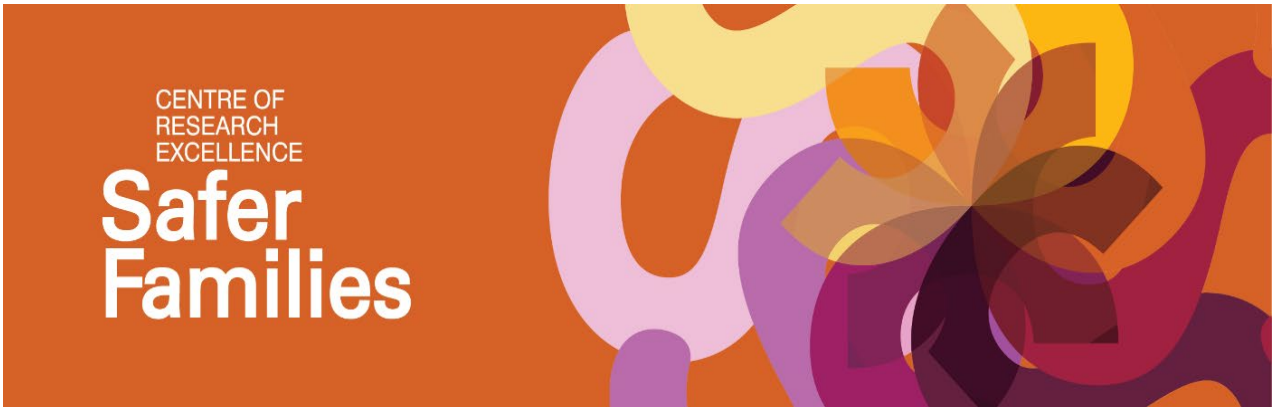

RACGP White Book

Abuse and Violence: Working with our patients in general practice.

Technical report of evidence reviews and summary of findings.

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Introduction

The Royal Australian College of General Practitioners (RACGP) produce clinical guidelines for General Practitioners (GPs) in addressing a wide range of clinical topics. In 2020, RACGP commissioned Safer Families Centre of Research Excellence at the University of Melbourne to update the evidence base for the Abuse and Violence: Working with our patients in general practice (The White Book) guideline 4th edition. The RACGP requested this guideline be updated using GRADE methods (1).

When using GRADE to develop guidelines, a systematic search of the literature is required for each clinical question. The result is a GRADE Summary of Findings tables showing the synthesis of findings along with a rating of certainty of evidence (also referred to as quality or confidence in evidence) and clinical importance.

These Summary of Findings tables are then presented to authors of relevant chapters to work through to move from the synthesized research evidence to making trustworthy recommendations, whilst ensuring that all relevant research findings are considered when making recommendations. In addition to systematic review and grading of clinical research questions, whenever possible, additional research findings (e.g., qualitative, quantitative and/or mixed method) and practice consensus are considered when making recommendations. This results in transparent recommendations that form the basis of the Abuse and Violence White Book Guidelines.

This document provides the technical report of the evidence review and summary of findings tables for the Abuse and Violence White Book guideline update. It includes a description of the methods, assessment of the risk of bias, data extraction, synthesized results per outcome and a summary of findings table per clinical question including a rating of certainty in the evidence.

In addition, as part of our search of the literature, we identified relevant systematic reviews and/or primary studies that did not specifically address our pre-developed research questions, yet these records provided relevant information. We have grouped these records as “additional relevant findings” to complement the GRADE processes and/or update key information within the relevant chapters.

Development of clinical questions and importance of outcomes

The research team engaged all members of the Advisory Panel in a Clinical Outcome Importance Rating Activity (Appendix A) and co-developed the clinical research questions along with patient or population of interest, intervention, control or comparison, and outcome of interest (PICO parameters – see Appendix B). Each member of the Advisory Panel rated the importance of each clinical outcomes on a five-point Likert scale of 'not at all important to very important". The results of this activity are available upon request. For the purpose of streamlining the search of the literature, the research team focused on addressing *a priori* co-developed clinical questions and outcomes rated as 'Important and Very Important'.

Whilst, the Advisory Panel rated the importance of each clinical outcome, the research team then utilized the Advisory Panel ratings, to consider levels of outcome importance when using the GRADE approach. The GRADE approach provides a system of rating the importance of outcomes. The GRADE approach has three outcomes 'levels' according to their importance for decision-making; critical; important but not critical; and limited importance.

Rating scale								
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
of least **importance**								of most importance
Of limited importance for making a decision (not included in evidence profile)			Important, but not critical for making a decision (included in evidence profile)			Critical for making a decision (included in evidence profile)		

Assessment of the certainty of the evidence

The GRADE method provides a system for classifying the certainty of an overall body of evidence (1). We used GRADEpro GDT software and followed standard methods to prepare a 'Summary of findings' table for each PICO question. GRADE provides a system for classifying the certainty of an overall body of evidence. These include high, moderate, low, and very low certainty of evidence.

Certainty of Evidence (GRADE)

High	additional research is unlikely to change our confidence in the estimate of a treatment effect
Moderate	additional research will impact on our confidence in the estimate and may change this estimate
Low	additional research is very likely to change the estimate
Very Low	any estimate of a treatment effect is uncertain

This classification is based on several characteristics that comprised the body of evidence, including trial design, risk of bias assessment of all individual studies, inconsistency between trial results, imprecision of the effect estimates, indirectness of evidence and potential publication and/or reporting bias.

As per GRADE methodology, the eventual quality ratings are sorted into four categories: ‘High’, ‘Moderate’, ‘Low’ and ‘Very low’. These categories reflect the reviewers’ confidence in the effect estimate and its proximity to the true effect of an intervention. ‘High’ grade evidence is designated a numerical equivalent of 4, with quality downgrades carrying a weight of –1 for ‘serious’ risk or –2 for ‘very serious’ risk. The ‘Very low’ rating carries a numerical equivalent of 1; once the quality of evidence has been downgraded to this point, it cannot be downgraded further.

We decreased grading for the following reasons.

- Serious (−1) or very serious (−2) trial limitation for risk of bias.
- Serious (−1) or very serious (−2) inconsistency between trial results.
- Some (−1) or major (−2) uncertainty about directness.
- Serious (−1) or very serious (−2) Imprecision of the pooled estimate.
- Strong suspicion of publication bias and other considerations (−1).

The resulting GRADE Evidence Profile contained:

- Whenever possible, pooled effect estimates calculated for each outcome,
- quality ratings for each outcome
- brief narrative summaries of the findings
- importance of each outcome
- overall quality of evidence rating.

Overall, we used the GRADE approach to rate the quality of evidence and this informed the strength of recommendations.

Strength of recommendations

Recommendation	Description
Strong recommendation for the intervention	The working group is very confident that the benefits of an intervention clearly outweigh the harms (or vice versa)
Strong recommendation against the intervention	The working group is very confident that the harms of an intervention clearly outweigh the benefits
Conditional recommendation for the intervention	Denotes uncertainty over the balance of benefits, such as when the evidence quality is low or very low, or when personal preferences or costs are expected to impact the decision, and as such refer to decisions where consideration of personal preferences is essential for decision making
Conditional recommendation against the intervention	Denotes uncertainty over the balance of harms, such as when the evidence quality is low or very low, or when personal preferences or costs are expected to impact the decision, and as such refer to decisions where consideration of personal preferences is essential for decision making
Conditional (neutral) recommendation	The working group cannot determine the direction of the recommendation

A recommendation could either be in favour or against the proposed treatment option, and strong or conditional. The recommendation can also be labelled as conditional neutral, where the working group cannot determine the direction of the recommendation.

A GRADE recommendation is categorized as strong if the research team, advisory group and chapter authors are very confident that the benefits of an intervention clearly outweigh the harms (or vice versa). A conditional recommendation denotes uncertainty over the balance of benefits and harms (e.g. evidence quality is low or very low).

Recommendations were formulated using standardized wording, such as using the term 'recommend offering' for strong recommendations and 'suggest offering' for conditional or weak recommendations or other terminology such as 'should' and 'may'.

However, when there was insufficient evidence for any recommendation, we considered opinions of experts based on clinical experience and consensus amongst members of the Advisory Panel. These recommendations were rated as Practice Point and based on Consensus of Experts.

Recommendation formulation and/or update

The research team engaged all chapter authors and advisory panel in formulating new recommendations and/or updating existing recommendations based on the available summary of findings and additional relevant findings. First, the summary of findings were presented to relevant authors via 2-hour workshops. The summary of findings formed the basis to generate

new recommendations and/or update existing recommendations. This activity was led by the research team and engaged key authors for each relevant topic.

Once authors had finalized key recommendations relevant to their chapter topic, the research team engaged all the advisory panel members in a recommendation agreement activity via Qualtrics platform. In this activity, the advisory panel were asked to rate their agreement (strongly disagree to strongly agree) with each of the recommendations and quality of evidence. The advisory panel were also asked to provide open-ended comments about each recommendation. The findings of this activity were then collated and presented back to the advisory panel, who discussed and finalized key recommendations.

Method

Search strategy

We identified clinical trials, Randomised Controlled Trials (RCTs) and/or systematic reviews for each clinical question (PICO question) using a search of key bibliographic databases. The search was conducted during August-September 2020, using relevant subject headings and key terms.

The searched bibliographic databases included:

- Medline
- Embase
- PsycINFO
- Cochrane databases
- Applied Social Sciences Index and Abstracts: ASSIA
- Web of Science
- PsycArticles

We also checked the reference lists of all included clinical trials, RCTs and relevant systematic reviews across various journals to identify additional relevant studies missed from the electronic searches. This included hand-searching and communication with experts in the field to identify any further potentially relevant sources of data.

Search terms

For each clinical question, search terms were developed and used to locate relevant studies. All searches were filtered to 1-January 2015 onwards. This timeframe was selected to only include relatively recent literature and update the previous 4th edition of the White Book published in 2014 (2).

However, where we identified a relevant published systematic and meta-analysis review, then we updated the search from the date of the published review. A list of developed search terms for each clinical question is listed in Appendix C.

Study selection

Titles and abstracts of all retrieved references were reviewed and screened to determine if they met the inclusion criteria for each clinical question. Then, the full text of all potentially relevant studies were identified and reviewed to determine eligibility for each of the clinical questions. Inclusion was limited to systematic reviews and/or meta-analysis and RCTs for each clinical question. However, as part of gathering additional relevant evidence, qualitative and quantitative studies (non-RCTs) were also retrieved, grouped together and described separately. These are included in Appendix D. These additional relevant findings were not critically appraised, and only served the purpose to complement the GRADE processes and support authors in updating key references for relevant chapters.

Risk of Bias assessment

The assessment of risk of bias for the included studies involved the domain-based evaluation criteria outlined in the Cochrane Handbook for Systematic Reviews of Interventions (3).

Domains to assess risk of bias in RCTs include:

1. **Random sequence generation** (methods used to generate the allocation sequence that would have produced comparable groups)
2. **Allocation concealment** (methods used to conceal the allocation sequence to determine whether group allocations could have been foreseen in advance)
3. **Blinding of participants and personnel** (methods used to blind trial participants and personnel from knowledge of which intervention a participant received)
4. **Blinding of outcome assessment** (methods used to blind outcome assessors from knowledge of which intervention a participant received)
5. **Incomplete outcome data** (whether participants' attrition and exclusion reasons were adequately reported).
6. **Selective outcome reporting** (whether trial authors selectively reported certain outcomes and not others).
7. **Other sources of bias** (concerns about bias not covered by points 1 to 6 above).

Where we included studies from eligible systematic reviews and/or meta-analysis (e.g., Cochrane reviews), existing risk of bias assessments of relevant studies were extracted and used in the GRADE processes. Where results of other reviews or RCTs did not have existing risk of bias assessment, we used the Cochrane risk of bias tool.

Data extraction

Descriptive study characteristics were extracted from each relevant study. These included study aims and objectives, design, setting, study location, participant characteristics and summary of findings. Outcome data related to each clinical question was also extracted and where possible, already complete meta-analysis and data syntheses were also extracted from systematic reviews.

Data synthesis and analysis

Relevant outcome data (consistent with the clinical questions) was extracted from eligible systematic reviews and/or RCTs and included in the GRADE processes.

Where meta-analyses from eligible Cochrane reviews and other systematic reviews were available, these were extracted to allow for ready completion of GRADE processes. Where additional studies were found, we performed a meta-analysis using RevMan software, if there were sufficient data and it was meaningful to pool the data across the included studies; for instance, if the treatments, participants and the underlying clinical question were similar enough for pooling to make sense. Alternatively, we synthesized the findings in a narrative format.

Results

Women who experience intimate partner abuse

Clinical question 1.

Does using standard assessment tools and screening measures improve GP's identification of IPA or risk level for women?

Criteria for inclusion and exclusion of studies

1. **Population**: women who experience IPA,
2. **Intervention**: screening and risk assessment
3. **Comparison**: NA
4. **Outcome**: IPVA identification, risk assessment,
5. **Study designs:** Randomised controlled trials, systematic reviews of RCTs.

Study selection: The search of electronic databases for clinical question 1 returned 482 records. Title, abstract and full-text screening identified 10 relevant records. However, only one Cochrane systematic review was retrieved as eligible for GRADE processes (4). The remaining records were included and synthesized as additional sources of evidence included in Appendix D (5-13).

Summary of Findings

Question: Does using standard assessment tools and screening measures improve GP's identification of IPA or risk level for women?

		Certainty assessment					No. of participants			Grades of Evidence	
Outcomes	**No. of studies**	**Risk of Bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other consideration**	**Intervention**	**Control**	**Effect (summary of finding)**	**Certainty**	**Importance**
Identification of IPA by health professionals	8 (RCT)	serious † (quality of the body of evidence was low to moderate)	Not serious	Some uncertainty about directness (outcome measure) †	Not serious	None	259/5006 (5.2%)	86/5068 (1.7%)	Screening increased clinical identification of victims/survivors (OR 2.95, 95% CI 1.79 to 4.87)	Moderate	Critical
Referrals following IPA screening	2 (RCT)	serious †	Not serious	Not serious	Not serious	Small number of studies	7/555 (1.3%)	4/743 (0.5%)	No evidence of an effect of screening on referrals (OR 2.24, 95% CI 0.64 to 7.86)	Low	Critical

Sources of data: (4)

Summary points:

- Screening increased identification of IPA, but not referral to services (4)
- Screening appeared to decrease IPA, risk level, and increase safety behaviours, but due to wide statistical confidence intervals, there was no difference between women who were screened compared to those who were not screened. Hospital-based primary care screening did not increase identification (4). Overall, no study reported adverse effects from screening (4)
- WHO consensus guidelines 2013 and VEGA guidelines 2019 (Canada) recommend case finding and first line response by all health practitioners (14)
- Screening tools were very heterogeneous (7, 12)
- Women generally supportive of screening, but mixed findings about mandatory reporting (9)
- Computer-assisted self-report measure increased IPVA disclosure (10)

Clinical question 2.

Do psychological therapies for women who experience IPA improve mental health and sense of safety?

Criteria for inclusion and exclusion of studies

1. **Population**: women who experience IPVA,

2. **Intervention**: Psychological therapies

3. **Comparison**: Control

4. **Outcome**: Mental health Sense of safety

5. **Study designs:** Randomised controlled trials, systematic reviews of RCTs.

Study selection: The search of electronic databases for clinical question 2 returned 51 records. Title, abstract and full-text screening identified 1 relevant record (15).

Summary of Finding

Question: Do psychological therapies for women who experience IPA improve mental health and sense of safety?

