A brief guide to intimate partner violence and abuse

July 2015

Dr Eileen Scott,
Public Health Adviser
Evidence for Action

Contents

1   Introduction

This briefing is one of an occasional series which explore topics of current interest and provides an introduction to concepts and current thinking.

From adolescence and early adulthood, intimate partner violence and abuse cuts across all levels of society and can affect everyone. However, it is clear from the evidence that the vast majority of those experiencing intimate partner violence and abuse are heterosexual women, and those perpetrating it are heterosexual men. It is important to recognise that men can, and do, also experience violence and abuse in both heterosexual and same-sex relationships, and that women may be perpetrators. Nonetheless, the degree and severity of violence, particularly sexual violence, perpetrated against women within intimate relationships is greater. Whilst we know that women are disproportionately affected by intimate partner violence and abuse, it remains that the majority of incidents are unreported and unrecorded. Furthermore, the impact of intimate partner violence and abuse can be far reaching, affecting the next generation. Children exposed to intimate partner violence and abuse, whether or not they are directly abused, are more likely to either experience or perpetrate as adults.

> 'Violence against women is not a small problem that only occurs in some pockets of society, but rather is a global public health problem of epidemic proportions, requiring urgent action'
> (World Health Organization (WHO), 2013, p5)

This briefing looks at the scale of the problem of intimate partner violence and abuse against women, at how we can explain and understand the underlying causes, and at the impact that it has. It also draws upon scientific evidence for ways to effectively prevent, identify and reduce intimate partner violence and abuse. The interventions discussed may, where highlighted, also be applicable for violence perpetrated on men and those in same-sex relationships. This briefing also covers interventions to support children exposed to intimate partner violence and abuse.

Executive summary

The scale of the problem

- Globally, the lifetime prevalence of physical and sexual intimate partner violence and abuse for women is around 30%, information about levels of psychological violence is lacking at a global level.
- A recent European study reports:
  - That, across Europe, an average of 22% of women report experiencing physical and/or sexual violence and that 43% have experienced psychological abuse from the age of 15.
  - The reported rate of physical and/or sexual violence in the UK was 29% and psychological abuse 46%. 80% of the UK sample believed that violence against women in the UK was common.
  - Inequality in financial decision-making is linked to psychological abuse. 58% of women across Europe who did not feel that they had an equal say in household finances experienced psychological abuse compared to 22% of women who believed that they had an equal say.
  - Women were most likely to contact healthcare services about the most serious incident of abuse they had experienced.
  - In the UK, 25% of women had reported the most serious incident of intimate partner violence and abuse. 75% of women made no contact with any services.
- In Scotland in 2012/13, 60,080 incidents were reported to police. Of these, 80% were reported as a female victim and male perpetrator.

The health impact

- Intimate partner violence and abuse can have a significant effect on women's physical, psychological, sexual and reproductive health.
- Globally, 38% of murders of women are committed by their intimate partners, compared to 6% of male murders.
- In Scotland, over the past 10 years 52% of women murdered were killed by their partner or ex-partner compared to 7% of male murders.

- 42% of women who have been physically and/or sexually abused by their partners have experienced injuries as a result of that violence.

- There is an association with: HIV infection; sexually transmitted infections; induced abortion; low birth weight; premature birth; intrauterine growth restriction/babies that are small for gestational age; alcohol use; depression and suicide; injuries; and death from homicide.

- Other health outcomes believed to be associated with intimate partner violence and abuse include: adolescent pregnancy; unintended pregnancies; miscarriage and stillbirth; intrauterine haemorrhage; nutritional deficiency; abdominal pain/GI problems; neurological disorders; chronic pain; disability; anxiety and PTSD; as well as non-communicable diseases including hypertension, cancer and cardiovascular disease.

- Pathways between intimate partner violence and abuse and poor health outcomes may be direct, for example, between physical assault and injury or indirect by increasing exposure to risk i.e. unprotected sex.

- Intimate partner violence and abuse is linked to adverse health and development outcomes for children exposed to it.

The causes of intimate partner violence and abuse

Intimate partner violence and abuse against women is believed to be the outcome of a dynamic interaction of risk and protective factors that range from broad social factors to individual risk factors. This can be understood by using an explanatory ecological model (WHO, 2010).

Globally, two factors related to gender inequality are strongly associated with intimate partner violence and abuse:

1 The unequal position of women in relationships and society – violence occurs at higher levels in societies in which men are viewed as superior and possess the economic and decision making power.
2 Social norms supporting violence as a means of conflict resolution.

These are reflected in the gender roles and behaviours that a society regards as appropriate for men and women.

Societal-level factors include systems where men are socially, economically, politically and religiously superior to women. These gender norms have an impact on women's roles and access to resources, and involvement in decision-making at all levels.

At a **community** level:
- Societies with the lowest levels of intimate partner violence and abuse are those with the strongest community sanctions against it. Acceptance of violence is linked to higher levels of intimate partner violence and abuse.
- Women living in poverty are disproportionately affected, however, intimate partner violence and abuse occurs at all levels of society,
- Increasing women's access to education, resources and decision-making is associated with lower levels of intimate partner violence and abuse.

At a **relationship** level:
- Men with multiple sexual partners are more likely to perpetrate intimate partner and sexual violence.
- Educational disparity within a relationship can be linked to higher levels of intimate partner violence and abuse, especially where women possess a higher level of education than their partner.
- Lack of marital/relationship satisfaction and high levels of conflict are associated with higher levels of intimate partner violence and abuse.
- Disputes over traditional gender roles.

Individual level factors include:
- Young age is a risk factor for being either a victim or perpetrator of intimate partner violence and abuse.
- Similarly, a low level of education is linked to both perpetration and victimisation.

- Women who have previously been abused are more likely to experience abuse in the future.

- There is a strong risk of future perpetration among men who have previously perpetrated intimate partner violence and abuse.

- There is also a strong association between being exposed to, or experiencing, abuse as a child and perpetration as an adult.

- Women exposed to violence in childhood are more likely to be abused in adulthood.

- There is an association between antisocial personality characteristics and intimate partner violence and abuse perpetration but more evidence is needed to establish that this is causal.

- There is a strong association between harmful levels of alcohol use and perpetration and victimisation. However, the evidence that this is causal is weak – suggesting that alcohol may exacerbate abusive behaviour in a relationship where it already exists.

- Men who believe that using abusive behaviour in a relationship is acceptable are more likely to perpetrate.

- Women who believe that abusive behaviour is acceptable are more likely to be subject to it.

Prevention

Overall, it is difficult to determine if preventative interventions have any impact on levels of future violence and abuse. The outcomes of studies are often limited to the impact of interventions on attitudes or educational change rather than any impact on behavioural outcomes. This is in part due to the challenges of assessing domestic abuse outcomes at a community level.

Most interventions focus on young people, with the aim of preventing violence or abuse before it occurs. However, the key time point for effective delivery of primary preventative interventions remains to be identified. Interventions aimed at adults have tended to be media or awareness-based campaigns, but the evidence for these is inconsistent – some interventions have been effective and others haven't.

Identifying intimate partner violence and abuse

It isn't possible to recommend the single most effective assessment tool for identifying violence and abuse. However, a tool that asks whether someone has experienced specific acts of violence and abuse over a defined period of time seems to be better at identifying abuse than simply asking whether or not someone is being abused.

All formats of screening, including self-report and computer-based assessment, appear to be acceptable, with no clearly preferable format. Cueing healthcare providers to further assess risk using assessment outcomes can improve identification and disclosure.

From the evidence reviewed, it isn't possible to develop an optimal training programme for staff that results in increased identification rates, but organisational policy or change measures that promote screening can have a positive impact on identification and onward referral.

Finally, universal screening or routine enquiry during pregnancy has been found to have a positive impact on identification rates in the evidence considered.

Interventions for those experiencing intimate partner violence and abuse

A range of interventions have been shown to have a positive effect on outcomes for women experiencing intimate partner violence and abuse. Advocacy, a diverse range of skill-building, counselling and therapeutic interventions can improve a range of outcomes (including reducing rates of intimate partner violence and abuse, increased safety, improved mental health and wellbeing, improved pregnancy and child outcomes and increased access to community resources).

Many of the studies included feature samples of women recruited from shelters who are already accessing support. These represent a small minority of women who experience intimate partner violence and abuse and may have an impact on levels of effectiveness.

More evidence is needed about the effectiveness of interventions with more diverse populations of those experiencing abuse and interventions tailored to women from specific equalities groups, such as those with disabilities and/or from ethnic minorities. There is an absence of evidence about interventions to address 'honour'-based violence against women or forced marriage.

Interventions for perpetrators

Taken together, these findings suggest that no single intervention has been clearly and definitively associated with consistent long-term, positive impact on violence or reoffending outcomes. There are some promising interventions, such as cognitive behaviour therapy (CBT), substance misuse treatment and couples interventions, but more, and robust, evaluation of these is urgently needed.

There is a lack of evidence around family interventions and interventions solely focused on reducing psychological violence. The difficulty in achieving sustained changes to outcomes highlights the need to strengthen efforts to prevent violence and abuse before it occurs.

