Title

Effectiveness of UK-based support interventions and services aimed at adults who have experienced or used domestic and sexual violence and abuse: A systematic review and meta-analysis.

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Abstract (293/350 words)

Background: Domestic and sexual violence and abuse (DSVA) is prevalent and harmful. There are a range of support services and interventions available to those affected by it, but evidence of their effectiveness is uncertain. We synthesised evidence on the effectiveness of UK-based interventions and services for DSVA.

Methods: We conducted a systematic review and, where possible, meta-analysis. We searched MEDLINE, EMBASE, PsycINFO, Social Policy and Practice, ASSIA, IBSS, Sociological abstracts, SSCI and grey literature sources for publications published from inception to July 2023. We included randomised controlled trials, non-randomised comparative studies, pre-post studies, and service evaluations of support interventions or services for adults who had experienced or perpetrated DSVA. The intervention typology and selection of outcomes was determined based on co-production with stakeholders. The quality of the studies was assessed independently by two reviewers. Where meta-analysis was not possible, we synthesized studies with vote counting based on the direction of effect.

Results: Twenty-nine UK-based studies were included: 11 on advocacy, five on outreach, six on psychological interventions or services for victims-survivors, and six on perpetrator programmes. Meta-analyses showed benefits, with 58.7% (95% CI 53.6, 63.8) of advocacy and 46.2% (95% CI 39.1, 53.3) of outreach intervention and service participants reporting cessation of abuse at case closure. Vote counting was performed for psychological support interventions and perpetrator programmes, and showed positive effects on self-esteem and attitudes towards sexual offending. Most studies had a high risk of bias.

Conclusions: There appear to be benefits of UK-based advocacy and outreach services, psychological support interventions, and perpetrator programmes. However, risk of bias and methodological heterogeneity means that there is uncertainty regarding the estimated effects. There is need for more robust research, and a co-produced core-outcome set to facilitate future research in this field.

Review registration: PROSPERO (CRD42022339739).

Key words

Domestic abuse, sexual violence, services, interventions, safety, wellbeing, systematic review

Background

Domestic and sexual violence and abuse (DSVA) refers to physical, sexual, emotional, and any other form of violence and abuse from a current or former partner or family member, and sexual violence and abuse from non-partners. DSVA is prevalent globally, including in the UK. In the year ending March 2022 over 1.5 million domestic abuse-related incidents and crimes were recorded by the police [1], and a further 193,000 sexual offences were recorded in the same period [2]. An estimated 10.4 million people aged 16 years and over have experienced domestic abuse [1], while 7.9 million have experienced sexual assault in England and Wales since the age of 16 [3]. These figures are likely to be underestimates, with fewer than 24% of domestic abuse-related crimes being reported to police [4], and five in six women who are raped not reporting [5]. Underreporting experiences of violence in surveys such as the Crime Survey for England and Wales can result from social stigma [6], or from fear where victim-survivors are still living with someone who uses violence, and be influenced by the survey framing (e.g., whether focused on health or crime) [7].

The impacts of DSVA are wide ranging, for both individuals and society. DSVA damages both physical [8-14] and mental health [7, 15-19], financial stability, relationships, and housing security [20-22]. Societal costs include strain on the criminal justice system, health and social services, and police. For instance, police in England and Wales receive an estimated 100 calls per hour relating to domestic abuse [23], and the total police costs associated with domestic abuse incidents are estimated at £999 million [24]. The overall cost of domestic abuse over a one-year period (March 2016-2017), including costs to victims, the economy, health services, police, government and charities, has been estimated at £66 billion [24]. Further, the economic and social cost of rape and other sexual offences for 2015-2016 has been estimated at £12.2 billion [25].

Due to the high cost of DSVA, developing effective responses is crucial. It is internationally recognised that preventing the recurrence of DSVA and preventing or limiting its impacts means changing social norms, attitudes and behaviours that underpin violence, which requires intervention at individual, relationship, community/organisational and societal levels [26]. Interventions to prevent revictimisation and perpetration focus on addressing these root causes, as well as risk and protective factors known to be associated with violence, by providing remedy and support to victim-survivors to empower them to regain control of their lives, and holding perpetrators accountable whilst offering them meaningful opportunities to change [27]. Whilst the theory(s) underpinning DSVA interventions differ according to their specific aims and remits, most draw upon a combination of patriarchal/feminist, psychopathological, intersectional and systems-level theories and principles [28, 29].

In the UK, there are a range of support services and interventions for people who have experienced DSVA, including refuges, advocacy such as Independent Domestic Violence Advisors (IDVAs), referral, outreach, and helplines. These are often provided by the Voluntary and Community Sector (VCS), although may also be located in the public or private sectors. The specific aims of each type of service and intervention vary, as do the specific type(s) of support offered, be that practical (e.g., housing, financial support), psychological (e.g., increased coping and resilience, space to process trauma), or informational (e.g., about other services, options, and next steps). While the specific mechanisms underlying the benefits of such support for those accessing them are unclear and vary between individuals, one potential mechanism is that accessing these types of support and resources may improve mental health, wellbeing, and feelings of empowerment. In turn, this may facilitate those experiencing DSVA to be in a better position to achieve their own goals and live a life free from abuse [30, 31]. Domestic Abuse Perpetrator Programmes (DVPPs/ DAPPs; hereon referred to as perpetrator programmes) are another type of support service that aims to keep survivors safe and hold perpetrators accountable [32].

