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# A realist review of which advocacy interventions work for which abused women under what circumstances: an exemplar (Protocol)

Rivas C, Vigurs C

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**[Prototype Protocol]**

# A realist review of which advocacy interventions work for which abused women under what circumstances: an exemplar

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## ABSTRACT

This is a protocol for a Cochrane Review (Prototype). The objectives are as follows:

To assess advocacy interventions for intimate partner abuse in women, in terms of which interventions work for whom, why and in what circumstances. Our strategic objective reflects our higher-order (realist) question (Greenhalgh 2016), with four more specific descriptive questions as subcomponents and foci in our initial exploration of the data. We will determine all answers (as much as possible) from existing evidence.

Research questions

How do the key mechanisms associated with the delivery or use of complex interventions that include advocacy as a component interact with contextual influences, and with one another, to explain the successes, failures and partial successes of advocacy as an intervention?

- What are the active ingredients of advocacy interventions?
- What are the important moderators or contexts that determine whether the different mechanisms produce their intended outcomes?
- To what extent do the views and experiences of women who have used advocacy services match the intervention's aims and outcomes?
- How do organisational and system factors influence implementation of advocacy interventions?

These questions may change as the realist review progresses. We will consider active ingredients, impact and outcomes in relation to qualitatively and quantitatively measured effects.

Strategic objectives

Our strategic objectives are to explain successes, failures, partial successes and small effect sizes in published, empirical studies of advocacy interventions delivered in different settings, and, in particular, to explain mechanisms of effect in heterogeneous, complex, advocacy-containing interventions. This will enable us to make clear decisions on which studies should be aggregated or synthesised in future reviews, as well as how to interpret the evidence in future reviews of advocacy interventions for abused women. It will also enable researchers and developers to design more effective advocacy interventions in the future, determine which outcomes to include, and improve their reporting and evaluation. In addition, it will help policy makers and practitioners to better understand advocacy interventions, and their likely benefit in the local contexts in which they operate.

# BACKGROUND

For a glossary of terms used in this review, please see Appendix 1.

## Description of the condition

### Agency definitions

Partner abuse is recognised as a basic human rights issue (Ingram 2005), but local, national and international institutions have historically disagreed on how to characterise and define it. This is largely due to differences in the ways that agencies work, the outcomes they seek, and the role they play in society (Rivas 2010). One reflection of this lack of consensus are the terms used to describe the phenomenon, sometimes employed interchangeably and sometimes highlighting conceptual nuances or overlapping concepts (domestic violence, battered woman, spouse/wife abuse or (intimate) partner abuse). This confusing situation has hampered coherent, multi-agency responses from the judiciary, health care and community support services (Rivas 2010), reducing their efficacy (Felson 2005). For example, in 2005 an England and Wales cross-government agreement established a core definition of domestic violence as a potential solution. However, it was criticised for considering abuse in terms of discrete acts, or single 'incidents', a result of the various government agencies' reactive way of responding to partner abuse (Rivas 2010). It also ignored the chronicity of partner abuse and the impact on associated social and psychological issues (Feder 2006), which were included in the earlier, international, World Health Organization's (WHO) public health definition of "intimate partner violence" as "behaviour within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours by both current and former spouses and partners" (Heise 2002; WHO 2013a). Therefore, in 2013 the England and Wales Government updated the definition to consider: "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, emotional [abuse]" (Home Office 2013). The official definition in Scotland does not include family members and has no age restrictions (Bell 2017), so it is similar to the US definition (US Office on Violence Against Women 2018). The Northern Ireland definition does not include patterns of incidents (Bell 2017).

While the WHO's definition is crucially different in that it emphasises the effect while the others emphasise the intent, practically the difference may be less great. For example, section 76 of the Serious Crime Act ('s 76') makes 'coercive or controlling behaviour' that has a 'serious effect' on the victim a criminal offence. The provision came into force in England and Wales on 29 December 2015. The Australian definition (of family violence including partner violence), like the WHO definition, explicitly considers both coercion and effect as "violent, threatening or other behaviour by a person that coerces or controls a member of the person's family, or causes the family member to be fearful" (Phillips 2014; Signorelli 2012).

### Review definition

The definition that a study of partner abuse adopts will affect the study in various ways, from its design and participant inclusion criteria to its outcomes and interpretations. This review, therefore, aims to be broad in its definition and so simply defines intimate partner abuse as the abuse of a woman by a male or female partner who currently is, or formerly was, in an intimate relationship with her. We will include abuse perpetrated by ex-partners in the review, since a woman is often at greatest risk when she is preparing to leave or has just left her partner (Brownridge 2006; Wilson 1993), and because women often return to an abusive partner several times before leaving for good (Campbell 2002; Campbell 2004; Holt 2015; Mullen 1999; Shalaunsky 1999). Intimate partner abuse perpetrated against male partners or ex-partners also occurs, but we do not consider this is in this review because the outcomes tend to be less serious (Henwood 2000; Roe 2010), and the risks are thought to differ by gender (Henwood 2000; Roe 2010).

We will include all forms of intimate partner abuse, including physical violence (ranging from slaps, punches and kicks to life-changing physical injuries or homicide), sexual violence (such as non-consensual sex or forced participation in sexual acts), emotionally abusive behaviours (such as stalking; surveillance; intimidation and threats of abuse; involvement of children; prohibition of a woman being away from her partner, leaving the home without a chaperone, or socialising with family and friends; and ongoing belittlement or humiliation), economic control, economic exploitation or employment sabotage (such as preventing a woman from working, determining what work she can do or restricting activities within a work role, confiscating her earnings, restricting access to money or resources in-kind), and other controlling behaviours (Adams 2008; Watts 2002).

