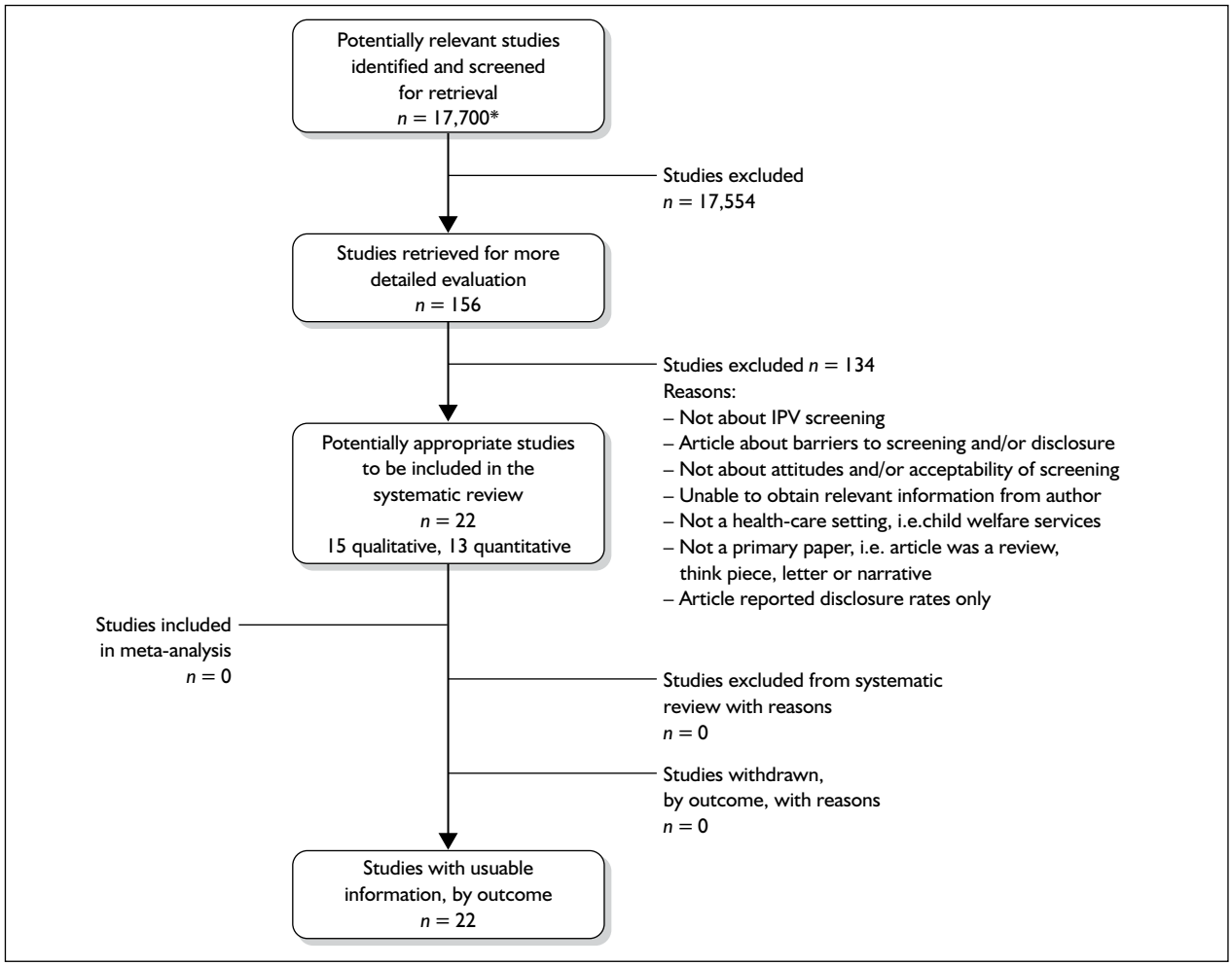
QUORUM statement checklist

Heading	Subheading	Descriptor	Reported?	Page number
Title		Identify the report as a systematic review	Yes	In report title
Abstract		Use a structured format	Yes	iii–iv
		Describe		
	Objectives	The clinical question explicitly		
	Data sources	The databases (i.e. list) and other information sources		
	Review methods	The selection criteria (i.e. population, intervention, outcome and study design); methods for validity assessment, data abstraction and study characteristics, and quantitative data synthesis in sufficient detail to permit replication		
	Results	Characteristics of the studies included and excluded; qualitative and quantitative findings (i.e. point estimates and confidence intervals); and subgroup analyses		
	Conclusion	The main results		
		Describe		
Introduction		The explicit clinical problem and rationale for review	Yes	1–6
Methods	Searching	The information sources in detail (e.g. databases, registers, personal files, expert informants, agencies, hand searching), and any restrictions (years considered, publication status, language of publication)	Yes	12
	Selection	The inclusion and exclusion criteria (defining population, intervention, principal outcomes and study design	Yes	8–11
	Validity assessment	The criteria and process used (e.g. masked conditions, quality assessment and their findings)	Yes	15–16, Appendices 6.1 and 6.2

Heading	Subheading	Descriptor	Reported?	Page number
	Data abstraction	The process or processes used (e.g. completed independently, in duplicate)	Yes	12
	Study characteristics	The type of study design, participants' characteristics, details of intervention, outcome definitions and how clinical heterogeneity was assessed	Yes	8–11, 12–13
	Data synthesis	The principal measures of effect (e.g. relative risk), method of combining results (statistical testing and confidence intervals), handling of missing data; how statistical heterogeneity was assessed; a rationale for any *a priori* sensitivity and subgroup analyses and any assessment of publication bias	Yes	13–14
Results	Trial flow	Provide a meta-analysis profile summarising trial flow (see figure)	Yes	
	Study characteristics	Present descriptive data for each study (e.g. age, sample size, intervention, dose, duration, follow-up period)	Yes	39–44, Appendix 6.3
	Quantitative data synthesis	Report agreement on the selection and validity assessment; present simple summary results (for each treatment group in each trial, for each primary outcome); present data needed to calculate effect sizes and confidence intervals in intention-to-treat analyses (e.g. 2×2 tables of counts, means and SDs, proportions)	Yes	43–44
Discussion		Summarise key findings; discuss clinical inferences based on internal and external validity; interpret the results in light of the totality of available evidence; describe potential biases in the review process (e.g. publication bias); and suggest a future research agenda	Yes	45, 73–77

QUOROM statement flow diagram for studies

This figure* represents the total number of abstracts identified by search string. It is not possible to separate abstracts according to review questions as the search string identified all potentially relevant studies for each review question at the same time. Furthermore, the true number of abstracts is likely to be less than 17,700 because some abstracts were duplicated across databases.



DOI: 10.3310/hta13160

Appendix 11.5: Modified QUORUM statement checklist and flow diagram for intervention studies

QUORUM statement checklist

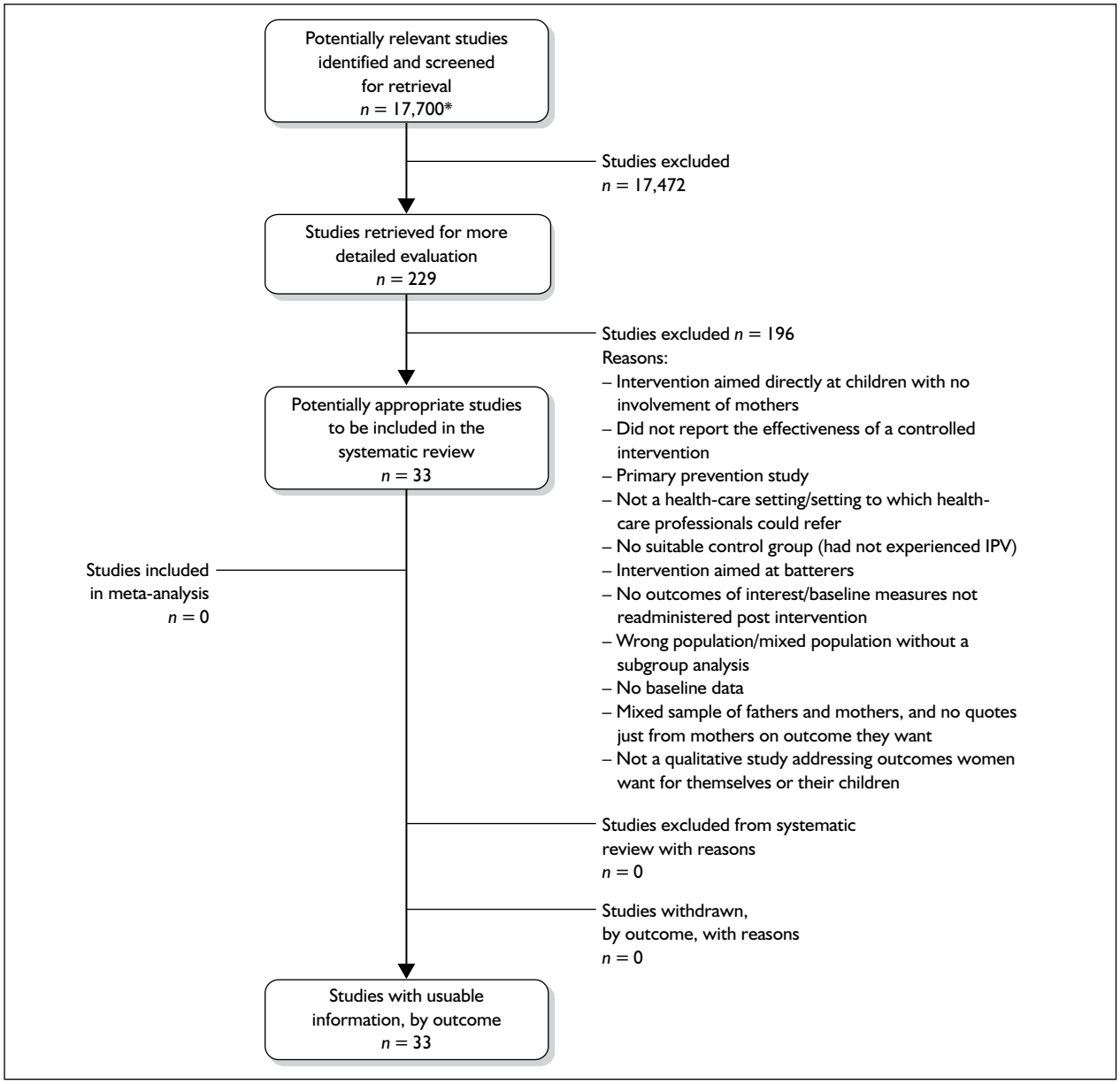
Heading	Subheading	Descriptor	Reported?	Page number
Title		Identify the report as a systematic review	Yes	In report title
Abstract		Use a structured format	Yes	iii–iv
		Describe		
	Objectives	The clinical question explicitly		
	Data sources	The databases (i.e. list) and other information sources		
	Review methods	The selection criteria (i.e. population, intervention, outcome and study design); methods for validity assessment, data abstraction and study characteristics, and quantitative data synthesis in sufficient detail to permit replication		
	Results	Characteristics of the studies included and excluded; qualitative and quantitative findings (i.e. point estimates and confidence intervals); and subgroup analyses		
	Conclusion	The main results		
		Describe		
Introduction		The explicit clinical problem and rationale for review	Yes	1–6
Methods	Searching	The information sources in detail (e.g. databases, registers, personal files, expert informants, agencies, hand searching), and any restrictions (years considered, publication status, language of publication)	Yes	12
	Selection	The inclusion and exclusion criteria (defining population, intervention, principal outcomes and study design	Yes	8–11

continued

Heading	Subheading	Descriptor	Reported?	Page number
	Validity assessment	The criteria and process used (e.g. masked conditions, quality assessment and their findings)	Yes	15–16, Appendices 7.2 and 7.3
	Data abstraction	The process or processes used (e.g. completed independently, in duplicate)	Yes	12
	Study characteristics	The type of study design, participants' characteristics, details of intervention, outcome definitions and how clinical heterogeneity was assessed	Yes	8–11, Appendix 7.1
	Data synthesis	The principal measures of effect (e.g. relative risk), method of combining results (statistical testing and confidence intervals), handling of missing data; how statistical heterogeneity was assessed; a rationale for any *a priori* sensitivity and subgroup analyses and any assessment of publication bias	Yes	12–13
Results	Trial flow	Provide a meta-analysis profile summarising trial flow (see figure)	Yes	
	Study characteristics	Present descriptive data for each study (e.g. age, sample size, intervention, dose, duration, follow-up period)	Yes	47–56, Appendix 7.1
	Quantitative data synthesis	Report agreement on the selection and validity assessment; present simple summary results (for each treatment group in each trial, for each primary outcome); present data needed to calculate effect sizes and confidence intervals in intention-to-treat analyses (e.g. 2×2 tables of counts, means and SDs, proportions)	Yes	Appendices 7.2 and 7.4
Discussion		Summarise key findings; discuss clinical inferences based on internal and external validity; interpret the results in light of the totality of available evidence; describe potential biases in the review process (e.g. publication bias); and suggest a future research agenda	Yes	56–58, 73–77

QUORUM statement flow diagram

This figure* represents the total number of abstracts identified by search string. It is not possible to separate abstracts according to review questions as the search string identified all potentially relevant studies for each review question at the same time. Furthermore, the true number of abstracts is likely to be less than 17,700 because some abstracts were duplicated across databases.