Rehabilitative work with domestic violence perpetrators exists largely in the form of behavioural change “treatment” interventions, based on the principle that men must take responsibility for their abusive behaviour and that such behaviour can be unlearned [33]. Perpetrator programmes provide various services and information to clients, including skills training, cognitive behavioural therapy (CBT), motivational interviewing, psychoeducational interventions and work around social learning, power and control [34]. As well as working with perpetrators on a one-to-one or group basis, some perpetrator programmes often work with partners and/or families as well. UK evaluations have employed a wide range of outcome measures, including reductions in or cessation of abusive behaviour, attitudes and beliefs on gender, women and violence, levels of and resilience to repeat victimisation, quality of life (of both the perpetrator and the victim/partner), feelings of safety and well-being of women/partners (and their children), and levels of parenting stress [33, 35].

Existing systematic reviews of DSVA services and interventions [36-39] and perpetrator programmes [33, 40] are limited in that: (1) they focus on a single type of support intervention or service and therefore cannot make comparisons across service types; (2) many have not performed comprehensive grey literature searches or included stakeholder advisory groups and therefore may not be accurate reflections of the full picture, a particular drawback given that much of the evidence-base in the field of DSVA is not published in peer-reviewed formats; and (3) they are not directly applicable to the UK service and policy context.

One problem facing syntheses of evidence in this field is the wide-ranging outcomes used to assess effectiveness. Our recent scoping review identified 426 outcomes across 80 studies, with only 46.9% used in more than one evaluation [41]. As a result of this scoping review, we recommended the development of a core outcomes set, co-developed with funders, service

providers and people with lived experience, so that a more cohesive and relevant evidence base can be built. For this review, we use findings from our scoping review which identified the most commonly reported outcomes, including outcomes relating to safety and wellbeing, together with stakeholder consultation, to inform and direct the focus of the review, and to best synthesise the current evidence base.

Our aim was to review the peer reviewed and grey literature to identify studies that assessed the effectiveness of support interventions and services for people who have experienced DSVA. This review was conducted as part of a programme of research undertaken by the VISION Consortium aiming to reduce violence and health inequalities through better measurement and integration of data.

Review question

How effective are UK-based support interventions and services (targeted at adults of any gender who have experienced or used DSVA) at improving safety and wellbeing?

Methods

Protocol and registration

The review follows the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA)[42] checklist and Synthesis without meta-analysis (SWiM) reporting guidelines [43] (Additional file 1). The protocol for the review has been registered on Prospero: CRD42022339739.

Deviations from the protocol

The review largely adhered to the published protocol. However, one exception was the categorisation of interventions and services. In the protocol, we proposed intervention and service categories that included combined outreach and IDVAs under the umbrella term 'community outreach'. However, during the process of the review, this was amended in line with a series of reports published by SafeLives, a UK-based domestic abuse charity that provides frontline services and collects and publishes national data and evaluation reports. These SafeLives Insights reports provide data from the largest dataset on domestic abuse in the UK, gathered from services working with victim-survivors of domestic abuse. On the basis of these reports, which provide data separately for outreach and IDVA services, we also separated these into two forms of intervention and services.

Additionally, we originally aimed to describe the included studies according to the TIDieR framework [44], however ultimately opted not to as many of the studies described services rather than traditional interventions, which did not map well onto the TIDieR framework.

Eligibility criteria

Population: Adults who have experienced DSVA or who have perpetrated DSVA. Adults were defined as those aged 16 years or older, consistent with the National Institute for Health and Care Excellence quality standard for domestic violence and abuse. DSVA was defined according to the UK cross-governmental definition of domestic violence and abuse (DVA) (2013) [45], the Domestic Abuse Act 2021 [46], the Istanbul Convention (Article 36) [47], the World Health Organisation definition of sexual violence and abuse [48], and the Rome Statute of the International Criminal Court's (ICC) Elements of Crimes (2013) [49]. The distinctions and overlaps between these definitions were discussed in the review protocol [50]. While this review uses the term 'people who have experienced DSVA', it

should be noted that there are different terminology preferences between organisations within the VCS, therefore this may also be used interchangeably to mean victims of DSVA, survivors of DSVA, and victim-survivors. Similarly, while this review refers to 'perpetrators of DSVA', this term has been contested by some who prefer the term 'people who use violence'. No limit was placed on time since the experience of DSVA, so long as participants accessed the intervention or service as an adult.

Interventions/services and outcomes: The specific forms of interventions and services (hereafter referred to as 'interventions' only) included in this review were determined by a two-stage process. Initially, any outcome relating to safety or wellbeing and any form of support intervention meeting the following criteria was included:

- Studies of any secondary or tertiary prevention support interventions were eligible for inclusion. Primary prevention was not included as these target people who have not yet experienced violence.
- Entry to the intervention had to be determined by the experience of DSVA.
- There was no restriction placed on the format or duration of the intervention.
- Interventions that are not primarily aimed at DSVA were excluded.
- Perpetrator programmes were included as they are another form of intervention that may be effective in reducing DSVA and improving outcomes for people who have experienced DSVA.
- Outcome data had to be reported for two or more time-points and/or for two or more groups, so that cause and effect could be inferred.

Following consultation with stakeholders (see the stakeholder consultation section for more details) and according to the results of our scoping review [51], it was agreed that only the most commonly reported outcome for each category of intervention would be included (or outcomes, if the most commonly reported outcome was tied between more than one).