	Certainty assessment						No. of participants			Grades of Evidence	
Outcomes	**No. of studies**	**Risk of Bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other consideration**	**Intervention**	**Control**	**Effect (summary of finding)**	**Certainty**	**Importance**
Mental health (short-term follow up, under 6-months post intervention)	2	Serious	Serious	Not serious	Not serious	Small number of studies	173	180	The mean overall mental health score in the intervention group was 0.34 standard deviations better than control group, 95% CI 0.13 – 0.55)	Low	Critical
Mental health (long-term follow-up, 12 months and above post intervention)	2	Not serious	Not serious	Not serious	Not serious	Small number of studies	178	177	The mean overall mental health score in the intervention group was 0.27 standard deviations better than control group, 95% CI 0.06 – 0.48)	Low	Critical
Sense of safety (short-term follow up, under 6-months post intervention)	1	Serious	Not serious	Not serious	Not serious	Only 1 study	70	68	More women in intervention group had greater sense of safety OR 1.38, 95% CI 0.66, 2.89	Very low	Critical
Sense of safety (long-term follow-up, 12 months and above post intervention)	1	Not serious	Not serious	Not serious	Not serious	Only 1 study	95	97	More women in intervention group had greater sense of safety OR 2.14, 95% CI 1.18, 3.91	Very low	Critical
Depression (short-term follow up, under 6-months post intervention)	15	Very serious	Not serious	Not serious	Not serious	None	614	633	Improved depression scores for women receiving psychological therapy (SMD -0.45, 95% CI -0.67, -0.22)	Moderate	Critical
Depression (long-term follow-up, 12 months and above post intervention)	3	Not serious	Not serious	Not serious	Not serious	Small number of studies	265	238	No significant improvement in depression scores (SMD -0.08, 95% CI -0.30, 0.14)	Low	Critical
Anxiety (short-term follow up, under 6-months post intervention)	4	Very serious	Not serious	Not serious	Not serious	Small sample size	79	79	Improved anxiety scores (SMD -0.96, 95% CI -1.29, -0.63)	Moderate	Critical
Anxiety (long-term follow-up, 12 months and above post intervention)	1	Not serious	Not serious	Not serious	Not serious	Only one study	83	83	No significant improvement in anxiety scores (SMD -0.20, 95% CI -0.51, 0.10)	Low	Critical

Sources of data: (15)

Summary points:

- Psychological therapies appear to improve short-term mental health,
- Psychological therapies reduce depression and anxiety symptoms,
- There is insufficient evidence of beneficial therapy effect in reducing IPA and/or enhancing safety planning / safety behaviour,
- Generally, no difference in type of therapy, however, patient-centered care and active listening, motivational interviewing, psychoeducation, cognitive restructuring, social-skills building, problem-solving techniques for validating women's experiences and feelings, trauma-informed and/or mindfulness-based cognitive therapy were promising,
- No difference in who delivers the therapies (15)

Clinical question 3.

Do advocacy interventions for women who experience IPA improve sense of safety, mental health and reduce re-exposure to IPA?

Criteria for inclusion and exclusion of studies

1. **Population**: women who experience IPVA,
2. **Intervention**: Advocacy interventions
3. **Comparison**: Control
4. **Outcome**: Sense of safety, Mental health, Reduction in IPA
5. **Study designs:** Randomised controlled trials, systematic reviews of RCTs.

Study selection: The search of electronic databases for clinical question 3 returned 368 records. Title, abstract and full-text screening identified 2 relevant records eligible for GRADE processes (16, 17). These studies specifically assessed the effectiveness of advocacy interventions for women who experience IPA. The retrieved additional records are synthesized as part of additional research findings included in appendix D (18-20).

Summary of Findings

Question: Do advocacy interventions for women who experience IPA improve sense of safety, mental health and reduce re-exposure to IPA?

	Certainty assessment						No. of participants			Grades of Evidence	
Outcomes	**No. of studies**	**Risk of Bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other consideration**	**Intervention**	**Control**	**Effect (summary of finding)**	**Certainty**	**Importance**
IPA reduction (any type)	3	Very serious	Serious	Not serious	Not serious	Small number of studies	147	87	There was no evidence to suggest that women who received advocacy reported less abuse than women in the control arm at up to 12 months (SMD − 0.26, 95% CI − 0.52 to 0.01)	Very low	Critical
Depression	2	Serious	No serious	No serious	No serious	Small number of studies	119	120	Reduction of depression in women receiving brief advocacy OR 0.31, 95% CI 0.15 to 0.65	Low	Critical
Safety behaviours	3	Serious	Not serious	Not serious	Not serious	Small number of studies	280	278	No significant increase in safety behaviours 1.39 [0.92, 1.87]	Low	Critical

Sources of data: (16, 17)

Brief advocacy interventions may provide small short-term mental health benefits and reduce IPA in short term (6 months) but not long term (greater than 12 months) and no harm linked to study participation (16, 17). We updated the search for all advocacy trials. Overall, only one trial (21) found a small statistically significant difference (40.82 intervention compared to 35.87 control) in the decrease in IPA over time. The clinical significance of this is likely to be low and the trial was rated as moderate quality. For most trials, which measured IPVA as an outcome, there were no differences between women in intervention and control groups for re-exposure to IPA (22-25). For mental health outcomes, there were no differences between women in intervention and control groups for symptoms of depression and psychological distress (21, 22). Only one trial rated as moderate quality (22) showed that women who received an advocacy intervention compared to women in the control group, had fewer symptoms of post-traumatic stress.

The following is a summary of additional trials; yet most were classified as trials with high or unclear risk of bias (low quality trials).

Reference	Setting	Intervention	Participants		Outcomes / measures	Summary of findings	Limitations and study quality
			Intervention	Control			
(22)	Women transitioning from shelter to community	Out-reach advocacy intervention	70	66	QoL interview IPVA (single item - Have you been abused since the last interview?)	Primary outcomes: • No differences were found for quality of life, re-abuse, symptoms of depression, psychological distress, self-esteem, family support, and social support Secondary outcome: • Women in intervention group compared to control had fewer symptoms of post-traumatic stress (secondary outcome) adjusted mean difference -7.27, 95% CI -14.31 to -0.22)	• Personnel not blinded to women's group allocation • IPVA/abuse was measured using a single item
(25)	Perinatal	Nurse home visitation advocacy	105	133	IPVA (measured using 3 tools, AAS, WEB, PMWI)	• No difference in IPVA for those already experiencing IPVA • No harm reported	• Women were randomized at referral rather than after consent • no intervention fidelity assessment
(21)	perinatal	Domestic Violence Enhanced Home Visitation Program (DOVE)	124	115	IPVA (CTS2) Depression (EPDS)	• difference in decrease in IPVA over time between groups (mean decline 40.82 intervention vs. 35.87 control group) • no difference in depression ($p > 0.05$) • No adverse events reported	• About 20% of eligible women refused to participate • Up to 50% attrition in both groups at 24 months' follow-up • Assessors and statistical analysis team blinded, other researchers not blinded
(26)	obstetrics and gynaecology	empowerment programme	30	30	Self-esteem (SEI) Learned resourcefulness (RLRS) Ways of coping (WCI)	• women in intervention compared to control group had improved self-esteem ($\chi2 = -8.06$, $p = 0.000$) and learned resourcefulness (($\chi2 = -6.15$, $p = 0.001$)	• no information about blind allocation and/or blinding any of personnel • no fidelity assessment
(23)	public health clinics	nurse-delivered advocacy	470	480	IPVA (research-made survey)	• no significant treatment effects were observed (OR, 0.78; 95% CI, 0.49–1.24; P = 0.30)	• neither the researchers nor the clinic staff were blinded to participants' allocation • possibility of treatment contamination, as control nurses may have provided more comprehensive counselling to participants beyond what the study protocol asked of them

Reference	Setting	Intervention	Participants		Outcomes / measures	Summary of findings	Limitations and study quality
			Intervention	Control			
(27)	Community	Outreach advocacy and motivational interviewing	10	9	IPVA (CTS2; WEB; Danger Assessment) Depression (CES-D) PTSD (PTSD - primary care screen) AOD (AUDIT-C; DAST-10)	• Due to small sample size, no statistical analyses were done • study participants in both groups reported high satisfaction with the study and indicated that study participation made them feel safer	• very small feasibility trial • no fidelity assessment • no blind allocation
(28)	Community	culturally sensitive empowerment intervention	44	44	Self-esteem (TSEI) Hopefulness (BHS) Readiness to change IPVA (URICA-IPVA) Readiness to change suicidal behaviour	• no impact (weak) on self-esteem, hopefulness, and perceived effectiveness of obtaining resources	• randomization not clear • no blind allocation and/or blinding of personnel • no fidelity assessment
(29)	Community	Survivor focused Advocacy/ case Management intervention: HELLP (comparing online and face-to-face)	11 (online)	10 (face to face) and 11 (control)	Social support (ISEL) PROMIS (Anxiety, Depression, Anger)	• feasibility of online delivery of interventions to survivors of IPVA • no differences between groups (no treatment effect)	• no blind allocation and/or blinding of personnel • no fidelity assessment

Notes: The Coopersmith Self-Esteem Inventory (SEI); The Rosenbaum's Learned Resourcefulness Scale (RLRS); The Ways of Coping Inventory (WCI); The Taylor Self-Esteem Inventory (TSEI); Beck Hopelessness Scale (BHS); The University of Rhode Island Change Assessment Scale—Intimate Partner Violence (URICA-IPVA); IPVA Experience Questionnaire (IPVAEQ); Interpersonal Support Evaluation List (ISEL);

Summary points:

- Brief advocacy may provide small short-term mental health benefits and reduce IPA in short term (6 months) but not long term greater than 12 months and no harm linked to study participation (16, 17)

Clinical question 4.

Does peer support for women who experience IPA improve mental health?

Criteria for inclusion and exclusion of studies

1. **Population**: women who experience IPA,
2. **Intervention**: Peer support
3. **Comparison**: Control
4. **Outcome**: Mental health
5. **Study designs:** Randomised controlled trials, systematic reviews of RCTs.

Study selection: The search of electronic databases for clinical question 4 returned 178 records. Title, abstract and full-text screening identified no RCT or systematic review that specifically explored peer support for women who experience IPVA in primary health or other settings. Hence Grades of Evidence is not available.

However, some relevant findings were extracted from previous reviews shown in the additional research findings in Appendix D (30, 31).

Summary of Findings

Grades of Evidence is not available.

Clinical question 5.

Do social support interventions for women who experience IPA improve mental health?

Criteria for inclusion and exclusion of studies

1. **Population**: women who experience IPA
2. **Intervention**: Social support interventions
3. **Comparison**: Control
4. **Outcome**: Mental health
5. **Study designs:** Randomised controlled trials, systematic reviews of RCTs.

Study selection: The search of electronic databases for clinical question 5 returned 340 records after removing duplicates. Title, abstract and full-text screening identified no RCT or systematic review that specifically explored social support for women who experience IPA. Hence Grades of Evidence is not available. However, some relevant findings were extracted from qualitative reviews, quantitative cross-sectional studies shown in the additional research findings in Appendix D (32-34). Generally, these studies assessed social interventions combined with community advocacy. Overall, for IPA survivors, social support interventions which included community wide advocacy improved mental health outcomes of survivors (e.g., reduction in depression scores, psychological distress), but no consistent evidence of effect on IPA reduction (32).

Summary of Findings

Grades of Evidence is not available.

Men who use intimate partner abuse

Clinical question 1.

Does using standard assessment tools improve clinician's identification of IPA or risk level of harm?

Criteria for inclusion and exclusion of studies.

1. **Population**: men who use IPA
2. **Intervention**: standard assessment tools, screening, and risk assessment
3. **Comparison**: NA
4. **Outcome**: IPVA identification, risk assessment,
5. **Study designs:** Randomised controlled trials, systematic reviews of RCTs.

Study selection: The search of electronic databases for clinical question 1 returned 872 records upon removing duplicates. Title, abstract and full-text screening identified 4 relevant records (reviews). The identified records included no RCT that directly assessed the effectiveness of using standard assessment tools by clinicians to identify use of IPA or risk level of harm. Hence, Grades of Evidence is not available. Nevertheless, we have narratively synthesized the body of evidence derived from four recent reviews.

Health-care providers, in particular primary health care providers have a unique opportunity to identify their patients who are using intimate partner abuse (IPA) (35, 36). A recent scoping review narratively synthesized findings from five studies related to brief-IPA identification tools within health-care settings (37). While, five tools were identified with appropriate psychometric properties, the clinical utility of the tools and whether standard assessment tools improve clinician's identification of IPA or risk level of harm warrant further research.

Summary of Findings

Grades of Evidence is not available.

With regard to risk assessment, Salvin & Lavander (38) reviewed the predictive validity of IPA risk assessment tools in 10 studies in criminal justice settings and one study in a treatment setting. In most of the studies, the predictive validity for the global risk assessments with recidivism (re-occurrence of IPA) as the outcome, ranged from low to medium. The highest Area Under Curve (a measure of the validity of the tool) was presented by Lauria et al. (2017). This related to the ODARA tool total scores against the outcome of non-physical assault against the same victim.

Overall, this review's conclusion was that the predictive accuracy of tools was limited and warrants further investigation.

Standard risk assessment and other tools

Risk Assessment Tools
• Brief Spousal Assault Form for the Evaluation of Risk
• Brief Spousal Assault Form for the Evaluation of Risk-Version 2
• Chinese Risk Assessment Tool for Perpetrators
• Danger Assessment-5 items
• Danger Assessment (20-item Revised Version)
• Danger Assessment-Immigrant
• Danger Assessment–Revised
• Domestic Violence Risk Appraisal Guide
• Domestic Violence Screening Instrument–Revised
• Kingston Screening Instrument for Domestic Violence
• Ontario Domestic Assault Risk Assessment
• Risk Assessment Scale for Domestic Violence
• Severe Intimate Violence Partner Risk Prediction Scale
• Spousal Assault Risk Assessment Guide
• Spouse Violence Risk Assessment Inventory
• Secondary Risk Assessment for Partner Abusers
Other Tools
• Conflict Tactics Scale Revised
• Domestic Violence Screening Instrument
• Domestic Violence Supplementary Report
• General Statistical Information on Recidivism
• Historical Clinical Risk Management-20
• Historical part of the HCR-20
• Interpersonal Behavior Survey
• Violence Risk Appraisal Guide
• Police Screening Tool for Violent Crimes

However, none of the reviewed standard assessment tools included practice guidelines practitioners should follow if a patient screens positive for IPA use as a part of administering the screener. Nevertheless, Hegarty et al (39) provided some practical guidelines about questions to ask men about IPA if there are clinical indicators.

The unstructured clinical approach is the most used approach historically (40), that is, assessments conducted without the use of a standard tool. Most studies were administered or coded by researchers rather than administered in real-world settings (40). While, from a practice point of view, IPA risk assessment has the potential to play an important role in preventing repeat violence and protecting victims. However, from a research point of view, there is insufficient research to recommend their use in clinical practice.

Summary points:

- Health care providers have a unique opportunity to identify their patients who use IPA; in particular questions to ask men about IPA if there are clinical indicators (39)
- Brief-IPA identification tools (5 tools) within health-care settings had appropriate psychometric properties (37), but predictive accuracy of risk assessment tools was limited (38)
- Clinical utility of screening tools and whether standard assessment tools improve clinician's identification of IPA or risk level needs further research (40)

Clinical questions 2 & 3.

2. Do psychological therapies for men who use IPA, reduce IPA, and improve men's mental health?

3. Does concurrent treatment (AOD and mental health) for men who use IPA, reduce IPVA and AOD issues and improve men's mental health?

Criteria for inclusion and exclusion of studies

1. **Population**: men who use IPA,
2. **Intervention**: psychological therapies, combined therapies, concurrent therapies
3. **Comparison**: control, treatment as usual
4. **Outcome**: IPVA reduction, mental health, AOD reduction
5. **Study designs:** Randomised controlled trials, systematic reviews of RCTs.

Study selection: The search of electronic databases for clinical questions 2 and 3 returned 992 records (upon removing duplicates). Title, abstract and full-text screening identified seven systematic reviews, and two additional primary studies, not included in previous reviews. A recent systematic review of 14 studies described 10 interventions in health settings for males who use IPA (41). However, this review (41) searched the literature for up to 2017. Hence, we replicated and updated the search from 2017 onwards.