### Prevalence of intimate partner abuse

Worldwide, on average, 30% of women experience physical or sexual intimate partner abuse at some time in their adult (post 16-year-old) lives (WHO 2013a). The 2018 Crime Survey for England and Wales reported a similar figure of 26% (ONS 2018); this lifetime prevalence rate is echoed in US statistics (Black 2011; NCIPC 2003). An estimated 15% to 71% of women experience partner abuse in 10 low- and middle-income countries (Garcia-Moreno 2006). Prevalence rates for psychological abuse are generally considered to be much higher but with variation between studies (Carney 2012). Economic abuse rates are similarly uncertain, though an Australian survey suggested a 15.7% rate for

women across age groups (Kutin 2017). In a review of prevalence rates, 4.5% of women have been said to experience forced sexual intercourse by a partner (Carney 2012).

### Economic burden of intimate partner abuse

Women experiencing intimate partner abuse are frequent users of healthcare services and require a wide range of medical services that may be linked to the abuse (Campbell 2002; Davidson 2001; Plichta 2007). The economic cost of healthcare for abused women in the UK (including hospital, general practitioner and ambulance services as well as prescriptions) is estimated to be around GBP 1.73 billion (2008 figures; Walby 2009). There are also substantial costs to other public services (GBP 2.13 billion) as well as costs from lost economic output (GBP 1.92 billion) and human suffering (GBP 9.95 billion; Walby 2009). Studies from the USA also suggest considerable economic consequences for society from intimate partner abuse (Bonomi 2009; Jones 2006; NCIPC 2003), as do studies from Australia (Access Economics 2004; NCRVAWC 2009). The economic burden from childhood exposure to interparental partner abuse in the USA for people aged 20 to 64 years has been calculated as over USD 55 billion (or USD 50,000 per person) (2016 figures; Holmes 2018). These are costs of healthcare spending, criminal behaviour and loss of labour market productivity (Holmes 2018).

Repeat victimisation accounts for 73% of all incidents of intimate partner abuse (WHO 2013a), and there is evidence of a positive, linear relationship between severity of abuse and the use of healthcare services (Koss 1991). Therefore, there has been wide interest in the development of interventions to stop repeat victimisation or at least reduce such recidivism or the severity of the abuse, and to help women to overcome the consequences of abuse.

## Description of the intervention

In this review we will focus on one type of intervention aimed to stop or reduce repeat victimisation: advocacy programmes provided directly to women. Other interventions for women, which we may consider but only if they are given within an advocacy intervention programme, include the provision of: psychological therapy; refuge or shelter care; and basic, first-line response by healthcare professionals, as recommended by the WHO, which may include referral to other services (Bair-Merritt 2014; Colombini 2017; Feder 2013; García-Moreno 2015; Kalra 2017; WHO 2013b).

This review will consider all advocacy programmes. The features of advocacy interventions vary both within and between countries, since their precise aims and content as well as implementation and delivery depend partly on the setting in which they are delivered and the way they are funded (Rivas 2015), and partly on local historical developments of the advocate role (Feder 2006). Advocacy interventions may, for example, include: advice and support for abused women to access and use a specific service or resource or a range of these, including legal, housing, financial, refuges or shelters, emergency housing; informal counselling; guidance on safety planning; education on relationships; and support to improve the women's physical or psychological health. In some settings, advocates may also have a role in bringing about systemic change in the recognition of abused women by clinicians (WHO 2013b). Advocates may be trained lay mentors; community, healthcare or judicial service employees; or volunteers, and they may deliver advocacy for different time periods and at different intensities as well as in different ways and with different foci.

Advocacy usually aims to empower women and so tends to involve the advocate and woman working in partnership to help the woman set and achieve her own goals and understand and make sense of her situation as an expert in her own life (Campbell 1993). It is therefore an individualised, person-centred approach rather than a prescriptive or directive intervention. Advocacy may be offered as a stand-alone service or as part of a multi-component (and possibly multi-agency) intervention. On the one hand, this individualised and multi-access approach is likely to result in more efficacious advocacy, but on the other hand it makes effectiveness and mechanisms of effect hard to evaluate, complicating comparisons in evidence syntheses (Rivas 2015). In this review we will compare and contrast the different approaches to determine what type of contact works for whom, when and where.

## How the intervention might work

There has been no systematic evaluation of the underlying mechanisms in stand-alone advocacy interventions, let alone advocacy combined with other interventions. However, there is some indication as to what these mechanisms may be. Empowerment tends to be described as the mechanism that needs to operate for the active ingredients of advocacy interventions to activate. There are several theoretical frameworks that take empowerment as the mechanism for change at the macro, meso and micro level. At a macro level, feminist perspectives assert that the causes of intimate partner abuse stem from a social and cultural patriarchal ideology that allows men to control women through power and violence. The experience of intimate partner abuse is understood to be fundamentally disempowering (Vigurs 2016; Wood 2015). The proposed solution to this social and cultural problem, then, is one that aims to effect change through the empowerment of women at a social and cultural level. Typically in this approach, advocates can be seen to facilitate access to resources that are a women's right, by connecting and liaising with community supports and services at a meso level for a co-ordinated response to intimate partner abuse. Advocacy approaches that operate at the individual (micro) level to empower women tend to focus on helping her to change behaviours, such as safety planning and help-seeking behaviours. Such approaches will typically include or facilitate access to: cognitive behavioural therapies (CBT); counselling; or motivational

interviewing. Not only do these approaches change a woman's ways of thinking, they may also alleviate depressive symptoms and improve mental health and well-being. Also at the micro level, strengths-based approaches aim to work with survivors of abuse to increase their knowledge, agency and self-efficacy. Strengths-oriented advocates empower the people they work with by setting future goals (Wood 2015), enabling women to access their own strengths and skills and apply them to current problems (Black 2003; Howe 2009).