Appendix 11.6: Modified QUORUM statement checklist and flow diagram for morbidity and mortality outcomes of screening studies

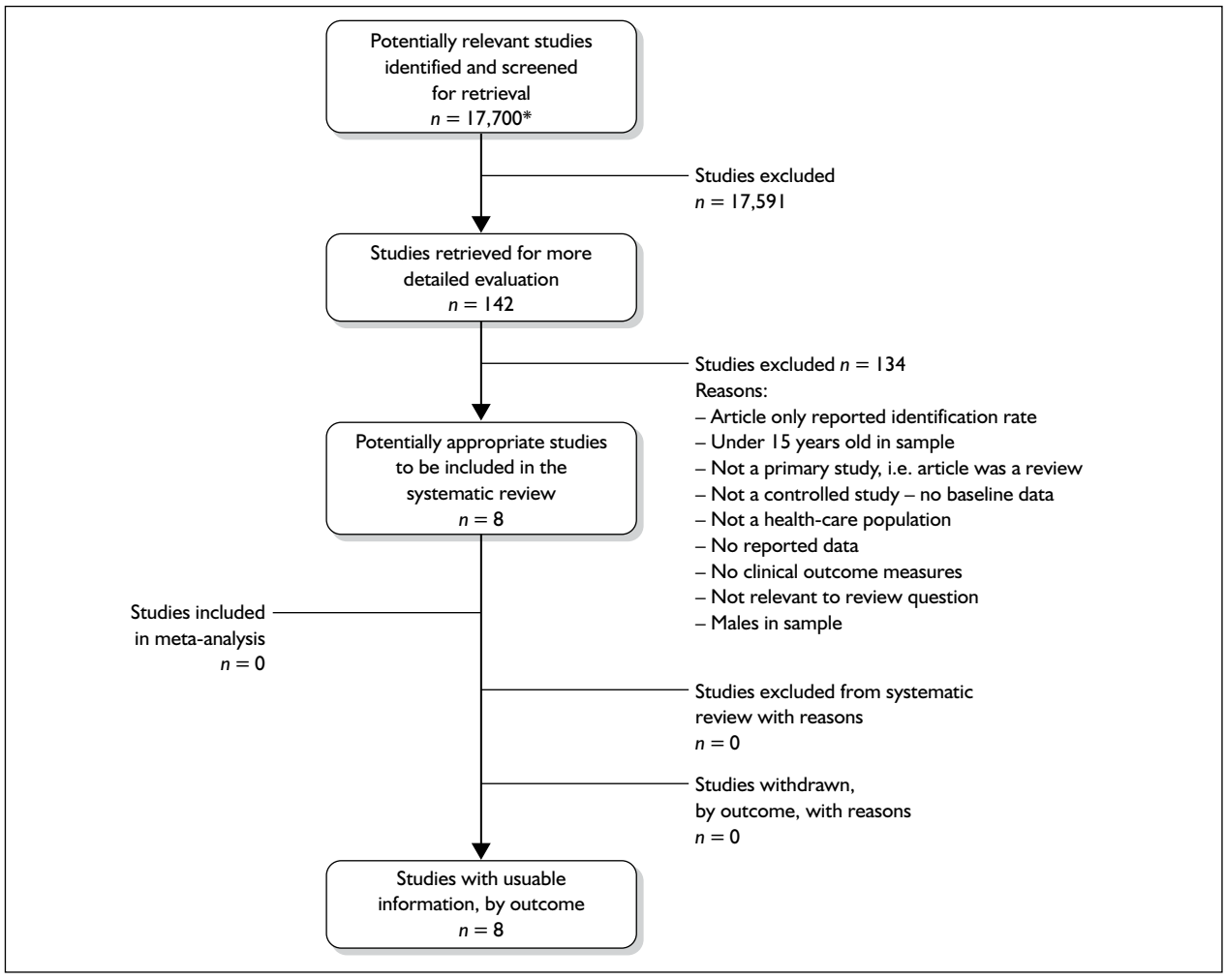
QUORUM statement checklist

Heading	Subheading	Descriptor	Reported?	Page number
Title		Identify the report as a systematic review	Yes	In report title
Abstract		Use a structured format	Yes	iii–iv
		Describe		
	Objectives	The clinical question explicitly		
	Data sources	The databases (i.e. list) and other information sources		
	Review methods	The selection criteria (i.e. population, intervention, outcome and study design); methods for validity assessment, data abstraction and study characteristics, and quantitative data synthesis in sufficient detail to permit replication		
	Results	Characteristics of the studies included and excluded; qualitative and quantitative findings (i.e. point estimates and confidence intervals); and subgroup analyses		
	Conclusion	The main results		
		Describe		
Introduction		The explicit clinical problem and rationale for review	Yes	1–6
Methods	Searching	The information sources in detail (e.g. databases, registers, personal files, expert informants, agencies, hand searching), and any restrictions (years considered, publication status, language of publication)	Yes	12
	Selection	The inclusion and exclusion criteria (defining population, intervention, principal outcomes and study design	Yes	8–11
	Validity assessment	The criteria and process used (e.g. masked conditions, quality assessment and their findings)	Yes	15–16, Appendix 8.3
	Data abstraction	The process or processes used (e.g. completed independently, in duplicate)	Yes	12

Heading	Subheading	Descriptor	Reported?	Page number
	Study characteristics	The type of study design, participants' characteristics, details of intervention, outcome definitions and how clinical heterogeneity was assessed	Yes	8–11, Appendix 8.1
	Data synthesis	The principal measures of effect (e.g. relative risk), method of combining results (statistical testing and confidence intervals), handling of missing data; how statistical heterogeneity was assessed; a rationale for any *a priori* sensitivity and subgroup analyses and any assessment of publication bias	Yes	12–13
Results	Trial flow	Provide a meta-analysis profile summarising trial flow (see figure)	Yes	
	Study characteristics	Present descriptive data for each study (e.g. age, sample size, intervention, dose, duration, follow-up period)	Yes	59–60, Appendix 8.2
	Quantitative data synthesis	Report agreement on the selection and validity assessment; present simple summary results (for each treatment group in each trial, for each primary outcome); present data needed to calculate effect sizes and confidence intervals in intention-to-treat analyses (e.g. 2×2 tables of counts, means and SDs, proportions)	Yes	Appendix 8.2
Discussion		Summarise key findings; discuss clinical inferences based on internal and external validity; interpret the results in light of the totality of available evidence; describe potential biases in the review process (e.g. publication bias); and suggest a future research agenda	Yes	61–62, 73–77

QUORUM statement flow diagram

This figure* represents the total number of abstracts identified by search string. It is not possible to separate abstracts according to review questions as the search string identified all potentially relevant studies for each review question at the same time. Furthermore, the true number of abstracts is likely to be less than 17,700 because some abstracts were duplicated across databases.



DOI: 10.3310/hta13160

Appendix 11.7: Modified QUORUM statement checklist and flow diagram for acceptability of screening to health-care professionals

QUORUM statement checklist

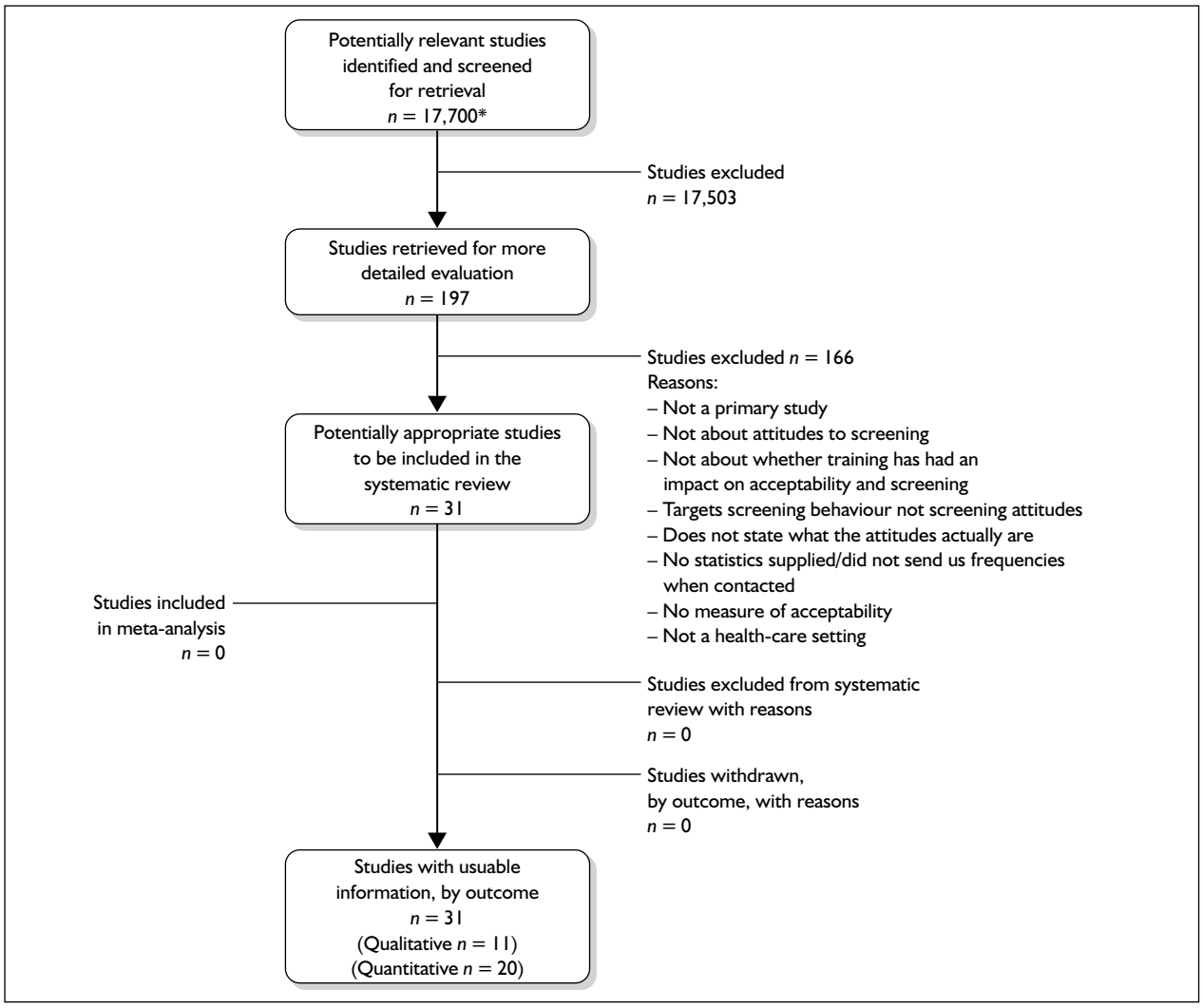
Heading	Subheading	Descriptor	Reported?	Page number
Title		Identify the report as a systematic review	Yes	In report title
Abstract		Use a structured format	Yes	iii–iv
		Describe		
	Objectives	The clinical question explicitly		
	Data sources	The databases (i.e. list) and other information sources		
	Review methods	The selection criteria (i.e. population, intervention, outcome and study design); methods for validity assessment, data abstraction and study characteristics, and quantitative data synthesis in sufficient detail to permit replication		
	Results	Characteristics of the studies included and excluded; qualitative and quantitative findings (i.e. point estimates and confidence intervals); and subgroup analyses		
	Conclusion	The main results		
		Describe		
Introduction		The explicit clinical problem and rationale for review	Yes	1–6
Methods	Searching	The information sources in detail (e.g. databases, registers, personal files, expert informants, agencies, hand searching), and any restrictions (years considered, publication status, language of publication)	Yes	12
	Selection	The inclusion and exclusion criteria (defining population, intervention, principal outcomes and study design	Yes	8–11
	Validity assessment	The criteria and process used (e.g. masked conditions, quality assessment and their findings)	Yes	15–16, Appendix 9.3

continued

Heading	Subheading	Descriptor	Reported?	Page number
	Data abstraction	The process or processes used (e.g. completed independently, in duplicate)	Yes	12
	Study characteristics	The type of study design, participants' characteristics, details of intervention, outcome definitions and how clinical heterogeneity was assessed	Yes	8–11, 12–13 Appendices 9.1 and 9.2
	Quantitative data synthesis	The principal measures of effect (e.g. relative risk), method of combining results (statistical testing and confidence intervals), handling of missing data; how statistical heterogeneity was assessed; a rationale for any *a priori* sensitivity and subgroup analyses and any assessment of publication bias	Yes	13–14
Results	Trial flow	Provide a meta-analysis profile summarising trial flow (see figure)	Yes	
	Study characteristics	Present descriptive data for each study (e.g. age, sample size, intervention, dose, duration, follow-up period)	Yes	63–67, Appendices 9.1 and 9.2
	Quantitative data synthesis	Report agreement on the selection and validity assessment; present simple summary results (for each treatment group in each trial, for each primary outcome); present data needed to calculate effect sizes and confidence intervals in intention-to-treat analyses (e.g. 2×2 tables of counts, means and SDs, proportions)	Yes	67, Appendix 9.3
Discussion		Summarise key findings; discuss clinical inferences based on internal and external validity; interpret the results in light of the totality of available evidence; describe potential biases in the review process (e.g. publication bias); and suggest a future research agenda	Yes	67–68, 73–77

QUORUM statement flow diagram

This figure* represents the total number of abstracts identified by search string. It is not possible to separate abstracts according to review questions as the search string identified all potentially relevant studies for each review question at the same time. Furthermore, the true number of abstracts is likely to be less than 17,700 because some abstracts were duplicated across databases.



