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How accurate and useful are published UK prevalence rates of intimate partner violence (IPV)? Rapid review and Methodological commentary

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MANUSCRIPT DETAILS

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ABSTRACT:

To estimate the prevalence of intimate partner violence (IPV) in the UK general population and in the low-risk clinical population and to identify the methodological challenges presented by this task.

A rapid review of the evidence was conducted. Data were extracted with the help of a pre-designed tools and were synthesized to answer the two study aims. Data were mixed quantitative and qualitative.

In the general population, crime survey data gave a range of past-year IPV prevalence from 1.8-4.5%. This was higher in women than men (2.5-6.3% vs 0.9-2.7%). In both the general and low-risk clinical population, there was little data on pregnant women or gay men and lesbians. No significant relationships between IPV and ethnicity were found. Different surveys used different definitions of IPV and domestic violence, making it difficult to give an accurate estimate. There were also problems with data accuracy.

CUST_RESEARCH_LIMITATIONS/IMPLICATIONS_(LIMIT_100_WORDS) :No data available.

CUST_PRACTICAL_IMPLICATIONS_(LIMIT_100_WORDS) :No data available.

CUST_SOCIAL_IMPLICATIONS_(LIMIT_100_WORDS) :No data available.

The research is original and contributes to the knowledge about IPV screening and if prevalence studies help.

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How accurate and useful are published UK prevalence rates of intimate partner violence (IPV)? Rapid review and Methodological commentary

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ABSTRACT

Purpose: To estimate the prevalence of intimate partner violence (IPV) in the UK general population and in the low-risk clinical population and to identify the methodological challenges presented by this task.

Design: Rapid review as defined by Grant and Booth (Grant and Booth, 2009) – it is used under time or financial constraint to assess what is known using systematic review methods.

Methods: Data were extracted with the help of a predesigned tool and were synthesized to answer the two study aims. Data were mixed quantitative and qualitative.

Results: In the general population, crime survey data gave a range of past-year IPV prevalence from 1.8-4.5%. This was higher in women than men (2.5-6.3% vs 0.9-2.7%). In both the general and low-risk clinical population (i.e., that which is not routinely screened for IPV), there was little data on pregnant women or gay men and lesbians. No significant relationships between IPV and ethnicity were found. There were methodological challenges. For example, different surveys used different definitions of IPV and domestic violence, making it difficult to give an accurate estimate. There were also problems with data accuracy.

Originality: The research updates knowledge about IPV prevalence and adds to knowledge about the challenges of judging such prevalence from current data.

Key words: nurses, midwives, intimate partner violence, UK, official statistics

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INTRODUCTION

Domestic violence and abuse (DVA) is defined in the UK as: *"any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial or emotional* (Home Office, 2013). This definition also encompasses acts of 'honour' based violence, such as female genital mutilation (FGM) [cutting] and forced marriage. DVA can manifest in several forms, including child abuse, elder abuse and intimate partner violence (IPV). All these except IPV can also take non-domestic forms whereas IPV involves only a current or former intimate partner. The term IPV is also termed "partner violence" (Feder *et al.*, 2009). While it is acknowledged that IPV men can also be subjected to IPV, it exists in heterosexual as well as homosexual relationships and women can also perpetrate IPV, most victims remain women and the intensity and severity of abuse experienced by women is much greater.

IPV can result in serious health impacts. For instance, according to World Health Organization (WHO) approximately 42% of women who experience physical or sexual IPV, sustain injuries as a result (Ahmad *et al.*, 2017). Sexual IPV can result in unwanted pregnancy, miscarriage, sexually transmitted infections (STI) and other gynaecological problems (Casique and Furegato, 2006; Black, 2011; Ali and McGarry, 2018). Psychological effects of IPV may include fear, depression, low self-esteem, anxiety disorders, headaches, obsessive-compulsive disorder, post-traumatic stress disorder, disassociation, sleep disorders, shame, guilt, self-mutilation, drug and alcohol abuse and eating disorders (Romito, Molzan-Turan and De Marchi, 2005; Plichta and Falik, 2011). IPV is also associated with harm to indirect victims, particularly other family members, such as children (Ahmad *et al.*, 2017).