Trauma-informed approaches for advocacy link the safety and resource needs of advocacy from both feminist and strengths-based approaches. Trauma-informed advocacy involves an understanding of the ways in which trauma is overwhelming, and the ways in which this impacts on beliefs, cognition, memory, emotions and behaviours, constituting a normal response to the trauma rather than a mental health issue.

Trials, and therefore evidence syntheses of complex interventions such as advocacy, increasingly include components from different disciplines, such as psychology and social work, because of the drive to provide the most efficient and cost-effective healthcare in times of austerity (Campbell 2000; Monitor 2013). The coming together of different approaches with different theoretical underpinnings within advocacy programmes (typified by trauma-informed approaches) has not been formally explored to determine additive mechanisms of effect. However, it has been suggested that multi-component interventions that include advocacy are particularly effective because the advocacy addresses an abused woman's immediate needs, which then increases her receptiveness to other interventions (such as psychotherapy or childcare support) (Rivas 2015). It may be instructive to consider the mapping of the different theoretical underpinnings.

## Why it is important to do this review

We believe this is the first realist review of advocacy interventions in intimate partner abuse. We consider that it will offer important insights into how advocacy interventions work. Systematic reviews, such as that by Rivas 2015, typically consider only randomised controlled trials (RCTs) and quasi-experimental studies, and the desired output is a meta-analysis (statistical summary) of the evidence on intervention effectiveness. This is appropriate to the aim of such reviews, which is to determine what works, given that these studies control for intrinsic and external factors to show a clear cause and effect relationship between the intervention itself and specific outcomes. However, meta-analysis of positive effect, negative effect and no effect, and heterogeneity between and within studies, essentially cancel each other out, to little or no effect overall, masking the finding that the intervention may work for some people and not others, or only under some conditions. A realist review draws on a wider range of study types, as its aim is to describe how, why and in what contexts complex social interventions work. The desired output is a 'programme theory': an interpretative, narrative summary of what should happen in different contexts when an intervention or programme is used, and why this happens (Wong 2012), that is, the underlying mechanisms that lead the intervention to work or not work in different contexts (Pawson 2005; Pawson 2006).

By focusing on the mechanisms, moderating and mediating variables, and implementation issues that impact on the effectiveness of different programme components of advocacy interventions, as well as their effectiveness, we believe that more theoretically informed future intervention strategies can be developed and evaluated in more informative ways. This realist review approach will also enable policy makers, practitioners and commissioners of services to understand existing interventions and identify those active ingredients that may be transferable to their local priorities and contexts.

Ultimately, this review will enable more useful, future syntheses of these heterogeneous, complex interventions by helping reviewers and other researchers to make decisions about the focus or design of a systematic review. Importantly, this review was stimulated by a 'what works' or effectiveness review of advocacy interventions for women who have experienced or are experiencing intimate partner abuse (Rivas 2015), and it will specifically inform the next update of that review and partner reviews on psychological interventions for these women. In particular, it is likely to enable a more focused research question for the effectiveness review and more explicit inclusion criteria; the first iteration of the review was written before complex advocacy interventions had gained ground, and its focus and criteria may therefore be out of date. Our realist review will therefore have immediate impact on the evidence base for policy and practice.

Past versions of our Cochrane Review to evaluate the effectiveness of advocacy interventions to support abused women focused only on what works. Without contextualisation, and given the individualised approach to advocacy, as well as primary study and intervention heterogeneity, these versions have been able to draw only limited conclusions and therefore weak recommendations. Our 2009 Cochrane Review, Ramsay 2009, excluded studies evaluating advocacy as an adjunct to another intervention if the control arm was not the other intervention alone, as a deterministic way of separating out the different components. In the updated effectiveness review, Rivas 2015, which included 13 studies internationally, we made the decision to include trials where women in the intervention arm may have received advocacy plus some other form of intervention compared with no care or usual care. We felt that important information might otherwise be excluded from the review given the increasing number of trials evaluating advocacy within multi-component interventions. However, we were not able to make use of this information beyond a narrative synthesis of outcomes, as the heterogeneity of combinations made it unclear which components were leading to - or even diluting - effectiveness. In particular, we included one study that provided advocacy within the context of three possible, further distinct in-

terventions, depending on the abused woman's risk profile: CBT, if at risk of depression; and smoking cessation or reduction sessions, if at risk of smoking or environmental tobacco smoke exposure (Kiely 2010). However, we were uncertain how these additional linear interventions affected results.

Even when effectiveness reviews have considered multi-component interventions directed at abused women, there has been no consideration of the interplay of the different components or of moderating and mediating factors. For example, Tirado-Muñoz 2014 considered psychological interventions, and Rivas 2015 advocacy interventions. Where there was overlap from studies that considered an intervention combining both types of component, each review considered only those components of direct relevance to their focus. As well as being deterministic, choices were not always clear-cut. The two reviews had authors in common and were undertaken over a similar period. We noted author disagreement and uncertainty as to how to classify some components of the different interventions due to a lack of clarity around how individual components led to particular effects within the context of, and interaction with, other intervention components. In Rivas 2015, where necessary information was lacking in papers and not provided by the primary study authors on request, we had to decide whether terms such as 'counselling', 'supportive listening' or 'peer counselling' described facilitation of access to resources (which fit our criteria for advocacy) or psychological therapy (which did not). The results of the realist review may better support such decisions, inasmuch as it may become clearer whether any of these components (even if poorly described) add to the effectiveness of advocacy, and which combination approaches may have most effect. If this happens, and we obtain sufficient understanding from interventions that are detailed more completely, we will make recommendations as to how such components should be described in future trials, to enable further development of our understanding of what works for whom, when and where. The realist review will provide more clarity, not only by exploring the different possibilities in existing studies, but also by drawing more broadly on the literature where this can provide further information (e.g. on theoretical underpinnings).