Additionally, outcomes (and therefore interventions) would only be included if the most common outcome for that category of intervention was reported by at least three studies, to allow for meta-analysis. As a result, four types of interventions and four distinct outcomes were included in the review:

Victim-survivor interventions:

- Advocacy: Cessation of abuse according to the Severity of Abuse Grid
- Outreach: Cessation of abuse according to the Severity of Abuse Grid
- Psychological support: Self-esteem according to the Rosenberg Self Esteem Scale

Perpetrator programmes:

- Balanced Inventory of Desirable Reporting (BIDR); Questionnaire on Attitudes Consistent with Sexual Offending (QACSO)

Comparator: Where applicable, comparators could be another intervention, usual care, no support intervention or wait-list controls. For uncontrolled before and after studies, the comparison was the change from pre- to post-intervention.

Study designs: Any type of interventional study reporting outcomes at two or more time-points and/or making comparisons between two groups, including randomised controlled trials (RCTs), non-randomised comparative trials, and uncontrolled before and after studies were included. Cross-sectional studies, case control designs, qualitative studies and studies that were descriptive only and did not provide data on effectiveness were excluded.

Setting: Any UK setting was included.

Other criteria: Given the focus of the review on the UK setting, only English language reports were included. There was no restriction in terms of date.

Information sources and search strategy

Searches of the following electronic databases of peer-reviewed articles were conducted to identify potentially eligible studies: MEDLINE, EMBASE, PsycINFO, Social Policy and Practice, ASSIA, IBSS, Sociological abstracts, and SSCI. Key search terms included terms relating to DSVA (e.g., “domestic violence”, “partner”, “sexual violence”), specialist support services and interventions (e.g., “specialist service”, “support”, "outreach", “refuge”), and the UK (e.g., “United Kingdom”, “England”, “Wales”, “Scotland”, “London”). Terms were combined using Boolean operators.

A comprehensive grey literature search was also conducted comprising three strategies. Four electronic grey literature databases were searched: National Grey Literature Collection, EThOS, Social Care Online, and the Violence Against Women Network, using a simplified version of the previous search strategy. Search terms included “domestic violence”, “sexual violence”, “service”, “support”, and “intervention”. A call for evidence was also circulated via email to 295 local and national DSVA services and organisations and relevant research networks to request any service evaluations or reports relevant to the review questions and meeting the inclusion criteria to be shared. Contacts were emailed again if there was no initial response after two weeks. Finally, websites of relevant UK-based DSVA organisations were searched for relevant reports, research and publications. Where there were numerous pages of potentially relevant results, only the first five pages were assessed. For websites with a search function, the following terms were searched: “Service”, “Evaluation”, “Intervention”, and “Report”. Both the peer reviewed and grey literature searches were conducted on 21st June 2022 and updated on 5th July 2023.

Backwards and forwards citation tracking was carried out for all included studies, and reference lists of identified and relevant systematic reviews were also checked to identify

261 further potentially relevant studies. See Additional file 2 for an example of the search
262 strategy used for one peer-reviewed and one grey literature database.

263

264 **Selection of studies**

265 The process for the selection of studies varied according to the method of identification. All
266 records identified from peer reviewed and grey literature databases were exported into
267 Endnote. All reports obtained from the call for evidence were manually added to the same
268 Endnote Library. Finally, rather than manually adding all reports identified on individual
269 websites, titles and abstracts or descriptions of reports were assessed according to the
270 inclusion and exclusion criteria, and only those deemed potentially relevant were
271 downloaded and manually added to the Endnote library. Duplicates were then removed. The
272 de-duplicated records were uploaded into Rayyan [52], and all were then screened by title
273 and abstract against the inclusion and exclusion criteria for possible inclusion. Where there
274 were multiple reports from the same study, such as a protocol or appendices, the primary
275 report was identified, and additional reports were labelled as subsidiary and given the same
276 study identifier. Thus, the unit of analysis for the review was the study, not each individual
277 report. Reports that appeared to satisfy the eligibility criteria based on titles and abstracts, or
278 where it was unclear, then underwent a full text screening. This was primarily done by one
279 reviewer, with a second reviewer independently screening 20% of titles and abstracts and
280 then full texts. Disagreements between reviewers were resolved by discussion, or through
281 discussion with a third reviewer until consensus was reached.

282

283 **Data extraction**

284 A piloted data extraction spreadsheet was used to extract and record information from each
285 included study. This included basic study information, such as authors, date, study design,
286 and funding, information about the setting, participant details, intervention details including

comparator groups where appropriate, the reported outcomes and results. Where there were multiple reports from the same study, relevant data from all reports were extracted into a single entry. Data extraction was completed by one reviewer, and independently checked by a second. Any disagreements were resolved through discussion, with a third reviewer involved where discussions could not be resolved. Where data were missing, corresponding authors were contacted and asked to supply said data.

Risk of bias

All studies underwent a risk of bias assessment. Randomised controlled trials were assessed using the Cochrane Collaboration RoB2 tool [53]. Non-randomised comparative studies were assessed using the Cochrane Collaboration ROBINS-I tool [54]. Non-controlled before and after studies were assessed using an adapted version of the ROBINS-I tool. Finally, grey literature was assessed using the AACDOS tool [55]. Two reviewers independently assessed risk of bias. All disagreements were discussed until a consensus was reached.

Synthesis of results

We conducted meta-analyses where the data permitted (i.e., there are three or more studies reporting the same outcome measure and sufficient data is reported), and a narrative synthesis for outcomes where meta-analysis was not possible, following the SWiM guidelines [43]. Specifically, we adopted the method of vote counting based on the direction of effect where meta-analysis was not appropriate. The selection of this method was based on the available data in the studies. All studies meeting the inclusion criteria were included in the synthesis, regardless of study design, risk of bias or indirectness. For both meta-analysis and vote counting analysis, studies were grouped according to the type of intervention. This was because the different types of interventions varied in terms of their aims, the type of

support provided, and outcomes reported. For vote counting analysis, results are presented using tabular methods, reporting key study characteristics (including study design, sample size and risk of bias), and discussed narratively.