Measuring the prevalence of IPV is challenging, as studies use different definitions, examine different populations in different contexts and use a variety of methods and questionnaires. The self-reporting nature of IPV can result in underrepresentation of the true extent of IPV while the timing of enquiry can affect recall. Nevertheless, it is estimated that the lifetime prevalence of IPV in women range from 13-31% in community-based samples (general population) and from 13-41% in health service

settings (clinical populations) (Romito, Molzan-Turan and De Marchi, 2005; Feder *et al.*, 2009; Plichta and Falik, 2011; Ahmad *et al.*, 2017). In the UK, it was reported that 2.4 million adults, including 1.6 million women and 786,000 men, aged 16-74 years experienced domestic abuse in 2018/19 (Office for National Statistics, 2020). It is believed that in lesbian and bisexual women, IPV is experienced at a similar rate to women in general (Hunt and Fish, 2008). Studies demonstrating the prevalence of IPV in men are limited, however, the Office for National Statistics estimated that 4% of men (between the ages of 16-74) experienced IPV in 2019 (Office of National Statistics, 2020). Similarly, between the year ending March 2016 and the year ending March 2018, 74% of victims of domestic homicide were female compared with 13% of victims of non-domestic homicide (Office of National Statistics, 2020). Compared with heterosexual men, 49% of gay and bisexual men have experienced one or more incident of IPV (Guasp, 2012). IPV has cost implications and we know that for women affected, estimated cost of providing increased public services and the lost economic output is around £66 billion per year (Oliver *et al.*, 2019).

Evidence suggest that there are several sociodemographic and clinical factors that increase the risk of experiencing IPV. These include being female, aged 16-24 for women or aged 16-19 for men, long-term disease or disability, mental health problems, women separated from partners and pregnant women or women who have recently given birth (Harrykissoon, Rickert and Wiemann, 2002; Smith *et al.*, 2011; Trevillion *et al.*, 2012; National Institute for Health and Clinical Excellence (NICE), 2014).

Health and social care professionals including nurses, midwives, health visitors, social workers and others are well placed to identify and treat IPV as they have access and fairly intimate knowledge; as such, they have been tasked with doing so (Svavarsdottir and Orlygsdottir, 2009; Bradbury-Jones, Clark and Taylor, 2017; Rossiter *et al.*, 2017) and treating its consequences (Alhalal, 2018). One question that arises, therefore, is when screening for IPV should be undertaken. At present, it is performed routinely only in areas identified as high risk such as emergency departments, antenatal and postnatal settings within the context of healthcare. Decisions about screening and intervention to prevent IPV require accurate data on prevalence in the population in general and amongst specific groups. The rapid review presented here examines the prevalence of IPV in the general population in the UK and in clinical areas not identified as high risk. The research question for this review was, what is the prevalence of IPV: i) in the

general population in the UK; and ii) in the population using clinical areas that are not identified as high risk (and which do not, therefore, routinely screen for IPV)? This non-high-risk population includes, for example, attenders at GP clinics and at sexual health clinics.

METHODS

Design

This was a rapid review of the literature as defined in the typology of Grant and Booth.(Grant and Booth, 2009) Here a caveat is required. The technology of rapid reviews is changing, particularly since the establishment in 2015 of the Cochrane Rapid Review Methodology Group. This published guidance in 2020.(Garritty *et al.*, 2021) This post-dated our review which, therefore, does not meet all its recommendations. This is a limitation of our study. Nonetheless, as a rapid review of earlier type, it aims to examine a representative range (rather than all available) published of the prevalence of IPV in the UK population by gender (male or female) and, where possible, by sexual orientation, pregnancy status and ethnicity. In addition, it seeks to estimate the prevalence of IPV in the clinical population that is not routinely screened for IPV in the UK (which we have termed the low-risk clinical population). Finally, the review aims to identify and discuss the methodological challenges presented by this task.

Search Strategy

MEDLINE, PsycINFO, Embase and Cochrane Library databases were searched on 18/10/2018 using the term “intimate partner violence” and synonyms, such as battered women and spouse abuse combined with terms related to incidence, prevalence and epidemiology. Two reviewers undertook study selection (Pallm and PA). Any queries at the abstract or the full text stage were resolved through discussion.

Studies were included if they:

1) concerned IPV affecting men or women aged 16 and above; (below this age, incidents are likely to be characterised differently, as, for example, child abuse);

2) contained relevant data from the UK or its regions.