A further issue that we wish to address is that the outcomes of a complex intervention (and indeed any intervention) are context-dependent, that is, they are affected by various macro-, meso- and micro-level internal and external contextual factors, from the ethnicity and socioeconomic status of the abused women involved to the role and training of the person delivering the advocacy, as well as the setting and the precise content of what is offered to whom (Pawson 2003; Pawson 2009). It is important, therefore, to consider not just what works, but where, in what circumstances, for whom and how, with more focus not only on the interaction and adjunctive nature of different components of an intervention but also on the contexts in which they are played out. These data are available from, and reported by many of the effectiveness studies of advocacy interventions, but they have not been considered in terms of mechanisms of effect. The realist review approach affords us the structure by which to do so.

In a preliminary scope of the literature, we determined that for a woman attending a healthcare setting for a different reason than help-seeking for the abuse, the healthcare setting offers a potential opportunity for first contact, and to frame the intimate partner abuse as a healthcare issue supported by a tacit agreement of confidentiality and trust between client and clinician. The mechanism of empowerment may be moderated by the woman's assessment of her current situation and risk at that time. By contrast, advocacy delivered in shelters can assume that the woman has left the home, if not necessarily the relationship. Advocacy delivered in a shelter may be a proxy measure of another moderator: that of the level of the seriousness of the abuse from which the woman has already taken steps to leave, as a baseline characteristic that may impact on the effectiveness of the intervention. Mechanisms for advocacy delivered as part of judicial services could be a trust in the 'strong arm of the law' and the use of force available to police to protect the woman from her abuser; however, this mechanism could be moderated by the extent to which the woman believes she can maintain control over the degree of judicial involvement.

### Special features of the realist review

During the course of a realist review, authors develop, test and refine a programme theory, which ultimately comprises a set of CMO (context; mechanism; outcome) configurations. These constitute a 'middle-range theory'; that is, a theory "which involve[s] a certain amount of abstraction but which [is] close enough to observed data to be incorporated in propositions that permit empirical testing" (Greenhalgh 2016). To get to this stage, we will consider different CMO configurations during the review. These combine: contextual factors operating when the intervention is used (C); core mechanisms (M) or strategies of the intervention (e.g. empowerment in the case of many advocacy interventions); outcomes (O) of the intervention (planned or unplanned, visible or not, proximal or distal, intermediate or final) (Jagosh 2012). The theory must encompass each possible intervention pathway from strategy to outcome (with each strategy likely to have multiple outcomes), and, for each pathway, all possible interactions of mechanisms and contextual factors.

In developing theory, realist syntheses aim to balance comprehensiveness with theoretical saturation, so they may include fewer and different studies than an effectiveness review on the same topic. Ultimately, a realist review seeks to identify 'demi-regularities' within the fuzzy reality of complex interventions, based on the expectation that although outcomes will vary in different contexts, there will be some patterning in CMO configurations (Jagosh 2012).

In this realist review we will develop theory from qualitative literature as well as from effectiveness and more conceptual studies. The final theory and linked outcomes or impacts, therefore, may be different to, or add to, outcomes already included in the effectiveness review (Rivas 2015), and they are likely to include

more qualitative outcomes that are less easily or less commonly measured. For example, we know from one study that women and their partners valued improved communication after an intervention directed at abusive men, which had not been an expected outcome and therefore was not a primary study outcome (Kelly 2015; Westmarland 2013). This may make it hard to use theory to evaluate previous effectiveness reviews. However, should such qualitative outcomes be seen as important, this would enable us to make recommendations for future studies. Moreover, there is increasing acknowledgement of the need for more qualitative outcomes within effectiveness studies, and for the use of mixed methods. Additionally, and importantly, we are involved in development of a core outcome set for intimate partner abuse (Williamson 2017), with a study design that foregrounds the qualitative experiences of abused women and their families. Therefore, any recommendations to include more qualitative outcomes in future effectiveness studies will feed into the development of this core outcome set.

# OBJECTIVES

To assess advocacy interventions for intimate partner abuse in women, in terms of which interventions work for whom, why and in what circumstances. Our strategic objective reflects our higher-order (realist) question (Greenhalgh 2016), with four more specific descriptive questions as subcomponents and foci in our initial exploration of the data. We will determine all answers (as much as possible) from existing evidence.

## Research questions

How do the key mechanisms associated with the delivery or use of complex interventions that include advocacy as a component interact with contextual influences, and with one another, to explain the successes, failures and partial successes of advocacy as an intervention?

- What are the active ingredients of advocacy interventions?
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- How do organisational and system factors influence implementation of advocacy interventions?

These questions may change as the realist review progresses. We will consider active ingredients, impact and outcomes in relation to qualitatively and quantitatively measured effects.

## Strategic objectives

Our strategic objectives are to explain successes, failures, partial successes and small effect sizes in published, empirical studies of advocacy interventions delivered in different settings, and, in particular, to explain mechanisms of effect in heterogeneous, complex, advocacy-containing interventions. This will enable us to make clear decisions on which studies should be aggregated or synthesised in future reviews, as well as how to interpret the evidence in future reviews of advocacy interventions for abused women. It will also enable researchers and developers to design more effective advocacy interventions in the future, determine which outcomes to include, and improve their reporting and evaluation. In addition, it will help policy makers and practitioners to better understand advocacy interventions, and their likely benefit in the local contexts in which they operate.