Where appropriate, meta-analysis was conducted using a random effects model in Stata 18. The specific method of meta-analysis varied according to outcome and data type, and study design where applicable. For instance, all but one of the studies reporting the cessation of abuse outcome were uncontrolled before and after studies. There were no statistically robust approaches to meta-analyse dichotomous data for single-group data, and given that at baseline none of the participants would report cessation of abuse, therefore the event rate would be zero, a meta-analysis of proportions was conducted using the post-intervention data only. In effect, this provided both the pooled prevalence of the cessation of abuse, and the change, from pre- to post-intervention. For the three outcomes using continuous data, meta-analyses of change scores were planned using mean change and standard errors, however a combination of insufficient reported data, small study sizes, and inconsistency in how outcomes were utilised ultimately meant that meta-analyses were not appropriate. Results of the meta-analyses are presented using forest plots and discussed narratively.

Levels of heterogeneity were assessed using the I^2 statistic and Cochran's Q. Subgroup analyses were planned where heterogeneity was substantial or considerable (defined as I2 =50-90% and I2 =75-100%) [56]. Subgroup analyses to investigate heterogeneity included: study design; setting (VCS; private sector; public sector); relationship between the person who has experienced violence and the perpetrator of violence (e.g., (ex)intimate partner; stranger; domestic but not partner; friend/acquaintance; professional; mixed/any); the population the service or intervention is aimed at (e.g., those who have experienced violence; perpetrators of violence; both); type of service or intervention provider (e.g.,

specialist DSVA; specialist but not DSVA; non-specialist); and type of violence (e.g., primarily DVA focused; primarily sexual violence and abuse (SVA) focused; combined DSVA).

We conducted sensitivity analyses, removing studies that had a high or very high risk of bias and removal of one study at a time, to explore for potential biases. Certainty was assessed using the GRADE framework, which takes into account risk of bias, inconsistency, imprecision, indirectness and publication bias.

Stakeholder consultation

An advisory stakeholder group comprising professional representatives from six specialist DSVA organisations involved in the delivery, planning, funding or support of specialist DSVA support services in the UK was established as part of the VISION Consortium. The group included representatives from two second-tier (i.e., organisations that support front-line services but do not provide services themselves) domestic abuse organisations, one second-tier organisation for violence against Black and Minority Ethnic women and girls, one domestic abuse organisation that provides a range of front-line services, one service focusing specifically on supporting male victims, working with perpetrators of domestic violence, and working with young people using violence in close relationships, and one service focusing specifically on sexual violence and abuse. The group was recruited by the VISION programme of research to contribute to and co-produce research that improves the understanding of the relationship between violence, health and inequalities and improves data collection for public benefit.

We held two workshops with stakeholders; one in September 2022 and one in June 2023. The two-hour workshops were structured and included a mixture of presentations focused on the systematic review methodologies, and discussions based on open ended questions.

During the first workshop, the group inputted to the design of the study protocol and provided insight and context regarding the challenges in measuring the effectiveness of support services in the VCS. Their input resulted in several changes, including broadening the scope of this review to try to identify evidence relating to victim-survivor wellbeing and perpetrator attitudes and behaviour, rather than focusing only on outcomes directly related to violence cessation, to reflect the priorities of the sector.

During the second workshop, stakeholders aided with the interpretation of preliminary data, and helped to shape the analysis approach. For instance, the initial approach to the systematic review was to use the scoping review to identify the five most commonly reported outcomes, and then to work with stakeholders to prioritise these in terms of importance and relevance. However, through discussion with the stakeholders it became clear that it was not appropriate to apply one outcome to each and every type of intervention, as they do not all have the same aims and therefore would not be expected to impact the same outcomes. As a result, the method described in the eligibility criteria section was adopted, whereby the most commonly reported outcomes for each individual intervention were identified.

Results

Selection of sources of evidence

The peer reviewed literature search retrieved 19289 records, and the grey literature search retrieved an additional 1096 records. After duplicates were removed, there was a total of 13527 records, of which 12517 were excluded and 903 underwent full text screening. Overall, 28 studies were included from 36 reports [57-92] (Figure 1).

Study characteristics

Details of the included studies can be found in Table 1. Of the 28 studies, 23 described interventions for people who have experienced DSVA, while six described programmes aimed at perpetrators of DSVA. The interventions for people who have experienced DSVA involved a total of 42,850 participants, the majority of whom were heterosexual, White British, and predominantly women. A further 246 participants were included in the perpetrator programmes, all of whom were men. Eighteen of the studies focused on DVA only, five focused on adult victims of childhood sexual abuse (CSA), three focused on SVA, and two included multiple forms of abuse. The majority (n=17) were based in the VCS. Of the 23 studies describing interventions for victim-survivors, ten were produced by SafeLives as part of their Insights outcome measurement reports.