In terms of interventions in health settings, a systematic review of 14 studies describing 10 interventions in health settings for males who use IPVA found that overall, the evidence for effectiveness in health-care settings was weak (41). In this review, eight (80%) of the included RCTs (n = 10) were classified as high risk of bias. Nevertheless, results found that IPA interventions (e.g., cognitive behavioural therapy, motivational interviewing) combined with alcohol treatment show some promise.

In terms of substance-use health treatment settings, a recent meta-analysis of nine trials (1,014 men who use substances) showed that CBT and Substance Use Treatment (SUT) had no difference in substance use (3 trials) or IPVA outcomes (4 trials) versus treatment as usual (42). Further CBT-only interventions showed no beneficial impact on reducing IPVA. Nevertheless, CBT and motivational interviewing therapies were the most common approaches with men who use IPVA.

A recent small scale RCT trial delivered in an outpatient health service setting (43) compared Cognitive behavioural group therapy (n = 67) versus mindfulness-based stress reduction group therapy (n = 58). Overall, results provided support for the efficacy of both the cognitive-behavioural group therapy and the mindfulness-based stress reduction group therapy in reducing intimate partner violent behavior in men voluntarily seeking treatment. While promising findings, the lack of a control group confounds understanding treatment effect versus time effect.

In terms of trials within community and/or court ordered settings, a small-scale RCT trial compared individual versus group CBT with 42 men, court ordered (79%) to attend services at a

community domestic violence agency (44). Results found that participant self-reports revealed significant reductions in abusive behavior and injuries across conditions with no differential benefits between conditions. Another small-scale RCT trial compared Internet-delivered cognitive behaviour therapy (iCBT) with a trauma focus compared to monitored waitlist with 65 men recruited from the community (45). Results showed reduction in psychological and physical forms of IPVA and depressive symptoms. However, this trial had small samples of 32 men in intervention and 33 men in monitored waitlist control group. In addition, this trial was classified as high risk of bias. Further, the use of a monitored waitlist control does not rule out that the positive effects observed were nonspecific. Furthermore, IPA assessment was only based on reports from men who use IPA.

Summary of Findings

			Certainty assessment					No. of participants		Mean difference (effect)	Grades of Evidence	
Intervention	**Reference / setting**	**Outcomes**	**No. of studies**	**Risk of Bias**	**Inconsistency & Indirectness**	**Imprecision**	**I^2 Hetero**	**Ex**	**C**	[95% Confidence Interval)	**Certainty**	**Importance**
CBT + SUT (group therapy)	(42) **SU-outpatient**	Drugs	2	Serious	Not serious	Very serious	59%	55	59	3.74 [-0.10 to 7.58]	Low	Critical
		Alcohol	2	Serious	Not serious	Very serious	87%	55	59	3.38 [-0.86 to 15.41]	Low	Critical
		Substance use	3	Serious	Not serious	Serious	48%	137	143	2.07 [0.00 to 4.13]	Low	Critical
		IPVA	4	Very serious	Not serious	Not serious	65%	100	93	0.15 [-0.37 to 0.67]	Low	Critical
CBT only (group therapy)	(Karakurt et al., 2019) **Community and Court-ordered**	IPVA immediatel y post intervention	3	Very serious	Not serious	Not serious	42%	157	148	-0.25 [-0.56 to 0.05]	Low	Critical
CBT only (individual therapy)	Satyanarayan a et al., 2016 **SU-inpatient**	IPVA 12wks post intervention	1	Serious	Not serious	Serious	-	88	89	-2.90 [-6.41 to 0.61]	Very low	Critical
CBT + trauma focus (only intervention with this combination in the reviews) (group therapy)	Taft et al., 2015 **Community**	IPVA	1	Very serious	Not serious	Not serious	-	67	68	-2.11 [-2.92 to -1.30]	Very low	Critical
i- CBT (individual therapy)	Hesser et al., 2019 **Community**	IPVA – total	1	Serious	Not serious	Serious	-	28	32	-6.70 [-11.21, -2.19]	Very low	Critical
		Depression		Serious	Not serious	Serious	-	28	32	-3.28 [-5.49, -1.07]	Very low	Critical
		Anxiety		Serious	Not serious	Serious	-	28	32	-2.07 [-3.98, -0.16]	Very low	Critical

Notes: CBT = Cognitive Behavioural Therapy; SUT: Substance Use Treatment; i-CBT = Internet Cognitive Behavioural Therapy; SU = Substance Use;

Summary points:

- CBT and motivational interviewing therapies were most common approaches
- Meta-analysis CBT and Substance Use Treatment (SUT) showed no difference in substance use (3 trials) or IPVA outcomes (4 trials) versus usual treatment (42)
- CBT-only interventions showed no beneficial impact on reducing IPA
- CBT with a trauma focus showed significant reduction in IPA; only one trial and classified as high risk of bias; poor quality; small sample size (Taft 2015)
- Internet-delivered CBT using emotion-regulation and conflict resolution techniques) showed reduction in psychological and physical forms of IPVA and depressive symptoms; one trial only and classified as high risk of bias; poor quality; small sample size (45)

Clinical question 4.

Do Men's Behavioural Change Programs reduce men's use of IPA and increase partners' sense of safety?

Criteria for inclusion and exclusion of studies

1. **Population**: men who use IPA
2. **Intervention**: men's behavioural change program
3. **Comparison**: control, treatment as usual
4. **Outcome**: IPVA reduction, increase partners' sense of safety
5. **Study designs:** Randomised controlled trials, systematic reviews of RCTs.

Study selection: The search of electronic databases for clinical question 4 returned 548 records (upon removing duplicates). Title, abstract and full-text screening identified **7** relevant recent records (reviews).

A meta-analytical review of 25 primary studies of batter intervention programs found medium effect size ($\delta = 0.44$) for batterer interventions on recidivism; however, results are not generalizable due to high heterogeneity of programs (46). Further, the methodological quality of the included studies was unclear, with insufficient information about major risk of biases (e.g., randomization method, participant and personnel blinding). Despite these limitations, in terms of intervention duration, long programs (>16 sessions) were more effective in reducing recidivism in comparison to short interventions. In this review, the 8 included RCTs had small (n = 4 trials) or large effect sizes for recidivism (n = 4 trials) (46).

Another meta-analysis examined effectiveness of batterer intervention programs in decreasing recidivism of IPA by focusing on studies with nontreated comparison groups (N = 17 studies) (47). Results of meta-analysis indicated that BIPs were effective in decreasing IPVA recidivism and general offense recidivism when reported by the criminal justice system, but not when assessed by the survivor (partner). In addition, results varied by research design; non-significant pooled effect size for randomized controlled trials (pooled OR = .74, p = .140), but a significant pooled effect size for quasi-experimental design studies (pooled OR = .15, p < .001).

A key feature of MBCPs is the high drop-out rates (5.7%-57%), and the wide variability in success and improvement rates obtained (23.8%-93.5% of completers) (48); these figures were based on a systematic review of 23 batterer programs. Studies of MBCPs continue to suffer from significant heterogeneity in sample size, treatment model, research design, outcome measures analytic approaches, follow-up duration, and data sources (Arce et al., 2020; Cheng et al., 2019; Arias et al., 2013; Babcock et al., 2004; Eckhardt et al., 2013; Feder & Wilson, 2005).

Female IPA survivor perspectives on the changes brought about by IPA perpetrator programs, including MBCPs is that there is some level of positive change through their partner's engagement with a program, but the sustainability of this change is unclear and there was also some negative feedback (49). Key barriers to behaviour change include alcohol dependency,

mental health challenges, relationship dynamics (49). In contrast, facilitators of change include (a) survivor validation as their partner engaged in MBCPs, (b) survivor empowerment , peer interaction and group facilitator effects, and motivation to change connected with fatherhood and threat of losing their family and judicial mandates (49).

Summary of Findings

Grades of Evidence is not available.

Summary points:

- There is currently limited evidence as to the effectiveness of MBCPs in Australian context (Day et al., 2019; O'Connor et al., 2020).

Clinical question 5.

Do intervention orders reduce men's use of IPA and increase partners' sense of safety?

Criteria for inclusion and exclusion of studies

1. **Population**: men who use IPA
2. **Intervention**: intervention order, protection / legal order
3. **Comparison**: no protection order
4. **Outcome**: IPVA reduction, increase partners' sense of safety
5. **Study designs:** Randomised controlled trials, systematic reviews of RCTs.

Study selection: The search of electronic databases for clinical question 5 returned 71 records (upon removing duplicates). Title, abstract and full-text screening identified 2 relevant recent records (one review and one PhD dissertation).

Our search identified no RCT; this also aligned with recent systematic review which found "no studies to date have examined the effectiveness of protection orders using a randomised control trial" (50). However, in this review, four studies were included in meta-analysis which utilized a non-random pre-post intervention with a matched control comparison. Hence Grades of Evidence is not available.

The review by Dowling et al., (50) identified four studies which were deemed eligible for inclusion in the meta-analysis examining the effectiveness of protection orders in reducing re-victimization—three carried out in the US, and one in the UK. The overall results of the meta-analysis show that victims who received a protection order were significantly less likely to experience re-victimization than victims who did not (OR=0.59; CI=0.47–0.73; $p<0.001$). While these results were statistically significant, the magnitude of the effect that protection orders have on domestic violence re-victimization was regarded as small. One of the key limitations of this study was that only four studies were eligible for inclusion in the meta-analysis, and none from Australia. This impacts the validity of the results and their generalisability to an Australian context.

Summary of Findings

Grades of Evidence is not available.

Summary of Findings

Study	Aim / question	Study type	Setting	Study location	Studies	Summary of findings	Study quality and limitations
(50)	To review the use and impact of protection orders for IPVA	Systematic review	Legal	21 (Australia)	63 studies **Only 4 studies fit for meta-analysis (with non-random pre-post group and matched control)**	• protection order reduced re-victimization (OR=0.59; CI=0.47–0.73; p<0.001); Small effect • protection order less effective for offenders with a history of crime, violence, and mental health issues	• No studies to date have examined the effectiveness of protection orders using a randomised control trial
(51)	To explore factors related to IPVA in a population of IPVA victims filing for a emergency protective order (EPO)	PhD thesis	Domestic Violence Intake Center in Louisville, KY	USA	Auditing archival data	• more EPO filings with a reported history of IPVA and/or use of controlling behaviors by the perpetrators • perpetrators utilizing controlling behaviors were found to be more likely to have an IPVA history and to use physical violence. • reported IPVA history • nearly two-thirds of filings (N= 1776) listed the alleged perpetrator as an "Intimate partner" (31.9%; n = 566) or "Former Intimate Partner," (32.5%; n = 577)	• file audit investigation • lack of data related to socio-demographics, e.g. gender of perpetrator

Summary points:

- protection order reduced re-victimization (OR=0.59; CI=0.47–0.73; p<0.001); small effect (50)
- protection order less effective for offenders with a history of crime, violence, and mental health issues (50)

Men who experience intimate partner abuse

Clinical question

There was no clinical question for this topic. We conducted a general search to identify records related to men who experience IPVA. The search of electronic databases filtered from January 2015 onwards, returned 178 records (upon removing duplicates). Title, abstract and full-text screening identified 3 relevant recent reviews and six primary studies.

Narrative synthesis: A recent systematic review of 12 qualitative studies explored help-seeking experiences and interactions with support services of male victims of IPVA (52). This review highlighted that "barriers to help-seeking are complex, but fear of disclosure is central, overlapping with the challenge to both men's personal sense of and societal interpretations of masculinity and the importance of the relationship with the abuser" (52)

Men were less likely to seek-help due to commitment to intimate relationships and keeping the family intact (53). Furthermore, societal attitudes and perceptions of men as abusers were amongst barriers to help seeking or leaving the abusive relationship (54). While some men who disclosed abuse, received support from family and friends, other men also reported secondary abusive experiences, with police and other support services responding with ridicule, doubt, indifference, and victim arrest (55).

Overall, barriers to help-seeking included:

- social (traditional gender roles and norms),
- personal (shame, identity impacts),
- practical (cost, fit) barriers to support service access
- further victimization from services
- fear of seeking help and
- nowhere to go (lack of services)

Summary of Findings

Grades of Evidence is not available.

Child abuse

Clinical questions 1 & 2.

1. Do home-based supports and visits for children who experience abuse, reduce abuse, and improve child mental health?

2. Does parent-child psychotherapy for children who experience abuse, reduce abuse, and improve child mental health, parent child attachment?

Criteria for inclusion and exclusion of studies

1. **Population**: children who experience child abuse,
2. **Intervention**: home-based visitations programs and interventions, parent-child psychotherapy
3. **Comparison**: control, treatment as usual
4. **Outcome**: Abuse reduction, improve child mental health and parent child attachment
5. **Study designs:** Randomised controlled trials, systematic reviews of RCTs.

Study selection: Due to substantial number of systematic reviews addressing the topic of Child Abuse, we decided to only draw on a recent review by the Childhood Adversity and Mental Health CRE (56), and selectively summarize findings from recent systematic reviews and/or meta-analysis. A rapid search of seven electronic databases for the below-mentioned research questions returned 2031 records upon removing duplicates. Title, abstract and full-text screening identified 266 relevant records, published since 2010; most of these retrieved records were systematic reviews, meta-analysis, scoping and/or narrative focused reviews.

Summary of Findings

As mentioned above, due to substantial number of reviews in this field, GRADE was not utilized. Alternatively, authors relied on a recent systematic Review by the Childhood Adversity and Mental Health CRE (56). The Centre of Research Excellence (CRE) in Childhood Adversity and Mental Health is a five-year research program (2019-2023) co-funded by the National Health and Medical Research Council (NHMRC) and Beyond Blue. For the purpose of reviewing interventions for child abuse, we drew on a recent review by the Childhood Adversity and Mental Health CRE (56). The aim of this systematic review was to provide clinicians, policy makers, teachers, educators, health services and families with evidence-based information about the effectiveness of interventions to prevent adverse childhood experiences (ACE). A systematic search of PsycINFO (Ovid), PubMed, and Embase, Cochrane Database of Systematic Reviews, and Cochrane Controlled Register of Trials (Central) was conducted to identify interventions published between January 2010 and January 2020. A total of 26 different interventions were identified. These have been categorized along with their quality of evidence. Interventions were categorized into parenting programs (n = 10, only 2 classified as very high quality of evidence), home-visitation (n = 9, 6 classified as very high quality of evidence), community-based (n = 3), economic support (n = 3), school-based (n = 2), and psychological therapy (n = 1) (56).

A selection of additional evidence about child abuse is described in Appendix D and summarized below.

Summary points:

Associative factors:

- Prospective studies:
    - risk of any type of violence following childhood maltreatment was 1.8 (95% CI = 1.4 to 2.3), but there was substantial heterogeneity (I^2 = 92%) (57)
- Retrospective studies:
    - significant positive relationship between total & subtype child abuse and use of IPA (r=0.16, p < .001) effect size of child abuse on use of IPA was stronger for males (r = 0.20, 95% CI = 0.16 to 0.24, p < .001) than for females (r = 0.11, 95% CI = 0.09 to 0.14, p < .001) (58)
- Cross-sectional studies:
    - Child abuse was significantly associated with an early sexual debut (odds ratio (OR) = 2.22; 95% CI: 1.64–3.00), multiple sexual partners (OR=2.22; 95% CI: 1.78–2.76), transactional sex (OR = 3.05; 95% CI: 1.92–4.86) and unprotected sex (OR = 1.59; 95% CI: 1.22 2.09), but there was substantial heterogeneity (I^2 > 80%) (59)

Interventions and support:

- Pediatric health care setting (22 RCTs):
    - Most interventions combined parenting education, social service referrals, and social support for families of children aged 0−5 years (60)
- Families with High-Risk behaviours (8 RCTs):
    - Only home visitation was found to have a significant evidence base for reducing child abuse, and the findings vary considerably (61)
- Parenting support interventions (10 pre-post design, 3 RCTs):
    - ACT Raising Safe Kids Program; significant increase of positive parenting and decrease of corporal punishment.
    - But most studies utilized pre-post single group design (62)
- Experiences with psychosocial interventions (Cochrane Protocol):
    - Qualitative synthesis exploring experiences of child and adult survivors of sexual abuse and violence and their caregivers, regarding psychosocial interventions (63)

Adolescent-to-parent abuse

Clinical questions 1 & 2

1. Do psychological therapies for adolescents who use violence at home, reduce adolescent violence towards parents and improve mental health?