Appendix 12

Studies excluded from the reviews

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Question I			
Schiff and Zeira, 2005[275]	Dating violence and sexual risk behaviours in a sample of at-risk Israeli youth	Not set in UK	QII – No age of children
Jain *et al.*, 2004[276]	Violence against women in India: evidence from rural Maharashtra, India	Not set in UK	
Mahony and Campbell, 1998[277]	Children witnessing DV: a developmental approach	Health impact but not a review	
Wiebe and Janssen, 2001[278]	Universal screening for DV in abortion	Not in the UK	
Coid *et al.*, 2006[279]	Violence and psychiatric morbidity in a national household population – a report from the British Household Survey	Not intimate partner violence	
Duxbury, 2006[280]	Recognising domestic violence in clinical practice using the diagnoses of post-traumatic stress disorder, depression and low self-esteem	A discussion paper – does not review literature on health impact, just discusses it	
Garcia-Moreno *et al.*, 2006[212]	Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence	Not set in UK	
Duffy *et al.*, 1999[281]	Mothers with histories of domestic violence in a paediatric emergency department	Not set in UK	
Stark and Flitcraft, 1995[282]	Killing the beast within: woman battering and female suicidality	A discussion paper – does not review literature on health impact, just discusses it	
Question II			
Perrin *et al.*, 1997[283]	Validation of the Keane MMPI-PTSD scale against *DSM-III-R* criteria in a sample of battered women	Does not address study question	
Anetzberger, 2001[284]	Elder abuse identification and referral: the importance of screening tools and referral protocols	Elder abuse, not specially DV	
Champion, 1996[285]	Women abuse, assimilation, and self-concept in a rural Mexican American community	Psychometric/psychosocial measures	
Ejaz *et al.*, 2001[286]	Evaluating the Ohio elder abuse scale and DV in late life screening tools and referral protocol	Not a validation study	
Punukollu, 2003[287]	DV screening made practical	Not a primary validation study	
Schofield *et al.*, 2002[288]	Screening for vulnerability to abuse amongst older women: Women's Health Australia study	Elder abuse, not DV	

DOI: 10.3310/hta13160

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Falk *et al.*, 2002[289]	Evaluation of a DV assessment protocol used by employee assistance counsellors	Employee-based sample	
Peace *et al.*, 2003[290]	Translation of DV instruments for use in research	Translation and validation study	
Lewis, 1985[251]	The wife abuse inventory: a screening device for the identification of abuse women	No gold standard	
Harris *et al.*, 2001[34]	Current methods of the US Preventive Services Task Force	Not a primary study	
Straus, 2005[220]	Measuring intrafamily conflict and violence: Conflict Tactics Scale	Not a primary study	
Waltermauer, 2005[291]	Measuring IPV: You may only get what you ask for	Not a primary study	
Scholle *et al.*, 2003[257]	Routine screening for IPV in an obstetrics and gynaecology clinic	No gold standard	QV – No baseline measure
Straus and Douglas, 2004[292]	A short form of the revised conflicts scales and typologies for severity and mutuality	No gold standard	
Straus *et al.*, 1996[221]	The revised Conflict Tactics Scale (CTS2) –- development and preliminary psychometric data	No gold standard	
Ross *et al.*, 2004[262]	Screening risks for IPV and primary care settings: implications for future abuse	Not a validation study	
Short and Rodriguez, 2002[240]	Testing an IPV assessment icon form with battered migrant and seasonal farm workers	No gold standard	
Anderst *et al.*, 2004[256]	A comparison of DV screening methods in a paediatric setting	Three different groups using three tools	
Prospero, 2006[293]	The role of perceptions in dating violence among young adolescents	Children aged 12–15 years in sample	
Sisley *et al.*, 1999[294]	Violence in America: a public health crisis – domestic violence	Not a primary study	
Rhodes *et al.*, 2002[295]	Between me and the computer: increased detection of intimate partner violence using a computer questionnaire	Females in sample	
Furbee *et al.*, 1998[252]	Comparison of domestic violence screening methods: a pilot study	No gold standard	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Canterino *et al.*, 1999[296]	Domestic abuse in pregnancy: a comparison of a self-completed domestic abuse questionnaire with a directed interview	Not clear if two tools used or one tool but presented differently	
Moraes *et al.*, 2002[297]	Portuguese-language cross-cultural adaptation of the revised Conflict Tactics Scale (CTS2), an instrument used to identify violence in couples	Translation study	
Meneghel *et al.*, 2000[298]	Women caring for women: a study on the 'Viva Maria' shelter, Port Alegre, Rio Gande do Sul, Brazil	Not a validation study	
Saltzman *et al.*, 1997[299]	Public health screening for intimate violence	Not a health-care population	
Reichenheim *et al.*, 2000[300]	Semantic equivalence of the Portuguese version of the abuse assessment screen tool used for the screening of violence against pregnant women	Translation study	
Tolman, 1999[246]	The validation of the psychological maltreatment of women inventory	Not validating a screening tool	
Weiss *et al.*, 2003[230]	The out-of-hospital use of a domestic violence screen for assessing patient risk	Males in sample	
Ernst *et al.*, 2002[301]	Comparison of three instruments for assessing ongoing intimate partner violence	Males in sample	
Weiss *et al.*, 2003[230]	Development of a screen for ongoing intimate partner violence	Males in sample	
Wetmore and Fairbairn, 2003[253]	A regional Californian programme to screen adolescent patients for intimate partner violence	Not a validation study	
Houry *et al.*, 2004[302]	A positive DV screen predicts future DV	Not a cross-sectional comparison	QVI – Not an objective/standardised/ interview measure
Bonomi *et al.*, 2005[303]	Ascertainment of IPV in women seeking legal advice	Not a health-care setting: police/legal	
Waller *et al.*, 1996[304]	Development and validation of an ED screening and referral protocol for victims of DV	Not a full validation study – included on screen positives (triage screen positive)	QVI – Not an objective/standardised/ interview measure
Hilton *et al.*, 2004[305]	A brief actuarial assessment for the prediction of wife assault recidivism: the Ontario domestic assault risk assessment	Recruited from police/legal population	
Heckert and Gondolf, 2004[306]	Battered women's perceptions of risk versus risk factors and instruments in predicting repeat reassault	Sample of batterers	
Sprecher *et al.*, 2004[307]	A neural network model analysis to identify victims of intimate partner violence	Not a validation study	

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Parker *et al.*, 1993[308]	Physical and emotional abuse in pregnancy: a comparison of adult and teenage women	13-year-olds in sample	
Cecil and Matson, 2006[309]	Sexual victimisation among African American adolescent females	Not a DV screening tool	
Lazzaro and McFarlane, 1991[310]	Establishing a screening programme for abused women	Not a primary study	
Hoff and Rosenbaum, 1994[249]	A victimisation assessment tool: instrument development and clinical implications	Not a validation study	
Norton *et al.*, 1995[311]	Battering in pregnancy: an assessment of two screening methods	Not a validation study	
Lavoie and Vezina, 2001[312]	Violence faite aux filles dans le contexte des frequentations à l'adolescence: elaboration d'un instrument	No gold standard, age group for women	
Majdalani *et al.*, 2005[313]	Validacion de un cuestionario breve para detector situaciones de violencia de genero en las consultas clinicas	No gold standard; no attitudes about screening	
McFarlene *et al.*, 2001[238]	Abuse Assessment Screen-Disability (AAS-D) measuring frequency, type and perpetrator of abuse towards women with physical disabilities	Not a validation study	
Swahnberg and Wijma, 2003[314]	The NorVold Abuse questionnaire	Not a health-care population	
Wolfe *et al.*, 2001[315]	Development and validation of the Conflict in Adolescent Dating Relationships Inventory	Sample contains < 15-year-olds	
Yost *et al.*, 2005[316]	A prospective observational study of domestic violence during pregnancy	Epidemiological study; no gold standard	
Higgins and Hawkins, 2005[317]	Screening for abuse during pregnancy – implementing a multi-site programme	Not a validation study	QIV – Not a test of efficacy; QVI – No data given
Wasson *et al.*, 2000[239]	Routine, single-item screening to identify abusive relationships in women	No gold standard	
Campbell *et al.*, 2001[318]	Family issues and dangerousness: 8. risk assessment for intimate partner homicide	Not a primary study	
Yoshihama *et al.*, 2002[241]	Measuring the lifetime experience of domestic violence: application of the history calendar method	Not a validation study	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Moraes and Reichenheim, 2002[319]	Cross-cultural measurement equivalence of the revised Conflict Tactics Scale (CTS2) Portuguese version used to identify violence within couples	Not a validation study	
Mears *et al.*, 2005[320]	Routine history as compared with audio computer-assisted self-interview for prenatal care history-taking	No valid comparator	
Webster and Holt, 2004[258]	Screening for partner violence: direct questioning or self-report?	Not a validation study; invalid comparator	
McFarlane *et al.*, 1995[321]	Abuse during pregnancy: frequency, severity, perpetrator and risk factors of homicide	Not about screening	
Jory, 2004[322]	The Intimate Justice Scale: an instrument to screen for psychological abuse and physical violence in clinical practice	No valid comparator	
Ramsden and Bonner, 2002[261]	A realistic view of domestic violence screening in an emergency department	Not a controlled study	
Hegarty *et al.*, 1999[218]	A multidimensional definition of partner abuse: development and preliminary validation of the composite abuse scale	30-item comparator	
Heyman *et al.*, 2001[323]	Can questionnaire reports correctly classify relationship distress and partner physical abuse?	30-item comparator	
Flowers *et al.*, 2002[324]	Validation of a screening instrument for the exposure to violence in African American children	Not a DV screening tool	
Fals-Stewart *et al.*, 2003[325]	The timeline follow-back spousal violence interview to assess physical aggression between intimate partners: reliability and validity	Not a DV screening tool	
Janssen *et al.*, 2002[326]	Introducing domestic violence assessment in a postpartum clinical setting	Not a validation study	QV – Identification rates only
Lo *et al.*, 1998[327]	Screening for domestic violence in the emergency department	Not a validation study	QV – Not a controlled study
McFarlane *et al.*, 1995[260]	Identification of abuse in the emergency departments: effectiveness of a two-question screening tool	Not valid comparator	QV – No additional outcomes
Campbell *et al.*, 1994[328]	The reliability and factor structure of the index of spouse abuse with African American women	No comparator	
Bass *et al.*, 2001[329]	Screening tools and referral protocol for stopping abuse against older Ohioans: a guide for service providers	Not a validation study	

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Anderson *et al.*, 2002[330]	Identifying intimate partner violence at entry to prenatal care: clustering routine clinical information	No valid comparator	
Wahl *et al.*, 2004[331]	Clinic-based screening for domestic violence: use of a child safety questionnaire	Children under 15 in sample	
Benight *et al.*, 2004[332]	Development and psychometric validation of a domestic violence coping self-efficacy measure (DV-CSE)	No valid comparator	
Schofield *et al.*, 2003[333]	Validity of self-report screening scale for elder abuse: Women's Health Australia study	Not a DV screening tool	
Mohr *et al.*, 2000[334]	Children exposed to violence: measurement considerations within an ecological framework	Not a primary study	
Kubany *et al.*, 2000[335]	Development and preliminary validation of a brief broad-spectrum measure of trauma exposure: the Traumatic Life Events Questionnaire	Not a DV screening tool	
McNamara and Fields, 2001[336]	The Abuse Disability Questionnaire: internal consistency and validity considerations in two samples	Not a DV screening tool	
Varvaro, 1998[337]	Violence against women: the role of orthopaedic nurses in the identification, assessment, treatment and care for abused women	Review paper	QIV – Not relevant, narrative
Gerard, 2000[338]	Domestic violence: how to screen and intervene	Guidelines	
Fishwick, 1998[339]	Assessment for women for partner abuse	Think piece	QIII – Quotes taken from a dissertation
Ward and Spence, 2002[340]	Training midwives to screen for domestic violence	Not a primary study	
Babcock *et al.*, 2004[341]	What situations induce IPV? A reliability and validity study of the Proximal Antecedents to Violent Episodes (PAVE) scale	Sample consisted of batterers	
Shackelford and Goetz, 2004[342]	Men's sexual coercion in intimate relationships: development and initial validation of the Sexual Coercion in Intimate Relationships scale	Not a screening tool	
Gregg and Parks, 1995[343]	Selected Minnesota Multiphasic Personality Inventory No.2 scales for identifying women with a history of sexual abuse	Not a DV screening tool	
Covington *et al.*, 1997[344]	Assessing for violence during pregnancy using a systematic approach	Sample split into two groups	QV – Only identification rate

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Covington *et al.*, 1997[345]	Improving detection of violence among pregnant adolescents	Children < 15 years old	QV – Only identification rate
Attala *et al.*, 1994[242]	A partial validation of two short-form partner abuse scales	No valid comparator	
McFarlane *et al.*, 1991[263]	Assessing for abuse: self-report vs nurse interview	Two separate samples of women	
Cascardi *et al.*, 1999[346]	Factor structure and convergent validity of the Conflict Tactics Scale in high-school students	Males in sample	
Berlinger, 2004[347]	Taking an intimate look at domestic violence	Not a validation study	
Datner *et al.*, 1999[348]	Utilisation of the 911 system as an identifier of domestic violence	No relevance to any review question	
Soeken *et al.*, 1998[227]	The Abuse Assessment Screen: a clinical instrument to measure frequency, severity and perpetrator of abuse against women	Psychometric validation only	
Brown *et al.*, 1996[235]	Development of the Women Abuse Screening Tool for use in family practice	No data on comparator	QIII – 'Comfort' not relevant
Paranjape and Liebschutz, 2003[234]	STaT: a three-question screen for IPV	Uses clinical interview as comparator	
Moonesinghe *et al.*, 2004[237]	Development of a screening instrument to detect physical abuse and its use in a cohort of pregnant women in Sri Lanka	Uses clinical interview as comparator	
McIntyre *et al.*, 1999[248]	Validation of a trauma questionnaire in veteran women	Uses clinical interview as comparator	
Gagan, 1998[349]	Correlates of nurse practitioners' diagnostic and intervention performance for DV	Not a validation study	QVI – Looks at barriers
Bair-Merritt *et al.*, 2006[259]	Screening for IPV using an audiotape questionnaire	Compares presentation of tool	QIII – Not about acceptability of screening
Hilton and Harris, 2005 [350]	Predicting wife assault: a critical review and implications for policy and practice	Not a primary study	
Halpern *et al.*, 2005[351]	Injury location and screening questionnaires as markers for IPV	Not a (true) validation study	
Boris *et al.*, 2002[244]	Partner violence among homeless young adults: measurement issues and associations	PVI (index test) has 26 items	
Williams *et al.*, 2003[352]	Violence against pregnant women	Not enough data present	
Koziol et al., 2001[353]	Predictive validity of a screen for partner violence against women	Not a health-care population	