Emerging evidence about the effectiveness of perpetrator programmes embedded as part of a coordinated community response is encouraging. This evidence is discussed in Section 6 (page 42), which looks at how effective partnership approaches for assessing and responding to intimate partner violence and abuse are.

Interventions for children exposed to intimate partner violence and abuse

Overall, there is evidence that interventions for children who have been exposed to domestic abuse can be effective in improving both children's behavioural and emotional outcomes and the outcomes of their mothers. Those single-component interventions which are targeted at both mothers and their children are more beneficial than those which target children alone. These interventions included mother–child therapy, a shelter-based parenting intervention, psycho-education and play/activity based therapies.

Similarly, a number of multi-component interventions have highlighted that benefits to children are linked to improved outcomes for their mothers, suggesting the value of a family approach. These include: multi-component interventions that focus primarily on advocacy; interventions that include both therapy and advocacy; resilience-building; and interventions that combine therapy and parental skills, training and support.

Evidence about the effectiveness of population-based or preventative approaches is lacking.

2 Definitions

The terms violence against women, domestic violence, domestic abuse, intimate partner violence and gender-based violence are often used interchangeably. There are, however, some differences in what these describe.

Gender-based violence

Gender-based violence is violence that is directed at an individual based on his or her biological sex, gender identity or perceived adherence to socially defined norms of masculinity and femininity. The United Nations Declaration on the Elimination of Violence against Women (1993) describes violence against women as:

> 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life'.
> (Article 1)

This incorporates many forms of abuse that occur throughout the life cycle, including within the family and within communities. Types of gender-based violence include: rape and sexual assault; sexual harassment and intimidation at work and other settings; childhood sexual abuse; domestic abuse; stalking; harmful traditional practices such as early and forced marriage, so-called 'honour' based violence and female genital mutilation; sex trafficking; and commercial sexual exploitation.

The **Istanbul Convention** provides the following definitions of violence against women and domestic violence.

Violence against women

> 'Violence against women is understood as a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life'
> (p8, Istanbul Convention 2011)

Domestic violence

> 'domestic violence shall mean all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim'
>
> (p8, Istanbul Convention 2011)

This definition takes account of both intimate partner violence, where the violence occurs between current of former spouses or partners, and intergenerational violence within the family (such as, violence against children or elderly family members).

Definition used in this briefing

This briefing looks specifically at domestic abuse against women when the perpetrator is a current or previous partner (whether or not they share the same home). The term intimate partner violence and abuse is used throughout.

3   The scale of the problem?

Data on levels of violence against women has, until very recently, been sadly lacking. The World Health Organization (WHO, 2013) suggests that the best way to measure women's exposure is through household surveys that take measures to protect women's safety.

Global prevalence of intimate partner violence and abuse

In 2013, the WHO published a systematic review of the prevalence and health effects of both physical and sexual intimate partner violence and abuse (WHO, 2013). Psychological intimate partner violence and abuse was excluded due to a lack of data.

Globally, the lifetime prevalence of women who have experienced physical or sexual intimate partner violence and abuse is around 30%. The prevalence of intimate partner violence and abuse (physical and sexual) is highest in the central sub-Saharan Africa region (65.64%). In contrast, the lowest reported prevalence is in East Asia (China and North Korea) at 16.3%. In other WHO regions, between one-quarter and one-fifth of women have experienced physical or sexual violence from a partner – Western Europe (19.3%), North America (21.3%), Central Asia 22.9% and Southern Latin America (23.7%). All remaining Global Burden of Disease regions have a prevalence of over 26%.

Prevalence of exposure to intimate partner violence and abuse progressively rises from woman aged 15–19 years (29.4%) to 40–44 years (37.8%) before tailing off. However, less is known about levels of violence against women over the age of 50, particularly in low and middle income nations, due both to a lack of evidence and more limited data points for this cohort.

European prevalence

Highlighting violence as a critical area of gender equality, the first European Gender Equality Index (European Institute for Gender Equality, 2013) included gender-based

violence as a satellite domain of the index. This domain remained empty due to the lack of data.

However, a recent study published by the European Union Agency for Fundamental Rights on violence against women (European Union Agency for Fundamental Rights (FRA), 2014) provides greater clarity. This study is based on interviews with a randomised sample of 42, 000 women aged 18–74 from across the 28 Member States of the European Union. A minimum 1,500 women were interviewed from each EU State, with the exception of Luxembourg (n=908). Asking respondents direct questions about their experience of specific behavioural acts of violence and abuse over a defined period of time is regarded as the gold standard method for estimating prevalence of violence (WHO, 2013) rather than using more generic questions about whether they have been abused or have experienced domestic violence.

Women were asked about their experience of physical, sexual and psychological violence, including intimate partner violence and abuse (domestic violence or abuse) and also stalking, sexual harassment and the role of new technology in their experience of abuse. The study also asks about the experience of violence in childhood. Of note, the survey sample did not include women in institutionalised settings. It is plausible that it, therefore, underestimates the level of violence as previous or current abuse may disproportionately affect women living in these settings.

The results of this study suggest that experience of abuse is extensive but systematically underreported throughout the EU, affecting the lives of many women. There is a strong correlation between the levels of partner and non-partner violence within a country. Of note, Member States scoring higher on the gender equality index also tend to have higher prevalence of intimate partner violence and abuse, explanations for this are beyond the findings of the study.

Intimate partner violence and abuse – physical and sexual

22% of women across Europe report experiencing physical or sexual violence from a current or previous partner since the age of 15. Rates range from 30–32% in

Finland, Denmark, and Latvia to 13% in Austria, Croatia, Poland, Slovenia and Spain. Within the UK, the reported rate of physical or sexual violence was 29%. There is not a lot of variation between European states in terms of the experience of physical and sexual violence from a current or previous partner within the past 12 months.

The most common forms of violence were pushing or shoving, slapping or grabbing, or pulling a woman's hair.

Intimate partner violence and abuse – psychological

Levels of psychological abuse have been studied less than physical violence. Psychological abuse includes controlling and coercive behaviours that reduce freedom and result in micro-management of everyday life:

Controlling behaviour describes a range of acts designed to make a person subordinate and/or dependent by: isolating them from sources of support; exploiting their resources and capacities for personal gain; depriving them of the means needed for independence, resistance and escape; and regulating their everyday behaviour.

Coercive behaviour describes an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim (NICE, 2013)

In this study, 43% of women across Europe have experienced some form of psychological abuse by an intimate partner (current or previous) since the age of 15. This includes psychologically abusive behaviour and other forms of psychological violence, including controlling behaviour, economic abuse and blackmail. At a state level, levels range from 60% of women in Denmark and Latvia to 30% in Ireland, Greece and Spain. Since the age of 15, almost half of the women (46%) in the UK sample reported experiencing some form of psychological abuse from any partner (15% within their current relationship).

What form does psychological abuse take?

Across Europe, 35% of women reported experiencing controlling behaviour[1] (16% within their current relationship). 32% indicated that they had experienced psychologically abusive behaviour[2] toward them (15% in their current relationship). The most common forms of psychological abuse were belittling/humiliating in private, insisting on knowing where she is going beyond general concern and being angry if she talks to another man or woman (if respondent had a female partner).

A majority of women who experienced four or more forms of psychological abuse were also likely to indicate that their partner had been physically or sexually violent against them (58%).

Economic violence

Preventing a woman from shopping independently or from working outside the home are considered forms of economic abuse, a subcategory of psychological abuse. In total, 5% of women have experienced this form of abuse within their current relationship and 13% within a previous relationship. This survey also asked women if they had an equal say in how household income is used – 58% of women who did not feel that they had an equal say experienced psychological abuse from their current partner compared to 22% of women who felt that they had an equal say.

Attitudes and awareness

Overall, 79% of women interviewed across the EU believed that intimate partner violence and abuse against women in their country is very common or fairly common. These findings correspond with the results of the Special Eurobarometer

---

[1] Trying to keep the respondent from seeing her friends or visiting her family or relatives, insisting on knowing where she is, getting angry if she speaks to other men (or women), suspecting her of being unfaithful.

[2] Belittling or humiliating the respondent in public or private, forbidding her to leave the house or locking her up, making her watch pornographic material against her wishes, scaring her or intimidating her on purpose, threatening her with violence or threatening to hurt someone else the respondent cared about.

344 (2010). 80% of the UK sample perceived intimate partner violence and abuse against women as commonplace in the UK.

Knowledge of other women

Another indirect measure of intimate partner violence and abuse is to ask women if they know anyone else who has experienced violence. 39% of women know someone in their family or a friend that has been a victim of intimate partner violence and abuse. Women in Finland (56%), France (52%), Lithuania (49%), Sweden (47%), Luxembourg and the UK (47%) are most likely to know someone.

According to the 2010 Special Barometer, the proportion of men and women who know a victim of domestic violence has increased by 6% in 10 years. The highest growth was in Belgium, Luxembourg and Sweden.

Contact with police and other services

Across Europe, women were most likely to contact healthcare services (a hospital, doctor or other healthcare provider), followed by reporting the incident to police. Two-thirds of women did not make any contact with any services in connection with the most serious incident of abuse experienced.