2. Does mental health assessment (for suicidality and risk of harm to others) with adolescents who use violence at home, reduce adolescence violent behaviours towards parents?

Criteria for inclusion and exclusion of studies

1. **Population**: adolescents,
2. **Intervention**: psychological therapies, mental health assessments
3. **Comparison**: control, treatment as usual
4. **Outcome**: Reduction in adolescent violence towards parents, improve mental health.
5. **Study designs:** Randomised controlled trials, systematic reviews of RCTs.

There was also additional two questions which were synthesized in a narrative format.

1. What interventions for adolescents who use violence at home, reduce violence towards parents?

2. What supports are available for parents experiencing violence from adolescents?

Study selection: The search of seven electronic databases for the above-mentioned research questions returned 1442 records upon removing duplicates. Title, abstract and full-text screening identified 47 relevant records. However, the search failed to find trials (either RCT or quasi-experiential) that directly assessed the effectiveness of psychological therapies and/or mental health assessments on reducing adolescent use of violence towards parents. Hence, Grades of Evidence is not available. Nevertheless, we have narratively synthesized the body of evidence derived from relevant literature.

Summary of Findings

Grades of evidence is not available.

Adolescent-to-parent violence (APV) or child-to-parent violence (CPV) are interchangeably terms used to describe a type of violence that is initiated by a child with the intention to cause psychological, physical, or financial pain to a parent and/or to obtain power over their parents (Walsh & Krienert, 2009). However, there are many other definitions and this inconsistency in definition is amongst the many challenges within the field of APV. A review of the literature concluded that in the 60 years since the first scientific study of Adolescent-to-parent violence (APV), our understanding of what it looks like and why it occurs remains fragmented and poorly developed. This is largely due to a weak theoretical foundation for much of the existing research, limited consideration of the multiple determinants of aggressive behavior, and the use of operational variables that do not reflect theoretical constructs (64).

Characteristics of adolescents

(adolescents who use violence towards parents and predictive factors)

Family factors

A recent meta-analysis of 19 primary studies investigated the correlation between child-to-parent and parent-to-child violence (65). The findings showed a significantly positive, medium magnitude ($\rho = .36$) mean true effect size for the relationship between child-to-parent violence and parent-to-child violence. More importantly, "parentally victimized children had 71% more probability of exercising child-to-parent violence as compared to children who had not suffered parent-to-child violence" (p. 54). Overall, the findings indicated that a child's exposure to parental violence was a significant predictor of child-to-parent violence. This is consistent with the broader literature that emphasizes that witnessing or being victim of violence within the home is a strong predictor of APV (Castillo-Eito et al., 2020). A recent study found that exposure to violence at home was related to adolescents' hostile social perception, anger, which may reflect a failure in emotional regulation (66). Witnessing or being a victim of violence within the home emerged as a strong characteristic of families who experience adolescent-violence-towards parents (67). In addition, a recent study found that the relationship between child abuse and APV was moderated by positive peer attachment (68). Victims of APV (mostly mothers) report poor family relationships and having previously experienced domestic violence in the home; and single mothers were often the targets of violence (69).

Individual factors

Research in cross-sectional studies that has focused on specific *individual-level factors* associated with APV, indicate that adolescents who use violence against parents also report high levels of hostility and anger, having low self-esteem and low self-worth, mental illness, drug and alcohol use, attentional and motor impulsiveness, exposure to a peer who uses violence at home and other offending outside the home (70). Correlational studies also found that the higher the APV, the lower the positive attitude towards other authority figures such as teachers or the police and the higher the positive attitude to transgress the established social norms (71). Whilst the methodological quality of these studies is considered "poor", due to lack of rigorous research designs, nonetheless these studies highlight a pattern of findings related to individual factors associated with APV.

Assessment of adolescent-to-parent violence

A scoping review of 23 articles explored assessment tools for APV (72). This review found a small number of instruments to measure child-to-parent violence. Specifically, the research only identified six standardized instruments.

The identified measures are all self-administered questionnaires and vary in terms of dimensions assessed. For example, while all tools included physical violence, psychological and emotional violence was measured by some tools and financial and economic was the dimension least measured by the instruments.

Assessment Tools

Tool	Items
• Child-to-Parent Aggression Questionnaire (CPAQ)	20
• Reactive-Proactive Aggression Questionnaire (RPQ)	23
• Child-Parent Conflict Tactics Scales (CP-CTS)	6
• Intra-family Violence Scale (IVS)	10
• Violent Behavior towards Authority Figures Scale (VAFS)	14
• Child-to-Mother Violence Scale (CMVS)	41

Interventions and support

Most studies identified in our search include adolescent use of aggression (not necessarily towards parents), and violence in dating relationships.

We briefly summarize these findings. There is a considerable lack of evidence-based interventions to use with youth who perpetrate violence against a parent (73). Nevertheless, recent literature indicate that improving adolescents' relationships with their peers may prevent them from being aggressive towards and perpetrating violence against their parents (68). Other studies highlight the importance of paying attention to family variables, such as parents' mode of implementation of disciplinary measures, and individual factors, such as adolescents' impulsivity and substance abuse (74).

Summary points: (adolescent use of aggression (not necessarily specific towards parents):

- Psychosocial interventions are effective in reducing adolescent aggression.
- Interventions targeted at adolescents at risk are more effective.
- Shorter interventions are more effective than longer interventions.
- Problem-solving and behavioural practice are the most effective techniques.
- Including more techniques does not make interventions more effective (67)

Adult survivors of child abuse

Clinical question 1.

Do psychological therapies for adult survivors of child abuse reduce PTSD, depression, anxiety and improve quality of life?

Criteria for inclusion and exclusion of studies.

1. **Population**: adult survivors of child abuse
2. **Intervention**: psychological therapies
3. **Comparison**: control / comparison group
4. **Outcome**: reduction in PTSD, depression, anxiety, and improvement in quality of life
5. **Study designs:** Randomised controlled trials, systematic reviews of RCTs.

Study selection: The search of electronic databases for clinical question 1 returned 2872 records upon removing duplicates. Title, abstract and full-text screening identified 45 relevant records (mostly reviews).

In terms of the research question, several previous reviews have assessed effectiveness of empirical studies of psychotherapy with adult survivors of child abuse (75-78).

A meta-analysis found moderate level of certainty in the effect of psychological therapies for post-traumatic stress disorder or trauma symptoms (g=0.72–0.77), internalizing symptoms (g=0.68–0.72), externalizing symptoms (g=0.41– 0.53), self-esteem (g=0.56–0.58), and global functioning or symptoms (g=0.57–0.60) (75). These findings are based on adults who experienced child sexual abuse. However, in a subsequent meta-analysis of 16 studies about adult survivors of any type of child abuse, while the effect size for any psychological therapy was moderate, the statistical confidence intervals indicated small to large beneficial effect of therapy (77). For example, (see below GRADE Table), the average between-group effect size comparing active treatments (any psychological therapy) versus waitlist/no contact control conditions at post-treatment (k = 9) was g = 0.72; 95% CI = [0.33; 1.11] on PTSD symptomatology. The comparison of trauma-focused vs. non-trauma-focused treatments found that there was a trend for trauma-focused treatments showing larger effect sizes than non-trauma-focused interventions on symptom levels of depression and dissociation, but not anxiety. However, this was only based on uncontrolled studies (e.g., non-randomised trials), (see GRADE Table below).

Summary of Findings

Between-group effect size comparing active treatments versus waitlist/control conditions at post treatment

			Certainty assessment				No. of participants		Hedges g (95% Confidence Interval)	Grades of Evidence	
Intervention type	**No. of Studies**	**Outcomes**	**Risk of Bias**	**Inconsistency & Indirectness**	**Imprecision**	**Other factors**	**Experimental**	**C**		**Certainty**	**Importance**
Any psychological therapy	9	PTSD	Serious	Serious	Not serious	High heterogeneity 72.02	283	198	0.72; 95% CI = [0.33; 1.11]	Moderate	Critical
	3	Depression	Serious	Serious	Not serious	Small studies	87	82	1.08, 95% CI = 0.70 – 1.45)	Moderate	Critical
	3	Anxiety	Serious	Serious	Not serious	Small studies	51	47	1.08, 95% CI = 0.63 – 1.54	Moderate	Critical
Trauma-focused *	4	PTSD	Very Serious	Serious	Not serious	Small studies	131	103	1.05, 95% CI = 0.18 – 1.92	Low Difference between TF vs. non-TF was significant (6.45, p = .01), favoring TF therapy	
Non-trauma-focused *	3	PTSD	Very Serious	Serious	Not serious	Small studies	174	95	**-0.12, 95% CI = -0.37 – 0.12**		
Individual therapy	5	PTSD	Serious	Serious	Not serious	Small studies	71	66	0.86, 95% CI = 0.43 – 1.30)	Moderate Subgroup analysis was significant (p = .03), favoring individual therapy	
Group psychotherapy	4	PTSD	Serious	Serious	Not serious	Small studies	176	121	**0.20, 95% CI = -0.19 – 0.59)**		

Sources of data: (75, 77) & updated search; Hedge's g effect size interpretation: 0.2 => small effect, 0.5 => medium effect, 0.8 => large effect

Summary points:

- Moderate level of certainty in the effect of any psychological therapy on reducing post-traumatic stress disorder or trauma symptoms, depression, anxiety (results based on RCTs)
- trauma-focused treatments showed larger effect sizes than non-trauma-focused interventions on symptom levels of depression and dissociation, but not anxiety (results based on non-randomised trials)
- Impact of therapy type on internalizing symptoms (results from RCTs): CBT (3 studies): 1.84, 95% CI = 1.43 – 2.25; Insight-oriented (10 studies): 0.44, 95% CI = 0.19 – 0.68; Eclectic (4 studies): 0.97, 95% CI = 0.42 – 1.52; Other (3 studies): 0.40, 95% CI = -0.39 – 1.20 (not significant)

We identified additional relevant findings; these have been described in Appendix D. In summary, these additional records included several systematic reviews addressing various aspects related to adult survivors of child abuse. For example:

- association between child abuse and female use of violence in adulthood (79)
- parenting after a history of childhood maltreatment (80, 81),
- perspectives and experiences of adult survivors of child abuse, including experiences of fatherhood (82-84),
- qualitative reflections of adult child sexual abuse survivors on their responses during the abuse (85),
- meta-analysis assessing dissociation in adults survivors of child abuse (86)
- Psychosocial interventions (perinatal settings) for mothers and fathers who are survivors of childhood sexual abuse (87)
- child abuse victimization among transgender and gender nonconforming people (88).

Adult survivors of rape and sexual assault in adulthood

Clinical question 1.

Do psychological therapies for adult survivors of sexual assaults reduce PTSD, depression, anxiety and improve quality of life?

Criteria for inclusion and exclusion of studies.

1. **Population**: adult survivors of rape and sexual assaults in adulthood
2. **Intervention**: psychological therapies
3. **Comparison**: control / comparison group
4. **Outcome**: reduction in PTSD, depression, anxiety, and improvement in quality of life
5. **Study designs:** Randomised controlled trials, systematic reviews of RCTs.

Study selection: The search of electronic databases for clinical question 1 returned 1723 records upon removing duplicates. Title, abstract and full-text screening identified 26 relevant records. In terms of this clinical question, we found a Cochrane protocol to assess the effects of psychosocial interventions on mental health and well-being for survivors of rape and sexual assault experienced during adulthood (89). This is a systematic meta-analysis which will include a comprehensive GRADE process. Hence, we decided not to undertake a GRADE for this topic. Nevertheless, we have narratively synthesized the body of evidence derived from relevant literature.

Summary of Findings

Grades of evidence is not available.

Overall, the body of evidence for psychological therapies for adult survivors of rape and sexual assault in adulthood is limited with major methodological limitations (90). While, the overall pattern of findings indicate that no specific type of psychological therapy is more effective than another (91), generally, cognitive-behavioral interventions, exposure interventions, and eye movement desensitization and reprocessing interventions were found (narratively) effective in enhancing mental health (92) and reducing PTSD symptoms, depression, anxiety, guilt and dissociation (93).

In terms of rape, sexual assault, and psychopathology, a meta-analysis of 195 studies found that people who have been sexually assaulted report significantly worse psychopathology than un-assaulted comparisons (average Hedges' g=0.61), suggesting moderate association. Larger effects were observed in samples with more assaults involving stranger perpetrators, weapons, or physical injury (94).

We identified additional relevant findings; these have been described in Appendix D. In summary, these additional records included several systematic reviews addressing various aspects related to adult survivors of rape and sexual assault in adulthood. For example:

- sexually transmitted disease, pregnancy, sexual or gynaecological problems (95)
- trauma-related sleep disturbances and somatic complaints such as pelvic pain (96)
- posttraumatic symptoms (97, 98), heightened risk for all forms of psychopathology (94)

- self-blame and suicidal behaviours (99, 100)

Clinical question 2.

Does yoga for adult survivors of sexual assault reduce PTSD, depression, anxiety and improve quality of life?

Criteria for inclusion and exclusion of studies.

1. **Population**: adult survivors of rape and sexual assaults in adulthood
2. **Intervention**: yoga
3. **Comparison**: control / comparison group
4. **Outcome**: reduction in PTSD, depression, anxiety, and improvement in quality of life
5. **Study designs:** Randomised controlled trials, systematic reviews of RCTs.

Study selection: The search of electronic databases for clinical question 2 returned 2597 records upon removing duplicates. Title, abstract and full-text screening identified no specific trial of yoga for adult survivors of sexual assaults. Hence, Grades of Evidence is not available.

Summary of Findings

Grades of evidence is not available.

We identified additional relevant findings; these have been described in Appendix D.

Specific populations

For chapters related to specific populations, we conducted a rapid general search of the literature. We supplied authors a list of relevant retrieved records, along with copy of full text. More precisely this was a general search (not systematic search) of the literature related to each specific population. Some examples of records supplied to authors is included in the below tables.

People with disabilities

Study	Design	Aim / question
(101)	Systematic review 56 studies	In this literature review, researchers used an intersectional approach to document the similarities and differences in how women with disabilities, elderly women, and immigrant women experience IPA, in terms of forms and consequences, as well as related risk factors, explanatory theories, and prevention strategies
(102)	Systematic review Six studies	To critically evaluate the existing empirical research concerning the use and experience of partner violence by adults with intellectual disabilities
(103)	Narrative review 197 studies	The aim of this review is to highlight the clinical impact of the IPA phenomenon on women with disabilities, describes the difficulties experienced while dealing with this phenomenon and suggests the most appropriate intervention strategies
(104)	Review of reviews (10 systematic reviews (reviewing 168 studies)	As compared with the general population, women with serious mental illness experience higher rates of intimate partner abuse, sexual assault, and are at a greater risk of future victimization, post-traumatic stress disorder, exacerbated symptoms of mental illness, and other negative health outcomes
(105)	Selective review	The objective was to provide evidence-based guidance for health care providers to engage in brief and extensive assessment of intimate partner abuse and to initiate appropriate safety precautions and referrals, all within the context of disability.
(106)	Conceptual paper	This paper argues that grounding violence prevention in a comprehensive human rights framework, offers a resolution to address the marginalization of gendered disability violence, and reduce the perpetuation of the systemic violence and abuse experienced by women with disabilities in a wide range of settings.