3) were published in English;

4) concerned victims (not perpetrators);

5) were published from 1 January 2007 (for women) or any date (for men and sub-groups of women by sexuality, pregnancy and ethnicity);

6) concerned either: a) the general population; b) the low-risk clinical population; or c) the high-risk clinical population serving exclusively pregnant or postnatal women (all other high-risk groups were excluded)

The last two criteria, b) and c), merit explanation. First, the differential dates for males and females arose from this review being an update of earlier National Screening Council (NSC) reviews which included figures up to 2007 but which only included women. Second, the requirement for specific populations arose from the fact that current National Institute of Clinical Excellent (NICE) public health guidance [PH50] (National Institute for Health and Clinical Excellence (NICE), 2014) and a quality standard [QS116] (National Institute for Health and Clinical Excellence, 2012) already recommend routine DVA screening in specific areas such as alcohol and drug misuse, children and vulnerable adults' services, and Emergency Departments. The focus of this study was on clinical areas where such routine screening does not take place.

We also examined the references and included studies in other systematic reviews. None of these exactly corresponded to the specifications of our review but they were used to verify inclusion of all relevant papers; this element of the search is shown on the PRISMA chart in the four papers included from hand-searches.

Analysis

Quality appraisal of all reviewed papers was performed by 2 reviewers. The Appraisal tool for Cross-Sectional studies (AXIS), a 20-item tool appraising introduction, methods, results, discussion and an 'other' category was used to assess the quality of the studies (Downes *et al.*, 2016). Police and Government data were not assessed for quality; we comment further on this in the results and discussion sections. The appraisals were used to assess the quality of the studies, but no studies were excluded on the basis of quality. The decision not to impose limitations by study type or quality was a function of the broad types of data sources that currently need to be drawn on by researchers seeking prevalence data for IPV in the UK. We also comment on this further in the results and discussion. Data were extracted by two reviewers using a tool that included author, date, extractor initials, numbers, gender, sexuality, ethnicity, pregnancy status and results.

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The data were primarily quantitative to answer the prevalence questions; however, qualitative commentary was also used to evaluate its usefulness and accuracy. The data were synthesized from the extraction tool prior to completion of a narrative analysis.

Ethics

As this was a review of published evidence, no formal research ethics approval was required or sought. There was, however, an element of patient and public involvement (PPI): first, the review went for public consultation before publication and, second, there were 2 PPI representatives on the UK NSC (the funding body) who were involved in its review and development.

Results

The main sources of data for the general population were official police and crime statistics. The database searches yielded i) papers providing novel analysis of the official data and ii) collection and analysis of data on the low-risk clinical population. The database searches yielded 737 results plus six collections of official data. Of these, 49 were examined as full text. 16 studies were included in the review. 33 papers were excluded, mainly because they added no additional detail on the prevalence of IPV. Included papers were assigned to one of two categories: A) General Population [9 papers] (Hunt and Fish, 2008; Howard *et al.*, 2010; Guasp, 2012; H Khalifeh *et al.*, 2013; Hind Khalifeh *et al.*, 2013; Jonas *et al.*, 2014; Khalifeh, Johnson, *et al.*, 2015; Khalifeh, Moran, *et al.*, 2015; Khalifeh, Oram, *et al.*, 2015); and B) Clinical Population [7 papers] (Johnson *et al.*, 2007; Dhairyawan *et al.*, 2013; Sanmani, Sheppard and Chapman, 2013; Wokoma *et al.*, 2014; Hester *et al.*, 2015; Warren-Gash *et al.*, 2016; Bacchus *et al.*, 2017). The PRISMA chart is shown in Figure 1.

INSERT FIGURE 1 HERE

In terms of the quality of the research, the key problem lay with the fact that in many of the included studies, UK prevalence was only an indirect focus. As such, many articles were good quality but were of limited value to the review because, for example, non-UK data was mixed up with the UK data (Costa *et al.*, 2015). For the general

population, most use was made of the Police and Crime Surveys. However, *c*oncerns about the quality and consistency of crime recording practice used for police data mean that these sources have been found not to meet the required standard for designation as National Statistics (Office for National Statistics, 2018). By contrast, Crime Survey statistics are badged as National Statistics with the implication of high quality; they are based on a survey of 50,000 households in England and Wales and proportionate numbers for the other two countries.