# METHODS

Our realist synthesis will follow the steps and procedures outlined in the 'Realist and meta-review evidence synthesis: evolving standards (RAMESES) publication standards for realist synthesis' and associated training materials (Wong 2013a; Wong 2013b; Wong 2017). We will use the information management tool, EPPI-Reviewer 4 (Thomas 2008), to systematically extract information from each study. We will employ the EMMIE realist evaluation framework (Johnson 2015), which codes the **e**ffectiveness of the intervention, the **m**echanism theorised to be at work, **m**oderators that could affect the response to the intervention, **i**mplementation issues in practice, and any **e**conomic costs and benefits information for each study. The EMMIE framework has been developed from health and criminal justice frameworks to evaluate not only the effectiveness of interventions but also to capture information that explain variation of outcomes. This realist approach to evaluation includes assessing the necessary programme components and implementation issues that are of interest to the policy makers or practitioners who wish to implement such interventions.

The review will have three phases and eight operational objectives as follows.

- Phase 1: scoping phase.
    - Gather the full texts of all studies included in the existing effectiveness review of advocacy interventions for women experiencing intimate partner abuse (Rivas 2015), as well as all studies excluded in the final screening stage of this review on the basis of a single criterion mismatch and cited in its 'Characteristics of excluded studies' tables, or determined from reviewers' unpublished records of exclusions.
    - Gain familiarity with the data set by close reading.

- Phase 2: theory generation.

    - Produce a descriptive summary of the scoping phase data to summarise the kinds of research questions that have been asked, how these questions have been addressed (considering intervention details and all possible contextual factors), and the key findings or outcomes. We will include any theories or mechanisms suggested by study authors.

    - Identify additional, relevant publications that might contribute to explanatory theory building about what works for whom in what circumstances, on the basis of the first two objectives. This will involve the development of a new search and selection criteria, informed by our descriptive summary and consideration of the theories, mechanisms and contexts that may be linked to outcomes, rather than effectiveness per se. We will add to this further searches of the literature, as needed, developed from a reading of the new material and rechecks of papers already collated. This iterative and recursive approach is important since studies that may seem less relevant at first could end up providing good evidence on specific areas as the review progresses.

    - Develop a realist analysis consisting of candidate theories linking context, mechanism and outcome.

- Phase 3: theory testing and refinement.

    - Undertake systematic data extraction of a range of qualitative, quantitative and mixed methods studies identified from the searches to update the existing Cochrane Review (Rivas 2015), and revisit the studies considered in first objective, to confirm, refute and refine our candidate theories.

    - Summarise middle-range theories for which there is strong empirical evidence of what works for whom in what contexts.

    - Clarify gaps in the knowledge base and make recommendations for further research.

We will keep a full audit trail at all times, with lists of studies included and excluded (along reasons for exclusion) at all stages.

In all searches in all phases, we are likely to exclude many papers at title and abstract screening, but we will obtain the full text of all papers that may possibly include sufficient detail for our review objectives. A second reviewer will check a 10% subsample of included and excluded papers for agreement. We will resolve any differences through discussion and, if necessary, by adjudication by a stakeholder group. This group comprises members of an existing stakeholder group with whom we are working on the development of core outcome sets. The group includes policymakers, academics, women who have experienced abuse, and advocacy providers, and they will have oversight of the study findings as they are developed. We will consult with the group by email or other remote means (e.g. videoconferencing). Although abused women participate in the group, we will not be applying for ethical approval since these women are acting as consultants, rather than study participants. We will, however, maintain ethical principles. We will ask this group to check emerging theory and comment on key decisions. Specifically, we will ask the women to:

- adjudicate on any decisions where the two reviewers cannot agree;

- contribute to developing, refining, adjudicating between, and refuting emerging theories; and

- in phase 3, comment on the credibility and validity of our explanatory theory and its coherence. This will include providing advice about and considering any gaps in the theory, as determined from our test of the theory against studies identified in the phase 3 literature search.

This approach will ensure our review has meaning to the relevant stakeholders, including potential end users.

## Phase 1: scoping phase

The aim of this search is to scope for information that can be used to inform the development of our emerging theory. It differs from some realist reviews in that it will not involve a new primary search, but rather:

- consideration of potentially relevant papers from those identified and included or rejected by Rivas 2015, as detailed in the published review and their unpublished records; and
- supplementary searches based on these papers.

As this is a realist review, based on a realist paradigm, we are interested in the nuanced detail as to why a particular intervention has been more or less successful at impacting on its target outcomes or behaviours and its 'critical ingredients' rather than in the actual effectiveness data (i.e. quantitative findings such as outcome scores and effect sizes). This means that we may exclude some studies from the Rivas 2015 review if they do not contain information that will contribute to the development or testing (or both) of our explanatory theory about why, how and when advocacy interventions for women experiencing partner abuse might work.
It also means that some papers identified and subsequently excluded from the Rivas 2015 review may be relevant to our realist review. For example, Rivas 2015 excluded some studies because they included a considerable counselling element, but these might still contribute key information for the realist review. Others were excluded because they did not fit the study design inclusion criteria; Rivas 2015 only considered randomised controlled trials (RCTs) and before-and-after study designs, whereas we will be inclusive in our use of different study types. We will consider all such papers in the scoping phase of this realist review since the

aim of this phase is to scope for candidate theories, mechanisms and contextual factors that may be linked to outcome, and that we can explore in more detail in phase 2.