In Member States, the highest rates of reporting of the most serious incident of partner violence to police were in Luxembourg (31%), Lithuania (30%), Malta, Poland and Ireland (28%). The lowest levels were reported in Denmark, Finland, Estonia and Slovakia (12%). The rate of reporting is higher for the most serious incident of sexual violence, with 39% of women contacting services. Only 4% of victims report using victim support; a similar level report using a women's shelter. Levels of reporting, specifically, in the UK were 25%. As intimate partner violence and abuse is likely to involve repeated incidents, reporting is likely to occur only after a series of violent incidents. Taken together, these figures suggest that the majority of women who are victims of partner violence do not come to the attention of service providers and the majority of incidents are unrecorded.

Scotland

It is unclear what percentage of those taking part in the European FRA (2014) study in the UK were Scottish. It isn't, therefore, possible to extract figures from this study about levels of intimate violence and abuse in Scotland alone. However, the study was designed so that every eligible female resident of the UK had the same chance of being included, so its findings remain generalisable to Scotland.

In Scotland, our understanding of national levels of intimate partner violence and abuse are largely limited to crime and justice statistics, based on the number of incidents of domestic abuse recorded by police.

The latest available statistics measuring the number of incidents of domestic abuse recorded by police in Scotland (Scottish Government, 2013) highlight:

- There has been an increasing trend in recorded incidents of domestic abuse from 41,235 in 2003–04 to 60,080 incidents 10 years later in 2013–14.
- 80% of incidents in 2012–13 had a female victim and a male perpetrator.
- 94.4% of sexual offences were perpetrated by men against women.
- 44%[3] of incidents involved an ex-partner or ex-spouse.
- 61%[4] (31,397) involved victims who had previously experienced domestic abuse.
- Most incidents occurred within the home (87%)
- Half of all incidents led to the recording of a crime or an offence (30,259) and of these, 78% were reported to the procurator fiscal (23,606).
- The most common offense recorded was common assault, accounting for 42% of offences. Threatening or abusive behaviour was the second most common offence.
- A total of 248 sexual offenses were recorded, including 159 incidents of rape.

---

[3] Where relationship status was recorded.
[4] For incidents where information regarding repeat victimisation of domestic abuse was available.

However, as seen in the FRA (2014) study, only a fraction of even the most serious incidents are likely to be reported to police. Reported incidents may be recorded in different ways. For example, historically, some Scottish police forces would not record an incident if no further action was to be taken, for instance, if the victim does not wish it to proceed. This means that this data should be treated with caution as provides an underestimate of levels of intimate partner violence and abuse in Scotland.

Homicide rates can also provide useful indicators of overall violence in a society and the most severe outcome of intimate partner violence and abuse. Recent statistics highlight that, over the past 10 years, levels of homicide have declined in Scotland with a rate of 11 victims per million of the population. Overall, the murder rate for men is three times higher than for women at 18 per million of the population compared to 5 per million of the population. Although the murder rate is much lower for women, proportionately women are more likely to be murdered by a partner or ex-partner. Men are more likely to be murdered by an acquaintance. 52% (n=92) of women murdered in Scotland were killed by their partner or an ex-partner. In contrast 7% (n=48) of male murder victims in this period were killed by their partner or ex-partner (Scottish Government, 2014).

4 The health impact of intimate partner violence and abuse

Intimate partner violence and abuse can have a significant effect on women's physical, psychological, sexual and reproductive health. There is an association with the following health outcomes: HIV infection; sexually transmitted infections; induced abortion; low birth weight; premature birth; intrauterine growth restriction/small for gestational age; alcohol use; depression and suicide; injuries; and death from homicide (WHO, 2013). Key findings from the WHO systematic review highlight:
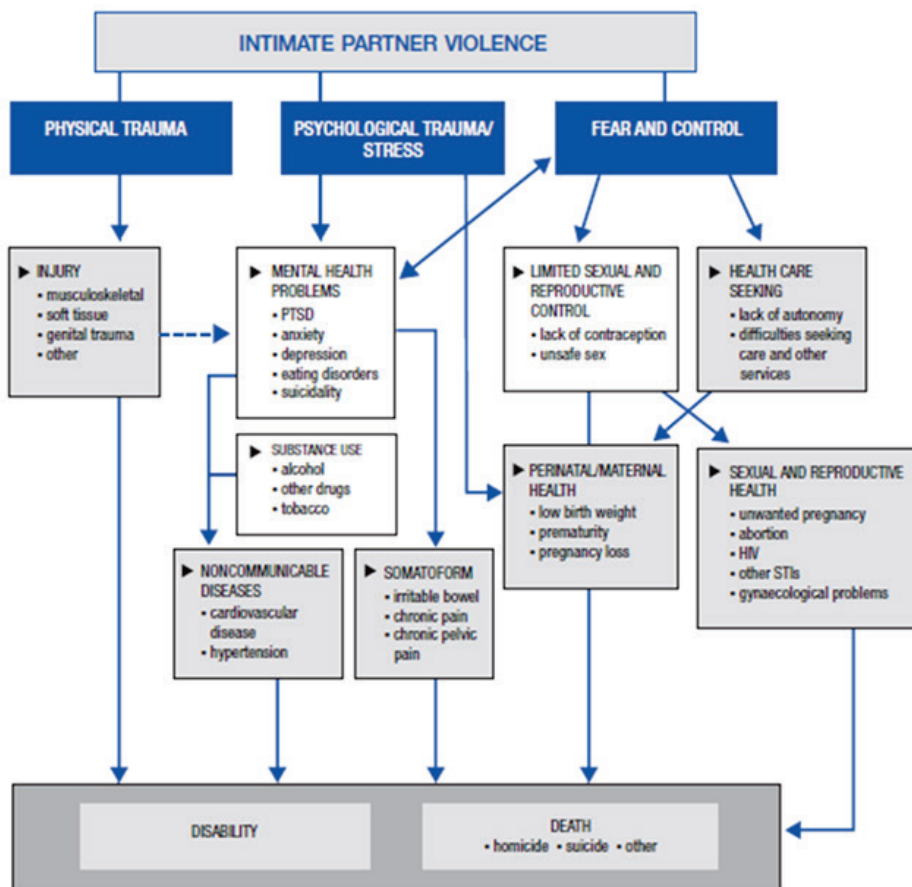
- 38% of murders of women are committed by their intimate partners compare to 6% of male murders. 38% of all murders of women are committed by intimate partners compared to 6% of all male murders.
- 42% of women who have been physically and/or sexually abused by their partners have experienced injuries as a result of that violence:
  - Women who have experienced intimate partner violence and abuse have higher rates of a range of health problems.
  - They are twice as likely to experience depression.
  - They are twice as likely to have an induced abortion.
  - They are at 16% greater odds of having a low birth weight baby.
  - At a global level, women in some regions (e.g. sub-Saharan Africa) are more than 1.5 times more likely to develop an HIV infection, 1.6 times more likely to develop syphilis and 1.8 times more likely to become infected with chlamydia or gonorrhoea.
  - They are 1.8 times more likely to develop an alcohol use disorder.
  - Data from a limited number of studies suggests that women who experience intimate partner violence and abuse are almost five times as likely to attempt suicide.

Whilst the WHO paper describes the extent of the association between intimate partner violence and abuse and a range of health outcomes, they highlight that these findings do not consider all health outcomes believed to be associated with intimate partner violence and abuse. These include: adolescent pregnancy; unintended

pregnancies; miscarriage and stillbirth; intrauterine haemorrhage; nutritional deficiency; abdominal pain/GI problems; neurological disorders; chronic pain; disability; anxiety and PTSD; as well as non-communicable diseases including hypertension, cancer and cardiovascular disease. Additionally, intimate partner violence and abuse is linked to adverse health and development outcomes for children exposed to it.

The relationship between intimate partner violence and abuse and health outcomes is complicated and the evidence has largely been informed by cross-sectional rather than longitudinal studies, so causality is inferred rather than conclusively proven (Figure 1, WHO, 2013). Pathways between intimate partner violence and abuse and poor health outcomes may be direct, for example, between physical trauma and injury or disability or indirect by increasing exposure to risk i.e. unprotected sex, other risky behaviours, and prolonged elevated stress or increase in turn, increasing health risk.

Figure 1: Pathways and health effects on intimate partner violence and abuse

INTIMATE PARTNER VIOLENCE

PHYSICAL TRAUMA

PSYCHOLOGICAL TRAUMA/ STRESS

FEAR AND CONTROL

▶ INJURY
- musculoskeletal
- soft tissue
- genital trauma
- other

▶ MENTAL HEALTH PROBLEMS
- PTSD
- anxiety
- depression
- eating disorders
- suicidality

▶ LIMITED SEXUAL AND REPRODUCTIVE CONTROL
- lack of contraception
- unsafe sex

▶ HEALTH CARE SEEKING
- lack of autonomy
- difficulties seeking care and other services

▶ SUBSTANCE USE
- alcohol
- other drugs
- tobacco

▶ PERINATAL/MATERNAL HEALTH
- low birth weight
- prematurity
- pregnancy loss

▶ SEXUAL AND REPRODUCTIVE HEALTH
- unwanted pregnancy
- abortion
- HIV
- other STIs
- gynaecological problems

▶ NONCOMMUNICABLE DISEASES
- cardiovascular disease
- hypertension

▶ SOMATOFORM
- irritable bowel
- chronic pain
- chronic pelvic pain

DISABILITY

DEATH
- homicide • suicide • other

There are multiple pathways through which intimate partner violence can lead to adverse health outcomes. This figure highlights three key mechanisms and pathways that can explain many of these outcomes. Mental health problems and substance use might result directly from any of the three mechanisms, which might, in turn, increase health risks. However, mental health problems and substance use are not necessarily a precondition for subsequent health effects, and will not always lie in the pathway to adverse health.