A) The General Population

Table 1 summarises the UK results based on Police and Crime Survey data (plus the 2007 Adult Psychiatric Morbidity Survey (APMS) data for England (Jonas *et al.*, no date)). The Crime Surveys provide estimates for partner abuse over the past year and over a lifetime since the age of 16. In addition, the Northern Ireland Crime Survey breaks down the past-year of partner abuse into non-physical abuse (1.4%), threats or force (0.8%), threats (0.4%) and force (0.7%). 0.5% of incidents were considered severe by respondents.

Gender

In all four UK countries, the percentages of IPV and partner abuse are higher in women than in men. The Crime Survey for England and Wales (CSEW) breaks this down further for past year abuse as non-physical (emotional, financial) (female 72.5%, male 57%), threats (female 37.8%, male 28.7%), force (female 28.0%, male 45.7%), sexual assault by rape or penetration (female 3.8%, male 0.5%), indecent exposure or unwanted sexual touching (female 4.2%, male 2.2%) and stalking (female 23.4%, male 18.1%).

Pregnancy

The review found no data on the prevalence of IPV in pregnant women in the general population; this is a gap in the evidence, although evidence from pre- and perinatal clinics provides some information. Estimates are reported below in the section on the clinical population.

Sexual Orientation

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Neither the Crime Surveys nor Police statistics collect data relating to sexual orientation, except for some limited data in Scotland. In Scotland, police statistics record the number of same sex incidents of IPV as male/male 2% (N=740) of the total; female/female 1% (N=617). In the crime survey, 6.6% of male respondents who reported abuse reported same-sex gender of abusive partner; for females, the equivalent figure was 0.6%.

Two health surveys by the campaign group Stonewall report on health amongst gay and bisexual men (Guasp, 2012) and amongst lesbian and bisexual women (Hunt and Fish, 2008). The first reports that 40% of gay and bisexual men have experienced IPV. 37% gay and bisexual men have experienced at least one incident of domestic abuse in a relationship with a man. 7% reported experiencing IPV perpetrated by a female partner. Psychological or emotional IPV was experienced by 18% of gay and bisexual men where they were repeatedly belittled and made to feel worthless. 17% reported experiencing physical IPV (kicked, bitten or hit with a fist). Of gay and bisexual men 14% reported to be stopped from seeing friends and relatives by a male partner; 9% of gay and bisexual men were forced to have unwanted sex; 6% continued to be abused after separation and 4% reported receiving death threats; and 78% of gay and bisexual men who have experienced domestic abuse have never reported incidents to the police.

Of lesbian and bisexual women 25% experience IPV (Hunt and Fish, 2008). In two thirds of cases, the perpetrator was another woman; the other perpetrators were men who were former or current partners. Psychological or emotional IPV was experienced by 20% of women who were repeatedly belittled and "made to feel worthless" (Hunt and Fish, 2008) and stopped from seeing friends and relatives. 20% of women reported experienced physical IPV (pushed, slapped, kicked and bitten). Of women 7% reported being forced to have unwanted sex.4% of women experienced death threats. Lesbian and bisexual women also report experiencing IPV from men; 15% reported to have been forced to have unwanted sex. 80% lesbian and bisexual women who have experienced IPV have never reported incidents to the police.

In both reports, the self-recruitment of participants means that the data is not of good quality but they are the most extensive available.

Ethnicity

The CSEW reported the ethnicity of victims of partner abuse aged 16-59 as: White (87.8%), Mixed/multiple (2%), Asian/Asian British (6.5%), Black/African/ Caribbean/Black British (3.1%) and Other (0.7%). Nearly 17% of the cases (N=88461) discussed at multi-agency risk assessment conferences (MARACs) identify with the Black and Minority Ethnic (BME) population. These figures are roughly in line with Census levels of each group in the population; for example, the 2011 Census classified 86% of the British population as White. As such, no significant relationship has been demonstrated between levels of IPV and ethnicity. Neither Scotland nor Northern Ireland surveys reported data on ethnicity and domestic abuse or partner abuse. However, a supplementary data document for Northern Ireland indicates that the percentage of domestic abuse crimes where White UK/Irish people were victims was around 90%. As for England and Wales, no significant relationship has been established between levels of IPV and ethnicity.