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Gendron, 1991[354]	Elaboration d'un questionnaire d'identication des femmes violentées en milieu conjugal	No comparator	
Dub *et al.*, 2005[355]	Etude exploratoire du point de vue des femmes et des hommes sur les services utilises en matière de violence conjugale	Not about screening	
Szafran and Fossion, 2005[356]	La conjugale violence	Opinion piece	
Rinfret *et al.*, 2002[357]	Un protocole de depistage systematique de la violence congugale. Mesure de l'efficacite	Not about screening	
Hasselmann and Reichenheim, 2003[358]	Adatacao transcultural da versao em portugues da conflict tactics scale f=Form R (CTS-1), usada para afeire violencia no casal: equivalencias semantica e de mensuracao	Adaptation of the CTS into Portuguese	
Heron *et al.*, 2003[359]	Do responses to an IPV screen predict scores on a comprehensive measure of IPV in low-income black women?	Only screen positives on index were recruited	
Nelson *et al.*, 2004[5]	Screening women and elderly adults for family and IPV	Review – not primary studies	
O'Leary, 1999[360]	Psychological abuse: a variable deserving critical attention in domestic violence	Review –- not primary studies	
Fogarty *et al.*, 2002[94]	Communicating with patients about IPV: screening and interviewing approaches	Review – not primary studies	
Miscellaneous, 2002[361]	Assessment for IPV in clinical practice	Resource pack	
Rodriguez, 1998[362]	Clinical interventions with battered migrant farm worker women	Not a validation study	
Barthauer, 1999[363]	Domestic violence in the psychiatric emergency service	Not a primary study	
Chuang *et al.*, 2002[364]	Screening for IPV in the primary care setting: a critical review	Not a primary study	QV – Not a primary study
Wyszynski, 2000[365]	Screening women for family violence in the maternal child health-care setting	Think piece	
King and Ryan, 1996[366]	Women abuse: the role of nurse-midwives in assessment	Think piece	
Coulthard *et al.*, 2006[367]	DV screening and intervention programmes for adults with dental or facial injury	Review – not primary studies	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Pontecorvo *et al.*, 2004[368]	Violencia domestica contra la mujer una encuesta en consultorios de atencion primaria	No gold standard	
Cook and Goodman, 2006[369]	Beyond frequency and severity – development and validation of the brief coercion and conflict scales	Prison population	
Goetz *et al.*, 2006[370]	Adding insult to injury: development and initial validation of the Partner-directed Insults Scale	Index tool has 47 items	
Williams and Grant, 2006[371]	Empirically examining the risk of IPV: the revised Domestic Violence Screening Instrument (DVSI-R)	Legal population	
Fikree *et al.*, 2006[255]	IPV before and during pregnancy: experiences of postpartum women in Karachi, Pakistan	No comparator	QIII – Asks about 'a good time to enquire', not about routine screening
Parmar *et al.*, 2005[372]	Tackling domestic violence: providing advocacy and support to survivors from black and other minority ethnic communities	None given	
Bateman and Whitehead, 2004[254]	Health visitors' domestic violence routine questioning tool: an exploration of women's experience, effectiveness and acceptability	None given	QIII – None given
Fogarty and Brown, 2002[373]	Screening for abuse in Spanish-speaking women	No gold standard	QIII – Not about attitudes to screening
Perry *et al.*, 1998[374]	Voices from an Afghan community	Not validation study	QIII – Not specific to screening for DV
Freund *et al.*, 1996[375]	Identifying domestic violence in primary care practice	No gold standard	QIII – Refusal to answer questions; QV – Only identification rate given
McHugo *et al.*, 2005[376]	The assessment of trauma history in women with co-occurring substance abuse and mental disorders and a history of interpersonal violence	No gold standard	QVI – Not about acceptability of routine screening
Kramer, 2002[377]	Domestic violence: how to ask and how to listen	Not a validation study, not primary data	QVI – Not a validation study, not primary data
Question III			
Keeling and Birch, 2004[378]	Asking pregnant women about domestic abuse	Not about screening, but asking about DV	
McCauley *et al.*, 1998[379]	Inside 'Pandora's box'. Abused women's experiences with clinicians and health services	Barriers to screening	
Thurston *et al.*, 1998[380]	Building a feminist theoretical framework for screening of wife-battering: key issues to be addressed	Not about acceptability of screening	QVI – Not about acceptability of screening
Kramer *et al.*, 2004[381]	Prevalence of IPV and health implications for women using emergency departments and primary care clinics	Unable to obtain relevant information from author	

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Magen *et al.*, 2000[382]	Domestic violence in child welfare preventative services: results from an intake screening questionnaire	Not a health-care setting (child welfare services, so was borderline)	
Sleutel, 1998[383]	Women's experiences of abuse, a review of qualitative research	Literature review	
Hamberger *et al.*, 2005[384]	TANF workers' responses to battered women and the impact of brief worker training	Not about attitudes to screening	QVI – Not about attitudes to screening
Curnow, 1997[385]	The open window phase: help-seeking and reality behaviours by battered women	Not about attitudes to screening	
Hamberger *et al.*, 1998[386]	Physician interaction with battered women	Not about attitudes to screening	
Moracco *et al.*, 2005[387]	Knowledge and attitudes about intimate partner violence among immigrant Latinos in rural north Carolina	Not about attitudes to screening	
Panchanadeswaran and Koverola, 2005 [388]	The voices of battered women in India	Not about attitudes to screening	QIV – Not about attitudes to screening
Lewis *et al.*, 2005[389]	Perceptions of service providers and community members on intimate partner violence within a Latino community	Not attributable to screening	QIV – Not attributable to screening
Sankar and Jones, 2005[390]	To tell or not to tell	Not about attitudes to screening	
Weisz and Black, 2001[391]	Evaluating a sexual assault and dating violence prevention programme for urban youths	Not about attitudes to screening	
Yoshioka *et al.*, 2003[392]	Social support and disclosure of abuse: comparing south Asian, African American and Hispanic battered women	Not about attitudes to screening	
O'Donnell, 2000[393]	Abuse in pregnancy – the experience of women	Just disclosure rates	
Jackson, 2002[394]	Abuse in dating relationships: young people's accounts of disclosure, non-disclosure, help-seeking and prevention education	Not about attitudes to screening	
Zweig *et al.*, 2002[395]	Assisting women victims of violence who experience multiple barriers to services	Not about attitudes to screening	
Cord-Duncan *et al.*, 2006[396]	Detecting potential intimate partner violence: which approach do women want?	Not about screening methods	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Boyle and Jones, 2006[397]	The acceptability of routine inquiry about domestic violence towards women, a survey in three health-care settings	Because of the way the authors formulated the question regarding attitudes to screening – 'I wouldn't mind if a doctor would ask me'	
Jones and Bonner, 2002[398]	Screening for domestic violence in an antenatal clinic	Is a discussion paper rather than a report of a proper examination into attitudes to screening	QVI – No statistics
Hester and Westmarland, 2005[399]	Tackling domestic violence: effective interventions and approaches	Not really about attitudes to screening	
Bateman and Whitehead, 2004[254]	Health visitors' domestic violence routine questioning tool: an exploration of women's experience, effectiveness and acceptability	None given	QII – None given
Varcoe, 2001[400]	Abuse obscured: an ethnographic account of emergency nursing in relation to violence against women	Not really about attitudes to screening	QVI – Not really about attitudes to screening
Coid *et al.*, 2003[54]	Sexual violence against adult women primary care attenders in east London	None given	
Bates *et al.*, 2001[401]	'A little encouragement': health services and domestic violence	It does not seem to include anything about attitudes to screening	
Rodriguez *et al.*, 1996[402]	Breaking the silence: battered women's perspectives on medical care	Not really about attitudes to screening but opinions about asking directly	
Dienemann *et al.*, 2005[403]	Survivor preferences for response to IPV disclosure	Unclear	
Peterson *et al.*, 2003[404]	Women's perspective on IPV services: a hope in Pandora's box	Unclear	
Curry *et al.*, 2003[405]	Development of an abuse screening tool for women with disabilities	Not about attitudes to screening	
Liang *et al.*, 2005[406]	A theoretical framework for understanding help-seeking processes among survivors of intimate partner violence	Not about screening	
Taylor and Sorenson, 2004[407]	Injunctive social norms of adults regarding teen dating violence	Not about screening	
Crandall *et al.*, 2005[408]	No way out: Russian-speaking women's experiences with domestic violence	Not about screening	
Sullivan *et al.*, 2005[409]	For us it is like living in the dark: Ethiopian women's experiences with domestic violence	Not about attitudes	
Mattson *et al.*, 2002[410]	Exploring tele-health opportunities in domestic violence shelters	Not about attitudes to screening	
Battaglia *et al.*, 2003[411]	Survivors of intimate partner violence speak out	Not about attitudes to screening	

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
McNutt *et al.*, 2000[412]	Partner violence and medical encounters	Not screening attitudes	
O'Connor, 2002[413]	Consequences and outcomes of disclosure for abused women	Letters	
Renker, 2002[414]	Keeping safe: teenagers' strategies for dealing with perinatal violence	Not about screening	
Burke *et al.*, 2004[415]	Ending intimate partner violence: an application of the transtheoretical model	Not about attitudes to screening	
Taylor, 2004[415]	Moving from surviving to thriving: African American women recovering from intimate male partner abuse	Not about attitudes to screening	
Koziol-McLain *et al.*, 2004[416]	Prevalence of intimate partner violence among women presenting to an urban adult and paediatric emergency care department	Prevalence study, not about attitudes to screening	
Davis and Taylor, 2002[417]	Voices from the margins part 2: narrative accounts of the support needs of indigenous families experiencing violence	Not about attitudes to screening	
Washington, 2001[418]	Disclosure patterns of black female sexual assault survivors	Not about attitudes to screening	
McMurray and Moore, 1994[419]	Domestic violence: are we listening? Do we see?	Not about attitudes to screening	
Gerbert *et al.*, 1996[420]	Experiences of battered women in the health setting: a qualitative study	Not about attitudes to screening	
Kearsey, 2002[421]	Listening for silent screams	Not a primary study. Discussion type paper – with no real empirical data	
McCarraher *et al.*, 2003[422]	Are reproductive health services a good place to screen for intimate partner violence?	Not about attitudes to screening	
Campbell and Soeken, 1999[423]	Women's responses to battering: a test of the model	Not about attitudes to screening	
Plichta *et al.*, 1996[424]	Spouse abuse – patient–physician communication	Not about attitudes to screening	
Weingourt, 1985[425]	Wife rape: barriers to identification and treatment	Not about attitudes to screening	
Rodriguez *et al.*, 1998[426]	Factors affecting patient–physician communication for abused Latina and Asian immigrant women	Not about attitudes to screening	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Hayden *et al.*, 1997[427]	Domestic violence in the emergency department: how do women prefer to disclose and discuss the issues?	No question on routine questioning/screening	
Bacchus *et al.*, 2003[428]	Experiences of seeking help from health professionals in a sample of women who experienced domestic violence	None given	
Hou *et al.*, 2005[429]	Domestic violence against women in Taiwan: their life-threatening situations, post-traumatic responses, and psychophysiological symptoms. An interview study	Not about attitudes towards screening	
Peckover, 2003[430]	'I could just have done with a little more help' – an analysis of women's help-seeking from health visitors in the context of domestic violence	Not really about acceptability of routine screening	
Scheiman and Zeoli, 2003[431]	Adolescents' experiences of dating and intimate partner violence: once is not enough	Narrative	
McCosker *et al.*, 1999[432]	Evaluation of a self-paced education package on violence against women for rural community-based health workers	Not about acceptability of routine screening	
Flinck *et al.*, 2005[433]	Survival of intimate partner violence as experienced by women	Not about acceptability of routine screening	
De Mendoza, 2001[434]	Culturally appropriate care for pregnant Latina women who are victims of domestic violence	Narrative	
Feder *et al.*, 2006[33]	Women exposed to intimate partner violence	Not a primary study	
Choi and Harwood, 2004[435]	A hypothesised model of Korean women's responses to abuse	Not about acceptability of routine screening	
Brendtro and Bowker, 1989[436]	Battered women: how can nurses help?	Not about attitudes towards screening	
Petersen *et al.*, 2004[437]	Moving beyond disclosure: women's perspectives on barriers and motivators to seeking assistance for intimate partner violence	Not about acceptability of routine screening	
Grynbaum *et al.*, 2001[438]	Domestic violence: prevalence among women in a primary care centre – a pilot study	No questions about screening	
Fugate *et al.*, 2005[439]	Barriers to domestic violence help-seeking	Not about screening	QIV – Not about outcomes women want from an intervention
Bauer *et al.*, 2000[440]	Barriers to health care for abused Latina and Asian immigrant women	Not about acceptability of routine screening	
Bair-Merritt *et al.*, 2006[259]	Screening for intimate partner violence using an audiotape questionnaire	Not about acceptability of routine screening	

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Gerbert *et al.*, 1999[441]	When asked, patients tell: disclosure of sensitive health-risk behaviours	Not really about acceptability of routine screening	
Chatzifotiou, 2003[442]	Violence against women and institutional responses: the case of Greece	Not about attitudes to screening	
Freund *et al.*, 1996[375]	Identifying domestic violence in primary care practice	Because 3% refused to answer searching questions	QII – No gold standard; QVI – Only identification rate given
Edwards, 2005[443]	Raising the subject of domestic violence	Not a primary study	QVI – Not a primary study
Fraser *et al.*, 2002[444]	Social support choices for help with abusive relationships: perceptions of African American women	Not about attitudes to screening	
Perry *et al.*, 1998[374]	Voices from an Afghan community	Not specific to screening for DV	QII – Not validation study
Richardson and Feder, 1996[445]	Domestic violence: a hidden problem for general practice	Not a primary study	
Fogarty and Brown, 2002[373]	Screening for abuse in Spanish-speaking women	Not about attitudes to screening	QII – No gold standard
Campbell *et al.*, 1994[446]	Battered women's experiences in the emergency department	Not about attitudes to screening	
Sethi *et al.*, 2001[447]	Experience of 'screening' for domestic violence in women's services	Not about attitudes to screening	
Milberger *et al.*, 2003[448]	Violence against women with physical disabilities	Not about attitudes to screening	
Dienemann *et al.*, 2002[449]	A critical pathway for intimate partner violence across the continuum of care	Maybe for QII, not really discussing attitudes to screening	
Yam and Oradell, 2000[450]	Seen but not heard – battered women's perceptions of the emergency department experience	Not really about attitudes to screening	
El-Khoury *et al.*, 2004[451]	Ethnic differences in battered women's formal help-seeking strategies: a focus on health, mental health and spirituality	Not about screening	
Goodyear-Smith, 2002[452]	National screening policies in general practice: a case study of routine screening for partner abuse	Literature review, very good for references	QVI – No gold standard
Brown *et al.*, 1996[235]	Development of the woman abuse screening tool for use in family practice	None given	QII – No comparator group as such
McCloskey *et al.*, 2005[453]	Intimate partner violence and patient screening across medical specialities	Women's behaviour	
Busch *et al.*, 2002[454]	Battered women speak out	Barriers to disclosure	QVI – Not a longitudinal study, doesn't meet inclusion criteria