The FRA study (2014) also gives us further information on the psychological impact of physical or sexual violence. Women who reported the experience of violence were asked further questions about short-term emotional impact and longer-term psychological consequences.

There is little difference in the short-term emotional responses of women who have experienced intimate partner violence and abuse and those who were victims of non-partner violence. However, women who experience sexual violence are more likely to feel shame, embarrassment, guilt and fear in the short term.

Long-term psychological consequences including anxiety, feelings of vulnerability, loss of self-confidence and difficulties in relationships have been reported. These are more common among women who have experienced intimate partner violence and abuse compared to non-partner violence, especially if intimate partner involved sexual violence. This may reflect the repeat victimisation of women within the context of intimate partner violence and abuse and the association with multiple forms of violence including psychological abuse.

Impact on children

The evidence tells us that exposure to intimate partner violence and abuse can have a negative impact on infant and child health on a broad range of health and wellbeing outcomes in comparison to those children who had not witnessed abuse (NICE, 2013).

There is a lack of consistency regarding the term exposure, this can include children who are witness to, or directly experience abuse. It also encompasses a spectrum from one-off incidents to chronic, recurring exposure. This can include:

- overhearing abuse
- observing abuse or the consequences of abuse
- intervening during abuse
- being held 'hostage' by perpetrator of abuse.

The type and duration of exposure may have an impact on the child's response to the experiences. It is important that outcome data and interventions provide information on the form and duration of exposure. Consequently accurately measuring the outcomes of exposure is also complex.

In infants, exposure is associated with poor health, sleep, excessive crying and screaming. In children it is associated with a range of difficulties including increased levels of fear, anxiety, stigma, aggressive behaviours, sleeping problems and poor social competence, verbal skills and school performance.

In adolescence, exposure to intimate partner violence and abuse in childhood is associated with mental health issues including anger, depression, fear and suicidal thoughts.

Finally, in adulthood there greater rates of depression and experiences of being either a victim or perpetrator for those exposed to domestic abuse in childhood. There is mixed evidence regarding the differential impact of exposure to violence on boys and girls. The evidence suggests that boys are more likely to demonstrate behaviours that are directed externally and harmful to others, e.g. aggression and socially disruptive behaviours.

However, a significant minority of children continue to do as well as other children suggesting resilience effects. It is important not to make assumptions about the wellbeing of children exposed to abuse. The NICE (2013) review highlights the importance of recognising the ability of mothers and children to recover when they have access to a safe place.

The following factors are highlighted as protective:

- self-esteem
- self-efficacy
- the availability of a supportive adult/parent
- friendships and community support.

The following are highlighted as increasing risk:

- co-existing parental mental health issues
- parental substance misuse
- co-occurrence of direct experience of abuse or neglect.

The specific contribution of risk and protective factors to children's health outcomes has not been clarified, due in part to the complexity of the interaction between these and the consequent ability to study these. There are issues regarding separating exposure from direct experience of abuse or neglect. Samples are often biased by studies being undertaken among women and children is shelters, not the wider population studies.

5   Understanding the causes of intimate partner violence and abuse

The following model and underpinning evidence is derived from the work of the World Health Organization/London School of Hygiene and Tropical Medicine (*Preventing intimate partner and sexual violence against women: taking action*, 2010). This model takes a socioecological perspective for understanding and explaining intimate partner violence and abuse. The majority of the following evidence on risk factors comes from studies undertaken in high income countries. However, the extent to which these factors apply in low and moderate income countries is unclear. Fewer risk factors have been identified by the World Health Organization/London School of Hygiene and Tropical Medicine (2010) at community and social levels. This is believed to be due to a lack of research on risk factors at these levels rather than an absence of additional risk factors.

Figure 2: Ecological model of intimate partner violence and abuse
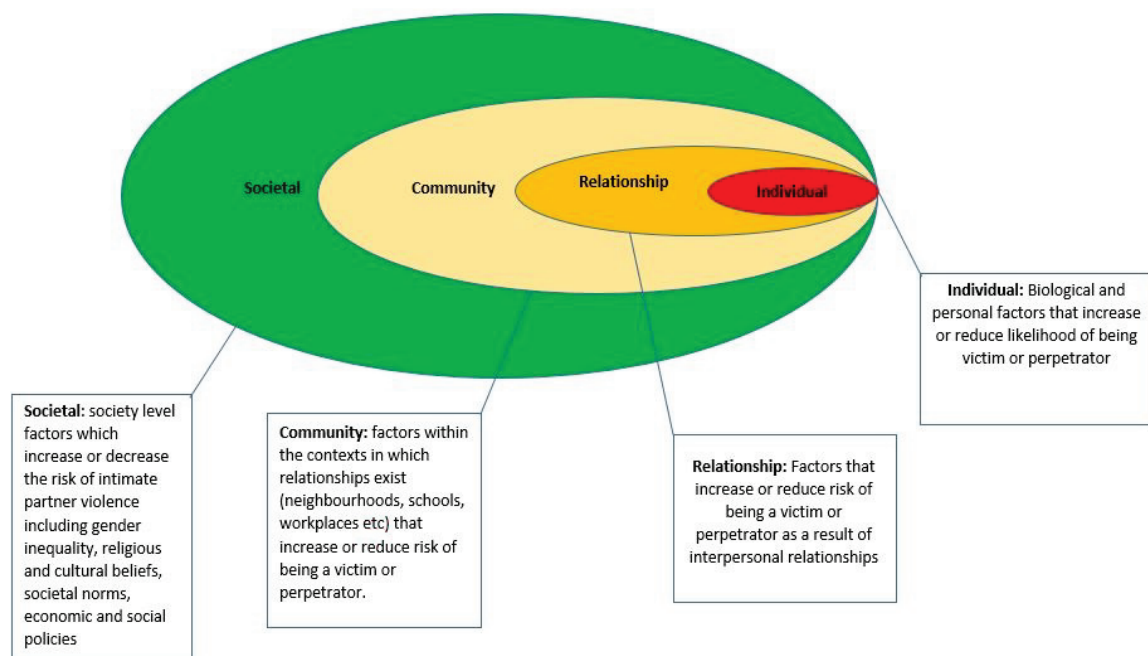
An ecological model enables us to appreciate the dynamic interaction of risk and protective factors for intimate partner violence and abuse across multiple domains of influence, from broad social factors and structures through to individual risk.

Societal level

Globally, two factors are strongly associated with intimate partner violence and abuse:

1   The unequal position of women in relationships and society.
2   The use of violence to resolve conflicts.

Violence occurs at a higher level in cultures where:

- Men possess the greater economic and decision making power.
- Women don't have access to divorce.
- Violence is used culturally to resolve conflict.
- There is a lack of all-female workgroups.

Intimate partner violence and abuse is considered by the WHO to be an expression of gender inequity and gender inequalities at a societal level, linked to patriarchal systems and male dominance. That is, systems where men are economically, politically and religiously superior to women. In such systems men are educated to believe that they are entitled to a higher social status and that women are subordinate. Submissiveness by women is regarded as attractive and normal and, consequently, women who are educated and have increased power may be disliked or stigmatised within wider society.

Whilst gender norms exist at a societal level, their manifestation is apparent at the level of communities, relationships and the individual. Women have reduced access to resources, employment and promotion, lower income levels and lower involvement in decision-making at every level.

These norms legitimise intimate partner violence and abuse as a means of gaining power and reinforcing entitlement to superior social status. It is anticipated that levels of intimate partner violence and abuse may be highest in those societies where the status of women is in transition.

Such norms, and the attitudes and behaviours that they shape, are learned and can be transferred across generations through communities and societies. As learned responses, they can be changed and, consequently, structural and other interventions that increase gender equality and reduce the acceptability of the use of violence to resolve conflict or reinforce power can offer opportunities to break cycles of violence.

Based on interviews with men participating in Domestic Violence Perpetrator Programmes (Kelly and Westmarland, 2015) and their partners (ex), the recently published Project Mirabal report on also suggests that tensions about gender and presumed gender roles within heterosexual relationships underpin intimate partner violence and abuse. The paper highlights that:

> 'A broad consensus emerged in which gender inequality was considered a thing of the past. At this surface level most articulated a belief in gender equality and individual freedom, but at a deeper level concepts of gender operate much more subtly through taken-for-granted ways of being within the routines of everyday life' (p34)

The authors conclude that traditional concepts of masculinity subtly persist for these men: men should be a protector, a provider and the head of the family. They assume the right to have the final say in their relationship and that women were in need of instruction, help or guidance. The role of men as protector within a family is also reflected in some women's explanations of gender roles. Perceived feminine weakness and fragility legitimised beliefs about a man's right to decide on relationship norms and to use disciplinary power to gain control over a situation to get the outcome they want or believe that they are entitled to. Attempts by women to gain influence in the relationship by challenging or contesting these gender norms within these relationships tended to result in violence and abuse.