Other sub-population characteristics

Secondary analysis of the Crime Survey for England and Wales data showed other groups at increased risk of IPV: i) DVA was reported by a higher proportion of disabled over non-disabled victims (44% v 31%, $p<0.01$) (H Khalifeh *et al.*, 2013); ii) there was a statistically significant positive association between some markers of social deprivation (low household income, poor educational attainment, low social class and living in a multiply deprived area) and the prevalence of IPV in women but not in men; social housing tenure was significantly associated in both men and women (Hind Khalifeh *et al.*, 2013); and iii) both men and women with chronic mental illness were more likely to be victims of IPV (Howard *et al.*, 2010; Khalifeh, Johnson, *et al.*, 2015; Khalifeh, Oram, *et al.*, 2015). Another secondary analysis, this time of the Adult Psychiatric Morbidity Study in England, showed a significant association between IPV and some psychiatric disorders in men and women; being a victim of IPV was strongly associated with common mental disorders (CMDs), PTSD, eating disorders, and drug and alcohol misuse (Jonas *et al.*, 2014). The excess risk of IPV for those with mental illness requires further investigation: the nature of cause may be bidirectional but, as Khalifeh *et al* (2010) say, most studies to not investigate the context sufficiently to address such questions.

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B) The Clinical Population

Two studies of HIV clinics show high incidence of IPV in their clinical populations, between 29.4% (Warren-Gash *et al.*, 2016) and 52% (Dhairyawan *et al.*, 2013). GUM clinics also showed high incidence of IPV (Sanmani, Sheppard and Chapman, 2013). One of the studies showed a prevalence of 14.1% during present pregnancy, although this corresponded to the prevalence for past-year IPV and, as such, pregnancy did not seem to carry increased risk (Dhairyawan *et al.*, 2013). Outside of HIV clinics, one study notes a higher prevalence rate of IPV in a current relationship for pregnant women attending a termination of pregnancy clinic than for those attending antenatal clinic (5.8% against 0.9%) (Wokoma *et al.*, 2014). Gynaecology clinics recorded prevalence rates of between 24-19% (Johnson *et al.*, 2007).

A survey of 532 gay men attending a sexual health clinic in London defined IPV in terms of negative behaviours, such as needing to ask permission to work or go shopping as well as more blatant physical abuses (Bacchus *et al.*, 2017). The main result was that of 532 men, 33.9% (95% CI 29.4-37.9%) experienced and 16.3% (95% CI: 13.0-19.8%) reported carrying out negative behaviour.

Only one study explored the prevalence of IPV in primary health care clinics, namely 16 general practices in SW England (Hester *et al.*, 2015). Male patients (N=1368) completed the questionnaire, which used the IPV definition as "negative behaviours" (as in the Bacchus study reported above). For lifetime IPV, 22.7% of men reported ever experiencing negative behaviour from a partner (feeling frightened, physically hurt, forced sex, ask permission to go out, and so on); 7.6% reported experiencing any negative behaviours in the past 12 months.

Discussion

This study aimed to explore how accurate and useful are published UK prevalence rates of intimate partner violence (IPV) and lessons can be learned with regards to completeness, accuracy, relevance, timeliness, relevance and consistency with other studies.

Completeness

Findings of the review suggest that gaps exist in the official data and in the studies. Definitions are problematic throughout the data. In the Police statistics, IPV is not

recorded as a separate category; in addition, in some but not all of the Home Countries a distinction is made between incidents and crimes of domestic abuse, because not all incidents are sent for prosecution in the courts. The Crime Surveys are more useful in this regard, but the three sets utilise different definitions. The Northern Ireland survey specifies partner abuse by a past or present partner, which is synonymous with IPV. The Scottish and England/Wales crime surveys only specify partner abuse but are not clear that this includes past partners, although it might be implied. In terms of sub-categorisation, gender and ethnicity are covered in the official data; pregnancy and sexual orientation is generally not. Some official data covers disability, social deprivation and mental illness.

Turning to the clinical population not deemed high risk, the same problem of gaps in the data exist. In addition, the data on this population is not routinely collected (UK National Screening Committee, 2019; Portnoy *et al.*, 2020). As such, whether and how such data is available depends on researchers and research funding decisions or on the auditing decisions of individual NHS bodies. As such, it is unlikely that, for example, annual comparative data will become readily available to researchers. In this review, the data found largely came from sexual-health-related clinics in the South of England.