Interventions

Advocacy/IDVAs

Eleven studies reported on IDVA services [57, 59-61, 63, 64, 67, 69, 71, 73, 75]. Eight of the studies provided data from multiple IDVA services, representing a total of 158 IDVA services between them. Five of the eight studies were SafeLives Insights reports. All but two of the studies were found in the grey literature search, and the majority (n=9) were located in the VCS. One was a mix of sectors, with one hospital-based IDVA (public sector) and one community-based IDVA (VCS), and for one the sector was unclear. Most studies used an uncontrolled pre-post design (n=10), while one used a non-randomised comparative study design. The eight studies that reported on multiple IDVA services did not describe the individual services in detail, however they did report the usage of various types of support interventions. The most commonly accessed support intervention as part of the IDVA service for all reports was safety planning. Other forms of support commonly accessed included housing, mental health, child-related issues, and multi-agency risk assessment conferences (MARACs). Of the three studies that evaluated a single IDVA service, one compared a

hospital based IDVA to a community based IDVA, one described an IDVA service that supported the work of MARACs and four specialist domestic violence courts (SDVCs), and one described an IDVA service that offered intensive one-to-one support in a medium-term timeframe, that focused on safety planning and risk assessments.

Outreach

Five studies provided data for a total of 86 outreach interventions [65, 66, 68, 70, 72]. All five studies were SafeLives Insights reports. All were found in the grey literature search, all used uncontrolled pre-post designs, and all services were located in the VCS. Because of the nature of the SafeLives Insights measurement service and the datasets it produces, details of the included outreach services are not provided. However, for each publication, the types of intervention and support accessed by people using the outreach service are reported. For all but one publication, the most commonly accessed type of support was safety planning, while for one publication health and wellbeing advice and support was the most commonly accessed support type. The average duration of outreach support ranged from 1.9-4.5 months.

Psychological support

Six studies reported on psychological support interventions [76-81]. All of these were peer reviewed, and five used uncontrolled pre-post designs. One study included a comparator group, but data on self-esteem were not collected for this group, thus only data from the intervention arm were included. Two of the six interventions were in the VCS, while the rest were based in the public sector. Three of the studies used Cognitive Analytic Therapy, which uses a mix of psychodynamic, cognitive and behavioural techniques to aid reprocessing, assertiveness, and transference. One study described a Trauma, Recovery and Empowerment Model, which is a group based cognitive-behavioural therapy. One study

reported a parenting programme called Domestic Abuse Recovering Together, which focuses on rebuilding mother-child relationships and increasing confidence and self-esteem. One paper reported a group therapy which involved journal work, recovery writing and art therapy. The duration of the support interventions ranged from eight to 24 weeks.

All but one study focused exclusively on adults who had experienced child sexual abuse. One included people with a history of interpersonal trauma, including child sexual abuse, neglect, physical abuse, domestic violence or assault. Five of the six studies comprised of women only, while one study only included men.

Perpetrator programmes

Six studies evaluated perpetrator programmes, three reporting the Questionnaire on Attitudes Consistent with Sexual Offending (QASCO) [89, 90, 92], and three reporting the Balanced Inventory of Desirable Reporting (BIDR) [82, 88, 91]. Of the three reporting the BIDR, all were aimed at men who had previously perpetrated domestic abuse. Two of the studies were peer reviewed, and one was found in the grey literature. One used a randomised controlled trial design, whilst the other two used uncontrolled pre-post designs. One was based in the VCS, one in the public sector, and one was mixed. The programme described by Gilchrist (2021) was a behaviour change intervention developed using the Behaviour Change Wheel and the COM-B model of behavioural interventions, while the programme used by Bowen (2003) used a psychoeducational approach, and the programme described by Ormston (2016) utilised a systems approach to change men's behaviour which also works with women and children. The three studies reporting the QASCO all recruited men with intellectual disability who had sexually assaulted women. All three studies were peer-reviewed, used a pre-post design (one used a comparative study design but the second arm was excluded as the population were men who had perpetrated against

children, which is outside of the scope of this review), and two were based in the public sector, while for the third study the setting was unclear. All three programmes used group work and focused on understanding their behaviour, addressing cognitive distortions, and prevention relapse.

Effects of the interventions and services

Advocacy/IDVAs

Twelve arms from eleven studies were included in the meta-analysis (Figure 2). All showed an increase in participants reporting cessation of abuse from pre- to post-intervention (i.e., at case closure). The overall pooled prevalence of cessation in abuse was 58.7% (95% CI 53.6-63.8). The IDVA service reported by Taylor-Dunn and Erol (2019) showed the greatest increase in participants reporting cessation of abuse (77.0%, 95% CI 72.3-81.2), while the dataset collating data from 22 IDVA services produced by SafeLives in 2019 showed the lowest increase (45.3%, 95% CI 43.2-47.4).

Heterogeneity levels were very high ($I^2 = 98.4\%$; Cochran's Q: $\chi^2(10) = 703.7$, $p < .01$), however planned subgroup analyses could not be undertaken because for each analysis, either one subgroup had less than three contributing studies (e.g., study design, sector, type of violence), or studies did not report enough information (e.g., relationship to the perpetrator, type of provider).

Outreach

Five studies were included in the meta-analysis (Figure 3). All showed an increase in cessation of abuse from pre- to post-intervention. The overall pooled prevalence of abuse cessation was 46.2% (95% CI 39.0-53.2). Individual prevalence ranged from 31.5% to 57.1%. As with advocacy interventions and services, there was very high heterogeneity ($I^2 =$

97.6%; Cochran's Q: $\chi^2(10) = 166.5$, $p < .01$). Planned subgroup analysis to explore the potential causes of this could not be carried out because all studies fell into the same category (i.e., study design, sector, source of literature, type of violence, type of provider, relationship to perpetrator).