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Gill, 2004[455]	Voicing the silent fear: south Asian women's experiences of domestic violence	Barriers to disclosure but not attitudes to screening	
Edwardsen *et al.*, 2004[456]	Pilot educational outreach project on partner violence	Not only about screening rates	
Rodriguez *et al.*, 2001[457]	Factors affecting patient–physician communication for abused Latina and Asian immigrant women	Not about attitudes to screening	
Gerbert *et al.*, 1999[458]	How HCP help battered women: the survivors' perspective	Not about attitudes to screening	
Burge *et al.*, 2005[459]	Parents advice to physicians about intervening in family contact	Doesn't have subgroup analysis for women's attitudes	
Zink *et al.*, 2004[460]	Hidden victims: the health-care needs and experiences of older women in abusive relationships	Not about attitudes to screening	
Hegarty and Taft, 2001[461]	Overcoming barriers to disclosure and inquiry of partner abuse for women attending general practice	Not about attitudes to screening	
Romito and Gerin, 2002[462]	Asking patients about violence: a survey of 510 women attending social and health services in Trieste, Italy	Not about attitudes to screening	
Larsen *et al.*, 1985[463]	Vold mod kvinder i samlivsforhold	Not relevant. Violence against women in their partnerships. Pattern of contact with public institutions	
Stenius and Veysey, 2005[464]	It's the little things – women, trauma and strategies for healing	Views on interventions, not screening	
Question IV			
Savage and Russell, 2005[465]	Tangled in a web of affiliation. Social support networks of dually diagnosed women who are trauma survivors	Baseline comparisons only	
Reed and Mazelis, 2005[466]	Scholarship, collaboration, struggle and learning in the WCDVS: introduction to the 6-month outcome papers	Not an intervention study	
Finkelstein *et al.*, 2005[467]	Building resilience in children of mothers who have co-occurring disorders and histories of violence	Intervention is aimed directly at children	
Jaffe *et al.*, 1986[468]	Promoting changes in attitudes and understanding of conflict resolution among child witnesses of family violence	Intervention is aimed directly at children	

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
McCaw *et al*., 2002[469]	Women referred for on-site DV services in a managed care organisation	Not reporting a controlled intervention	
Foshee *et al*., 2005[470]	Assessing the effects of the dating violence prevention programme 'Safe Dates2' using random coefficient regression modelling	Primary prevention	
Riesen and Porath, 2004[471]	Perceived social support of maritally abused women and their children's global self-worth	Not assessing the effectiveness of an intervention	
Sullivan *et al*., 1992[472]	After the crisis: a needs assessment of women leaving a domestic violence shelter	Not qualitative	
Foshee *et al*., 2004[473]	Assessing the long-term effects of the 'Safe Dates' programme and a booster in preventing and reducing adolescent dating violence victimisation and perpetration	Primary prevention	
Davies, 1991[474]	Intervention with male toddlers who have witnessed parental violence	Not an intervention study (single case study)	
Khemka *et al*., 2005[475]	Evaluation of a decision-making curriculum designed to empower women with mental retardation to resist abuse	Primary prevention	
Weisz, 2005[476]	Reaching African American battered women: increasing the effectiveness of advocacy	Not a health-care setting	
Panchanadeswaran and Koverola, 2005[388]	The voices of battered women in India	Not reporting the effectiveness of an intervention	
Cannon and Sparks, 1989[477]	Shelters – an alternative to violence: a psychosocial case study	Case study	
McBride and Korell, 2005[478]	Wilderness therapy for abused women	Descriptive paper	
Rhodes and Zelman, 1986[479]	An ongoing multifamily group in a women's shelter	Not assessing the effectiveness of an intervention	
Angless *et al*., 1998[480]	Battered women seeking solutions. A South African study	Not assessing the effectiveness of an intervention	
Attala and Warmington, 1996[481]	Client's evaluation of health-care services in a battered women's shelter	No controls	
Frick-Helms, 1997[482]	'Boys cry better than girls': play therapy behaviours of children residing in a shelter for battered women	Descriptive paper	
Evans and Shaw, 1993[483]	A social group work model for latency-aged children from violent homes	Not a controlled intervention study	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Grusznski *et al.*, 1988[484]	Support and education groups for children of battered women	Descriptive, not a controlled evaluation	
Walker, 2001[485]	DV: analysis of a community safety alarm system	Not women-centred outcomes	QVII– Not screening cost-effectiveness
Thomas *et al.*, 2005[486]	Telepsychiatry programme for rural victims of DV	No controls	
Drotar *et al.*, 2003[487]	Identifying and responding to the mental health service needs of children who have experienced violence: a community-based approach	No controls	
Kozlowska and Hanney, 2001[488]	An art therapy group for children traumatised by parental violence and separation	Not a controlled study	
Hillard, 1985[489]	Physical abuse in pregnancy	Not assessing the effectiveness of an intervention	QV – No baseline measure
Short *et al.*, 2002[490]	Assessing the success of the WomanKind programme: an integrated model of 24-hour health-care response to DV	No women-based outcomes	QV – No baseline measure; QVI – Doesn't measure the acceptability of routine screening
Bennett *et al.*, 1999[491]	Children's needs in shelters: mothers' perceptions	Not a health-care intervention; needs addressed are for the shelter not a health-care intervention	
Sullivan, 2003[492]	Using the ESID model to reduce intimate male violence against women	Trial data published elsewhere	
Vives *et al.*, 2006[493]	Deteccion temprana de la violencia del companero intima en el sector sanitario. Una intervencion basada en la evidencia?	Systematic review	
Few, 2005[494]	The voices of black and white rural battered women in DV shelters	Qualitative, but does not look at health-care services	
Kerig *et al.*, 2000[495]	Assessment and intervention for PTSD in children exposed to violence	Guidelines and review of PTSD in children	
Cook and Frantz-Cook, 1984[496]	A systematic treatment approach to wife battering	Not woman-centred intervention	
Gehart and Morales, 2000[497]	Reclaiming one's voice: a narrative intervention for women who have been battered	Descriptive, not evaluative of a therapy for abused women	
Yoshihama, 2002[498]	Policies and services addressing DV in Japan: from non-interference to incremental changes	Narrative	
Webb, 1992[499]	Treatment issues and CBT with battered women	Narrative	
Milner, 2004[500]	From 'disappearing' to 'demonized': the effects on men and women of professional interventions based on challenging men who are violent	Wrong population	
Martin, 1993[501]	Psychotherapy with abused women in a women's agency	Narrative	

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Datner *et al.*, 2004[502]	Universal screening for IPV: inability to prove universal screening improves provision of services	Observational study, not an intervention	
Scott-Tilley, 1999[503]	Nursing interventions for DV	Not assessing the effectiveness of an intervention	
Van Dalen and Glasserman, 1997[504]	My father, Frankenstein	No quantitative data	
Usdin *et al.*, 2005[505]	Achieving social change on gender-based violence: a report on the impact evaluation of Soul City's fourth series	Primary prevention at a community/national level	
Coker *et al.*, 2003[506]	Social support protects against the negative effects of partner violence on mental health	Cross-sectional study, not an intervention	
Frohmann, 2005[507]	The framing safety project. Photographs and narratives by battered women	Discussion of a qualitative study, but not about what is needed re health outcomes from an intervention	
Mueller and Thomas, 2001[508]	The effectiveness of public health interventions to reduce or prevent spousal abuse towards women	Systematic review, but check references	
Jones *et al.*, 2005[509]	Family support and mental health in pregnant women experiencing IPV: an analysis of ethnic differences	No intervention	
Rosen and Stith, 1993[510]	Intervention strategies for treating women in violent dating relationships	Qualitative, but not outcomes women want from interventions	
Kataoka *et al.*, 2006[511]	A community participatory research partnership: the development of a faith-based intervention for children exposed to violence	Not IPV	
Silvern *et al.*, 1995[512]	Individual psychotherapy for the traumatised children of abused women	Narrative and only about intervening with children not the mother	
Kerig *et al.*, 2000[495]	Assessment and intervention for PTSD in children exposed to violence	Narrative	
Rabenstein and Lehmann, 2000[513]	Mothers and children together: a family group treatment approach	No control group, only discussion and no evaluation	
Ahmed, 2005[514]	IPV against women: experiences from a woman-focused development programme in Matlab, Bangladesh	Not an evaluation of an intervention aimed at abused women, and not relevant to health care	Q1 – Not UK prevalence
Becker and Gatz, 2005[515]	Introduction to the impact of co-occurring disorders and violence study	Background to the other studies, no data	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Coker *et al.*, 2003[506]	Social support reduces the impact of partner violence on health: application of structural equation models	Not an evaluation of an intervention	Q1 – Not a review
Kheder and VandenBosch, 2001[516]	IPV: a health system's response	Protocol, not a controlled intervention	
Rhodes and Levinson, 2003[517]	Interventions for IPV against women	Case studies around screening	
Datner *et al.*, 2004[502]	Universal screening for DV. Inability to prove JCAHO-mandated screening makes an immediate impact	Observational study, not about post-identification intervention	
Ambuel *et al.*, 1996[518]	Partner violence: a systematic approach to identification and intervention in outpatient health care	Guidelines, not an intervention	
Campbell *et al.*, 2003[519]	Medical lethality assessment and safety planning in DV cases	Narrative, guidelines	
Berkowitz, 2005[520]	Recognising and responding to DV	Narrative	
Duggan *et al.*, 2004[521]	Randomised trial of a statewide home visiting programme: impact in preventing child abuse and neglect	Child abuse, not IPV	
Varvaro, 1998[337]	Violence against women: the role of orthopaedic nurses in the identification, assessment, treatment and care for the abused woman	Not relevant, narrative	
Mattson and Ruiz, 2005[522]	IPV in the Latino community and its effect on children	Descriptive and intervention is aimed directly at children. Qualitative focus groups, but not about outcomes of interest	
Webb *et al.*, 2001[523]	The health of children in refuges for women victims of DV: a cross-sectional descriptive survey	No evaluation of an intervention	
Ham *et al.*, 2005[524]	Life constraints and psychological well-being of DV shelter graduates	Not a controlled intervention	
Goodkind *et al.*, 2004[525]	A contextual analysis of battered women's safety planning	Not a quantitative evaluation of an intervention	
Vinton, 2003[526]	A model collaborative project toward making DV centres elder ready	Narrative, no data	
Stein *et al.*, 2003[527]	A mental health intervention for school children exposed to violence. A randomised controlled trial	Mothers are not involved in the treatment	

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Quinlivan and Evans, 2005[528]	Impact of DV and drug abuse in pregnancy on maternal attachment and infant temperament in teenage mothers in the setting of best clinical practice	Not suitable control group (had not experienced IPV)	
McDermott, 2004[529]	When advocacy for DV victims backfires. Types and sources of victim disempowerment	Narrative	
Peled, 1997[530]	Intervention with children of battered women	Narrative	
Walton-Moss and Campbell, 2002[531]	IPV: implications for nursing	Review	
Hotch *et al.*, 1996[532]	An ED-based DV intervention programme: findings after one year	Not an intervention study	
Breton and Nosko, 2005[533]	Group work with women who have experienced abuse	Narrative	
Sudermann *et al.*, 2000[534]	Evaluation of the London (Ontario) Community Group Treatment Programme for Children who have Witnessed Woman Abuse	Intervention is directed at the children, rather than mothers	
Pynoos and Eth, 1986[535]	Special intervention programmes for child witnesses to violence	Narrative, child-centred intervention	
Foshee *et al.*, 1998[536]	An evaluation of Safe Dates, an adolescent dating violence prevention programme	No health outcomes	
Goodman *et al.*, 2005[537]	Women's resources and use of strategies as risk and protective factors for reabuse over time	Not an intervention	
Bybee and Sullivan, 2002[538]	The process through which an advocacy intervention resulted in a positive change for battered women over time	Not a primary study	
MacMillan and Wathen, 2001[18]	Prevention and treatment of violence against women. Systematic review and recommendations	Review. Check why excluded Berk *et al.*, 1996	
Allen *et al.*, 2004[539]	Battered women's multitude of needs. Evidence supporting the need for comprehensive advocacy	Expanding on findings published in another paper. Outcomes not health related	
Statham, 2004[540]	Effective services to support children in special circumstances	Review	
Groves, 1999[541]	Mental health services for children who witness DV	Narrative. Check references	
Tutty *et al.*, 1999[542]	Residents' views of the efficacy of shelter services for assaulted women	Women's views on shelters are too removed from health-care settings	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Graham-Bermann and Hughes, 2003[543]	Intervention for children exposed to IPV: assessment of needs and research priorities	Review	
Haggerty and Goodman, 2003[544]	Stages of change-based nursing interventions for victims of IPV	Narrative	
Hender, 2001[8]	Is therapy/counselling/group work more effective than no treatment for women who are victims of DV?	Not primary study	
Ogle and Baer, 2003[545]	Addressing the service linkage problem. Increasing substance abuse treatment engagement using personalised feedback interventions in heavy-using female domestic violence shelter residents	Wrong outcomes, doesn't measure change in abuse or health	
Davis *et al.*, 2001[546]	Narrative accounts of tracking the rural DV survivors' journey: a feminist approach	Not related to health-care settings	
Gutman *et al.*, 2004[547]	Enhancing independence in women experiencing DV and possible brain injury: an assessment of an occupational therapy intervention	No DV survivors subgroup analysis	
Norton and Schauer, 1997[548]	Hospital-based DV group	Not qualitative, wrong outcomes (looks at satisfaction)	
Chalk, 2000[549]	Assessing family violence interventions: linking programmes to research-based strategies	Not a primary study	
Wathen and MacMillan, 2003[550]	Interventions for violence against women: scientific review	Review	
Noether *et al.*, 2005[551]	Design strengths and issues of SAMHSA's Women Co-occurring Disorders, and Violence Study	Not assessing the effectiveness of an intervention	
McFarlane *et al.*, 2004[136]	Protection orders and IPV: an 18-month study of 150 black, Hispanic and white women	Not a health-care setting	
Sullivan and Allen, 2001[552]	Evaluating coordinated community responses for abused women and their children	Narrative	
Peled and Edleson, 1998[553]	Predicting children's DV service participation and completion	Intervention is child-centred	
Bullock, 1998[554]	Nursing interventions for abused women on obstetrical units	Narrative	
Stone, 1984[555]	Shelters for battered women: a temporary escape from danger or the first step toward divorce?	Not assessing the effectiveness of an intervention (descriptive study)	
Chambers, 1988[556]	Group work with women from refuges	Narrative, no quantitative data	