Intimate Same Sex Partner Violence

Study	Design	Aim / question
(107)	Systematic review and meta-analysis 85 studies	To systematically review the quantitative literature on prevalence and correlates of IPVA in transgender populations.
(108)	RCT	The aim of this study was to investigate the prevalence of IPA, associations of socio-economic and psychosocial factors with IPA, and the association of IPA with depression and sexual behaviour, among gay, bisexual, and other men who have sex with men in the PROUD trial of pre-exposure prophylaxis (PrEP).
(109)	Systematic review and Meta-analysis 24 studies	Using meta-analytic techniques, this study was conducted to examine the relative strength of various risk markers for men and women being perpetrators and victims of physical IPA in same sex relationships
(110)	Systematic review and Meta-analysis 8 studies	A meta-analysis was conducted to investigate the association between internalized homophobia and use of intimate partner abuse and victimization in same-sex relationships
(111)	Narrative review 119 studies	This paper presents a narrative review on intimate partner abuse occurring in same sex couples.
(112)	Systematic review 10 studies	To clarify the role of sexual minority stressors on intimate partner abuse in same-sex relationships, the authors undertook a systematic review of literature on this topic from 2005 to 2015.
(113)	Narrative review	This article reviews the literature on LGBTQ IPA and suggests three major barriers to help-seeking exist for LGBTQ IPVA survivors: a limited understanding of the problem of LGBTQ IPA, stigma, and systemic inequities
(114)	Narrative review	This paper analyzes the most recent approaches to this phenomenon and reviews studies referring to the prevalence and type of violence exerted. Factors associated with this violence are analyzed in depth, along with its effects on victims' health. In addition, methodological limitations concerning this topic are stated. Finally, this paper highlights future research areas and also key issues for those who work in prevention, treatment and/or intervention
(115)	Systematic review 14 studies	This article presents the first systematic review on intimate partner abuse in self-identified lesbians in same-sex couples. Studies published from January 1990 to December 2013 were analyzed

Study	Design	Aim / question
(116)	Narrative review	This review provides a critical review of the literature, focusing upon empirical findings regarding same-sex domestic violence.
(117)	Systematic review 96 studies	These authors provide an overview and critical analysis of research on intimate partner abuse among lesbian, gay, and bisexual persons and discuss recommendations for future research on the topic
(118)	Meta-analysis 14 studies	The present study is the first meta-analytic study about the prevalence of intimate partner abuse in self-identified lesbians in same-sex couples

Abuse of older people

Study	Design	Aim / question
(119)	Longitudinal Survey on Senior's Health and Health Services	We aimed to document in primary care older adults the relationship between family violence and mental and physical health, satisfaction with life, and health service use, by gender
(120)	descriptive-analytical, cross-sectional study	The present screening study aimed to determine the prevalence of domestic abuse and its relationship with demographic characteristics among elderly people referred to primary healthcare centers of Shiraz, Iran in 2018.
(121)	systematic review and meta-analysis 50 studies	To determine the extent of abuse against women aged 60 years and over
(122)	Narrative review 48 studies	We present a narrative review of 48 studies exploring IPA in women aged ≥45 years, focusing on: (1) prevalence of IPA; (2) factors associated with IPVA; (3) impact of IPA; (4) responses to IPA; (5) IPVA interventions; and (6) key populations
(123)	Secondary data analysis (Medicare admin data analysis)	We evaluated Medicare claims data from 2012–2014 for beneficiaries who had a diagnostic code for Elder abuse and mistreatment discharged from any types of facility. We extracted records for 10,181 individuals examining demographic characteristics, residential characteristics, residential location, type of facility providing care, disease co morbidities, and disability-related conditions.
(124)	Narrative review 9 studies	This article presents a critical review of the literature reporting empirical research in three overlapping fields of inquiry: elder abuse, domestic violence and sexual violence, identifying points of theoretical and methodological similarity and difference across academic disciplines
(125)	Meta ethnographic synthesis of qualitative evidence	The purpose of this meta-synthesis was to explore qualitative evidence in older women with a history of Intimate partner abuse and their accounts and experiences of mental health.

Study	Design	Aim / question
	22 studies	
(126)	Cross-sectional survey	The present analysis examines the association of perpetrator, victim, and interaction factors with the occurrence of physical, financial, and psychological abuse of older persons, committed by relatives with psychiatric disorder
(127)	Systematic review and meta-analysis 34 population-based and 17 non– population-based studies	Elder abuse is increasingly recognised as a global public health and social problem. There has been limited inter-study comparison of the prevalence and risk factors for elder abuse. This study aimed to estimate the pooled and subtype prevalence of elder abuse worldwide and identify significant associated risk factors
(128)	Systematic review Eleven screening tools	To review the efficacy and accuracy of tools administered to older people, intended to detect, and measure elder abuse
(129)	A critical review of the literature 76 studies	This article provides a critical review of current literature on the sexual assault of older women—including an exploration of the specific features and emotional and physical impacts of older women's experiences—and highlights current gaps and future directions for research, practice, and theory
(130)	Systematic review 9 studies	Elder abuse and neglect is a societal issue that requires prevention and intervention strategies at the practice and policy level. A systematic review on the efficacy of community-based elder abuse interventions was undertaken to advance the state of knowledge in the field
(131)	Police information related to 655 cases of rape and sexual assault of older people	The aim of this research was to investigate the nature and extent of serious sexual offences reported to the police by older victims
(132)	Cochrane systematic review 7 studies	The objective of this review was to assess the effectiveness of primary, secondary and tertiary intervention programme used to reduce or prevent abuse of the elderly in their own home, in organizational or institutional and community settings. The secondary objective was to investigate whether intervention effects are modified by types of abuse, types of participants, setting of intervention, or the cognitive status of older people.

Aboriginal and Torres Strait Islander

Study	Design	Aim / question
(133)	Documentation analysis 72 documents across 11 countries	This study describes the level of government commitment in preventing domestic violence towards Indigenous women in countries of the Global North.
(134)	Qualitative interview with 23 Australian Indigenous people	Indigenous peoples face substantial barriers when accessing support for family violence. Delivering family violence resources through technological means has the potential to address barriers, but there is insufficient evidence of their acceptability and appropriateness with Indigenous populations
(135)	Cross-sectional survey	To begin to understand associations between compounding social stressors and IPVA in this population (Indigenous Men Who Have Sex with Men in the United States), a 30-min online survey consisting of instruments previously validated in LGBT or Indigenous communities was targeted to Indigenous MSM using social media algorithms
(136)	Scoping review 15 studies	Indigenous peoples are more likely than non-Indigenous peoples to experience family violence (FV), with wide-reaching impacts on individuals, families, and communities. Despite this, service providers indicate that Indigenous peoples are less likely to seek support than non-Indigenous peoples. Little is known about the reasons for this, particularly from the perspective of Indigenous people themselves. In this scoping review, we explore the views Indigenous peoples have on help seeking for FV.
(137)	Systematic review 13 studies	This study systematically reviewed the global literature on mental health outcomes and risk factors for mental ill health among Indigenous women who experienced IPVA

Migrant and refugee communities

Study	Design	Aim / question
(138)	Systematic review 10 studies	This paper contains a systematic review of peer-reviewed published articles within the past 25 years addressing IPA prevention and intervention programming designed for this vulnerable population (Immigrant Latinas)
(139)	Systematic review 13 studies	Exploring the needs and lived experiences of racial and ethnic minority Domestic Violence Survivors through Community-Based Participatory Research: A Systematic Review
(140)	Scoping review	Explore and review Intimate Partner abuse in Canada's Immigrant Communities

Study	Design	Aim / question
	30 studies	
(141)	Narrative review 8 studies	This study explores what is known about coping strategies among immigrant women who have experienced intimate partner abuse in North America.
(142)	Systematic review 17 studies	To explore cross-cultural differences in help-seeking behaviour of women who have experienced IPA
(143)	Cross sectional survey 130 participants	the purpose of this study was to determine the extent to which migrant women in Australia experience IPA, and to understand the factors that influence their help-seeking behavior
(144)	Systematic review 15 studies	The current systematic review summarizes the evidence from studies examining the risk and protective factors associated with family related violence in refugee families
(145)	Systematic review 7 studies	The purpose of this article is to systematically review and synthesize the available empirical research related to intimate partner abuse in the lives of African immigrant women
(146)	Systematic review 24 studies	This systematic review intends to document the violence that is experienced by immigrant women within their host country and its prevalence

Training and Education

Study	Design	Aim / question
(147)	Case study four primary health care teams	To analyze how team level conditions influenced health care professionals' responses to intimate partner abuse

Study	Design	Aim / question
(148)	Systematic review 21 studies (3 RCTs & 18 pre-post intervention surveys)	To review educational and structural or whole-system interventions that aim to improve professionals' understanding of, and response to, DVA survivors and their children
(149)	Systematic review 18 studies	This study was designed to examine the effects of IPA educational interventions on the knowledge, attitudes, skills and behaviours of allied health care practitioners (AHCPs).
(150)	Single group training intervention	To evaluate a training intervention for general practice-based doctors and nurses in terms of the identification, documentation, and referral of male patients experiencing or perpetrating domestic violence and abuse (DVA) in four general practices in the south west of England

Doctor and self – care

Study	Design	Aim / question
(151)	Narrative review	To describe what is known about burnout among women physicians and identify contributing factors, categories of impact, and methods for mitigating the phenomenon. The authors conclude with current gaps in research.
(152)	Narrative review	To review the psychosocial burden and relevant prevention strategies for GPs with a special emphasis on GP trainees
(153)	Cross-sectional survey 400 respondents (physicians)	Our study describes IPA experienced by U.S. physicians.
(154)	Case study	Case study format discussion about physician burnout, signs, and possible solutions
(155)	Qualitative 14 GP registrars	This study aimed to explore these issues among general practice registrars (trainee general practitioners (GPs)
(156)	Systematic review 11 studies	The purpose of this systematic review is to analyze and summarize the current knowledge regarding the use of yoga to manage and prevent stress and burnout in healthcare workers.
(157)	RCT	The aim of this study was twofold: a) to determine the effectiveness of an intensive multimodal training programme

Study	Design	Aim / question
	Control group (18 GPs) Experimental group (20 GPs)	for GPs designed to improve their management of mental-health patients; and b) to ascertain if the program could be also useful to improve the GPs management of their own burnout, job satisfaction and psychological well-being.
(158)	Cross-sectional	To estimate the prevalence of intimate partner abuse in physicians, nurses and nursing assistants and risk factors in the Spanish Health Service.
(159)	Narrative review	To explore and review organizational strategies for physician burnout
(160)	Systematic review	The purpose of this review is to provide an accurate, current summary of what is known about physician burnout and to develop a framework to reverse its current negative impact, decrease its prevalence, and implement effective organizational and personal interventions.
(161)	Meta-analysis 19 studies	To evaluate the effectiveness of interventions to reduce burnout in physicians. We also examined whether different types of interventions (physician-directed or organization-directed interventions), physician characteristics (length of experience) and healthcare setting characteristics (primary or secondary care) were associated with improved effects.
(162)	Systematic review 15 RCTs 37 cohort studies	To review interventions to prevent or reduce burnout among residents and practicing physicians
(163)	Narrative review 43 studies	The purpose of this integrative review was to identify, review, synthesize, and analyze the existing literature addressing compassion fatigue (CF) in healthcare providers (HCPs), with careful attention to provider role and practice area

Appendix A

WhiteBook clinical outcomes rating activity

The research team developed, implemented and analysed the results from this activity using Qualtrics platform. The research team engaged and consulted the advisory panel in this activity.

1. Screening and response with women who experience IPA.

1.1. Please rank the following outcomes in order of importance for **SCREENING** interventions for women:

Outcomes	Not at all important	Slightly important	Moderately important	Important	Very important
Sense of safety					
Re-exposure to IPA					
Mental health and wellbeing					
Quality of life					
Self-efficacy					

1.2. Please rank the following outcomes in order of importance for **ADVOCACY** interventions for women:

Outcomes	Not at all important	Slightly important	Moderately important	Important	Very important
Sense of safety					
Re-exposure to IPA					
Mental health and wellbeing					
Quality of life					
Self-efficacy					

1.3. Please rank the following outcomes in order of importance for **PSYCHOLOGICAL** interventions for women:

Outcomes	Not at all important	Slightly important	Moderately important	Important	Very important
Sense of safety					
Re-exposure to IPVA					
Mental health and wellbeing					

Outcomes	Not at all important	Slightly important	Moderately important	Important	Very important
Quality of life					
Self-efficacy					

1.4. What other interventions and/or clinical outcomes do you think are important to consider when supporting **women who experience IPA**?

1.5. What interventions and/or clinical outcomes do you think are important to consider when supporting **women who use IPA**?

2. Supporting men who use IPA.

2.1.. Please rank the following outcomes in order of importance for **Men's Behavioural Change Programs** for men:

Outcomes	Not at all important	Slightly important	Moderately important	Important	Very important
Reduction in use of IPVA					
Partner's sense of safety					
Reduction in AOD-related issues					
Mental health and wellbeing					

2.2. Please rank the following outcomes in order of importance for **PSYCHOLOGICAL THERAPIES** for men:

Outcomes	Not at all important	Slightly important	Moderately important	Important	Very important
Reduction in use of IPVA					
Partner's sense of safety					
Reduction in AOD-related issues					
Mental health and wellbeing					

2.3. What other interventions and/or clinical outcomes do you think are important to consider when supporting **men who use IPVA**?

2.4. What interventions and/or clinical outcomes do you think are important to consider when supporting **men who experience IPVA**?

3. Supporting children who experience child abuse.

3.1. Please rank the following outcomes in order of importance for **HOME-BASED SUPPORT and VISITS** for children who experience abuse:

Outcomes	Not at all important	Slightly important	Moderately important	Important	Very important
Reduction in child abuse					
Reduction in witnessing IPVA					
Child mental health and wellbeing					
Age-appropriate developmental milestones					
Improved sleeping patterns					

3.2. Please rank the following outcomes in order of importance for **PARENT-CHILD PSYCHOTHERAPY** for children who experience abuse:

Outcomes	Not at all important	Slightly important	Moderately important	Important	Very important
Reduction in child abuse					
Reduction in witnessing IPVA					
Child mental health and wellbeing					
Age-appropriate developmental milestones					
Improved sleeping patterns					

3.3. What other interventions and/or clinical outcomes do you think are important to consider when supporting **children who experience abuse**?

4. Supporting ADOLESCENTS who experience abuse.

4.1. Please rank the following outcomes in order of importance for **PSYCHOLLOGICAL THERAPIES** for adolescents who experience abuse:

Outcomes	Not at all important	Slightly important	Moderately important	Important	Very important
Reduction in abuse					
Reduction in witnessing IPVA					

Outcomes	Not at all important	Slightly important	Moderately important	Important	Very important
Mental health and wellbeing					
Healthy parent-adolescent relationship					
Reduction in violence towards parents					
Reduction in high-risk behaviours (e.g. sexual, AOD)					

4.2. What other interventions and/or clinical outcomes do you think are important to consider when supporting **adolescents who experience abuse**?

4.3. What other interventions and/or clinical outcomes do you think are important to consider when supporting **adolescents who use violence towards their parents?**

5. Supporting adults' survivors of child abuse (including child sexual abuse)

5.1. Please rank the following outcomes in order of importance for **PSYCHOLOGICAL THERAPIES** for adult survivors of child abuse

Outcomes	Not at all important	Slightly important	Moderately important	Important	Very important
Reduction in PTSD					
Reduction in depression, anxiety and other co-morbid mental dis-orders					
Improved sleeping					
Quality of life					
Healing and recovery from childhood traumatic experiences of abuse					
Physical health					

5.2. What other interventions and/or clinical outcomes do you think are important to consider when supporting **adult survivors of child abuse?**

6. Supporting adults' survivors of sexual assaults in adulthood

6.1. Please rank the following outcomes in order of importance for **PSYCHOLOGICAL THERAPIES** for adult survivors of sexual assaults in adulthood

Outcomes	Not at all important	Slightly important	Moderately important	Important	Very important
Reduction in PTSD					
Reduction in depression, anxiety, and other co-morbid mental dis-orders					
Quality of life					
Improved sleeping					
Healing and recovery from traumatic experiences of adult sexual assaults					
Reductions in sexual-related problems					
Physical health					

6.2. What other interventions and/or clinical outcomes do you think are important to consider when supporting **adult survivors of sexual assaults in adulthood?**

Appendix B

Clinical questions and PICOS parameters

The research team engaged and consulted the advisory panel in developing these research questions.