Psychological support

The Rosenberg Self-Esteem Scale was reported by six studies, however one only reported results graphically, therefore mean scores could not be extracted. None of the remaining studies reported enough data for robust meta-analysis, therefore synthesis was conducted using vote counting based on the direction of effect. This showed that all studies showed a positive impact of psychological support interventions on the outcome (see Table 2 for the effect direction table).

Perpetrator programmes

Meta-analysis was not possible for either the BIDR or the QASCO outcomes, due to either insufficient reporting (i.e., standard deviations not being reported), or discrepancies between studies in terms of whether the total score or subscale scores were reported. Therefore, both perpetrator programme outcomes were synthesised using the vote counting methods, and results are presented in Table 3. All three perpetrator programmes reporting the QASCO showed positive impacts on the outcome, although all had small sample sizes. For the BIDR, Bowen (2003) showed a slight increase in impression management, and a significant increase in terms of the self-deception subscale. Gilchrist et al., (2021) found no change from baseline to end of treatment, whilst the Ormston et al., (2016) found a slight increase in self-deception but no change in impression management.

Sensitivity analyses

We were unable to perform sensitivity analysis by removal of high risk of bias studies as all studies were assessed as having high risk of bias. Sensitivity analysis removing one study at a time was conducted for meta-analysed outcomes (Additional file 5). For both outcomes, removing each study did not substantially change the estimates.

Quality and certainty assessments

One randomised controlled trial [88] was assessed using the RoB2 tool. This study was assessed as having a high risk of bias, due to concerns regarding missing data and measurement of the outcome (Figure 4; Table A1).

Two non-randomised comparative trials [59, 81] were assessed using the ROBINS-I tool. Both studies were determined to have a serious risk of bias, primarily due to concerns regarding confounding variables, missing data, measurement of the outcome due to lack of blinding, and selection of the reported result as neither study had pre-registered protocols available (Figure 5; Table A1).

Nine uncontrolled before and after studies [61, 76-80, 89, 92, 93] were assessed using an adapted version of the ROBINS-I tool. All were judged as having a serious risk of bias. This was again primarily related to issues with potential confounding, some issues with missing data and some concerns regarding a lack of protocol meaning that there may be potential for selected reporting (Figure 5; Table A1).

Seventeen studies [57, 60, 63-73, 75, 82, 91, 94] found in the grey literature were assessed using the AACODS checklist. While this tool does not provide an overall risk of bias rating, it

does allow for the identification of key quality issues, which included concerns regarding a lack of detailed reference lists or sources for some of the publications, lack of transparency regarding limits of the research, and some concerns regarding significance (Table a2).

Evidence certainty was assessed using GRADE. For studies that were not meta-analysed, GRADE assessments were conducted following published guidance [95]. Taking into account the above risk of bias ratings, inconsistency, indirection, impression and publication bias, the certainty of evidence rating was very low for both cessation of abuse and for desirable responding, low for attitudes towards sexual offending, and moderate for self-esteem. Full details of the assessments can be found in Additional file 4 (Table A3).

Discussion

This review is the first to assess the effectiveness of multiple types of support services and interventions for people who have experienced DSVA in the UK, using a comprehensive search strategy encompassing both the peer-reviewed and grey literature, and drawing upon a stakeholder advisory group to guide the development and progress of the review. This review aimed to determine the effectiveness of support interventions and services at improving the safety and wellbeing of those affected by DSVA.

Overview of findings

The review found that both advocacy/IDVA services and outreach services had a positive effect in terms of the proportion of service users reporting that the abuse had ceased by case closure. These findings broadly concur with previous systematic reviews based on evidence primarily from the USA, which have concluded that there is weak support for advocacy in terms of cessation or reduction of some types of abuse, improved quality of life and improved mental health, but that further research and evaluation is necessary [36, 96].

The results for psychological support services similarly suggested a positive effect on self-esteem, with all studies showing a positive direction of effect. This is also broadly reflective of the international evidence, with one meta-analysis of three studies showing non-significant improvements in self-esteem following various forms of psychological support interventions, including cognitive trauma therapy, an empowerment programme, and stress management [97], and another review showing improvements in self-esteem and other wellbeing related outcomes following counselling interventions [98].

In terms of perpetrator programmes, results were more mixed. For the three studies reporting attitudes consistent with sexual offending, all studies showed effects consistent with a positive impact, although this evidence is limited only to sexual offenders with intellectual disabilities and cannot be generalised to other perpetrators of DSVA. Attitudes towards violence has been listed as one of the key factors underpinning prevention of violence perpetration, therefore this does suggest that there may be benefits in reducing violence perpetration. Results for the desirable reporting outcome showed either no effect or negative effects (i.e., increased levels of desirable reporting after the programme). It should be noted that while the BIDR was reported in the three perpetrator programmes as an outcome, with pre- and post-intervention values reported, it's intended use is to assess socially desirable reporting so that other self-reported scales of interest can be adjusted for, rather than being an outcome in and of itself. Thus, it would not necessarily be expected that a perpetrator programme would result in changes to social desirability, therefore these findings are not surprising.