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Barber *et al.*, 2000[557]	A survivor's group for women who have a learning disability	Not IPV, childhood abuse	
Gilson, 1997[558]	The YWCA women's advocacy programme: a case study of DV and sexual assault services	Not an intervention, service evaluation	
Gondolf, 1999[559]	Characteristics of court-mandated batterers in four cities	Intervention aimed at batterers	
Zust, 2000[560]	Effect of cognitive therapy on depression in rural, battered women	No usable data	
Veysey and Clark, 2004[561]	Responding to physical and sexual abuse in women with alcohol and other drug and mental disorders: programme building. Introduction	Not assessing the effectiveness of an intervention	
McHugo *et al.*, 2005[562]	Women, Co-occurring Disorders, and Violence Study: evaluation design and study population	Not a primary study	
Preston, 2002[563]	Claiming our place: women with serious mental health issues and support groups for abused women	Examines what women want from an intervention, but not outcomes they want for themselves or their children	
McFarlane *et al.*, 1997[133]	Resource use by abused women following an intervention programme: associated severity of abuse and reports of abuse ending	Pre-2003	
Mullender *et al.*, 1998[564]	Working with children in women's refuges	Qualitative, but doesn't address outcomes abused women want for themselves or their children	
Brown and Languedoc, 2004[565]	Components of an aboriginal-based family violence intervention programme	Wrong population (senior staff in national and provincial family violence divisions), not outcomes women want	QIII – Exclude, nothing on acceptability of screening
Ulrich, 1993[566]	What helped most in leaving spouse abuse: implications for interventions	Narrative	
Shavers *et al.*, 2005[567]	DV research: methodological issues related to a community-based intervention with a vulnerable population	Narrative	
Parker *et al.*, 1999[131]	Testing an intervention to prevent further abuse to pregnant women	Is in PRP review	QV – Not just about screening but a full intervention
Seagull and Seagull, 1991[568]	Healing the wound that must not heal: psychotherapy with survivors of DV	Narrative	
Clapp, 2000[569]	Ending DV is everyone's responsibility: an integrated approach to DV treatment	Narrative	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Campbell, 1986[570]	A survivor group for battered women	Narrative	
Gorgen and Nagele, 2005[571]	Nahraumgewalt gegen alte Menschen	Wrong population – older abused people without a subgroup analysis	
Morrissey *et al.*, 2005[572]	Outcomes for women with co-occurring disorders and trauma: programme and person-level effects	Not all participants experienced IPV	
Krishnan *et al.*, 2004[573]	From respite to transition: women's use of DV shelters in rural New Mexico	Not assessing the effectiveness of an intervention	
Dutton-Douglas and Dionne, 1991[574]	Counselling and shelter services for battered women	Narrative	
Anglin and Sachs, 2003[575]	Preventive care in the ED: screening for DV in the ED	Review	
Crockford *et al.*, 1993[576]	Play friendly and safe: a therapeutic group model for young children (5–8 years old) who have witnessed wife assault	Descriptive rather than evaluative	
Jaffe *et al.*, 1988[577]	Specific assessment and intervention strategies for children exposed to wife battering: preliminary empirical investigations	Child-centred study	
Whipple and Lindsey, 1999[578]	Music for the soul: a music therapy programme for battered women	No baseline data	
Peled and Edleson, 1992[579]	Multiple perspectives on groupwork with children of battered women	Mixed sample of fathers and mothers, and no quotes just from mothers on outcomes they want for their children.	
Morrissey *et al.*, 2005[580]	Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders	Not all participants had experienced IPV and no breakdown of results	QV – No data on referrals, identification, etc.
Curry *et al.*, 2006[581]	Nurse care management for pregnant women experiencing or at risk for abuse	Not all participants had experienced IPV, some were just at risk, and no breakdown of results	
Padala *et al.*, 2006[582]	Risperidone monotherapy for post-traumatic stress disorder related to sexual assault and domestic abuse in women	Not all participants had experienced IPV and no breakdown of results	
Kane, 2006[583]	The phenomenology of meditation for female survivors of intimate partner violence	No control group	
Shim and Haight, 2006[584]	Supporting battered women and their children: perspectives of battered mothers and child welfare professionals	Not outcomes women want for themselves from interventions	QIII – Nothing related to screening
Bullock *et al.*, 2006[585]	Abuse disclosure in privately and Medicaid-funded pregnant women	Not all women experienced IPV	QV – Disclosure only

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Katz *et al.*, 2006[586]	Domestic violence, emotion coaching and child adjustment	Not assessing the effectiveness of an intervention	
Parker and Stewart, 2006[587]	Research and intervention with adolescents exposed to domestic violence	The intervention does not include an element for abused mothers	
Zust, 2006[588]	Meaning of insight participation among women who have experienced intimate partner violence	Not about outcomes women want for themselves from an intervention	
Ford-Gilboe *et al.*, 2006[589]	Developing an evidence-based health advocacy intervention for women who have left an abusive partner	Not assessing the effectiveness of an intervention	QV – No outcomes of interest
Buschel and Madsen, 2006[590]	Strengthening connections between mothers and children: art therapy in a domestic violence shelter	Not a controlled trial	
Bergeron and Herbert, 2006[591]	Evaluation d' une intervention de groupe d'approche feministe auprès de femmes victims d'aggression sexuelle	No separate data for IPV only	
Lewis *et al.*, 2005[389]	Perceptions of service providers and community members on intimate partner violence within a Latino community	Not attributable to screening	QIII – Not attitude to screening
Brienza *et al.*, 2005[592]	Evaluation of a women's safe shelter experience to teach internal medicine residents about intimate partner violence	Not an intervention with battered women	QV – Not about changes in referral, etc. from screening; QVI – Not about whether training has had any impact on acceptability and screening
Fugate *et al.*, 2006[439]	Barriers to domestic violence help-seeking	Not about outcomes women want from an intervention	QIII – Not about barriers to screening
Thompson *et al.*, 2000[169]	Identification and management of DV, a randomised trial	No outcomes other than identification	QVI – No measure of acceptability
Ramsay *et al.*, 2002[2]	Should health professionals screen women for domestic violence? Systematic review	Review	QVI – Review
Question V			
Coonrod *et al.*, 2000[593]	A randomised controlled study of brief interventions to teach residents about domestic violence	Identification rate only	
Coonrod *et al.*, 2000[593]	The effectiveness of an ED-based violence prevention programme	Under 15-year-olds in sample	
Larkin *et al.*, 2000[594]	Effect of an administrative intervention on rates of screening for domestic violence in an urban emergency department	Identification rate only	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Holtrop *et al.*, 2004[595]	Screening for DV in a general paediatric clinic: Be prepared!	Identification rate only	
Olson *et al.*, 1996[596]	Increasing emergency physician recognition of domestic violence	Identification rate only	
Morrison *et al.*, 2000[597]	Improving the ED detection rate of DV using direct questioning	Identification rate only	
Wenzel *et al.*, 2004[598]	DV prevalence and detection in a family medicine residency clinic	Identification rate only	QV, QVI
McFarlane and Wiist, 1996[599]	Documentation of abuse to pregnant women: a medical chart audit in public health clinics	Identification rate only	
Ernst and Weiss, 2002[600]	IPV from the emergency medicine perspective	Not a primary study	
Richter *et al.*, 2003[601]	Detecting and documenting IPV	Not a controlled study – no baseline data	
Du Mont *et al.*, 2005[602]	Changing help-seeking rates for IPV in Canada	Not a health-care population	
Spinola *et al.*, 1998[603]	Developing and implementing an intervention	No data given	
Campbell *et al.*, 2001[604]	An evaluation of a system-change training model to improve emergency department response to battered women	No data given	
Perrin *et al.*, 2000[605]	Continuing education about physically abusive relationships: does education change the perceptions of health-care practitioners?	No clinical outcome measures – not about morbidity or mortality	
Siegel *et al*., 2003[606]	Screening for DV in the paediatric office: a multi-practice experience	Prevalence study	
Stenson *et al*., 2001[607]	The prevalence of violence investigated in a pregnant population in Sweden	No data on morbidity or mortality, e.g. referrals	
Morrissey *et al*., 2005[580]	Twelve-month outcomes of trauma-informed interventions for women with co-occuring disorders	No data on morbidity or mortality, e.g. referrals	QIV – Included
Dodge *et al.*, 2002[608]	Improving IPV protocols for ED	Identification rate only; documentation not in sufficient detail	
Garcia and Parson, 2002[609]	Effective screening for DV in the inpatient obstetric setting	Identification rate only	
Kothari and Rhodes, 2006[610]	Missed opportunities: ED visits by police-identified victims of IPV	Not a health-care population	
Coker *et al.*, 2002[611]	Missed opportunities: IPV in family practice settings	Documentation not in sufficient detail, Identification rate only	QII – Medical records not a valid comparator
Sixsmith *et al.*, 1997[612]	Telephone follow-up for case findings of DV in an ED	Identification rate only	

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Korenstein *et al.*, 2003[613]	An evidence-based DV education programme for internal medicine residents	Not about morbidity or mortality	
Hollander *et al.*, 2001[614]	The effects of written informed consent on detection of violence in the home	Looks at methodological design; Identification rate only	
Garcia-Moreno, 2002[615]	Dilemmas and opportunities for an appropriate health-service response to violence against women	Not a primary study	
Agar *et al.*, 2002[616]	Identification of abuse histories in community mental health care: the need for policies and training	Males in sample	
Paluzzi *et al.*, 2000[617]	The American College of Nurse-Midwives' DV education project: evaluation and results	Not about morbidity or mortality	
Shields *et al.*, 1998[618]	Interdisciplinary health care and female victims of DV	Not about mortality or morbidity	
Porcerelli *et al.*, 2003[619]	Violent victimisation of women and men: physical and psychiatric symptoms	Identification rates only	
Espinosa and Osborne, 2002[620]	DV during pregnancy: implications for practice	Not a primary study	
Berenson, 1994[621]	Perinatal morbidity associated with violence experienced by pregnant women	Not relevant to any review question	
Wallace, 2002[622]	DV: an education programme for hospital staff	Not about effect of screening on morbidity or mortality	
Shattuck, 2002[623]	A DV screening programme in the public health department	Identification rate only	
Matevia *et al.*, 2002[624]	Detection of IPV among members of a managed behavioural health organisation	Not a health-care setting	
Tilden and Shepherd, 1987[625]	Increasing the rate of identification of battered women in an ED: use of a nursing protocol	Identification rate only	
Roberts *et al.*, 1997[626]	DV in the ED: 2. Detection by doctors and nurses	Males in sample	
Bergman and Brismar, 1991[627]	A 5-year follow-up study of 177 battered women	Not about morbidity or mortality	
Tutty, 1996[138]	Post-shelter services: the efficacy of follow-up programmes for abused women	Not about screening	QIV – Pre-2003
Muelleman and Feighny, 1999[628]	Effects of an ED-based advocacy programme for battered women on community resource utilisation	Not relevant to QIV	QIV – Pre-2003

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Wessel and Campbell, 1997[629]	Providing sanctuary for battered women: Nicaragua's Casas de la Mujer	Not about screening	QIV – Not about outcomes women want for themselves (outcomes are intervention-centred)
Vives *et al.*, 2004[630]	Temporal analysis of mortality due to intimate partner violence in Spain	Not about screening	
Allert *et al.*, 1996[631]	Domestic violence: efficacy of health provider training in Utah	Cross-sectional survey, plus no baseline data	QVI – Not about attitudes to screening
Glowa *et al.*, 2003[632]	What happens after we identify IPV? The family physician's perspective	Cross-sectional survey, not a longitudinal or RCT design	QVI – Does not report attitudes to screening
Thompson *et al.*, 1998[633]	A training programme to improve domestic violence identification and management in primary care: preliminary results	Not investigating mortality or morbidity	QVI – No information on attitudes to screening
Davis *et al.*, 2003[634]	Victims of DV on the trauma service: unrecognised and under-reported	Definition of abuse includes elder and child abuse + males in sample	QVI – Same
Kohl *et al.*, 2005[635]	Child welfare as a gateway to domestic violence services	Epidemiological study in associated factors of DV services	
Rodriguez *et al.*, 2001[457]	The factors associated with disclosure of IP abuse to clinicians	Cross-sectional survey	QIII – Not about attitudes to screening
Davila, 2006[636]	Increasing nurses' knowledge and skills for enhanced response to IPV	No clinical outcomes or Identification rate	
McNulty *et al.*, 2006[637]	Can screening for domestic violence be introduced successfully in a sexual health clinic?	Identification rate only	
McCaw and Kotz, 2005[638]	Family violence prevention programme: another way to save a life	Narrative	
Duncan *et al.*, 2006[639]	Individualised performance feedback to increase prenatal domestic violence screening	Screening rate only, no other clinical outcomes	
Short *et al.*, 2006[640]	A community-based trial of an online IPV CME programme	No clinical outcomes	
Wong *et al.*, 2006[641]	Increased awareness of IPA abuse after training: a randomised controlled trial	Identification rate only	
Hsieh *et al.*, 2006[642]	Changing dentists' knowledge, attitudes and behaviour regarding domestic violence through an interactive multimedia tutorial	Intended behaviour as opposed to actual behaviour taken from medical records, etc.	QVI – Not routine enquiry/screening
Jonassen and Mazor, 2003[643]	Identification of physician and patient attributes that influence the likelihood of screening for intimate partner violence	Not longitudinal design	QVI – Not attributable to screening, but behaviour