Research Questions	PICOS parameters				
	Population	Intervention	Comparator	Outcomes	Study type
• Women who experience IPVA **Does using standard assessment tools and screening measures improve GP's identification of IPVA or risk level for women?**	Women who experience IPVA	Screening	NA	IPVA identification. Risk assessment	Systematic reviews RCTs
Do psychological therapies for women who experience IPVA improve mental health and sense of safety?	Women who experience IPVA	Psychological therapies	Control	Mental health Sense of safety	Systematic reviews RCTs
Do advocacy interventions for women who experience IPVA improve sense of safety, mental health and reduce re-exposure to IPVA?	Women who experience IPVA	Advocacy interventions	Control	Sense of safety Mental health Reduction in IPVA	Systematic reviews RCTs
Does peer support for women who experience IPVA improve mental health?	Women who experience IPVA	Peer support	Control	Mental health	Systematic reviews RCTs
Do social support interventions for women who experience IPVA improve mental health?	Women who experience IPVA	Social support interventions	Control	Mental health	Systematic reviews RCTs
• Men who use IPVA **Does using standard assessment tools improve clinician's identification of IPVA or risk level of harm?**	Men who use IPVA	standard assessment tools, screening, and risk assessment	NA	Identification of use of IPVA. Risk assessment	Systematic reviews RCTs
Do psychological therapies for men who use IPVA, reduce IPVA and improve men's mental health?	Men who use IPVA	Psychological therapies	Control	IPVA reduction Mental health	Systematic reviews RCTs
Does concurrent treatment (AOD and mental health) for men who use IPVA, reduce IPVA and AOD issues and improve men's mental health?	Men who use IPVA	Concurrent / combined therapies	Control	IPVA reduction Mental health AOD reduction	Systematic reviews RCTs

Research Questions	PICOS parameters				
	Population	Intervention	Comparator	Outcomes	Study type
Do Men's Behavioural Change Programs reduce men's use of IPVA and increase partners' sense of safety?	Men who use IPVA	Men's Behavioural Change Programs	Control	IPVA reduction, increase partners' sense of safety	Systematic reviews RCTs
Do intervention orders reduce men's use of IPVA and increase partners' sense of safety?	Men who use IPVA	intervention order, protection / legal order	Control	IPVA reduction Partners sense of safety	Systematic reviews RCTs
• Child abuse **Do home-based supports and visits for children who experience abuse, reduce abuse and improve child mental health?**	Children	home-based visitations programs and interventions	Control	Abuse reduction Mental health	Systematic reviews RCTs
Does parent-child psychotherapy for children who experience abuse, reduce abuse and improve child mental health, parent child attachment?	Children	Parent-child psychotherapy	Control	Abuse reduction improve child mental health and parent child attachment	Systematic reviews RCTs
• Adolescent-to-Parent Violence and Abuse **Do psychological therapies for adolescents who use violence at home, reduce adolescent violence towards parents and improve mental health?**	Adolescents	Psychological therapies	Control	Reduction in adolescent violence towards parents and improve mental health	Systematic reviews RCTs
Does mental health assessment (for suicidality and risk of harm to others) with adolescents who use violence at home, reduce adolescence violent behaviours towards parents?	Adolescents	Mental health assessments	Control	Reduction in adolescent violence towards parents	Systematic reviews RCTs
• Adult survivors of child abuse **Do psychological therapies for adult survivors of child abuse reduce PTSD, depression, anxiety and improve quality of life?**	Adult survivors of child abuse	Psychological therapies	Control	reduction in PTSD, depression, anxiety, and improvement in quality of life	Systematic reviews RCTs
• Adult survivors of rape and sexual assaults in adulthood **Do psychological therapies for adult survivors of sexual assaults reduce PTSD, depression, anxiety and improve quality of life?**	Adult survivors of rape and sexual assaults in adulthood	Psychological therapies	Control	reduction in PTSD, depression, anxiety, and improvement in quality of life	Systematic reviews RCTs

Research Questions	PICOS parameters				
	Population	Intervention	Comparator	Outcomes	Study type
Does yoga for adult survivors of sexual assaults reduce PTSD, depression, anxiety and improve quality of life?	Adult survivors of rape and sexual assaults in adulthood	Yoga	Control	reduction in PTSD, depression, anxiety, and improvement in quality of life	Systematic reviews RCTs

Appendix C

Clinical questions and search queries

Clinical questions	Search terms and queries!
• Women who experience IPVA **Does using standard assessment tools and screening measures improve GP's identification of IPVA or risk level for women?**	(Intimate partner violence OR battered women OR domestic violence OR spouse abuse OR family violence OR Abuse and violence) AND (screening OR identification OR measures OR tools OR assessment)
Do psychological therapies for women who experience IPVA improve mental health and sense of safety?	(Intimate partner violence OR battered women OR domestic violence OR spouse abuse OR family violence OR Abuse and violence) AND (psychological therapies OR psychotherapeutics) AND (mental health OR safety)
Do advocacy interventions for women who experience IPVA improve sense of safety, mental health and reduce re-exposure to IPVA?	(Intimate partner violence OR battered women OR domestic violence OR spouse abuse OR family violence OR Abuse and violence) AND (advocacy intervention) AND (mental health OR safety OR intimate partner violence reduction)
Does peer support for women who experience IPVA improve mental health?	(Intimate partner violence OR battered women OR domestic violence OR spouse abuse OR family violence OR Abuse and violence) AND (peer support OR peer intervention) AND (mental health)
Do social support interventions for women who experience IPVA improve mental health?	(Intimate partner violence OR battered women OR domestic violence OR spouse abuse OR family violence OR Abuse and violence) AND (social support OR social intervention) AND (mental health)
• Men who use IPVA **Does using standard assessment tools improve clinician's identification of IPVA or risk level of harm?**	(men OR male OR man) AND (Intimate partner violence OR domestic violence OR spouse abuse OR family violence OR Abuse and violence OR perpetration) AND (screening OR identification OR measures OR tools OR assessment OR standardized)
Do psychological therapies for men who use IPVA, reduce IPVA and improve men's mental health?	(men OR male OR man) AND (Intimate partner violence OR domestic violence OR spouse abuse OR family violence OR Abuse and violence OR perpetration) AND (psychological therapies OR psychotherapeutics) AND (mental health OR intimate partner violence reduction)
Does concurrent treatment (AOD and mental health) for men who use IPVA, reduce IPVA and AOD issues and improve men's mental health?	(men OR male OR man) AND (Intimate partner violence OR domestic violence OR spouse abuse OR family violence OR Abuse and violence OR perpetration) AND (combined therapies OR concurrent therapies OR psychological therapies OR substance use treatment) AND (mental health OR intimate partner violence reduction OR alcohol and other drugs reduction)
Do Men's Behavioural Change Programs reduce men's use of IPVA and increase partners' sense of safety?	(men OR male OR man) AND (Intimate partner violence OR domestic violence OR spouse abuse OR family violence OR Abuse and violence OR perpetration) AND (Men Behavioural Change Programs OR Batterer program) AND (mental health OR intimate partner violence reduction OR alcohol and other drugs reduction)
Do intervention orders reduce men's use of IPVA and increase partners' sense of safety?	(men OR male OR man) AND (Intimate partner violence OR domestic violence OR spouse abuse OR family violence OR Abuse and violence OR perpetration) AND (intervention order OR legal OR protection order) AND (intimate partner violence reduction OR partner safety)

Clinical questions	Search terms and queries!
• Child abuse **Do home-based supports and visits for children who experience abuse, reduce abuse and improve child mental health?**	('child* abuse' OR 'child* neglect' OR 'child* maltreatment' OR 'child* physical abuse' OR 'child* sexual abuse' OR 'child* emotional abuse' OR 'early trauma*' OR 'child* maltreatment' OR 'early life adversity' OR 'family violence' OR 'family conflict' OR 'parental care') AND (treat* OR therapy OR respon* OR outcome OR intervention OR psychological therapies OR home-based interventions OR parent-child psychotherapy OR family support OR school-based support)
Does parent-child psychotherapy for children who experience abuse, reduce abuse and improve child mental health, parent child attachment?	('child* abuse' OR 'child* neglect' OR 'child* maltreatment' OR 'child* physical abuse' OR 'child* sexual abuse' OR 'child* emotional abuse' OR 'early trauma*' OR 'child* maltreatment' OR 'early life adversity' OR 'family violence' OR 'family conflict' OR 'parental care') AND (treat* OR therapy OR respon* OR outcome OR intervention OR psychological therapies OR home-based interventions OR parent-child psychotherapy OR family support OR school-based support)
• Adolescent-to-Parent Violence and Abuse **Do psychological therapies for adolescents who use violence at home, reduce adolescent violence towards parents and improve mental health?**	(adolescent OR child OR young people OR aggression toward parents OR child to parent violence OR adolescent to parent violence OR violence against parents) AND (psychological therapies OR psychotherapeutics OR intervention OR support)
Does mental health assessment (for suicidality and risk of harm to others) with adolescents who use violence at home, reduce adolescence violent behaviours towards parents?	(adolescent OR child OR young people OR aggression toward parents OR child to parent violence OR adolescent to parent violence OR violence against parents) AND (assessment OR mental health assessment)
• Adult survivors of child abuse **Do psychological therapies for adult survivors of child abuse reduce PTSD, depression, anxiety and improve quality of life?**	(child* sex* abuse, child* sex* assault, ther*, counsel*, psych*, adult survivors OR male survivors OR female survivors OR survivors OR adult survivors of child abuse OR neglect) AND ((psychological therapies OR psychotherapeutics OR intervention OR support)
• Adult survivors of rape and sexual assaults in adulthood **Do psychological therapies for adult survivors of sexual assaults reduce PTSD, depression, anxiety and improve quality of life?**	(rape OR sexual victimization OR sexual aggression OR sexual violence OR sexual coercion OR sexual assault OR adult survivors OR male survivors OR female survivors OR survivors) AND (counsel* OR psych* OR psychological therapies OR interventions)
Does yoga for adult survivors of sexual assaults reduce PTSD, depression, anxiety and improve quality of life?	(rape OR sexual victimization OR sexual aggression OR sexual violence OR sexual coercion OR sexual assault) AND (yoga OR mind train* OR relaxation OR mindful* OR exercise OR meditation*)

Notes: ! these terms were adapted and varied across databases using appropriate search queries techniques.

Appendix D

Additional relevant findings

The following section provides a descriptive summary of some additional relevant studies and reviews that did not specifically address our clinical questions, but these were used to complement the GRADE process and inform development of new recommendations and/or update existing key recommendations. Further, these additional materials were utilized by authors to update key references within relevant chapters. This section presents some of these additional relevant materials.

Women who experience intimate partner abuse

Identification and Assessment of IPA with women

Qualitative data synthesis

Study	Aim / question	Design	Setting	Study location	Participants / studies	Summary of findings
(6)	Identify psychometric- tested screening tools to assess and screen IPVA in healthcare settings	Systematic review (narrative)	Mental health settings	USA (28)	36 studies	10 IPA screening tools were identified. Psychometrically evaluated tools for identifying victims: • Abuse Risk Inventory (ARI) • Composite Abuse Scale (CAS) • Index of Spouse Abuse (ISA) Only 3 tools assessed all areas of IPVA and had strong psychometric properties: • Women Abuse Screen Tool (WAST) • Abuse Assessment Screen (AAS) • Humiliation, Afraid, Rape and Kick (HARK)
(7)	Describe clinical usefulness of validated tools for screening and measuring risk of IPVA	Systematic review (narrative)	Primary health care and other settings	19 tools in English and then translated, culturally adapted to Arabic,	63 studies (39 tools)	• 10 screening tools • 19 evaluation tools (assess degree of violence) • 10 IPVA risk assessment tools

Study	Aim / question	Design	Setting	Study location	Participants / studies	Summary of findings
				Chinese, Spanish, Greek, Indonesian, Italian, Japanese, Spanish		
(164)	To synthesise evidence about screening and mandatory reporting of IPVA	Review (narrative)	Health care	USA (23) Korea (1) Australia (1)	25 studies	• Victims generally supportive of screening and reporting, however in a substantial number of studies women opposed mandatory reporting • Screening and reporting of IPVA among health professionals were mixed and inconclusive
(8)	Review how clinicians can best identify when a woman is experiencing IPVA, and provide appropriate care and assistance.	Narrative review	Healthcare	Various (focused-selected review)	Not specified	This review synthesis findings related to: • Possible indicators of intimate partner abuse • Possible questions to ask about IPA • Possible questions in assessing safety and safety planning

Quantitative data synthesis

Study	Aim / question	Design	Setting	Study location	Participants / studies	Summary of findings
(10)	Assess IPVA screening method: • computer-assisted self-administered screen • self-administered written screen • face-to-face interview screen	Review of RCTs	Not specified	USA Canada Japan	6 studies	Computer-assisted self-administered screen was found to increase the odds of IPVA disclosure by 37% in comparison to a face-to-face interview screen (odds ratio: 0.63, 95% CI: [0.31, 1.30])

Mixed method data synthesis

Study	Aim / question	Design	Setting	Study location	Participants / studies	Summary of findings
(12)	Explore primary health care providers IPVA screening practices	Systematic review (mixed method)	Primary care providers	25 (USA); Belgium (2), Canada (2), Colombia, England, Finland, India, Nicaragua, and Sweden	35 studies: 13 Qualitative. 22 quantitative 1 mixed method	IPA screening practices: • Rates of routine screening were typically low, with a range of 2–50% of providers reporting always or almost always routinely screening for IPA How are primary health providers screening for IPVA? • Provider screening for IPVA was completed via an array of strategies and with a variety of screening styles. • In terms of assessing for IPVA, providers broached the topic of IPVA with patients using general and nonthreatening questions such as: ○ ‘‘How are you feeling?’’ ○ ‘‘How are things going in your life?’’ ○ and ‘‘Happy at home?’’