Community level

Societies with the lowest levels of intimate partner violence and abuse are those with the strong community sanctions against it – these include legal sanctions and moral

pressure. In contrast, acceptance of intimate partner violence and abuse among the community is linked to higher levels. Increasing women's access to wealth, educational attainment, urbanisation, access to media and joint decision-making are all associated with lower levels of intimate partner violence and abuse.

Although intimate partner violence and abuse occurs across all levels of society, women living in poverty are disproportionately affected. The underlying reason for this is not well understood, but may reflect increased economic pressure and reduced access to resources to leave abusive relationships. Poverty may also increase the risk of coercion by those who promise access to desirable resources, such as money, education or employment.

Relationship level

Men with multiple sexual partners are more likely to perpetrate intimate partner violence and abuse. Both multiple partnership and perception of infidelity (by female partners) are strongly associated with both the perpetration and experience of intimate partner violence and abuse or sexual violence. It is believed that such men may seek out multiple sexual partners as a source of peer status and self-esteem, relating to their female partners impersonally and without adequate emotional bonding.

Globally, estimates range from a 1.5 to 17.1 times greater risk of the perpetration of intimate partner violence and abuse and sexual violence, and a 1.5 to 2.4 times greater risk of experiencing intimate partner violence and abuse only.

There is also an association between educational disparity and rates of intimate partner violence and abuse, it is thought that some men may use violence as a means of increasing power and control when their female partner is educated to a higher level.

Finally, a lack of marital/relationship satisfaction and high levels of conflict within a relationship are strongly associated with both the perpetration and experience of intimate partner violence and abuse.

Individual level

The following factors, at an individual level, have been identified by World Health Organization/London School of Hygiene and Tropical Medicine (2010) as being associated with perpetration or experiencing intimate partner violence and abuse:

- Age
  - Being young is a risk factor for being a victim or perpetrator of intimate partner violence and abuse.

- Education
  - There is an association between educational attainment and intimate partner violence and abuse, however, this relationship is complex. A low level of education is strongly and consistently associated with both perpetrating and experiencing intimate partner violence and abuse. A higher level of education may be protective, however, there is also evidence (discussed above) that educational disparity is a risk factor and that in some circumstances women with a higher level of education are at increased risk, for example of sexual intimate partner violence and abuse. Lower education reduces access to resources and potentially increases acceptance of violence and unequal gender norms.

- Past history of victimisation or perpetration of violence
  - A past history of victimisation or violence perpetration is a strong risk factor for future experience of intimate partner violence and abuse either as a victim or a perpetrator. Women who have previously been abused by an intimate or non-intimate partner are more likely to experience intimate partner violence and abuse in the future. A past history of perpetration of intimate partner violence and abuse among men is a strong risk factor for intimate partner violence and abuse in the future (especially during pregnancy and in the post-natal period).

- Exposure to child maltreatment
  - Another strong association is found between experiencing abuse as a child and experiencing or perpetrating intimate partner violence and abuse as an adult, suggesting that intimate partner violence and abuse spans generations. Violence perpetration is three to four times more likely among men who were exposed to violence in childhood. Childhood exposure to violence also increases the likelihood that women will be victimised.

- Antisocial personality
  - Whilst some studies have indicated a consistent association between antisocial personality characteristics such as lack of empathy and impulsivity and intimate partner violence and abuse, more studies are needed to support a causal relationship between these factors.

- Harmful use of alcohol
  - Evidence that alcohol misuse causes intimate partner violence and abuse is weak. There is, however, a strong association between harmful levels of alcohol use and intimate partner violence and abuse perpetration and victimisation. This suggests that alcohol may have an exacerbating effect within a relationship where abusive behaviour already exists or that abuse may increase alcohol use in victims.

- Acceptance of violence
  - Finally, attitudes to violence among men and women are strongly correlated with both perpetration and victimisation. Men who believe that use of violence within a relationship is acceptable are more likely to perpetrate and women's acceptance of violence increases the likelihood that they will experience violence.

6 What works to prevent, identify and reduce intimate partner violence and abuse?

The following section discusses the effectiveness of interventions to prevent, identify, reduce and respond to intimate partner violence and abuse. The included evidence is taken from recent reviews undertaken by NICE (2013); Miller and Drake (2013); Guy, Feinstein and Griffiths (2014) and a longitudinal study by Kelly and Westmarland (2015).

Preventing intimate partner violence and abuse

Preventative interventions can be delivered: before violence or abuse occurs (primary prevention); used to identify and intervene with those populations at increased risk, such as, young pregnant women (secondary prevention); and finally by intervening following the occurrence of violence and abuse, such as, treatment services (tertiary prevention). Interventions can be delivered universally, that is aimed at the entire population, or targeted to a specific subgroup of the population (these typically require more resources and specialist intervention).

Prevention approaches for young people

Overall, there is limited evidence about the effectiveness of primary prevention programmes for young people (NICE, 2013; Guy, Feinstein and Griffiths, 2014). The US programme safe dates (a universal adolescent dating violence prevention programme aimed at 11–18 year olds) has shown promise and one Scottish study, of moderate quality, evaluated the 'Respect' programme and reported mixed findings. In the Respect study, improvements were noted in knowledge of respect, communication, equality and power. However, attitudes to gender stereotyping and perceptions of violence, including sexual violence against women and harassment showed less improvement.

Whilst some primary prevention approaches are promising, there is not currently sufficient evidence to recommend a particular adolescent dating violence prevention programme over another.

There is moderate evidence that secondary prevention programmes targeted at young people designated as high risk of intimate partner violence and abuse can improve knowledge, attitudes towards violence, gender roles and interpersonal outcomes.

However, there is currently no evidence that either primary or secondary prevention interventions lead to a lasting change in perpetrator violence. Findings from some studies are equivocal and in others behavioural change has not been included as a measure of outcome. More work is needed to demonstrate that these programmes can have a long-term impact on behaviour.

Media campaigns

The evidence that media campaigns are directly associated with both improved awareness of, and attitudinal change towards, intimate partner violence and abuse is limited and inconclusive. Specifically, two studies report low levels of recall of the media campaign and two studies report increased awareness and attitudes towards intimate partner violence and abuse.

Interventions implemented in health settings

There is limited evidence, of moderate quality, that preventive interventions undertaken in emergency departments (using PowerPoint presentation and video; written material) may increase knowledge, change attitudes and improve practice (for example, willingness to intervene in a bystander situation). This evidence comes from two US studies, neither of these studies considered behavioural changes as an outcome, so the ultimate impact of these interventions on prevention is hard to determine. Given the differences in context and the populations from which participants were drawn, the findings of these studies may have limited generalisability to the Scottish population.

Interventions in community settings for at-risk women

There is some evidence from a limited number of studies from the USA (n=2) that community prevention programmes for women at risk of, or vulnerable to, intimate partner violence and abuse are associated with improved outcomes. The interventions considered were: 1) A small group work intervention for women with a learning disability delivered over six or 12 weeks and 2) a day-care based intervention aimed at both HIV and intimate partner violence and abuse prevention delivered to African-American women from low income backgrounds.

In the intervention designed for HIV and intimate partner violence and abuse prevention, significant changes in outcomes were only identified for women participating in the 12-weekly session version of the programme, with improvements seen in social support, self-esteem, readiness for change, attitudes to intimate partner violence and abuse and protective health behaviours.

Key points – prevention

Overall, it is difficult to determine if preventative interventions have any impact on levels of future violence. The outcomes of studies are often limited to the impact of interventions on attitudes or educational change rather than any impact on behavioural outcomes. This is in part due to the challenges of assessing domestic abuse outcomes at a community level.

Most interventions focus on young people, with the aim of preventing violence or abuse before it occurs. However, the key time point for effective delivery of primary preventative interventions remains to be identified. Interventions aimed at adults have tended to be media or awareness-based campaigns, but the evidence for these is inconsistent – some interventions have been effective and others haven't.

Interventions for identifying intimate partner violence and abuse

This section covers interventions in health and social care settings that are used to identify intimate partner violence and abuse.[5]

Screening tools and approaches

Screening questions vary between those that ask about the frequency of specific behavioural/violent acts versus dichotomous (yes or no) questions. The findings suggest that a screening tool that includes questions on frequency of abuse (past year and lifetime) may identify more women compared to short yes or no response tools. This is in-keeping with WHO research gold standard method for estimating the prevalence of violence (WHO, 2013) where direct questions about experiencing specific behavioural acts of violence over a defined period of time are asked rather than generic questions about whether they have been abused or have experienced domestic violence.

However, as a result of the variation in the screening tools used in studies and the levels of domestic violence and abuse identified, it is not possible to specify the most effective assessment tool.

Screening format

There is moderate evidence, from four studies, that the format of screening impacts on the disclosure of intimate partner violence and abuse, the form of abuse reported and knowledge/awareness of abuse. The current evidence is not strong enough to suggest the use of one format preferentially over another. However, it does suggest that women find self-report and computerised screening to be acceptable.