Discordance between review findings and stakeholder views

A major strength of this review was the involvement of the stakeholder advisory group, whose insight in terms of providing context, developing the scope and advising on analysis approaches was invaluable. The stakeholder consultation process also provided some unexpected challenges and incidental findings, such as when there were discrepancies between the evidence and stakeholder views. For instance, stakeholders were disappointed that some of the outcomes that they considered most important and relevant to service users and deliverers were not reflected in the findings of the review. As an example, some of the outcomes that were valued by the stakeholders could not be included in the review due to either lack of evidence, too much variation in how they were specifically operationalised, or because the way in which they were operationalised did not meet the eligibility criteria of the review (i.e., they were not measured at more than one time-point). For instance, stakeholders considered women's self-reported perception of their safety a key outcome of perpetrator programmes, however this could not be included in the review because it was often assessed retrospectively at the end of the intervention only or, when assessed at two time-points, there was too much divergence in how it was measured. On the other hand, the stakeholders considered *cessation of abuse* as an outcome of support services unrealistic. It was clear that for stakeholders the priority was to make those who have experienced DSVA safer, but that striving for perfection (i.e., complete cessation of all abuse, rather than a reduction in the frequency, severity and/or duration of DSVA), was unfeasible, and would likely understate the impact of the service. While cessation of abuse may be the ultimate long-term goal, other short and medium-term goals that focus on enhancing safety over time are more achievable.

Challenges

A challenge in terms of both evidence synthesis in this field and for those commissioning and delivering DSVA services is the large variation and inconsistency in outcomes being

measured to assess service and intervention effectiveness. This is largely driven by funding bodies and the fragile and fragmented funding landscape of DSVA services in the UK. Often various bodies are involved in the funding of a service, each with their own agenda and stipulations as to what service deliverers need to measure to assess effectiveness. This can lead to a single service being required to capture multiple forms of data and outcomes to fulfil different funders' requirements, and these data and outcomes differing between services. Additionally, these required outcomes may be at odds with the service deliverers' own concept of effectiveness, which may result in services choosing to collect further outcomes, where resources allow. A third contributing factor to the variation in outcomes measured is that some services, where funding allows, commission independent service evaluations, which often require additional outcomes to be measured. Thus, the outcomes measured may reflect differing agendas or understandings of what is an important measure of effectiveness.

The above has two consequences relevant to this review. First, the outcomes reported in the included studies may be reflective of what funders require services to report, rather than what service deliverers view as most important or relevant to those they are supporting, or what is most meaningful in the lives of victim-survivors and perpetrators. This may explain the discrepancies noted above in terms of stakeholder outcome preferences compared to those identified in the literature. The second issue is that by including these outcomes in the review, we run the risk of reinforcing that this is how effectiveness should be measured in this field. Therefore, it is important to acknowledge that while the outcomes utilised in this review represent the most consistently used and therefore amenable to synthesis through meta-analysis, they should not necessarily continue to be used if they are not the outcomes that are valued most by service providers and people with lived experience. Instead, focus should be on building up the evidence base for those outcomes that are most valued, identifying them through co-production with survivors and service providers, in a consistent

649 way (i.e., using consistent outcome measurement tools), which will allow for more
650 meaningful syntheses in the future. This may mean increased consistency in funders'
651 requirements and more sustainable funding to facilitate this data collection.

652

653 A further challenge to synthesis through meta-analysis is the inconsistency in how robustly
654 outcome data are reported. This challenge is illustrated in this review. The methods used to
655 identify outcomes should have ensured that meta-analysis was possible for all outcomes.
656 However, whilst meeting the criteria for the review (i.e., three or more studies reporting the
657 same outcome and using the same outcome measurement tool), three could not be meta-
658 analysed due to insufficient or inconsistent reporting (i.e., not reporting standard deviations,
659 only reporting results graphically, use of subscale scores versus total scores). Thus,
660 inconsistency is an issue both in terms of the outcomes used and how they are reported.

661

662 To address this in the future, and allow for subsequent meta-analysis that can be more
663 inclusive, we recommend improving reporting practices by following best practice guidance.
664 Reporting guidelines exist for a range of study types, including randomised trials (CONSORT
665 2010 [99]), observational studies (The Strengthening the Reporting of Observational Studies
666 in Epidemiology (STROBE) Statement [100]), and quality improvement studies (SQUIRE 2.0
667 – Standards for QUality Improvement Reporting Excellence [101]). While there is no
668 reporting guidance specifically for service evaluations, some of the guidance for other
669 designs do apply. In particular, it is important that if the aim is to demonstrate improvement,
670 change, or impact, outcomes need to be assessed at more than one time point. To facilitate
671 meta-analysis, authors should report mean values with a measure of variation (i.e., the
672 standard deviation), and clearly report the number of individuals who completed the outcome
673 measure at each time point. It is also important to avoid only presenting data graphically.

Better reporting, together with more consistency in outcome measures used, will enable larger, and therefore more powerful synthesis in the future.

Strengths and limitations

A major strength of this review is the inclusion of a comprehensive grey literature search strategy. This allowed for identification of reports and evaluations carried out by specialist support services that are not peer-reviewed or identifiable via traditional literature databases, thus reducing publication bias and allowing identification of a wider range of reports. As already noted, the continued involvement of stakeholders was another strength, as this group provided essential guidance on the review as it developed and ensured that the review process was sensitive to the context and the various political, financial and ethical issues and considerations. A limitation of our approach to stakeholder engagement was that we did not explicitly invite input from a lived experience perspective. Whilst many service providers in the domestic abuse sector also have lived experience of DSVA, the input we sought was from a service provider perspective. The insights we gained may have been further strengthened had we also gathered input from a lived experience perspective.