Accuracy

We noted earlier the *c*oncerns about the quality and consistency of crime recording practice used for police data. Crime Survey statistics are, however, good quality. Repeat offences constitute a particular reporting problem. In the Police data, one victim may report several incidents over a year; in the Crime Survey data an arbitrary limit of five incidents per person per year means that actual numbers may be under-reported (Walby and Towers, 2017). The data from the research studies is generally of limited value. It is often difficult to pick out specific UK data; definitions are variable, as with the official data; and recruitment strategies are such as to build in bias to many samples. There is, in addition, a possible distrust of officialdom in some groups, for example, ethnic or sexual minorities. This may lead to a reluctance to respond, or to respond accurately, to surveys both from Government and universities (Hester *et al.*, 2012; Siddiqui, 2018; Gangoli, Bates and Hester, 2020).

Relevance and timeliness

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The data are UK-based and all estimates derive from sources later than 2007. The Police and Crime Survey statistics are regularly updated. The data from the non-high-risk clinical areas is not routinely collected and, therefore, will not necessarily be relevant and timely for researchers.

Consistency with other studies

The figures reported here for IPV are consistent with those reported in previous studies: Feder et al found lifetime prevalence in UK women of between 13-31% and one-year prevalence of between 4.2-6% (Feder *et al.*, 2009); Spiby reported prevalence rates in clinical population studies of women of between 4-19.5% (Spiby, 2013). Following Spiby's report, commentators to the National Screening Committee asked for prevalence rates in other populations to be described; hence the work reported here. This has shown that, in the general population, men experience a lesser risk of IPV than women, although the former is not negligible. Men in intimate relationships with men may face a higher risk of IPV. Indications for ethnicity are that prevalence rates of IPV do not vary greatly but this finding is too weak to state with any confidence. Stronger indications, based on secondary analysis of CSEW, suggest that people with mental health problems and with dementia are at higher risk of IPV.

Study Limitations

A rapid review design was used in accordance with the requirements of the funder and the associated short time frame available. This is less thorough than a systematic review. For example, there was no search for grey or unpublished literature (although one [Jonas et al. n.d.] was included having been picked up from the four items found in the hand search of systematic reviews). In addition, quality appraisal of the articles was limited and was not performed on Police and Government data. We comment on the significance of this in the discussion above.

CONCLUSION

The study shows that published survey data show IPV to be a significant personal, social and health burden. However, problems with variable definitions of IPV make accurate estimation of prevalence difficult. There are important gaps in available data, particularly regarding sexual orientation and pregnancy; these are areas that might require specifically tailored interventions. The policy implications are that surveys,

particularly the crime surveys used in official data, should use a consistent definition of IPV and related violence and collect data using these consistent definitions. In addition, such data should include categories of pregnancy and sexual orientation.

Finding the data to answer even the broad-brush question of the extent of IPV in the UK population is constrained by problems of definition. Crime surveys provide the best data but use inconsistent definitions and terminology. Police data presents additional problems of quality. Parsing the data further to consider gender is reasonably straightforward as this is routinely collected in all cases. Ethnicity data are also routinely collected in England and Wales but not Scotland and Northern Ireland. Very little routine data relates to sexuality or to pregnancy. Crime survey data could be improved through the use of consistent subcategories of domestic violence, to include IPV. IPV data would also benefit from the consistent use of categories of interest, particularly those in the so-called protected characteristic groups.