---

[5] 28 studies were identified by the NICE (2013) review that had relevance, these screening and identification tools and approaches, screening formats, education of service providers, enhancing identification through cueing, organisational level, identification in pregnant and post-partum women.

Of the four studies, two studies found higher rates of disclosure using a self-report written or computerised format compared to face-to-face screening by a healthcare provider. In contrast, one poorer quality study found that the most effective format for screening varied between settings and the types of abuse reported. Women disclosed physical abuse more often in face-to-face interviews compared to written self-report. Finally, one study found that rates of disclosure of physical assault were higher on a computerised screening format, with rates of disclosure of sexual coercion higher on the written form.

Cueing

Gathering and providing information to a medical practitioner about a patient and their risk for intimate partner violence and abuse before a clinical appointment can 'cue' further assessment of this.

Moderate evidence, from seven studies suggests that providing cues improves discussion of, disclosure and onward referrals to, services provided to support those experiencing intimate partner violence and abuse. In general, these interventions featured computer-based screening and risk assessment prior to medical appointments. The results of the risk assessment were attached to the front of medical records as a prompt for medical staff to further assess this. All studies reported an improvement in identification and disclosure. Although the studies were undertaken in the US with specific populations, it is still reasonable to believe that these findings would applicable to the UK context.

Provider education

Whether educational interventions delivered to healthcare providers/clinicians improves their levels of screening or detection of intimate partner violence and abuse is not clear. Some studies report small increases in awareness or screening, identification of intimate partner violence and abuse and onward referrals. One study reports an increase in awareness but no associated impact on identification rates. Given the limited improvements shown and the variation in length and content of the educational interventions included, specifying the precise details of an optimal staff training programme is not possible.

Policy/organisation change

There is weak evidence from two studies that implementing policy or organisational change measures in relation to screening for intimate partner violence and abuse improves screening, onward referral, or the comfort of healthcare providers towards screening for intimate partner violence and abuse.

Identification in pregnancy/post-partum

There is a moderate level of evidence, from five studies, that universal screening also known as routine enquiry during pregnancy (when supported by staff training and organisational support) has a positive impact on identification of intimate partner violence and abuse during pregnancy. Moderate to large improvements were reported in screening practices, improvements in the level of privacy experienced by women during screening and recording of abuse.

Five studies evaluating implementation of universal screening/routine enquiry were conducted in a variety of settings. One was conducted in the UK, one in the USA and the remainder in Canada. There is no reason to conclude that their findings would not be relevant to the Scottish context.

Key points – identifying intimate partner violence and abuse

It isn't possible to recommend the single most effective assessment tool for identifying violence. However, a tool that asks whether someone has experienced specific acts of violence over a defined period of time seems to be better at identifying abuse than simply asking whether or not someone is being abused.

All formats of screening, including self-report and computer-based assessment, appear to be acceptable, with no clearly preferable format. Cueing healthcare providers to further assess risk using assessment outcomes can improve identification and disclosure.

From the evidence reviewed, it isn't possible to provide an optimal training programme for staff that may result in increased identification rates, but

organisational policy or change measures that promote screening can have a positive impact on identification and onward referral.

Finally, universal screening or routine enquiry during pregnancy has been found to have a positive impact on identification rates.

Responding to intimate partner violence and abuse

Interventions for those experiencing intimate partner violence and abuse

This section considers the effectiveness of interventions in health and social care settings for those who have experienced intimate partner violence and abuse. These interventions largely fall into four categories – advocacy, skill building, counselling/brief interventions and therapy.[6]

Advocacy

Advocacy interventions provide information and guidance to people experiencing intimate partner violence and abuse to enable them to access support and services and to ensure that their rights are achieved. There is moderate evidence from 10 studies that advocacy services can improve a range of outcomes:

- reduce rates of IPV
- improve their access to community resources
- improve safety
- reduce symptoms of depression and improve self-esteem
- reduce parenting stress and improve children's wellbeing.

Skill-building interventions

There is moderate evidence from six studies that interventions that focus on building skills in those who experience domestic abuse (through teaching, training,

---

[6] The NICE (2013) review included a total of 33 relevant studies judged to be of high and medium quality.

experiential or group learning) on a range of topics can have a positive impact on a range of outcomes. All studies report improvements but interventions vary widely in terms of the skills they are seeking to build, making it difficult to recommend one specific intervention over another.

Interventions with positive outcomes include:

- Coping skills training (based on stress and coping and cognitive behavioural models). This was linked to a significant decline in reports of physical violence
- Screening on intimate partner violence and abuse, education about reproductive coercion (pressure to either become pregnant or to end a pregnancy) and other forms of intimate partner violence and abuse, encouragement to leave an abusive partner and teaching of harm reduction behaviours.
- Use of computerised danger assessment and decisional aid tool providing feedback on risk, safety options, assistance with developing priorities and creating safety (delivered to women considered as having been in extreme danger within an intimate relationship over the previous year).
- An educational programme delivered to women in shelters who were experiencing economic abuse as a form of intimate partner violence and abuse improved financial ability and ability to make financial decisions. The intervention consisted of a 12-hour individual and group shelter-based intervention including education about money and power, credit, banking and investing and cost of living planning.
- A mother-child cognitive behavioural group that provided education about safety planning, trauma resolution, development of conflict resolution skills and reducing self-blame. In addition to positive health outcomes for women, this intervention resulted in significant improvement in children's mental wellbeing.
- A very small-scale study exploring the impact of listening to a choice of music combined with progressive muscle relaxation for 30 minutes on five consecutive days found a reduction in anxiety and increased sleep quality among abused women who had been staying in a shelter for less than a week.

Counselling and brief interventions

There is moderate evidence from studies including diverse samples of women, that counselling interventions can improve a range of outcomes. These include: post-traumatic stress disorder; depression; anxiety; self-esteem; stress management; independence; support; re-occurrence of violence; birth outcomes for pregnant women; motivational levels; and/or forgiveness. Most studies report improvements on a range of outcomes, others report only modest improvements in some, but not all, outcomes measured.

Therapy

Therapeutic interventions aim to reduce the negative mental health consequences of intimate partner violence and abuse. These interventions are more intensive than counselling and brief interventions.

Moderate evidence from eight studies suggests that therapeutic interventions can improve post-traumatic stress disorder symptoms, depression, psychological and social functioning, parenting and family outcomes and reduce the likelihood of experiencing future intimate partner violence and abuse or re-abuse. All studies reported improvement in the outcomes measured. Interventions with positive outcomes include cognitive therapy (CT), cognitive processing therapy (CBT), emotion-focused and goal-focused therapies (both included cognitive behaviour therapy techniques), psychosocial group therapy for mothers not living with the perpetrator and dialectical behavioural therapy (DBT).

Key points – Interventions for those experiencing intimate partner violence and abuse

A range of interventions have been shown to have a positive effect on outcomes for those experiencing intimate partner violence and abuse. Advocacy, a diverse range of skill-building, counselling and therapeutic interventions can improve a range of outcomes including reducing rates of intimate partner violence and abuse, increased safety, improved mental health and wellbeing, improved pregnancy and child outcomes and increased access to community resources.

Many of the included studies feature samples of women recruited from shelters who are already accessing support. These represent a small minority of women who experience intimate partner violence and abuse and may have an impact on levels of effectiveness.

More evidence is needed about the effectiveness of interventions with more diverse populations of those experiencing abuse and interventions tailored to women from specific equalities groups, such as those with disabilities and/or from ethnic minorities. There is an absence of evidence about interventions to address 'honour'-based violence against women or forced marriage.

Interventions for perpetrators of intimate partner violence and abuse

The following evidence is taken from the taken from NICE (2013)[7]; Miller and Drake (2013)[8]; Guy, Feinstein and Griffiths (2014).

The NICE (2013) review highlights that interventions for perpetrators are generally similar. Many interventions draw on the Duluth model from the USA. Interventions that are informed by the Duluth model discourage the use of individualised therapeutic approaches, interventions are frequently offered as group-based programmes that aim to change attitudes and behaviours and reduce or eliminate further violence.

Other approaches to perpetrator interventions typically focus on Cognitive Behavioural Therapy (CBT) techniques either delivered to individuals or within

---

[7] The NICE review includes both single studies and three systematic reviews, excluding single studies that appear in these reviews. The NICE review covers individual and group support for perpetrators of domestic violence (physical) and does not provide evidence about the effectiveness of interventions for psychological or other forms of domestic abuse. It focuses on interventions offered in community and health settings but not those solely offered by the justice/corrections sector.

[8] A systematic review and meta-analysis of group-based treatment for male domestic violence offenders published in 2013 (Miller and Drake) focuses on those who are criminal offenders (excluding volunteers or those under civil court treatment orders) with criminal recidivism as the outcome of interest. It includes 11 relevant studies.

groups. CBT is used to reduce male violence by bringing about changes in perpetrators beliefs about violence and techniques for managing their behaviour.