There are several further limitations to the evidence produced by this review. First, all of the peer-reviewed literature had a high risk of bias, primarily due to confounding factors and a lack of information provided, such as a study protocol. The grey literature should be interpreted with the understanding that it has not undergone a peer-review process. Additionally, quality appraisal of grey literature studies highlighted concerns about authority, accuracy and significance. Second, because of the inconsistency surrounding outcome reporting, three of the included outcomes could not be meta-analysed. Vote counting was used instead, based on the available data. This method is only able to determine whether there is any evidence of an effect, rather than what the average effect is, limiting the

conclusions that can be drawn. Third, much of the evidence, particularly for advocacy/IDVA services and outreach services, is based on publications from one service provider (SafeLives), but there is insufficient information regarding the structure and provision of each service represented by the data. It is possible that a service may self-define as advocacy, but a similar service may define itself as an outreach service. Similarly, the specific forms of support offered by advocacy/IDVA and outreach services appear similar (e.g., according to the SafeLives Insights reports, both frequently report safety planning and housing as common forms of support offered and accessed). Therefore, there may be overlap between the categories of services, but because information on how they self-define and descriptions of each contributing service are not reported, the extent of this cannot be determined. A final limitation, as explained above, this review only speaks to evidence for the outcomes that were most commonly measured, which is not necessarily synonymous with being the most relevant or useful outcomes. The danger of this is perpetuating a flawed system where services are evaluated on outcomes that are not necessarily consistent with their aims or ethos. To avoid this, we are clear that this review provides evidence for the effectiveness of support interventions based on the available data, but that work needs to be done to ensure that the most relevant and useful outcomes are measured consistently, to aid services in evidencing their effectiveness and to enable more meaningful syntheses of the evidence in the future.

Implications and future directions

This review highlights the value of UK-based advocacy and outreach interventions for reducing DSVA revictimisation, of psychological support for improving self-esteem and of perpetrator programmes for improving attitudes to sexual offending. However, the lack of high-quality evidence means that there is some uncertainty regarding the effect estimates. There is a need for high quality research that incorporates randomisation between interventions, where appropriate and ethical. Research practices such as publishing of study

protocols, following reporting guidelines and, for research where randomisation is not feasible, considering and accounting for potential confounding factors, would greatly improve the quality and robustness of research in this field.

Another way to improve the robustness of the evidence base would be greater consistency in outcomes being measured to assess effectiveness and greater consensus between researchers, service providers, and funders. Core-outcome sets have been developed through co-production with survivors, practitioners, commissioners, policymakers and researchers, in related areas such as child and family-focused interventions for child and domestic abuse [102]. Developing a core-outcome set specific to adult DSVA that reflect the short and medium-term goals that both service providers and survivors value, building on existing efforts that have been made in this area [103], and underpinning a theory of change towards ending violence, will facilitate cohesion and the development of a robust evidence-base.

It is important to acknowledge that the theory underlying perpetrator programmes in particular is evolving, with recent evidence from the US indicating a shift from traditional approaches, such as psychoeducation and CBT, towards trauma-informed approaches that focus more on the consequences of trauma that may lead to violence perpetration (e.g., [104]). Of the six UK-based perpetrator programmes identified in the current review, traumatic experiences and the potential benefits of using a trauma-informed approach are briefly mentioned in two. However, it is not clear if either programme did go on to incorporate these practices into the development of the interventions. Recent literature suggests that in the UK, trauma-informed perpetrator programmes are being developed and used [105, 106], however this work is still in its infancy. Future work in this area should therefore consider the evidence for more trauma-informed perpetrator programmes and look to assess the effectiveness of such programmes in the UK.

Finally, whilst this review focused on quantitative data to address the review question, there is a wealth of qualitative data that addresses the impact of support interventions on people who have experienced DSVA. Therefore, synthesis of this qualitative evidence would be valuable to complement the current review and provide a more holistic and representative overview of the evidence contributing to this field.

List of abbreviations

ASSIA: Applied Social Sciences Index & Abstracts

BIDR: Balanced Inventory of Desirable Reporting

CI: Confidence interval

DSVA: Domestic and sexual violence and abuse

DVA: Domestic violence and abuse

EMBASE: Excerpta Medica Database

IBSS: International Bibliography of the Social Sciences

IDVA: Independent domestic violence advocate

MARAC: Multi-agency

NRC: non-randomised comparative study

PsycINFO: Psychological Information Database

QASCO: Questionnaire on Attitudes Consistent with Sexual Offending

RCT: randomised controlled trial

RoB2: Risk of Bias 2 tool

RSES: Rosenberg Self-Esteem Scale

SSCI: Social Sciences Citation Index

Declarations

Ethics approval and consent to participate: Not applicable.

Consent for publication: Not applicable.

Availability of data and materials: The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

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Additional files:

Additional file 1. File format .pdf. Checklists (PRISMA and SWiM). Contains the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) and Synthesis Without Meta-analysis (SWiM) reporting checklists.

Additional file 2. File format .pdf. Example search strategy. Contains an example search strategy for one of the peer reviewed literature databases (Medline) and one of the grey literature databases (Social Care Online).

Additional file 3. File format .pdf. Risk of bias assessments. Contains tables A1 and A2, detailing the risk of bias assessments for randomised controlled trials, non-randomised comparative trials and uncontrolled before and after studies (Table A1), and for the grey literature (Table A2).

Additional file 4. File format .pdf. GRADE Certainty Assessment. Contains Table A3, which details the assessments of certainty for each of the outcomes using the GRADE framework.

Additional file 5. File format .pdf. Sensitivity analyses (leave one out analysis). Contains Figures A1 and A2 which show the leave one out analyses for the Cessation of Abuse outcome for advocacy/IDVA interventions outcome, and the Cessation of Abuse outcome for outreach interventions outcome.

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