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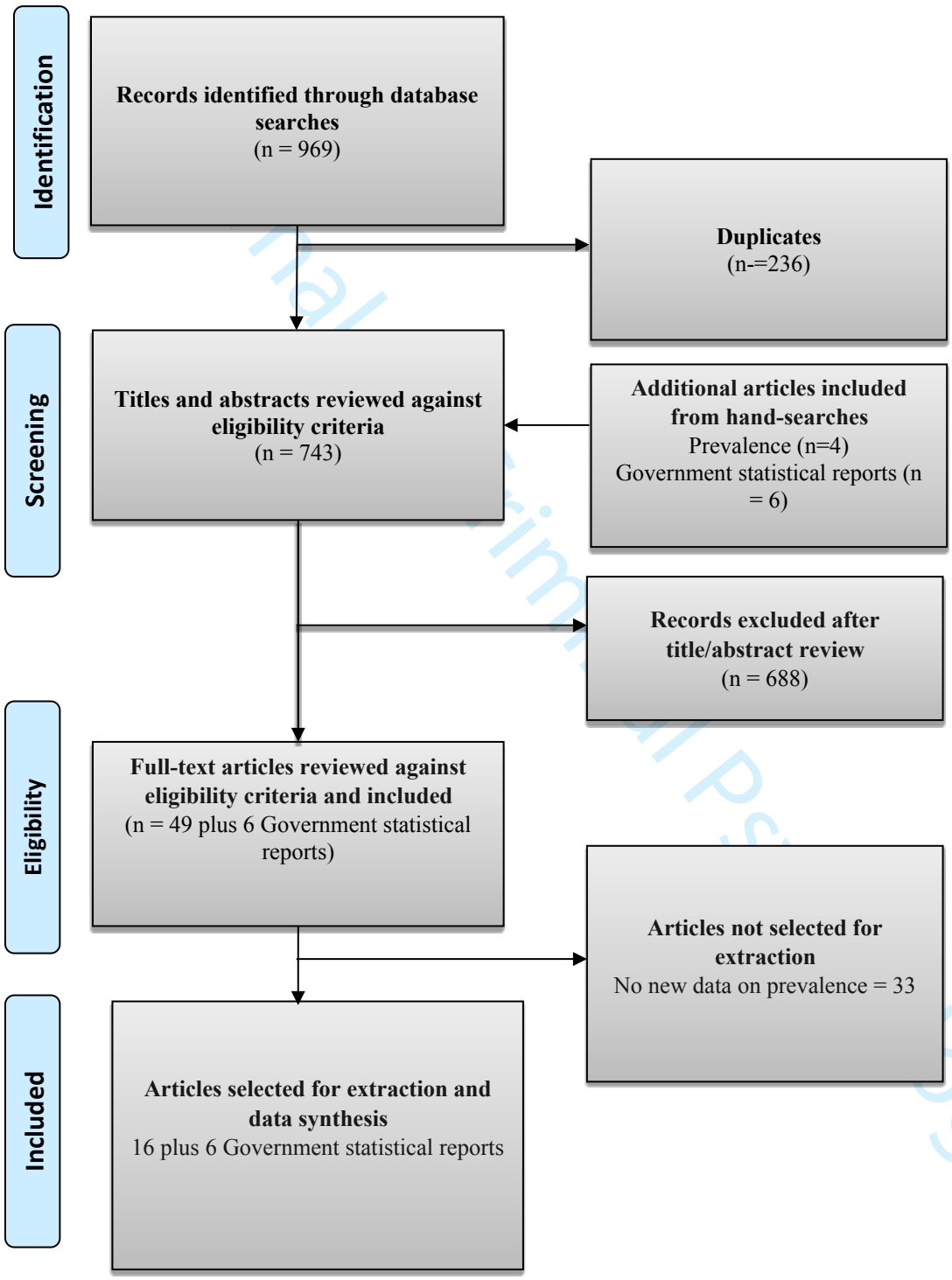
IPV Prevalence PRISMA CHART FIGURE 1

Figure 1: PRISMA CHART



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

Table 1. Intimate partner violence (or nearest definitional equivalent) in the UK: statistics from Police data, the Crime Surveys and the Adult Psychiatry Morbidity Study [APMS]

Region	Data source	Men and women		Men		Women	
		One year	Lifetime	One year	Lifetime	One year	Lifetime
England & Wales	Police	10%*	ND	ND	ND	ND	ND
	Crime survey	4.50%	17.4%	2.70%	13.2%	6.30%	28.9%
	APMS	ND	23.5% (England)	ND	ND	ND	ND
Scotland	Police	1.1%*	ND	0.37%	ND	1.60%	ND
	Crime survey	2.90%	14.10%	2.40%	9.20%	3.40%	18.50%
N Ireland	Police	1.6%*	ND	ND	ND	ND	ND
	Crime survey	1.8%	12.10%	0.9%	8.4%	2.5%	15.1%

* = Domestic Abuse or Domestic Violence (all other figures are for IPV or "partner violence"). For definitions see "Purpose of this review, above"
ND = No data
APMS = Adult psychiatric morbidity survey

Sources: Crime Survey of England and Wales;
Police incidents or crimes in England and Wales;
APMS;
Scotland Police incidents or crimes;
Scottish crime survey;
Northern Ireland Police incidents or crimes;
Northern Ireland Crime survey