Responding and therapeutic strategies with women who have experienced intimate partner abuse

Qualitative data synthesis

Study	Aim / question	Design	Setting	Study location	Participants / studies	Summary of findings
(30)	Review peer-led support groups for survivors of sexual abuse and assault	Systematic review (qualitative)	Not specified	Australia (1) Canada (1) USA (6)	8 studies	Thematic analysis: • Positive psychological impacts of participating in survivor peer groups • Positive interpersonal impacts of participating in survivor peer groups • Experiences of being part of a survivor peer group – understanding, emotional connectedness and healing • Mutuality and interconnectedness of benefit, pain and healing

Study	Aim / question	Design	Setting	Study location	Participants / studies	Summary of findings
						• Group mechanisms and lack of consensus on models
(32)	Review social support interventions for IPVA survivors	Systematic review (qualitative)	Not specified	Not clear	27 studies	Results showed improvements in social support and/or mental health outcomes of survivors, with little evidence of their effect on IPVA reduction or increase in healthcare utilization. Social support interventions included: • Survivor focused, advocate/case management interventions (15 studies) • Survivor focused, advocate/case management interventions with a psychotherapy component (3 studies) • community-focused, social support interventions (6 studies) • community-focused, social support interventions with a psychotherapy component (3 studies)

Quantitative data synthesis

Study	Aim / question	Design	Setting	Study location	Participants / studies	Summary of findings
(165)	To assess the effectiveness of psychological interventions for women in low-income countries with common mental disorders and IPVA	Systematic review (quantitative)	Community and health	Low-middle income countries	14 RCTs	Anxiety reduction (SMD = 0·31, 95% CI = 0·04 to 0·57) No beneficial effect on PTSD, depression or psychological distress
(20)	To determine the efficacy of Advocacy and Cognitive Behavioural Therapy interventions in reducing IPVA	Systematic review (quantitative)	Various	USA (14) China (2) Australia (2) Mongolia (1)	19 RCTs	Advocacy reduced: • Physical abuse (SMD = – 0.13; 95% CI = – 0.25, – 0.00) • Psychological abuse (SMD – 0.19; 95% CI = – 0.32, – 0.05) • But not sexual or any form IPVA CBT reduced:

Study	Aim / question	Design	Setting	Study location	Participants / studies	Summary of findings
						• Physical (SMD – 0.79; 95% CI = – 1.26, -0.33) • Psychological (SMD – 0.80; 95% CI = – 1.25, – 0.36) • But not sexual or any IPVA

Mixed method data synthesis

Study	Aim / question	Design	Setting	Study location	Participants / studies	Summary of findings
(16)	To assess advocacy interventions for intimate partner abuse in women, in terms of which interventions work for whom, why and in what circumstances	Systematic review (all methods)	Various (healthcare clinicians, shelter, judicial)	Various	98 studies (147 articles)	Key elements of advocacy intervention: • Good therapeutic alliance • education and information on abuse and on women's rights and sources of help (resources); • active referral to, and help in accessing other services; • assessment of risk of repeat abuse; • and safety planning to avoid it Factors that enhance effectiveness of advocacy: • Trust in the advocate • Advocates must help women consider their best options, depending on things like ethnicity, immigration status, where they live, the severity and type of the abuse experienced and finances • Advocates want to help women and can get stressed if they do not feel helpful enough, so they need support from organizations and other advocates, including repeat training, debriefs, and funding to do their job well.
(31)	Review effect of peer support interventions on empowerment, self-efficacy,	Systematic review (quantitative and qualitative)	Mental health	USA (16) European nations (5) Canada (2)	23 studies	Peer-facilitated group interventions can result in small but significant improvements in empowerment and self-efficacy compared with treatment as usual. There was mixed evidence for the impact of peer support interventions on internalized stigma

Study	Aim / question	Design	Setting	Study location	Participants / studies	Summary of findings
	and internalized stigma					

Men who use intimate partner abuse

Assessment tools and instruments

Study	Aim / question	Design	Setting	Participants / studies	Summary of findings
(37)	To review IPA perpetration instruments and tools used in health-care settings	Scoping review (narrative synthesis)	Community, emergency settings	5 studies No RCT	Five brief measures for use of IPA: • Extended Hurt/Insult/Threaten/Scream IPVA screening tool • Perpetrator Rapid Scale (PERPS) - 3-item screening tool • perpetration screening tool – 4-item • Jellinek Inventory for Assessing Partner Violence – 4-item • Rhodes et al., 2009 unnamed measure (8-items) All measures have adequate psychometric properties. owever, the clinical utility of the screening tools is not clear and whether standard assessment tools improve clinician's identification of IPVA or risk level of harm warrant further research.
(38)	To explore the predictive validity of practitioners' IPVA violence risk assessment	Systematic (narrative synthesis)	All in criminal settings (except one in treatment settings)	11 studies	• predictive validity ranged from low (not predictive at all) to moderate • The area under the curve (AUC) values for global risk assessments/numerical total scores, with the outcome IPVA recidivism varied between 0.49 and 0.72 in the studies (If AUC is 0.75, three of four predictions are correct) • only three AUCs were 0.70 or higher. Thus, overall, the predictive accuracy was small

Study	Aim / question	Design	Setting	Participants / studies	Summary of findings
					• The overall conclusion of this review is that the research regarding the accuracy of practitioners' IPVA risk assessments is limited
(40)	To review IPVA-re-assault and intimate partner homicide risk assessment tools	Systematic (narrative synthesis)	clinical and criminal justice settings	43 studies	• 18 tools used for IPVA / IPH risk assessment (5 to 35 items) • Most frequently tested (psychometrically) tools were Ontario Domestic Assault Risk Assessment (ODARA) and Danger Assessment (DA) • Most studies were administered or coded by researchers rather than administered in real-world settings.
(39)	How GPs can identify and respond to men who use violence in their relationships	Selected review	Primary health care	Selective (not clear)	• GPs have a role in the identification, management and referral of men who use violence in their relationships. • Great care needs to be taken when GPs are seeing the whole family, to ensure the safety of women and children • A selective review of the literature, yet provided some practical guidelines about questions to ask men about IPVA if there are clinical indicators

Batterer interventions

Study	**Aim / question**	Design	**Study location**	Participants / **studies**	**Summary of findings**
(46)	meta-analytical review of batterer intervention program efficacy	Meta-analysis	Not reported	25	• while results found medium effect size for batterer interventions on recidivism, results are not generalizable due to high heterogeneity of programs • higher effect size was obtained with group-CBT programs in comparison to the Duluth Model • long programs (>16 sessions) were more effective in reducing recidivism in comparison to short interventions
(166)	To examine MBCP content, implementation, and the impact on participant and family outcomes	systematic review	6 Australian MBCPs; 2 USA; 2 Spain;	13 articles published from 2013 onwards	• Positive changes were reported for MBCP participants, including communication, parenting, interpersonal relationships, aggression, abuse, responsibility for behavior, self-awareness power and control tactics, empathy, skills development, cognitive beliefs, behavior control, and abusiveness patterns

Study	Aim / question	Design	Study location	Participants / studies	Summary of findings
			1 each UK, Canada, Uganda	No RCT; mostly cohort studies / comparative	• *None of the articles examined the links between men's accountability and responsibility to the safety and well-being of women and children* • none of the articles included assessments of integrity of program delivery, system processes, or evaluations based on program logics
(167)	Review program quality and outcomes in MBCP	ANROWS Report (systematic review; qualitative synthesis)	Australia, UK, Canada, USA, New Zealand focused	92 articles	• *There is currently limited evidence as to the effectiveness of MBCPs.* • In Australia, the evaluations required by government funding bodies have commonly been process orientated, with success being defined in terms of outputs, such as participants completing the program • while RCTs may be the "gold standard" for establishing causality (Kaptchuck, 2001), this particular methodology is often beyond the resources and scope available to many MBCP providers
(47)	Meta-analysis of batterer intervention programs in decreasing recidivism of domestic violence by focusing on studies with nontreated comparison groups	Meta-analysis	Not reported	17 Only 5 RCTs	• results indicated a non-significant pooled effect size for randomized controlled trials (pooled OR = .74, p = • .140), but a significant pooled effect size for quasi-experimental design studies (pooled OR = .15, p < .001)

Interventions and support in health settings

Study	Aim / question	Design	Setting	Study location	Participants / Studies	Summary of findings
(41)	Intervention: effectiveness of interventions for male perpetrators or victims of IPVA in health settings	Narrative synthesis	Health settings	USA (10) UK (1) Norway (1) India (2)	14 studies, 9 RCTs 4 cohorts 1 case-control	effectiveness of interventions in health-care settings *was weak*, although *IPVA-psychological interventions conducted concurrently with alcohol treatment show some promise* Key limitations:

						• Most studies classified as high risk of bias • data were limited for meta-analysis due to the heterogeneity of the interventions included in the review and the variations across control groups
(42)	To assess effectiveness of interventions to reduce IPVA by men who use substances	Narrative and meta-analysis	Substance use treatment	6 USA 1 Norway 1 India 1 Netherlands	9 RCT CBT (4), CBT+MI (1) MI (4)	• Cognitive behavioral and motivational interviewing therapies were the most common approaches • Meta-analysis with integrated IPVA and substance use (SU) interventions showed no difference in SU (3 trials) or IPVA outcomes (4 trials) versus SU-treatment as usual Key limitations: • low number of trials identified and the still lower number suitable for inclusion in the meta- analysis • heterogeneity in terms of the interventions studied as well as differences in comparison groups, delivery approach, length of follow-up, and assessment methods in determining IPVA and SU behaviors

Interventions delivered in various settings (e.g., community, health, justice)

Study	Aim / question	Design	Setting	Study location	Participants / Studies	Summary of findings
(168)	Assess effectiveness of cognitive behavioural group therapy on men's violent behaviour towards their female partner	Systematic review (no meta-analysis, lack of consistent data)	Community, Mental health, Court / legal / prison	USA (3) Norway (1) Sweden (1) Spain (1)	6 studies, **RCTs (4)** Retrospective cohort (1) Quasi-experimental (1)	• 3/6 studies found a reduction in physical IPVA • All RCTs judged as poor quality • **insufficient evidence** to confirm that cognitive behavioural group therapy for perpetrators of intimate partner violence has a positive effect Key limitations: • Most studies classified as high/unclear risk of bias
(169)	Assess effectiveness of different batterer intervention programs and psychological therapies in reducing violence for male IPVA perpetrators	Meta-analysis	Court mandated (5 studies) & voluntarily seeking treatment (8 studies)	USA (10) Canada (1) Spain (1) Hong Kong (1)	13 RCTs (3)	• Significant reduction in IPVA in pre-post assessment • But interventions compared to control showed mixed effects Key limitations: • Many studies had poor methodological rigor • Majority were pre-post single group design studies • In the 13 included studies, drop-outs ranged from 3% to 41% when reported with most >24%.

Pre-post single design trials

For these pre-post single design trials, the main argument for not including a control group was that a randomized design involving a no-treatment control group was ruled out on ethical grounds.

				Certainty assessment		Average mean difference between pre-and post	Grades of Evidence	
Intervention	**Outcomes**	**No. of studies**	**No. of participants**	**Risk of Bias**	**Other consideration**		**Certainty**	**Importance**
Any intervention	IPA	10	1492	Very serious	I^2 = 87%, 95% CI 80% to 91% indicating substantial heterogeneity	Significant reduction in IPVA: -0.85, 95% CI -1.02 to -.69	Very Low	Critical
Any intervention + SUT	IPA	6	317	Very serious	Very diverse interventions	Significant reduction in IPVA: -2.14, CI -3.20 to -1.08	Very Low	Critical
Any intervention + Trauma	IPA	2	73	Very serious	Small number of studies / participants	Significant reduction in IPVA: -1.47, CI -2.63 to -0.30)	Very Low	Critical
CBT only	IPA	3	190	Very serious	Small number of studies / participants	Significant reduction in IPVA: -2.45, CI -4.12 to -0.77	Very low	Critical
CBT + MI	IPA	2	150	Very serious	Small number of studies / participants	Significant reduction in IPVA: - 3.83, CI -5.77 to -1.89	Very low	Critical
MI + SUT	IPA	2	187	Very serious	Small number of studies / participants	Significant reduction in IPVA: -1.94, CI -3.48 to - 0.41	Very low	Critical
CBT + Sex Roles	IPA	1	17	Very serious	Only one study	Significant reduction in IPVA -5.3, 95% CI -9.42 to -1.18	Very low	Critical

Notes: CBT = Cognitive Behavioural Therapy; SUT = Substance Use Treatment; MI = Motivational Interviewing
Sources of data and information: (169)

Primary trials

These trials compared two different forms of interventions, without a control group.

Study	Intervention	Control	Measures	Setting	Main findings
(43)	cognitive-behavioural group therapy (n = 67)	mindfulness-based stress reduction group therapy (n = 58)	Conflict Tactics Scale (self-report and partners' report)	outpatient health service setting	• IPVA reduction was found ***equally in both groups*** (posttreatment and at 12-months' follow up; self-report and partner report • Treatment attendance was very similar (93% Vs. 91%) Key limitations: • 25% of eligible participants refused to participate • Relatively small sample size • Only included voluntarily seeking help men • Lack of control group confounds understanding treatment effect versus time effect • *Lack of investigating mechanisms of behaviour change*
(44)	Integrating motivational interviewing strategies with cognitive-behavioral group therapy (ICBT) (n = 21)	standardized group cognitive behavioral approach (GCBT) (n = 21)	CTS2, Multidimensional Measure of Emotional Abuse	community domestic violence agency	Participant self-reports revealed significant reductions in abusive behavior and injuries across conditions with no differential benefits between conditions. Key limitations: • 14% (6) of allocated participants, dropped from trial • Small sample size derived from one agency • *Lack of investigating mechanisms of behaviour change*

Protection orders

Study	Aim / question	Design	Setting	Study location	Participants / studies	Summary of findings
(50)	To review the use and impact of protection orders for IPVA	Systematic review	Legal	21 (Australia)	63 studies Only 4 studies fit for meta-analysis (with non-random pre-post group and matched control)	• protection order reduced re-victimization (OR=0.59; CI=0.47–0.73; p<0.001); Small effect • protection order less effective for offenders with a history of crime, violence, and mental health issues. • No studies to date have examined the effectiveness of protection orders using a randomised control trial
(51)	To explore factors related to IPVA in a population of IPVA victims filing for a emergency protective order (EPO)	PhD thesis	Domestic Violence Intake Center in Louisville, KY	USA	Auditing archival data	• more EPO filings with a reported history of IPVA and/or use of controlling behaviors by the perpetrators. • perpetrators utilizing controlling behaviors were found to be more likely to have an IPVA history and to use physical violence. • reported IPVA history • nearly two-thirds of filings (N= 1776) listed the alleged perpetrator as an “Intimate partner” (31.9%; n = 566) or “Former Intimate Partner,” (32.5%; n = 577) • file audit investigation • lack of data related to socio-demographics, e.g. gender of perpetrator

Men who experience intimate partner abuse

Study	Aim / question	Design	Study location	Studies	Summary of findings
(52)	Help-seeking: understand help-seeking by male victims of domestic violence and abuse (DVA) and their experiences of support service	Systematic review (qualitative synthesis)	6 UK 4 USA 1 Sweden 1 Portugal	12 studies (all qualitative)	• barriers to help-seeking: o fear of disclosure, o challenge to masculinity, o commitment to relationship, o diminished confidence / despondency and o invisibility / perception of services; • experiences of interventions and support: o initial contact, o confidentiality, appropriate professional approaches and inappropriate professional approaches
(170)	Review current body of knowledge on male victims of domestic abuse, and implications for health visiting practice considered	Systematic (narrative)	14 (USA)	19 (most cross-sectional, surveys)	• Four qualitative themes: o Experience of abuse o Impact, harms o Risk factors (child abuse) o Seeking help (informal sources of help)
(171)	**Screening tools:** review IPVA screening instruments and approaches used to identify male victims	Narrative		Various (selective)	• Strengths of the 8 reviewed instruments included: o (a) use of gender-neutral language in item wording, o (b) screening for multiple forms of PA, o (c) assessment of frequency of violent acts, and o (d) collection of psychometric data with men

Primary studies

Study	Aim / question	Study design	Setting	Study location	Participants	Summary of findings

(53)	explores internal and external barriers to help seeking for IPVA among men	*Qualitative* (online focus group)	Community (online data collection)	Four English-speaking countries	41 men	• Internal barriers to help-seeking:
						  ○ blind to the abuse,
						  ○ maintaining relationships (keep the family intact),
						  ○ male roles (masculine stereotypes)
						  ○ excuses for partner's abuse
						• External barriers to help seeking:
						  ○ fear of seeking help and
						  ○ nowhere to go (lack of services)

(54)	explore the impact of men's experiences of IPVA in a non-help-seeking sample	*Qualitative* (anonymous, online, qualitative survey)	Community (online)	UK	161 men	• Impact of men's experiences of IPVA:
						  ○ physical and mental health,
						  ○ the development of future relationships, and
						  ○ their relationships with their children
						• societal perceptions:
						  ○ Perception of weakness,
						  ○ perceptions of men as abusers
						• barriers to help-seeking or leaving the abusive relationship
						  ○ inappropriate service responses
						  ○ further victimization from services
						  ○ Responses from Friends and Family

(172)	explore the IPVA experiences of men over 60s	*Qualitative*	Community (online)	UK	8 older man (sub-analysis of the above sample)	• Experiences if IPVA was similar to younger men • Men described abuse that included reference to age-related cognitive decline, manipulation of pensions and finances, and the longevity of the relationships and experiences
(55)	Explore men's experiences of female-perpetrated IPVA in Australia, defined as "boundary crossings	Qualitative (online survey)	Community	Australia	28 men	• Men reported experience of a range of physical, sexual, verbal, coercive controlling, and manipulative behaviors. • Male victims noted how disclosure of abuse to family and friends was variously met with shock, support, and minimization. • Participants also reported secondary abusive experiences, with police and other support services