Interventions delivered to abusers as individuals

There is moderate evidence from eight studies that interventions delivered to perpetrators as individuals may have a positive impact on some outcomes. These outcomes include aggressive feelings toward partner, change in attitudes towards domestic violence and knowledge and understanding of domestic violence. One study included both male and female perpetrators, the remaining targeted male perpetrators. Interventions included – case management, individual intervention combined with community outreach services solution-focused therapy, educational interventions and motivational interviewing. Interventions appeared to have a greater effect on attitudinal outcomes than violence outcomes or repeat offending.

Group interventions – short-term

Interventions are classed by NICE (2013) as short-term if they are completed in 16 weeks or less. These interventions include – family of origin group therapy, solution and goal-focused group treatment, CBT, unstructured supportive group therapy, group counselling and group sessions based on the Duluth Model.

Evidence is available from 10 studies about the effectiveness of short-term group interventions (NICE, 2013). Two studies consider interventions for female perpetrators, two include both male and female perpetrators and the remaining focus on male perpetrators alone. Across the studies there is moderate evidence that these interventions are associated with improved attitudinal, psychological and interpersonal outcomes for perpetrators. However, the evidence that these interventions result in a reduction in violence or reoffending is inconsistent. The implication is that attitudinal change or psychological improvement does not automatically translate to a reduction in violence.

Group interventions – long-term

Group-based interventions that last longer than 16 weeks are considered to be long-term approaches. These interventions include CBT, psycho-educational interventions, abuser schema therapy, Duluth-based group therapy, and an approach based on the stages of change model. Taken as a whole, the evidence for the effectiveness of these interventions is inconsistent, both in terms of reduction of violence and re-offending and in changes to attitudinal, psychological and interpersonal outcomes. Studies variously report un-sustained reductions in violence, significant improvements in violence and abuse and levels of recidivism and no or limited improvement.

Comparative effectiveness of group intervention programmes

When the effects of Duluth and non-Duluth based models are looked at separately, there is evidence that approaches based on the Duluth Model (n=6) did not reduce reoffending and, in some instances, were associated with higher rates (Miller and Drake, 2014).

In contrast, non-Duluth group-based treatment programmes for offenders were associated with an average reduction in reoffending of 33%. None were associated with increased reoffending. These programmes include a diverse range of interventions from CBT (n=2), substance abuse treatment (n=1) and relationship enhancement (n=1). A group couples counselling approach for couples who wished to stay together was associated with a non-significant reduction in recidivism.

Overall, the approaches based solely on the Duluth Model appear to have no effect on future incidents of intimate partner violence and abuse, however, broader approaches do show promise. In particular, CBT and, where appropriate, substance abuse treatment – again highlighting the potential value of tailored interventions for specific populations of perpetrators. However, it is important to bear in mind that Miller and Drake (2014) focused specifically on the population of offenders at the more severe end of the intimate partner violence and abuse spectrum who, as a result, may need more intensive, individualised treatment approaches.

Interventions for couples

Moderate evidence from four studies suggests that behavioural couples therapy (included within substance misuse treatment) is associated with improved abuse outcomes including reduced partner violence/aggression (NICE 2013).
There is some weak evidence from three studies that couples interventions (including communications skills training, psycho-educational group sessions for parents, and motivational interviewing for couples) that don't include substance misuse treatment are associated with a reduction in aggression and improvement in relationship skills.

These findings are promising, however, given the limitations of the evidence base it is difficult to conclusively state that couples-based approaches for non-substance using couples are effective.

Effectiveness of batterer intervention programmes on reducing intimate partner violence and abuse

Based on the findings of three systematic reviews, evidence presented by NICE (2013) for the effectiveness of batterer intervention programmes is inconclusive. These reviews include studies featuring both court-mandated and non-mandated participants.

Key points – interventions for perpetrators

Taken together, these findings suggest that no single intervention has been clearly and definitively associated with consistent long-term, positive impact on violence or reoffending outcomes. There are some promising interventions, such as CBT, substance misuse treatment and couples interventions, but more and robust evaluation of these is urgently needed.

There is a lack of evidence around family interventions and interventions solely focused on reducing psychological abuse. The difficulty in achieving sustained changes to outcomes highlights the need to strengthen efforts to prevent violence and abuse before it occurs.

Emerging evidence about the effectiveness of perpetrator programmes embedded as part of a coordinated community response is encouraging. This evidence is discussed in the following section, which looks at how effective partnership approaches for assessing and responding to intimate partner violence and abuse.

The effectiveness of partnership approaches for assessing and responding to intimate partner violence and abuse

Multi-agency responses to intimate partner violence and abuse are aimed at improving the safety of victims and any dependent children, perpetrator accountability and developing effective prevention strategies. In addition to criminal justice services, these approaches may involve input from a range of agencies from the public and third sector as well as the broader community as only a small element of intimate partner violence and abuse is reported to police.

Multi-agency responses in the UK

This section covers the effectiveness of multi-agency responses to intimate partner violence and abuse. This is taken from Kelly and Westmarland (2015) and NICE (2013).[9]

Domestic violence perpetrator programmes – as part of a coordinated community response

Kelly and Westmarland's (2015) longitudinal study considers outcomes of Domestic Violence Perpetrator Programmes, not as stand-alone interventions, but embedded as part of a coordinated community response to domestic violence.

---

[9] The NICE (2013) review consists of 21 studies, all of which were judged to be of medium quality. Studies include collaborations between service providers including intimate partner violence and abuse agencies, child welfare services, police, mental health services, impact of source of referral on outcomes, Multi-agency Risk assessment Conferences (MARAC) evaluations, and evaluations of community coordinating council.

The **Coordinated Community Response (CCRM)** to domestic violence is a coordinated interagency approach that focuses on:

- an increase in the safety of domestic violence survivors
- an increase in the safety of children who live with domestic violence
- holding abusers accountable for their actions
- effective prevention strategies
- a system where the onus of holding abusers accountable lies with service providers, and the wider community, rather than the survivor.

Based on 12 domestic violence perpetrator programmes accredited through the UK Respect programme, including one in Scotland based on the Caledonian System, this study is highly relevant to the Scottish context. At 12 months following their partner or ex-partner starting the programme, women reported large decreases in the use of physical and sexual violence. Some reduction in acts of coercive control were apparent at 12 months, but intimidation and belittling remained common.

Although there is some evidence that men's understanding of the impact of their abusive behaviour on their children improved, this was limited particularly with babies and infants. Similarly, women's assessment of positive changes to fathering showed some improvement, however, almost half of women remained anxious about leaving their child alone with their partner or ex-partner.

Overall, the findings of this study are encouraging and have relevance to the Scottish context, however, methodological limitations make it difficult to be absolutely certain about the effectiveness of this approach. The resistance of acts of coercive control to change and ongoing lack of awareness of the impact of abuse on children highlights the need for such programmes to be delivered alongside ongoing support for women and children.

Increasing referrals and addressing violence

Evidence from 11 studies suggests that partnerships are effective at increasing referrals, reducing further violence and supporting victims of intimate partner

violence and abuse. Partnership approaches were associated with reduced family conflict, reduced rate of re-victimisation or threat of violence, improved response to and safety for victims and increased referrals to support agencies. However, one cross-sectional study that includes but is not specific to intimate partner violence and abuse found that such an approach was not effective for vulnerable adults (elders, adults with disabilities).

Interagency sharing and policy development

Moderate evidence from nine studies suggests that partnership approaches have effectively improved relationships, practices and policies of partner agencies in addressing intimate partner violence and abuse. Findings, usually based on stakeholder reports, suggest that improvements can be obtained in relationships and collaboration between partners, training, knowledge and sharing of information and resources, the development of policies and protocols, involvement of key agencies and stakeholders.

Enabling factors to partnership working

Moderate evidence from six studies suggests that the following factors may help partnership working to be successful: strong leadership; management and coordination; active membership; community involvement; strong relationships and communication; and training and resources.

Barriers to partnership working

Moderate evidence from nine studies suggests that barriers to effective partnership working include:

- limited resources (financial and people)
- cultural differences between agencies
- leadership and management issues
- lack of commitment
- limited monitoring and addressing needs of diverse populations
- inconsistent application of protocols and guidelines

- confidentiality issues among multi-disciplinary case review teams
- lack of diversity in partnerships
- challenges addressing intimate partner violence and abuse among certain groups including LGBT, BME and women who experience sexual abuse.

7 Interventions for children exposed to intimate partner violence and abuse

Effectiveness of Interventions for children who are exposed to Intimate partner violence and abuse

This section covers the effectiveness of interventions to address negative outcomes in children who are exposed to intimate partner violence and abuse as outlined in NICE (2013).[10]

Single component therapeutic interventions for mother and child

Moderate to strong evidence from USA studies indicates that therapeutic interventions comprising of a single component are effective in improving child behaviour, mother–child attachment and stress and mothers trauma-related symptoms. Interventions included mother–child therapy, shelter-based parenting training intervention, and play/activity based therapies. Two of the most rigorous studies feature the evaluation of a manualised weekly mother–child (aged three to six years) psychotherapy intervention informed by cognitive behavioural, attachment and ecological theories. The content of this intervention consisted of individual and joint sessions and the use of play. Both demonstrate improved behavioural outcomes for children and reduced trauma symptoms for both children and their mothers.