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Reviewer 1	
However, the study is not appropriately described - it is titled and described in the title and the methods as a 'rapid review' and reference is made to Nunn in BMC; however, this article refers to scoping reviews - which I think this is what the present review is. A rapid review uses a specific and more comprehensive methodology as described by the Cochrane Library. Therefore. the authors should clarify this, decide which it is and justify and explain accordingly.	We used the term rapid review in accordance with an older definition, that of Grant and Booth in 2009. This is less specific than that described by Cochrane whose recommendations we would now follow. We have addressed this in the design section.
In Table 1 reference is made to APMS but this is not explained in full anywhere else in the text. Also, Table 1 needs a much more explicit title as it is quite hard to understand what the table is telling the reader - or maybe more explanation in the le	The APMS reference is clarified in the text, on page 8. The table title is changed.
Reviewer 2	
It does, however, need to make a much stronger case for exactly how it contributes to the literature, and how it addressed its second research aim.	See below – section on Discussion.
Abstract	
Please give some more detail on the 'low risk clinical population ' Please give some examples of methodological challenges, and define rapid review Results – what about the clinical population? Originality – original how?	These points are now addressed.
Introduction	
p.4 – line 23 – Please provide some references to support these Sentence structure is also confusing and would benefit from being re-written with more clarity	This section has been substantially amended with a removal of some repetition. The references required are now earlier (from the paragraph beginning "Measuring the prevalence of IPV is challenging."
p4 – line 34 – Please give some examples of types of injuries. It might also be worth noting that the psychological effects can long-term result in further health problems as well	This is now covered in the paragraph beginning "IPV can result in serious health impacts".
p5 – line 3 – Please give some further detail on what exactly is defined as a clinical population	A sentence has been added for clarification just before the Methods section.
p5 – line 17 – I think the comment in domestic homicide is too brief. It the authors wish to discuss this (which I think is	In this article we do not have any particular focus on homicide. Here it is used mainly to reinforce the point that women suffer IPV to a greater extent than men.

useful) – please give some more detail on this	
p5 – line 44 – this paragraph appears to be mostly a repetition of the same one above?	Yes – we have removed it.
p6 – line 7 – A consideration of how this group of professionals might be particularly useful for this as they can theoretically identify victims who are not themselves disclosing IPV would be good. Overall, I think this point should be stressed throughout.	Sentence altered to make this point PLUS some changes to the discussion.
p6 – Please write RQs in present tense	The research question is set out in the paragraph before the Methods section. In addition, tense changes are made in the Methods-design subsection.
p6 – Please give some more detail on what is meant by a clinical population in this context. Were high risk groups excluded?	A short phrase in parenthesis has been added – there is also some clarification in the abstract.
p7 – Some further comment on the utility of including a quality measurement (if not informing study inclusion) necessary	A small change is made in the section headed "Analysis". A more significant change, the addition of a paragraph, is made in the results section.
Results	
Overall, I would like more of an engagement with the research aim of 'usefulness' in the results, as this is key for this review. I would also like further engagement with the study quality of the reviews here. This is briefly discussed in the 'discussion', but I think it is warranted further comment in the results, too.	This is done, particularly in the paragraph headed "In terms of the quality of the research …"
p10 – line 21 – Who were the perpetrators in the other instances?;	Sentence altered – adding "the other perpetrators were men who were former or current partners"
line 25 – Where is this quote from?	"made to feel worthless" – reference added.
p10 – line 40 – I think some comment on the potential for reduced reporting rates among these groups; lack of trust in societal institutions etc would be useful	A sentence is added to the discussion.
p11 – Line 30 – Some comment on cause and effect would be useful on the topic of mental disorders – isn't this data mainly in line with the consequences of IPV?	Sentence and reference added in the section headed "Other sub-population characteristics".
Discussion	
The discussion needs to engage much more with how the review addressed the second RQ, and also specifically outline (I would recommend using sub-headings for this) how the review addressed lessons learned in terms of completeness, accuracy, relevance, timeliness, and relevance. Currently this is largely missing,	The two-part research question is set out in the section just above "Methods". As such, we believe you are referring to the population in clinical areas not identified as high risk. In line with this we have structured the discussion around subheadings of completeness, accuracy and so forth. Under three of the headings (Completenesss, Accuracy and Relevance/timeliness) we have added specific

and the contributions of the review are, as such, rather opaque.	points concerning the clinical population which were, as you say, largely missing from the discussion.