Study	Aim / question	Study design	Setting	Study location	Participants	Summary of findings
						responding with ridicule, doubt, indifference, and victim arrest
(173)	how men, both straight and gay as well as cisgender and transgender, conceptualize, understand, and seek help related to sexual violence	Qualitative	Community	USA	32 men	• Only once participants labeled their experience as violence, did they seek help • barriers to help-seeking reported by participants included: o social (traditional gender roles and norms), o personal (shame, identity impacts), o and practical (cost, fit) barriers to support service access
(174)	case studies of cisgender men who presented to an emergency department for care after experiencing a sexual assault	Case study	Emergency department		3 cases	• Victims of sexual violence, regardless of gender, show commonalities in their victimization experiences and hesitancies in reporting or seeking health care • sexual assault nurse examiner role in providing consistent care to all sexual assault patients

Child abuse

Child abuse and associated behaviours and outcomes

Study	Aim / question	Design	Participants / Studies	Summary of findings
(58)	Assess relationship between childhood maltreatment (CM) and IPVA perpetration	Meta-analysis	63 (retrospective)	• significant positive relationship between total & subtype CM and IPA perpetration (r=0.16, p < .001) • effect size of CM on IPA perpetration was stronger for males (r = 0.20, 95% CI = 0.16 to 0.24, p < .001) than for females (r = 0.11, 95% CI = 0.09 to 0.14, p < .001) key limitations: • effect sizes are relatively small according to Cohen's standard • all studies utilized retrospective data collection
(57)	Assess risk of any type of violence following childhood maltreatment	Meta-analysis	18 (prospective)	• The overall OR of violent outcomes in childhood maltreatment was 1.8 (95% confidence interval [1.4, 2.3]) with substantial heterogeneity (I^2 = 92%) key limitations: • The most common methodological limitation, identified in eight studies, was a short duration between outcome and exposure (<10 years
(59)	Assess association between childhood maltreatment and risky sexual behaviours	Meta-analysis	19 (14 cross-sectional & 5 cohort)	• Childhood maltreatment was significantly associated with an early sexual debut (odds ratio (OR) = 2.22; 95% confidence interval (CI): 1.64–3.00), multiple sexual partners (OR=2.22; 95% CI: 1.78–2.76), transactional sex (OR = 3.05; 95% CI: 1.92–4.86) and unprotected sex (OR = 1.59; 95% CI: 1.22 2.09) key limitations: • Substantial heterogeneity (I^2 > 80%) • Mostly cross-sectional studies
(175)	Assess association between CM and treatment outcome in psychotic disorders	Meta-analysis	7	• CM was related to poorer treatment outcomes in psychotic disorders (OR = 1.51, 95% CI = [1.08, 2.10]) key limitations: • Small number of studies and no assessment of heterogeneity

Interventions and support

Study	Aim / question	Review type	Studies	Summary of findings
(60)	To summarize evidence from RCTs for interventions involving pediatric health care to prevent poor outcomes associated with adverse childhood experiences measured in childhood	Systematic review	22 (RCTs)	• Multicomponent interventions that utilize professionals to provide parenting education, mental health counseling, social service referrals, or social support can reduce the impact of ACE • Most interventions combined parenting education, social service referrals, and social support for families of children aged 0−5 years key limitations: • Publication bias detected • Narrative synthesis (despite including only RCTs)
(61)	Assess effectiveness of RCTs to prevent child abuse among mothers identified as high-risk	Systematic review	8 (RCTs)	• Only home visitation was found to have a significant evidence base for reducing child abuse, and the findings vary considerably key limitations: • While much has been written about child abuse in high-risk families, few RCTs have been performed. • Small number of studies
(62)	Assess effectiveness of ACT Raising Safe Kids Program parenting support intervention	Systematic review	13 (only 3 RCTs)	• significant increase of positive parenting and decrease of corporal punishment key limitations: • data collected exclusively on self-reports absence of control group for comparison; most pre-post single group design

Adolescent-to-Parent Violence and Abuse

The followings are program evaluations (mostly single group), utilising mixed method, though major focus is on qualitative interviews with adolescents and some parents. Key limitation includes absence of post-program data and reliance on referral numbers and number of adolescents who complete the program.

Intervention program	Objectives	Country Setting	Population	Evaluation method	Main findings	Limitations
Adolescent Family Violence Program (176)	promote positive parent–adolescent relationships and attachment strengthen parenting capacity increase safety of all family members	Australia Community (City of Ballarat, the City of Greater Geelong, and Frankston)	24 young people Sons/daughters (12–17 years old)	Mixed method	positive impact on young people and their families, leading to improved parenting capacity and parent–adolescent attachment. However, there was mixed evidence of its impact on the prevalence, frequency and severity of violent behaviours.	Very small sample size (24) Absence of post-program data Major emphasize on qualitative interviews and number of referrals to the program
Step up - Building Respectful Family Relationships (177-179)	To learn skills, alternating joint and separate work for adolescents and parents	USA Judicial (court or prison)	222 youth (71% male) completed this program during 2006 – 2013 Sons/daughters (14-18 years) Parents	Mixed method	17 participating parents reported positive effects, including decreased violent behaviours and improved parent-child relationships	Absence of follow-up data Major emphasize on qualitative interviews and demographic variables including problems outside home (e.g. school)
Break4Change Programme Responding to Child to Parent Violence (Break4Change Association, 2015)	To define acceptable limits for children Frustration control in children Emotional support for parents Communication skills for parents	UK Judicial (court or prison) / clinical	Sons/daughters (11-18 years) Parents/ Guardians		This is a resource on how to set-up a Break4Change program and it mainly focuses on the cycle of change.	No published evaluation was located so far in the search

Nonviolent resistance parenting Programme - Responding to Child to Parent Violence (Coogan & Lauster, 2015) (180)	To promote a change in parent-child relationships To encourage a change in the parent's behavior and increase their positive presence in the life of their child	UK Judicial (court or prison) / clinical	Parents/ Guardians	Mixed method	decrease in parental helplessness and escalatory behaviors, and an increase in perceived social support The children's negative behaviors as assessed by the parents also decreased significantly	This is a program of treatment for parents of children with behaviour problems. These included verbal and physical violence towards parents, but also included vandalism, lying, truancy, substance abuse, and thefts
Early intervention in Child-to-Parent Violence (Ibabe, Arnoso, Elgorriaga & Alsa, 2017 & Erostarbe et al., 2018)	To improve parent-child relationships, decreasing the violent behavior of all members of the family	Spain Child protection	Sons/daughters (12-18 years) Parents Family	Mixed method	Preliminary data indicated that adolescents showed lower levels of physical and psychological child-to-parent violence, according to the opinion of their parents	"The evaluation of this program is ongoing, and it is expected that the results derived from the evaluation will be published in the coming years" (Erostarbe et al., 2018, p. 216)

Factors associated with adolescent violence against parents

Study	Aim / question	Review type	Study location / setting	Studies	Summary of findings
(65)	Meta-analyze relationship between child-to parent violence and parent-to-child violence	Meta-analysis	Community and judicial	19	• The results showed a significantly positive, medium magnitude ($\rho = .36$) meaning true effect size for the relationship between child-to-parent violence and parent-to-child violence Key limitations: • Lack of simultaneous analysis of both child-to-parent violence and parent to-child violence, and child-to-parent violence as a predictor of parent-to-child violence • Lack of consistent measurement tools

Characteristics of adolescent violence towards parents

Study	Aim / question	Review type	Study location / setting	Studies	Summary of findings
(69)	Explore characteristics of adolescent violence towards parents	Rapid review	Various (judicial, clinical, community)	20	• Adolescents who use violence towards parents typically experience high levels of comorbid mental health concerns, drug and alcohol use, anger difficulties and trauma. • The victims (parents) are characterized as having strained relationships with other family members and trauma profiles. Key limitations: • almost a third of published research in this area is explorative or small scale
(181)	Review the known and unknowns of adolescent violence towards parents	Selective review	Various	Selective	• Parental blame is a significant barrier to any coherent understanding of the problem and to families who seek help • Approximately one in 10 family violence incidents in Australia are perpetrated by an adolescent Key limitations: • Selective review • Narrative synthesis of findings with insufficient information about included studies

Interventions and support

Study	Aim / question	Review type	Study location / setting	Summary of findings
(182)	To review interventions for child-to-parent (CPV) violence (specific focus on children aged 10-12)	Narrative (selective) review	Not specified	• early-onset CPV users (10 and 11 years old) may be more likely to be reward dominant (less likely to learn from punishments or aversive conditioning efforts; these are classical conditioning theories), insensitive to punishment, and show deficits in emotion recognition • possess callous–unemotional (CU) traits and use proactive aggression (CU defined as a lack of guilt and empathy, as well as the unsympathetic use of others for personal gain (Frick & White, 2008) • interventions facilitating younger CPV users should consider programmes which are longer in duration, reward-based, and target empathy development, parental warmth, and mentalizing skills. Key limitations: • Selective review • Review methodology not specified
(183)	review of the programs of intervention in child-to-parent violence or similar programs with evidence of their efficacy	Scoping review	Various (judicial, clinical, community)	• A number of programs have been found of intervention treatment in child-to-parent violence, but they do not have consistent evidence of their efficacy. Key limitations: • Most included studies had small sample sizes with pre-post design with parents and their children

Assessment of adolescent-to-parent violence

Study	Aim / question	Review type	Study location / setting	Participants / studies	Summary of findings
(72)	To review assessment tools of child-to-parent violence	Scoping review	Most in community samples (1 judicial)	23 articles describing 6 instruments	Only Six self-administered instruments identified: • Child-to-Parent Aggression Questionnaire (CPAQ); • Reactive-Proactive Aggression Questionnaire (RPQ); • Child-Parent Conflict Tactics Scales (CP-CTS); • Intra-family Violence Scale (IVS); • Violent Behavior towards Authority Figures Scale (VAFS); • Child-to-Mother Violence Scale (CMVS) Key limitations: • Selective review • Only 3-instruments had some psychometric analysis (CTS, IVS and VAFS) • significant variety when defining and measuring CPV types

Qualitative primary studies

Study	Aim / question	Design	Study location / setting	Participants	Summary of findings
(184)	explores child-to-parent violence (CPV) in the UK based on the accounts of adolescents who exhibit this type of family violence	Qualitative (Interviews)	UK Community	8	• Results suggest that CPV is linked with adverse childhood experiences (ACEs), unsatisfactory relationships with parents, perceived emotional rejection from parents, and emotional dysregulation in young people Key limitations: • Small sample size

Study	Aim / question	Design	Study location / setting	Participants	Summary of findings
(185)	To explore youth aggression and violence against parents	Qualitative (interviews)	UK Independent Domestic Abuse Services	Young people (n=2) Mothers (n=3) Practitioners (n=5)	• Young people could be both victim and perpetrator. • The witnessing or experiencing of domestic aggression and violence raised the concept of 'bystander children'. • The impact of young people experiencing familial violence was underestimated by parents Key limitation: • Small sample size
(186)	explore how effective is the use of third-party resolution in adolescent to parent abuse	Qualitative (interviews)	Afro-Trinidadian descent Community	9 third-party interveners and 4 families (adolescents, age range 13–16 years)	• Some parents and third-party intervener's concurred that the adolescent aggressive behavior was in relation to experiencing abuse in the home; adolescent aggressive behavior was replicated by acting out what they witnessed their fathers displaying • Single parent mother households have a higher risk to be assaulted by adolescence • All parents responded that the persistence of conflict every day in the home was overbearing and felt the adolescent had no remorse to their actions Key limitation: • Small sample size

Quantitative primary studies

Study	Aim / question	Design	Study location / setting	Participants	Summary of findings
(68)	Investigate relationship between child exposure to IPVA and child abuse and adolescent-to-parent violence (APV)	Cross-sectional survey	South Korea Subset of Nationwide Survey of Domestic Violence in South Korea	709 (56% girls); Mean age 16.34 (SD = 1.3)	• child abuse victimization is significantly associated with APV, but peer attachment significantly buffers the negative effect of child abuse on APV • School counseling programs can help reduce adolescents' violent behaviors towards their parents by promoting positive peer relationships and peer bonding

					Key limitations: • No causal relationship due to cross-sectional research design • Use of non-probability sampling may reduce generalisability of findings. • No data on adolescent mental health status
(74)	address how multiple risk factors could explain child-to-mother and child-to-father violence	Cross-sectional	Spain offender residents of specialized closed institutions	298 (140 girls) mean age of 15.91 (SD= 1.89	Contextual (exosystem) level: • peer deviance was indirectly related to both types of CPV Family level (microsystem): • the strongest direct predictor was parental ineffectiveness in applying discipline & use of corporal punishment. Individual level (ontogenic): • strongest direct predictors were adolescents' impulsivity and substance abuse Key limitations: • self-reports of adolescents • non-representative sample
(66)	examine the role of social cognitive processing in the relation between violence exposure at home and child-to-parent violence	Cross-sectional	Spain	1,624 (54.9% girls) Mean age 14.7, SD = 1.7 years)	• exposure to violence at home is related to dysfunctional components of social-cognitive processing, • Anger, hostile attribution positively related to child-to-parent violence motivated by reactive reasons Key limitations: • Only adolescent data (no parent report) • No causal relationship due to cross-sectional design
(71)	analyze the relationships between child-to-parent violence (CPV) and the attitude towards authority, social reputation and school climate	Cross-sectional	Spain School	2101 (49.9% girls) Age 13 to 18	Adolescents with high CPV presented: • lower values of positive attitude towards institutional authority and school climate (involvement, friendships and teacher's help), and • higher values of positive attitude towards the transgression of social norms and of perceived and ideal non-conformist social reputation

					Key limitations: • No causal relationship due to cross-sectional design
(70)	analyze the role of minors' impulsiveness in the perpetration of child-to-parent violence	Cross-sectional	School	934 (496 girls) Mean age = 16.07; SD = 1.33	• Attentional ($\beta = .09$, $p < .05$; $\beta = .12$, $p < .001$) and motor impulsiveness ($\beta = .26$, $p < .001$; $\beta = .25$, $p < .001$) were related to the perpetration of CPV Key limitation: • correlational design precludes any causal interpretations. • the retrospective nature of this study involves a bias risk in the participants' memory
(187)	Explore relationship between childhood adversity, attachment, and internalizing behaviors in a diversion program for child-to-mother violence	Cross-sectional	Diversion (judicial) program	80 (48% girls) Mean age = 15 (SD = 1.55)	• insecure attachment predicted depression among females ($F(6, 73) = 4.87$, $p < 0.001$), and previous experience with child maltreatment and/or witness to parental violence predicted anxiety among females ($F(6, 73) = 3.08$, $p < 0.01$) key limitation: • small convenience sample

Notes: IPA = Intimate Partner Abuse; APV = Adolescent-to-parent violence

Adult survivors of rape and sexual assault in adulthood

Reference	Aim / question	Design	Study location / setting	Participants / studies	Summary of findings
(90)	Assess what psychosocial interventions work for victim/survivors of a recent sexual assault.	Systematic review (narrative synthesis)	Health (3) Forensic medical (4) Community (3)	10 studies evaluating 13 interventions. (2 RCTs)	The evidence is *sparse and scientifically weak*, common flaws are reviewed. There is some *weak evidence* for the impact of video and cognitive behavioural therapy (CBT) based interventions, especially trauma processing. Key limitations: • poor methodological quality (e.g. lacked a comparison, a wait list control or treatment intensity varied between comparator conditions • most studies did not report random allocation or blinding method (challenge)
(92)	Assess effectiveness of mental health interventions for adult female survivors of sexual assault	Systematic review (narrative synthesis)	USA (8) Spain (1) Health-clinic /care (8) University (1)	9 studies evaluating 10 interventions. (7 RCTs)	• no psych treatment was more effective than another: o *Cognitive-behavioral interventions,* o *exposure interventions, and* o *eye movement desensitization and reprocessing interventions* were typically more effective at improving mental health than no treatment Key limitations: • generalizability to survivors not in care may be limited poor study quality in terms of external validity and small sample size (power)

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