Single component psycho-educational interventions for mother and child

---

[10] One systematic review examined interventions that either directly or indirectly target children exposed to intimate partner violence and abuse. A further 13 additional studies are included in this review. Although the studies include interventions conducted in a number of countries globally, the authors conclude that the majority of interventions could be applied to the UK context. However, most interventions have been conducted with non-random convenience samples potentially limiting their effectiveness within the wider population of children exposed to domestic abuse.

Single-component psycho-educational interventions aimed at mothers and children have the potential to improve children's behaviour and coping skills, reduce maternal stress and increase parenting skills. However methodological limitations including small sample sizes and lack of follow up limit any strong conclusions regarding effectiveness of this approach.

Single component therapeutic interventions for children

Evidence about the effectiveness of single component therapeutic interventions directed solely at children is weak. Only three studies were identified, these covered different interventions (play therapy, expressive writing and equine assisted psychotherapy). Play therapy and equine therapy demonstrated some improvement in children's behavioural and emotional outcomes; however, given the overall lack of evidence and the methodological limitations it is not possible to draw any strong conclusions about their effectiveness.

Single component psycho-educational interventions for children

There is moderate evidence that single-component psycho-educational interventions are effective in improving children's knowledge about violence, their coping skills, behaviour and emotional adjustment. All studies report improvements in outcomes; however, methodological problems including a lack of follow-up mean that it is not possible to say whether these results are sustained over time.

Multi-component advocacy interventions

There is moderate evidence from five studies that multi-component interventions that focus primarily on advocacy are effective in improving psychological and behavioural outcomes (e.g. aggression) for children and in reducing trauma symptoms and stress in children and families. In some studies, increased intensity is associated with greater improvements.

Multi-component therapy and advocacy interventions

Evidence of moderate quality indicates that multi-component interventions including both therapy and advocacy can increase knowledge and awareness of safety

planning and improve self-esteem, self-competence and interpersonal relationships. There is limited evidence, from one study, that benefits observed following participation in a resilience-building intervention for children of mothers engaged in treatment for co-occurring mental health, violence and substance misuse issues are maintained at longer-term follow-up (12 months).

Multi-component parenting and therapy interventions

Similarly there is a moderate level of evidence of effectiveness that multi-component interventions providing therapy and parenting skills are associated with an improvement in children's behaviour, emotion and knowledge about violence. They are also associated with reductions in mothers stress and ability to manage children's behaviour.

Key points – interventions for children exposed to intimate partner violence and abuse

Overall, there is evidence that interventions for children who have been exposed to intimate partner violence and abuse can be effective in improving both children's behavioural and emotional outcomes and the outcomes of their mothers. Those single-component interventions, which are targeted at both mothers and their children, are more beneficial than those which target children alone.

Similarly a number of multi-component interventions have highlighted that benefits to children are linked to improved outcomes for their mothers, suggesting the value of a family approach. Evidence about the effectiveness of population-based or preventative approaches is lacking.

8 Policy

The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (2011)

Known informally as the Istanbul Convention, this Convention is the first legally-binding European treaty specifically targeting violence against women and domestic violence. Signatories to the Convention include the UK. Following ratification by the tenth country (Andorra) earlier in 2014, the convention came into force on 1 August 2014. The Istanbul Convention requires states to change their laws, introduce practical measures and allocate resources to address violence against women and domestic violence. It:

- Condemns all forms of violence against women and domestic violence;
- Recognises that the realisation of de jure (in law) and de facto (in practice) equality between women and men is a key element in the prevention of violence against women;
- Recognises that violence against women is a manifestation of historically unequal power relations between women and men, which have led to domination over, and discrimination against, women by men and to the prevention of the full advancement of women.
- Recognises the structural nature of violence against women as gender-based violence, and that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men;
- Recognises, with grave concern, that women and girls are often exposed to serious forms of violence such as domestic violence, sexual harassment, rape, forced marriage, crimes committed in the name of so-called "honour" and genital mutilation, which constitute a serious violation of the human rights

of women and girls and a major obstacle to the achievement of equality between women and men;

- Recognises the ongoing human rights violations during armed conflicts that affect the civilian population, especially women in the form of widespread or systematic rape and sexual violence and the potential for increased gender-based violence both during and after conflicts;

- Recognises that women and girls are exposed to a higher risk of gender-based violence than men;

- Recognises that domestic violence affects women disproportionately, and that men may also be victims of domestic violence;

- Recognises that children are victims of domestic violence, including as witnesses of violence in the family;

- Aspires to create a Europe free from violence against women and domestic violence.

More concretely, the Convention asks the states to:

- Provide safety and support for victims to rebuild their lives, through:
  - free national telephone helpline
  - shelters in sufficient numbers
  - medical, psychological and legal counselling
  - help with housing and financial issues
  - support in finding employment

- Protect victims at risk by introducing:
  - emergency barring orders
  - restraining and protection orders
  - risk assessment and risk management
  - If they do not have them, states will have to introduce a number of new offenses. These may include: psychological and physical violence, sexual violence and rape, stalking, female genital mutilation, forced marriage, forced abortion and forced sterilisation. They will also need to ensure that

culture, tradition or so-called 'honour' are not regarded as a justification for any of the above-listed courses of conduct

- Invest in preventive measures to:
  - tackle the root problem of violence against women – inequality and discrimination
  - change attitudes, gender roles and stereotypes including through and in partnerships with the media and the private sector
  - empower women
  - involve men and boys
  - support NGOs and their work at the service of victims of violence.

Equally Safe (2014)

Equally Safe sets out Scotland's strategy to take action on all forms of violence against women and girls including intimate partner violence and abuse. Produced by the Scottish Government and COSLA, in association with a wide range of partners including specialist violence against women support organisations such as Scottish Women's Aid and Rape Crisis Scotland, alongside Police Scotland and NHS Health Scotland. Its four priorities are:

1 Scottish society embraces equality and mutual respect, and rejects all forms of violence against women and girls.
2 Women and girls thrive as equal citizens: socially, culturally, economically and politically.
3 Interventions are early and effective, preventing violence and maximising safety and wellbeing of women and girls.
4 Men desist from all forms of violence against women and girls and perpetrators of such violence receive a robust and effective response.

The overall aim of the strategy is to prevent and eradicate violence against women and girls, creating a strong and flourishing Scotland where all individuals are equally safe and respected, and where women and girls live free from such abuse – and the attitudes that help perpetuate it.

9   References

World Health Organization, Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, South African Medical Research Council. *Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and abuse and non-partner sexual violence*. Geneva: World Health Organization; 2013.
www.who.int/reproductivehealth/publications/violence/9789241564625/en/

United Nations General Assembly. Declaration on the Elimination of Violence against Women. New York: United Nations;1993.
www.un.org/documents/ga/res/48/a48r104.htm

Istanbul Convention. *Council of Europe Convention on preventing and combating violence against women and domestic violence*. Istanbul: Council of Europe; 2011.
http://conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?CL=ENG&NT=210

European Institute for Gender Equality. *Gender Equality Index Report*. Lithuania: European Institute for Gender Equality; 2013.
http://eige.europa.eu/content/document/gender-equality-index-report

European Union Agency for Fundamental Rights. *Violence against women: an EU-wide survey: Main results.* Luxembourg: Publications Office of the European Union; 2014.
http://fra.europa.eu/en/publication/2014/violence-against-women-eu-wide-survey-main-results-report

National Institute for Health and Care Excellence, British Columbia Centre of Excellence for Women's Health. *Review of Interventions to Identify, Prevent, Reduce and Respond to Domestic Violence.* London: National Institute for Health and Care Excellence; 2013.
www.nice.org.uk/guidance/ph50/evidence

Scottish Government. *Statistical Bulletin Crime and Justice Series – Domestic Abuse Recorded by The Police in Scotland, 2012–13.* Edinburgh: Scottish Government; 2013.
www.gov.scot/Publications/2013/10/2411/downloads
Scottish Government. *Statistical Bulletin Crime and Justice Series – Homicide in Scotland, 2013–14.* Edinburgh: Scottish Government; 2014.
www.gov.scot/Publications/2014/12/6792

World Health Organization/London School of Hygiene and Tropical Medicine. *Preventing intimate partner and sexual violence against women: Taking action and generating evidence.* Geneva, World Health Organization; 2010.
www.who.int/violence_injury_prevention/publications/violence/en/

Kelly L, Westmarland N. *Domestic Violence Perpetrator Programmes: Steps towards change. Project Mirabal Final Report.* London and Durham: London Metropolitan University and Durham University; 2015.
www.dur.ac.uk/criva/projectmirabal

Miller M, Drake E, Nafziger M. *What works to reduce recidivism by domestic violence offenders?* (Document No. 13-01-1201). Olympia: Washington State Institute for Public Policy; 2013.
www.ncjrs.gov/App/Publications/abstract.aspx?ID=264947

Guy J, Feinstein L, Griffiths A. *Early Intervention in Domestic Violence and Abuse – Full report.* London: Early Intervention Foundation; 2014.
www.eif.org.uk/publication/early-intervention-in-domestic-violence-and-abuse

Scottish Government. *Equally Safe: Scotland's strategy for preventing and eradicating violence against women and girls.* Edinburgh: Scottish Government; 2014.
www.scotland.gov.uk/Publications/2014/06/7483