### Selecting papers for inclusion

We will begin by considering the full text of all articles included in our Rivas 2015 review, or excluded in the final screening stage on the basis of a single criterion mismatch and cited in its Appendix or, if necessary (e.g. for qualitative studies), noted in their unpublished search records. Thus, we will use the Rivas 2015 review as a starting point from which to develop a first iteration of a core list of papers that will differ from the final list of papers included in that review. Once we have this list, we will supplement it with:

- papers identified through citation chaining (through backward citation tracking of reference lists and Google Scholar forward citation tracking) of all papers that we judge as core to our realist question;
- papers identified through the 'search similar citations' function on PubMed, after entering the title of each key paper in turn; and
- papers that are linked to the effectiveness studies, identified as part of an integrated mixed-methods study or as a 'sibling study' (e.g. qualitative, economic or process evaluations associated with specific effectiveness studies).

We will then repeat the scoping phase process described in this section using the supplementary searches described directly above. We expect to use a comprehensive sampling approach. However, we may instead employ theoretical sampling or extreme case sampling if it becomes clear that this would optimise the analytical value of the realist synthesis.

In all cases, CV will review the full-text papers and make a judgement as to whether the paper includes sufficient descriptive detail or theoretical discussion, or both, to contribute to the explanatory theory, excluding those that do not. CR will check a 10% subsample of included and excluded papers for agreement. Both review authors will resolve any differences through discussion.

We will identify any existing explanatory theories connecting advocacy interventions to outcomes, including advocacy as part of a multi-component intervention. We will start with a list of possible theories drawn from those cited under 'How the intervention might work' in the Background, such as feminist, psychological, strengths-based and trauma-informed approaches to empowerment, and which we consider from prior experience to be especially relevant. We will add to this list as needed.

We will repeat this iteratively for all new papers added to our inclusion list until we have exhausted this search when we will then move to phase 2.

## Phase 2: theory generation

As we extract data from studies identified in the scoping phase and generate candidate theories as well as detail on relevant moderators or contexts, mechanisms or mediators, and outcomes, we will further augment our list of included studies. The activities in this phase will:

- take contextual or conceptual points from our initial data extraction as stepping stones out to a wider body of relevant literature; and
- focus the literature back down into a well-formed theory, as we iteratively formulate potential theories and search for support or refutation of these in the evidence, adopting, adjudicating between and discarding different versions as we work.

Our approach will therefore differ from the way we obtained supplementary studies in the scoping phase because we will develop new searches that will use keywords based on the theories identified in the first stages of the review and any further relevant keywords identified as we iteratively proceed.

### Search methods for identification of studies in phase 2

This search will be a result of identifying candidate theories in the scoping-phase literature and also gaps in information. These gaps may be filled from studies that might not have anything to do with advocacy or abuse but may describe relevant theories and mediating factors in other settings and for other types of intervention that explain responses to the advocacy interventions. Such studies will include 'kinship studies' that may share a common theoretical origin with the starting-point paper, links to a common antecedent study or a contemporaneous or spatial context. We will use the the BeHEMoTh framework to structure this search, where:

- Be = behaviour of interest: the way the population or patient interacts with the health context; for example, access for a service, compliance or attitude to policy;
- H = health context: that is the service, policy, programme or intervention (including contexts outside of health settings such as judicial settings, if relevant to our emerging model);
- E = exclusions: to exclude non-theoretical or technical models (dependent on volume); and
- MoTh = models or theories: operationalised as a generic "model* or theor* or concept* or framework*" strategy together with named models or theories, if required (Booth 2013).

In each case, our iteratively developed explanatory theory will guide the inclusion criteria.

As with the scoping phase, we will also consider iteratively, and this time recursively too, further papers:

- identified through citation chaining of all papers we include in the theory generation phase;
- identified through the 'search similar citations' function on PubMed for of all papers we include in the theory generation phase; and

- linked to the studies included in the theory generation phase, as part of an integrated, mixed-methods study or as a 'sibling study'.

We include a recursive element because, as theory develops, we may need to revisit previous papers for relevance or further information. Searching will continue until we find sufficient data to enable development of a coherent and plausible theory that is well rounded and can be tested; that is, when 'theoretical saturation' is achieved. This differs from the comprehensive sampling used in the scoping and theory-testing phases.

#### Electronic sources

We will search the electronic sources listed below.

- Cochrane Central Register of Controlled Trials (CENTRAL; current issue) in the Cochrane Library.
- MEDLINE Ovid (1948 to current).
- Embase Ovid (1980 to current).
- PsycINFO Ovid (1806 to current).
- PsycArticles American Psychological Association (1894 to current).
- ASSIA Cambridge Scientific Abstracts (1987 to current).
- CINAHL Plus EBCSCOhost (Cumulative Index to Nursing and Allied Health Literature; 1937 to current).
- Social Science Citation Index Web of Science (1970 to current).
- International Bibliography of Social Sciences ProQuest (1951 to current).
- Health Management Information Consortium Ovid (1979 to current).
- Maternity and Infant Care Ovid (1971 to current).
- *Cochrane Database of Systematic Reviews* (CDSR; current issue), part of the Cochrane Library.
- Database of Abstracts of Reviews of Effects (DARE; current issue), part of the Cochrane Library.
- UK Clinical Research Network Study Portfolio ( www.ukcrc.org/research-infrastructure/clinical-research-networks/uk-clinical-research-network-ukcrn).
- OpenGrey ( www.opengrey.eu).
- Dissertations & Theses ProQuest (1861 to current).
- UK Clinical Trials Gateway ( www.ukctg.nihr.ac.uk).
- WHO International Clinical Trials Registry Platform (ICTRP; www.who.int/ictrp/en).