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Rodriguez *et al.*, 1999[644]	Screening and intervention for intimate partner abuse: practices and attitudes of primary care physicians	Not a longitudinal design	QVI – Not about attitudes to screening; it is about behaviours
Brienza *et al.*, 2005[592]	Evaluation of a women's state shelter experience to teach internal medicine residents about intimate partner violence	Not about changes in referral, etc. from screening	QIV – Not an intervention with battered women; QVI – Not about whether training has had an impact on acceptability and screening
Wenzel *et al.*, 2004[598]	Domestic violence: prevalence and detection in a family medicine residence clinic	None given	QVI – Not about attitudes to screening
Harris *et al.*, 2002[645]	Can internet-based education improve physician confidence in dealing with domestic violence?	Not based on rates or identification	QVI – Not about attitudes to screening
Gerber *et al.*, 2005[646]	How and why community hospital clinicians document a positive screen for intimate partner violence: a cross-sectional study	Not a controlled study	QVI – None given
D'Avolio *et al.*, 2001[647]	Screening for abuse: barriers and opportunities	No baseline data	
Kripke *et al.*, 1998[648]	Domestic violence training programme for residents	Not a longitudinal study	QVI – Does not state what the attitudes actually are
Danis, 2003[649]	Social work response to domestic violence: encouraging news from a new look	One-shot survey, not a controlled trial or longitudinal study	
Freund *et al.*, 1996[375]	Identifying domestic violence in primary care practice	Only identification rate given	QII – No gold standard; QIII – Refusal to answer questions
Gunn *et al.*, 2006[650]	Putting women-centred care into practice: a new approach to psychosocial risk assessment during pregnancy	No measure of identification rate, only depression (self-reported), proxy measure by itself not enough	QVI – Not about screening
Busch *et al.*, 2002[454]	Battered women speak out	Not a longitudinal study, doesn't meet inclusion criteria	QIII – Barriers to disclosure
Ramsay *et al.*, 2002[2]	Should health professionals screen for domestic violence? Systematic review	Review	QIV, QVI – Review
Question VI			
Valdez *et al.*, 2004[651]	Experiencia de la parteras en la identificacion de mujeres maltratades durante el embarazo	Not about screening	
Krueger and Schafer, 2000[652]	Physician awareness of domestic violence: does continuing medical education have an impact?	Screening behaviour	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Lavoie and Martin, 1991[653]	L'aide psycho-sociale offerte par les medecins à la femme violentee par son conjoint	Not about screening	
Leblanc and Ouellet, 2004[654]	Depistage de la violence conjugale: le role de l'infirmière	Literature review	
MMWR, 2000[655]	Role of victims' services in improving IPV screening by trained maternal and child health-care providers – Boston, MA, 1994–1995	Not about attitudes to screening	
Zink *et al*., 2003[656]	How children affect the mother/victim's process in intimate partner violence	Not about attitudes to screening	
Saunders *et al*., 2005[657]	TANF workers' responses to battered women and the impact of brief worker training	Not about attitudes to screening	
Scobie and McGuire, 1999[658]	The silent enemy – domestic violence in pregnancy	None given	
D'Avolio *et al*., 2001[647]	Screening for abuse – barriers and opportunities	None given	
Zink *et al*., 2005[659]	Physician knowledge and management of children exposed to domestic violence in Ohio: a comparison of paediatricians and family physicians	None given	
Borowsky and Ireland, 2002[660]	Parental screening by paediatricians and family physicians for intimate partner violence	None given	
Lapidus *et al*., 2002[661]	A statewide survey of domestic violence screening behaviours among paediatricians and family physicians	None given	
Glaister and Kesling, 2002[662]	A survey of practising nurses' perspectives on interpersonal violence screening and intervention	None given	
Gerbert *et al.,* 2002[663]	Domestic violence compared to other health risks	None given	
Gadomski *et al*., 2001[664]	Changes in health-care providers' knowledge, attitudes, beliefs and behaviours regarding domestic violence following a multifaceted intervention	None given	
Chamberlain and Perham, 2002[665]	The impact of perceived barriers on primary care physicians' screening practices for female partner abuse	None given	
Goff *et al*., 2003[666]	Preparedness of health-care practitioners to screen women for domestic violence in a border community	None given	
McGrath *et al*., 1997[667]	Violence against women: provider barriers to intervention in emergency departments	Not specific enough to screening	

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Zink *et al.*, 2004[668]	Intimate partner violence: what are physicians' perceptions?	None given	
Steen and Bharj, 2003[669]	Midwives' reflections: exploring attitudes, feelings and experiences when caring for women who are being abused	Not a research study	
Price and Baird, 2001[670]	Domestic violence in pregnancy	Does not address our review questions	
Moore et al., 1998[671]	Attitudes and practices of registered nurses toward women who have experienced abuse/domestic violence	None given	
Brown and Sas, 1994[229]	Focus groups in family practice research	None given	
Brown *et al.*, 1993[672]	Identifying and treating wife abuse	Does not address attitudes towards screening	
Dickson and Tutty, 1996[673]	The role of public health nurses in responding to abused women	No attitudes to screening question	
Horan *et al.*, 1998[674]	Domestic violence screening practices of obstetrician/gynaecologists	Not about attitudes to screening	
Ortiz and Ford, 2005[675]	Existence of staff barriers to partner violence screening and screening practices in military prenatal settings	None given	
Ferris, 1994[676]	Canadian family physicians' and general practitioners' perceptions of their effectiveness in identifying and treating wife abuse	No attitude to screening question	
Janssen *et al.*, 2003[677]	Assessing for domestic violence exposure in primary care settings	Not about attitudes to screening	
Brienza *et al.*, 2005[592]	Evaluation of a women's safe shelter experience to teach internal medicine residents about intimate partner violence	Not about whether training has had an impact on acceptability and screening	
Lanzilotti *et al.*, 1999[678]	EMS and the domestic violence patient: a report care of existing policy, protocol and training	Not about attitudes to screening	
Rodriguez *et al.*, 1999[644]	Screening and intervention for intimate partner abuse	Not about attitudes to screening but about behaviours	
Jonassen and Mazor, 2003[643]	Identification of physician and patient attributes that influence the likelihood of screening for intimate partner violence	Not about attitudes to screening but about behaviours	
Harris and Kutob, 2002[645]	Can internet-based education improve physician confidence in dealing with domestic violence?	Not about attitudes to screening	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Wenzel *et al.*, 2004[598]	Domestic violence: prevalence and detection in a family medicine residency clinic	Not about attitudes to screening	
Williams *et al.*, 2000[679]	Health promotion practices of emergency physicians	Not about attitudes to screening	
Gerber *et al.*, 2005[646]	How and why community hospital clinicians document a positive screen for intimate partner violence: a cross-sectional study	None given	
Tower, 2006[680]	Barriers in screening women for domestic violence: a survey of social workers, family practitioners and obstetrician-gynaecologists	Because it targets screening behaviour not screening attitudes	
Kripke *et al.*, 1998[648]	Domestic violence training programme for residents	Does not state what the attitudes actually are	
Jones and Bonner, 2002[398]	Screening for domestic violence in an antenatal clinic	No statistics	
Chamberlain and Perham-Hester, 2000[681]	Physicians' screening practices for female partner abuse during prenatal visits	Not about attitudes to screening	
Guedes *et al.*, 2002[682]	Integrating systematic screening for gender-based violence into sexual and reproductive health services: results of a baseline study by the International Planned Parenthood Federation, western hemisphere region	None given	
Ahmed *et al.*, 2003[683]	Response of Sudanese doctors to domestic violence	Talks about behaviour and barriers not attitudes to screening	
Smith *et al.*, 1998[684]	Changing the health-care response to battered women: a health-care education approach	Only measures screening behaviour	
Derk, 1998[685]	Rural health-care providers' attitudes, practices and training experience regarding intimate partner violence – West Virginia, March 1997	No measures of attitudes towards screening	
Borowsky and Ireland, 1999[686]	National survey of paediatricians violence prevention counselling	Not about attitudes to screening	
Garimella *et al.*, 2002[687]	How physicians feel about assisting female victims of intimate partner violence	Not about attitudes to screening	
Pakieser *et al.*, 1998[688]	Battered women – where they go for help	Not about attitudes to screening	
Bacigalupe, 2000[689]	Family violence in Chile – exploring prevalence and clinical dimensions	Literature review	
Tilden, 1989[690]	Response of the health-care delivery system to battered women	Literature review	
Weiss *et al.*, 2000[691]	EMT domestic violence knowledge and the results of an educational intervention	Not about attitudes to screening	

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Sugg and Inui, 1992[692]	Primary care physicians' response to domestic violence	Not about attitudes to screening	
Tudiver and Permaul-Woods, 1996[693]	Physicians' perceptions of and approaches to woman abuse	Not about attitudes to screening	
Melvin, 1995[694]	Domestic violence: the physician's role	Clinical cases, nothing about attitudes to screening	
Chescheir, 1996[695]	Violence against women; response from clinicians	Letters, not a primary study	
Plichta *et al.*, 1996[424]	Spouse abuse, patient–physician communication, and patient satisfaction	Not about attitudes to screening	
Limandri and Tildren, 1996[696]	Nurses' reasoning in the assessment of family violence	Not about attitudes to screening	
Parmar *et al.*, 2005[372]	Tackling domestic violence: providing advocacy and support to survivors from black and other ethnic minority communities	None given	
Director and Linden, 2004[697]	Domestic violence: an approach to identification and intervention	Literature review, good for references	
Chez,1988[698]	Woman battering	Not a primary study	
Jones, 1993[699]	Domestic violence: let our voices be heard	Not a primary study, not about attitudes to screening	
Forcier *et al*., 2003[700]	Paediatric residents' attitudes and practices regarding adolescent dating violence	Not about attitudes to screening, about behaviours, barriers	
Groth *et al*., 2001[701]	Domestic violence: level of training, knowledge base and practice among Milwaukee physicians	Nothing specific to screening attitudes	
Varjavand *et al*., 2004[702]	A survey of residents' attitudes and practices in screening for, managing and documenting domestic violence	About behaviour and barriers not attitudes	
Currier *et al*., 1996[703]	Training and experience of psychiatric residents in identifying domestic violence	Not about attitudes to screening	
Gerbert *et al.*, 1999[704]	A qualitative analysis of how physicians with expertise in domestic violence approach the identification of victims	Only one vague result, which seems to be more of a barrier than an attitude *per se*. And only one sentence – not the main (or even secondary) focus of the study	
Larkin *et al.*, 1999[705]	Universal screening for intimate partner violence in the emergency department: importance of patient and provider factors	Nothing on attitudes	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Parsons *et al.*, 1995[706]	Methods of and attitudes toward screening obstetrics and gynaecology patients for domestic violence	Behaviour and barriers but not attitudes	
Erickson *et al.*, 2001[707]	Barriers to domestic violence screening in the paediatric setting	It is about actual behaviour and perceived barriers to screening, no mention of attitudes	
Haggblom *et al.*, 2005[708]	Nurses' attitudes and practices towards abused women	Nought on attitudes, only behaviour and barriers	
Knapp *et al.*, 2006[271]	Evaluation of a curriculum for intimate partner violence screening in a paediatric emergency department	Cannot see anything specific to screening	
Davis and Harsh, 2001[709]	Confronting barriers to universal screening for domestic violence	It's about barriers mostly	
Ferris and Tudiver, 1992[710]	Family physicians' approach to wife abuse: a study of Ontario, Canada, practices	Does not refer to attitudes towards screening	
Heinzer and Krimm, 2002[711]	Barriers to screening for domestic violence in an emergency department	No data about screening	
Varvaro and Gesmond, 1997[712]	ED physician house staff response to training on domestic violence	Not about attitudes to screening	
De Wit and Davis, 2004[713]	Nurses' knowledge and learning experiences in relation to the effects of domestic abuse on the mental health of children and adolescents	Not about attitudes to screening	
Shearer *et al.*, 2006[714]	Chiropractors' perceptions about intimate partner violence: a cross-sectional study	None given	
Renker, 2006[715]	Perinatal violence assessment: teenagers' rationale for denying violence when asked	Not really about attitudes to screening	
Rodriguez-Bolanos *et al.*, 2005[716]	Violencia de genero: actitud y conocimiento del personal de salud de Nicaragua	None given	
Mendez *et al.*, 2003[717]	Violencia contra la mujer: conocimiento y actitud del personal medico del Instituto Mexicano del Seguro Social, Morelos, Mexico	None given	
Tower, 2003[718]	Domestic violence screening: education and institutional support correlates	Exclude – behaviour	
Short *et al.*, 2002[490]	Assessing the success of the Womankind Program: an integrated model of 24-hour health-care response to domestic violence	Not about attitudes to screening	
Janssen *et al.*, 2002[326]	Introducing domestic violence assessment in a postpartum clinical setting	Not about attitudes to screening	

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Bryant and Spencer, 2002[719]	Domestic violence: what do nurse practitioners think?	Screening behaviour	
Cann *et al.*, 2001[720]	Domestic violence: a comparative survey of levels of detection, knowledge, and attitudes in health-care workers	No screening attitudes question	
Varcoe, 2001[400]	Abuse obscured: an ethnographic account of emergency nursing in relation to violence against women	Not really about attitudes to screening	
Elliott *et al.*, 2002[721]	Barriers to screening for domestic violence	Did not send us frequencies	
Hinderliter *et al.*, 2003[722]	The effect of intimate partner violence education on nurse practitioner feelings of competence and ability to screen patients	It is behaviour	
Ramsay *et al.*, 2005[11]	Interventions to reduce violence and promote the physical and psychosocial well-being of women who experience partner violence: a systematic review of controlled evaluations	None given	
Edwards, 2005[443]	Raising the subject of domestic violence	Not a primary study	
Gunn *et al.*, 2006[650]	Putting woman-centred care into practice: a new approach to psychosocial risk assessment during pregnancy	Not screening	
Schoening *et al.*, 2004[723]	Effect of an intimate partner violence educational programme on the attitudes of nurses	Not about screening	
Davies *et al.*, 1996[724]	Community health workers' response to violence against women	Not about acceptability of screening	
Glowa *et al.*, 2002[725]	Increasing physician comfort level in screening and counselling patients for intimate partner violence: hands-on practice	No investigation of acceptability of screening	
Kurz, 1987[726]	Emergency department responses to battered women: resistance to medicalisation	Does not directly address acceptability of screening	
Kelso, 1996[727]	Selections from current literature: clinical detection of abuse	Literature review	
Krimm and Heinzer, 2002[728]	Domestic violence screening in the emergency department of an urban hospital	Only screening rates	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Krantz *et al*., 2005[729]	Intimate partner violence: forms, consequences and preparedness to act as perceived by health-care staff and district and community leaders in a rural district in northern Vietnam	Not about attitudes to screening	
Cohen *et al*., 1997[730]	Barriers to physician identification and treatment of family violence: lessons from five communities	Not about screening	
Johnson and Benight, 2003[731]	Effects of trauma-focused research on recent DV survivors	Not about screening	
Thompson *et al*., 2000[169]	Identification and management of DV, a randomised trial	No measure of acceptability	
Gremillion and Kanof, 1996[732]	Overcoming barriers to physician involvement in identifying and referring victims of domestic violence	Narrative	
Coeling and Harman, 1997[733]	Learning to ask about domestic violence	Not about attitudes to screening	
Shadigian, 1996[734]	Domestic violence: identification and management for the clinician	Narrative, overview	
Stayton and Duncan, 2005[735]	Mutable influences on intimate partner abuse screening in health-care settings	Review	
Neufeld, 1996[233]	SAFE questions: overcoming barriers to the detection of domestic violence	Narrative	
Kim and Motsei, 2002[736]	'Women enjoy punishment': attitudes and experiences of gender-based violence among PHC nurses in rural South Africa	Not about acceptability of routine screening	
Durant *et al.*, 2000[737]	Opportunities for intervention: discussing physical abuse during prenatal care visits	Not about factors that affect acceptability of screening	
Waalen *et al.*, 2000[3]	Screening for intimate partner violence by health-care providers	Review	
Ronnberg and Hammarstrom, 2000[738]	Barriers within the health-care system to dealing with sexualised violence: a literature review	Literature review	
Protheroe *et al*., 2003[739]	An interview study of the impact of domestic violence training on midwives	Not about attitudes to screening	
Krugman *et al*., 2004[740]	Perceptions of help resources for victims of intimate partner violence	Not about attitudes to screening	
Loring and Smith, 1994[741]	Health-care barriers and interventions for battered women	Literature review	
Reid and Glasser, 1997[742]	Primary care physicians' recognition of and attitudes toward domestic violence	Not about attitudes to screening	