#### Other resources

We will also search the following websites:

- WHO Violence and Injury Prevention ( who.int/topics/violence/en); and
- Violence Against Women Online Resources ( vawnet.org/publisher/violence-against-women-online-resources).

### Data extraction and management

We will import records for all studies into EPPI-Reviewer 4 ( Thomas 2008), classifying each paper in each of the following four categories: study design, academic discipline (e.g. primary care, legal), country (where the primary study took place) and setting. Using paper annotations and EPPI-Reviewer 4 to aid data management (Thomas 2008), we will note from each study (e.g. from the Discussion sections of the empirical studies), how successful the study was and what explanations for this could be used to develop our candidate theories to be tested further in the next phase of the study. In our preliminary work on this, we have identified the following features as potentially important.

- The underlying programme theory.
- The length and intensity of the interventions.
- Programme fidelity.
- Expertise of the person delivering the intervention.
- The quality of the relationship between the participant and the advocate.
- Stage of change of the participant - whether the participant self-identified as experiencing intimate partner abuse (such as women offered advocacy in a shelter) at the time of recruitment or was identified from a screening process while attending an appointment for an unrelated issue.
- Whether the participant was pregnant or had children, and her socioeconomic status.
- The availability and quality of the services to which she was referred.
- Ethical and safety considerations.

Other possible factors - not identified from preliminary work - might include the following.

- Training and resources required for the intervention and whether these are, in fact, provided.
- Mode of delivery.
- Setting for recruitment and delivery.
- Attitudes and beliefs of those delivering the intervention.

Next, we will extract data on each of the following, if relevant, from each paper.

- Study aims and rationale.
- Academic discipline, determined by considering the academic department of the lead author, the journal of publication and the literature cited (Greenhalgh 2016).
- Country of the primary empirical study.
- Study design.
- Actual sample characteristics.
- Programme or intervention description.
- Programme strategies or underpinning theories.
- Comparator type (referral, counselling, advice).
- Outcomes.
- Methods - sampling strategy.
- Methods - recruitment and consent.
- Methods - data collection.

- Methods - data analysis.
- Length of time to follow-up.
- Effectiveness of the interventions or qualitative themes where relevant.
- Mechanisms (those aspects which explain how an intervention is to work) that are described by the original author. These should be described in the Aims and rationale, Methods, and Findings sections of the studies. In addition, we will consider the explanations offered by authors in the Discussion sections of papers, which we will tag as more speculative.
- Moderators of effect (these include pre-existing characteristics of the participants before entry to the study, such as age or socioeconomic status, whether or not they had children or were pregnant, or level of risk at baseline, which may explain different responses to the same intervention (Kraemer 2002)).
- Mediators (factors of potential influence that occur along a causal chain between the intervention and the aimed for outcomes; for example, the level of trust in the advocate, or feelings of self-efficacy (Johnson 2015)).
- Implementation issues (listing the key components and activities necessary for implementation and the barriers and facilitators to implementation described in the study, such as information on who delivers the intervention, its intensity (i.e. hours per session), duration (i.e. spread over how much time), or other contextual factors in which the intervention was implemented).
- Economic costs and benefits (we will extract these where they are described).
- Risk of bias.
- Weight of evidence.

Both reviewers will analyse the articles in this way and extract relevant passages into EPPI-Reviewer 4 for easier synthesis (Thomas 2008). They will give relevant features labels to aid data management. They will map or chart these data to form a tentative CMO matrix; that is, each study will be represented in the rows of a matrix, and the relevant moderator or context, mechanism or mediators, and outcome details for the study will be listed in the columns. Different extraction procedures will be relevant to different types of evidence. Both reviewers will work together on this, double charting 10% of the studies, and holding regular discussions to ensure agreement on the charted data for all studies.

## Phase 3: theory testing and generation

Phases 1 and 2 will result in a set of candidate theories linking outcomes with moderators or context, mechanisms or mediators, and implementation. In phase 3, we will undertake a systematic search of the literature for studies that can be used to test, confirm or refute our explanatory theory. In this way we will be able to refine it.

We will determine which of our small set of candidate theories is most useful when used with the studies identified in the phase 3 search. We will be open to combining theory elements as needed. We will check for gaps in the theory in relation to:

- aspects of intervention delivery, as these impact on programme outcomes;
- which moderators or context and mechanisms or mediators are driving different outcomes and implementation events at different times; and
- which active ingredients are relevant in different settings.

We will consult our stakeholder group for suggestions where gaps remain.

We will base our phase 3 literature search on the search terms used in Rivas 2015. We will include studies that consider abused women and advocacy interventions according to the definitions given earlier (Background, 'Description of the condition', 'Review definition'). To test our theory, effectiveness studies must consider at least one outcome (planned or unplanned, visible or not, proximal or distal, intermediate or final). We will consider textual data in qualitative studies of views and experiences of advocacy interventions for the contextual factors they describe and any other relevant information. We will exclude studies lacking sufficient descriptive detail. We will require qualitative and narrative studies to include a systematic analysis of primary or secondary data.

As in previous phases, we will also consider for all papers we include in this stage:

- papers identified through citation chaining;
- papers identified through the 'search similar citations' function on PubMed; and
- papers that are linked to the studies identified, as part of an integrated, mixed-methods study or as a 'sibling study'.