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Gerbert *et al.*, 2000[743]	Interventions that help victims of domestic violence	No data about screening	
Larance and Porter, 2004[744]	Observations from practice: support group membership as a process of social capital formation among female survivors of domestic violence	Not about attitudes to screening	
Ferris, 1994[745]	Detection and treatment of wife abuse in aboriginal communities by primary care physicians: preliminary findings	Not about attitudes to screening	
Shea, 1997[746]	Breaking through the barriers to domestic violence intervention	Not really about attitudes to screening	
Mortlock, 1996[747]	The battered woman in the accident and emergency department	Letter	
Chung, 1996[748]	Wife battering in Hong Kong: accident and emergency nurses' attitudes and beliefs	Not really about screening	
Goodyear-Smith, 2002[452]	National screening policies in general practice: a case study of routine screening for partner abuse	Literature review	
McHugo *et al.*, 2005[376]	The assessment of trauma history in women with co-occurring substance abuse and mental disorders and a history of interpersonal violence	Not about acceptability of routine screening	
Peltzer *et al.*, 2003[749]	Attitudes and practices of doctors towards domestic violence victims in South Africa	Not about attitudes to screening	
Peckover, 2002[750]	Focusing upon children and men in situations of domestic violence: an analysis of the gendered nature of British health visiting	Not about attitudes to screening	
Hamberger, 2004[751]	Evaluation of a health-care provider training programme to identify and help partner violence victims	Not about acceptability of screening	
Zachary *et al.*, 2002[752]	Provider evaluation of a multifaceted system of care to improve recognition and management of pregnant women experiencing domestic violence	Not about screening	
Kramer, 2002[377]	Domestic violence – how to ask and how to listen	Narrative – not a validation study	
Carbonell *et al.*, 1995[753]	Florida physician and nurse education and practice related to domestic violence	None given	
Ramsay *et al.*, 2002[2]	Should health professionals screen women for domestic violence? Systematic review	Review	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Bryant and Spencer, 2002[719]	Domestic violence: what do nurse practitioners think?	Not about attitudes to screening but about behaviours	
Protheroe *et al.*, 2004[739]	An interview study of the impact of domestic violence training on midwives	Not about screening	
Taft *et al.*, 2004[754]	General practitioner management of intimate partner abuse and the whole family: qualitative study	Not about attitudes to screening	
Steen, 2000[755]	Developing midwifery responses to women in their care who are living with violent men	Not really about attitudes to screening	
McKie *et al.*, 2002[756]	Time to disclose	Unclear	
McCosker *et al.*, 1999[432]	Evaluation of a self-paced education package on violence against women for rural community-based health workers	Nothing specific about screening attitudes	
Trute *et al.*, 1988[757]	Medical response to wife abuse: a survey of physicians' attitudes and practices	Is it about screening?	
Davidson *et al.*, 2001[758]	Training programmes for health-care professionals in domestic violence	Good for references: it is a review	
Bessette and Peterson, 2002[759]	Attitudes of adult nurse practitioner students towards women experiencing domestic violence	Not about screening attitudes	
Wright, 2003[760]	Asking about domestic violence	Literature review, maybe for references	
Bates and Brown, 1998[761]	Domestic violence: examining nurses' and doctors' management, attitudes and knowledge in an accident and emergency setting	No screening attitudes question	
Marchant *et al.*, 2001[762]	Addressing domestic violence through maternity services: policy and practice	It is about policies and practice related to DV	
Corbally, 2001[763]	Factors affecting nurses' attitudes towards the screening and care of battered women in Dublin A&E departments: a literature review	Literature review, good for references	
Frost, 1999[764]	Health visitors' perceptions of domestic violence: the private nature of the problem	Not about attitudes to screening	
Question unknown			
Boyle *et al.*, 2004[49]	Domestic violence in emergency medicine patients	Narrative	
Scales, 2004[765]	Domestic violence awareness in the perianaesthesia setting	Narrative – not relevant to any questions	
Sullivan *et al.*, 2005[766]	Participatory action research in practice	Not relevant to any questions	
McAfee, 2001[767]	Domestic violence as a women's health issue	Narrative	

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Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Dowd, 2004[768]	The emerging role of the paediatric emergency department in IPV	Narrative/guidelines	
Shadigian and Bauer, 2004[769]	Screening for partner violence during pregnancy	Narrative	
Ely, 2004[770]	Domestic violence and immigrant communities in the USA: a review of women's unique needs and recommendations for social work practice and research	Narrative	
Daniels, 2005[771]	IPV and depression: a deadly comorbidity	Narrative	
Jaeger, 2000[772]	Screening for DV	Narrative	
Lehrman and Berner, 1997[773]	Physician as detective: discerning and recording DV injuries	Guidelines	
Cox, 2003[774]	Synergy in practice: caring for victims of IPV	Not a primary study	
Koziol-McLain and Campbell, 2001[775]	Universal screening and mandatory reporting: an update of two important issues for victims/survivors of IPV	Not a primary study	
Klein, 2001[776]	Screening for risk of DV within HIV partner notification: evolving practice and emerging issues	Commentary	
Goodman and Epstein, 2005[777]	Refocusing on women: a new direction for policy and research on IPV	Narrative	
Resick, 2004[778]	A suggested research agenda on treatment-outcome research for female victims of violence	Narrative	
Watts, 2004[779]	Screening for DV: a team approach for maternal/newborn nurses	Narrative	
Biroscak *et al*., 2006[780]	IPV against women: findings from one state's ED surveillance system	Not relevant to any review question	
Zlotnick *et al*., 2006[781]	IPV and long-term psychosocial functioning in a national sample of US women	Q1 – not a review, not a health-care population	
Eisenstat and Bancroft, 1999[782]	Domestic violence	Narrative	
Heath, 2001[783]	DV as a women's health issue	Not a primary study	
MMWR, 1994[784]	Physical violence during the 12 months preceding childbirth – Alaska, Maine, Oklahoma, and West Virginia, 1990–1991	Prevalence study	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Carlson, 2005[785]	The most important things learned about violence and trauma in the past 20 years	Not a primary study	
Ferris *et al.*, 1997[786]	Documenting wife abuse: a guide for physicians	Guidelines	
Mayer and Liebschutz, 1998[787]	DV in the pregnant patient: obstetric and behavioural interventions	Narrative	
Attala *et al.*, 1999[788]	An analysis of nurses' communications in a shelter setting	Not about screening and not an intervention	
Nelms, 1999[789]	An educational programme to examine emergency nurses' attitudes and enhance caring intervention with battered women	Not about screening	
Jezierski, 1999[790]	Family violence screening: opportunities in prehospital settings	Guidelines/think piece	
Campbell and Sheridan, 1989[791]	Emergency nursing interventions with battered women	Narrative, guidelines	
Williams-Evans and Sheridan, 2004[792]	Exploring barriers to leaving violent intimate partner relationships	Protocol for pilot, not about screening	
Loraine, 1981[793]	Battered women. The ways you can help	Guidelines	
Short *et al.*, 1997[794]	Family violence: an intervention model for dental professionals	Model/guidelines	
Goldner, 1999[795]	Morality and multiplicity: perspectives on the treatment of violence in intimate life	Narrative	
Davidhizar and Giger, 2002[796]	Domestic violence	Narrative	
Humphreys *et al.*, 2001[797]	IPV against women	Narrative	
Schiavone and Salber, 1994[798]	Hitting close to home. DV and the EMS responder	Guidelines	
Stark, 2004[799]	Insults, injury and injustice	Narrative	
Thompson and Krugman, 2001[800]	Screening for IPA at well-baby care visits. The right thing to do	Commentary	
Griffin and Koss, 2002[801]	Clinical screening and intervention in cases of partner violence	Narrative	
Gantt and Bickford, 1999[802]	Screening for DV	Guidelines	
El-Bayoumi *et al.*, 1998[803]	DV in women	Narrative	
Weiss, 2005[804]	Domestic violence	Narrative	
Hannigan, 1999[805]	DV: the response of health care	Guidelines	
Cassidy, 1999[806]	How to assess and intervene in DV situations	Narrative	

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Davidhizar *et al*., 1998[807]	Recognising abuse in culturally diverse clients	Narrative	
Chiodo *et al*., 1998[808]	The dentist and family violence	Narrative	
Butler, 1995[809]	DV: a nursing imperative	Narrative	
Cattaneo and Goodman, 2005[810]	Risk factors for re-abuse in IPV	Narrative	
Rickert *et al*., 2002[811]	Adolescent dating violence and date rape	Review	
King, 1993[812]	Changing women's lives: the primary prevention of violence against women	Narrative	
Lundy and Grossman, 2001[813]	Clinical research and practice with battered women. What we know, what we need to know	Review	
Ford-Gilboe *et al*., 2005[814]	Strengthening capacity to limit intrusion: theorising family health promotion in the aftermath of woman abuse	Not about screening or interventions	
Coombes, 2004[815]	Making a fist of it	Narrative	
Helton *et al*., 1987[816]	Prevention of battering during pregnancy: focus on behavioural change	No data	
Belinger, 2001[817]	Domestic violence: how you can make a difference	Narrative/guidelines	
Harris *et al*., 1997[818]	The road to freedom: ending violence against women	No data	
Taket and Mann, 2005[819]	Clinical effectiveness: information bulletin 18	Information source	
Evans, 2001[820]	Children living with domestic violence	Narrative	
Garcia and Davidson, 2002[821]	Researching domestic violence and health: national perinatal epidemiology unit	Review	
Henderson and Ericksen, 1994[822]	Enhancing nurses' effectiveness with abused women	Not a primary study	
Hoff, 1993[823]	Battered women: intervention and prevention	Narrative	
Wescott, 1995[824]	Help for the hurting: when pregnant women are battered	Narrative	
Germain, 1984[825]	Sheltering abused women: a nursing perspective	Narrative	
Baird *et al*., 2005[826]	Learning from the Bristol Pregnancy and DV programme	Not about screening	

continued

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Hardacre, 2005[827]	Routine enquiry into domestic abuse – the All-Wales Clinical Pathway	Narrative	
Powers, 2004[828]	DV: what can nurses do?	Guidelines	
Kipps, 2005[829]	Sexual health needs of women in violent relationships	Narrative/guidelines	
Willis and Porche, 2004[830]	Male battering of intimate partners: theoretical underpinnings, intervention approaches and implications	Narrative	
Attala, 1996[831]	Danger signs: detecting abuse against women in the home	Narrative	
McFarlane and Goodmark, 1998[832]	Preventing abuse during pregnancy: a clinical protocol	Narrative	
Rhodes and Levinson, 2003[517]	Interventions for IPV against women	Case studies and guidelines with not enough data	
Harris *et al.*, 2005[833]	Qualitative interviews on substance abuse relapse and prevention among female trauma survivors	Not relevant to any question	
Hassouneh Phillips, 2005[834]	Understanding abuse of women with physical disabilities: an overview of the abuse pathway model	Not about screening	
Taket *et al.*, 2003[16]	Routinely asking women about DV in health settings	Not a primary study	
Peled and Edleson, 1994[835]	Advocacy for battered women: a national survey	Not really about screening	
Mohr *et al.*, 2001[836]	Safeguarding themselves and their children: mothers share their strategies	Not a health-care population	

Author and year	Study title	Reason for exclusion	Paper relevant to another question?
Weitlauf *et al.*, 2000[837]	Generalisation effects of coping-skills training: influences of self-defence training on women's efficacy beliefs, assertiveness and aggression	Not relevant to any question	
Turnbull, 2001[838]	Domestic violence	Narrative	
Onyskiw, 2001[839]	Research on violence and abuse in Canada: challenges and opportunities	Narrative	
Ryan and King, 1998[840]	Scanning for violence	Narrative	
Belfiglio, 2001[841]	Should primary care providers screen for DV?	Narrative	
Hague and Malos, 1996[842]	Tackling DV: a guide to developing multiagency initiatives	Guidelines	
Henrion, 2005[843]	Les violences conjugales pendant la grossesse: depistage et orientation par les soignants	Not about screening	
Chez, 1995[844]	Aider les victims de la violence domestique: traces de coups	Not a primary study	
Nicolaidis and Touhouliotis, 2006[845]	Addressing IPV in primary care: lessons from chronic illness management	Narrative	
Roberts and Roberts, 2005[846]	Ending intimate abuse. Practical guidance and survival strategies	Narrative and case studies	

Feedback

The HTA Programme and the authors would like to know your views about this report.

The Correspondence Page on the HTA website (www.hta.ac.uk) is a convenient way to publish your comments. If you prefer, you can send your comments to the address below, telling us whether you would like us to transfer them to the website.

We look forward to hearing from you.

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