### Criteria for considering studies for phase 3

#### Types of studies

We will include all empirical studies (e.g. process evaluations, qualitative research, RCTs, before-and-after studies and systematic reviews). Our more inclusive approach, compared with our effectiveness review (Rivas 2015), has led to changes in the forms of outcomes evidence that we have listed below under 'Types of outcome measures'; for example, the need to include qualitative research outcomes.

We will undertake a separate synthesis of RCT and non-RCT quantitative studies, and of qualitative studies, and then use the realist methodologies described, with CMO charting, to bring the two components together.

#### Types of settings

Examination of studies included in our previous review and the grey literature showed that, in general, women are referred to advocates by healthcare clinicians. Sometimes delivery of advocacy may be through other services such as shelters or judicial services (Rivas 2015). Different settings indicate different circumstances for the woman accessing advocacy. Given the wide variety of settings, even within healthcare, we will consider the way the intervention is specifically delivered in a specific setting in a specific context, as relevant to our determination of potential mechanisms and moderators or contexts. We will therefore consider all settings, as in Rivas 2015 and our scoping phase.

### Types of participants

As with Rivas 2015, we will include women aged 15 years and over who have experienced intimate partner abuse (as defined in the Background under 'Description of the condition', 'Review definition'), with no upper age limit. Partner abuse may coexist with other forms of violence within families, such as child abuse or elder abuse, but such abuse is not the focus of this review.

### Types of intervention and advocacy activities

We will include all advocacy interventions or multi-component interventions that include advocacy. We have developed a list of activities that make up the advocacy components of an advocacy intervention in order to be consistent with our existing review. Thus, for the purposes of this review, we define the core activities of advocacy as:

- providing legal, housing, and financial advice;
- facilitating access to and use of community resources such as legal, housing, financial advice and help, refuges or shelters, emergency housing, and psychological interventions and counselling;
- giving safety planning advice; and
- providing ongoing support and informal counselling.

As the Rivas 2015 review excluded interventions with dominant counselling components, our final list of studies may be more comprehensive in terms of the interventions included. This list should help to define more focused intervention inclusion criteria for future reviews on advocacy interventions for abused women that are based on consideration of the active ingredients as elucidated in our realist review.

### Types of outcome measures

We have organised the outcomes into primary and secondary outcomes in a way that is consistent with those of Rivas 2015. These were determined, in turn, with reference to the WHO definition of intimate partner abuse (WHO 2013a). We have added qualitative outcomes to this list.

Abuse may take various forms (see Background, 'Description of the condition', 'Review definition'), and all need to be covered by the programme theory. Thus, we will consider outcomes relating to any and all of these forms; there will be no restriction on how the outcomes are measured.

#### Primary outcomes

- Incidence of any form of abuse
    - Physical
    - Sexual
    - Emotional
    - Financial
    - Other (such as risk of death, harassment, coercion to have children). Abuse may be assessed using self-report measures or other validated tools, or a single question about continuing abuse or professional observations of abuse such as in healthcare, social service or judicial service records, or from qualitative analyses.
- Psychosocial health
    - Quality of life (using validated tools or from qualitative analyses)
    - Depression (using validated tools or from reports of prescribed medication)
    - Anxiety (using validated tools or from qualitative analyses)

#### Secondary outcomes

- Physical health (quantified incidents or descriptions of incidents, including frequency)
    - Deaths, all-cause and partner-abuse related (documented in medical or police records, regional and national databases or from study follow-up records)
    - Physical injuries, such as fractures and bruises (self-reported or formally documented (e.g. in medical, dental or judiciary records), or from qualitative analyses)
    - Any chronic health disorders such as gynaecological problems, chronic pain, or gastrointestinal disorders (self-reported or formally documented (e.g. in healthcare or dental records), or from qualitative analyses)
    - Any general measures or observations of physical health (self-reported or formally documented, or from qualitative analyses)
    - Birth outcomes (self-reported or formally documented (e.g. in health or social care records), or from qualitative analyses)
- Psychosocial health (both qualitative and quantitative formats)
    - Post-traumatic stress (using validated tools or from qualitative analyses)
    - Self-efficacy (using validated tools or from qualitative analyses)
    - Self-esteem (using validated tools or from qualitative analyses)

- Perceived social support (using validated tools or from qualitative analyses)
- Alcohol or drug abuse (using validated tools, self-reported or formally documented (e.g. in health or social care records), or from qualitative analyses)
- Attempted suicide (self-reported or formally documented (e.g. in health or social care records), or from qualitative analyses)
- Self-harm (self-reported or formally documented (e.g. in health or social care records), or from qualitative analyses)
- Impact on relationships inside and outside the family (using validated tools, self-reported or formally documented (e.g. in health or social care or judiciary records), or from qualitative analyses)
- Any measures of the quantity or quality of network ties not included above

- Socioeconomic outcome measures
  - Income
  - Housing
  - Participation in education
  - Participation in work
  - Any other socioeconomic outcomes reported in studies
  - Benefits applications
- 'Proxy' or intermediate outcome measures (including uptake of referrals to other agencies)
  - Use of safety behaviours (e.g. use of coded telephone messages to a friend, keeping clothes at a friend's house, hiding emergency money)
  - Use of refuges or shelters
  - Use of counselling
  - Calls to police
  - Filing of police reports
  - Solicitation of protection orders
  - Maintenance of family ties (i.e. children staying with mother)
  - Any other such outcomes
- Other qualitative outcomes
  - Improved communication with the intimate partner
  - Reduced fear and anxiety and other unwanted feelings, and improvement in desirable feelings
  - An improved sense of security

Post-intervention, there may be both positive and negative, planned and unplanned outcomes for abused women, and this will require careful interpretation. For instance, increased refuge or shelter usage may reflect proactive behaviour on behalf of abused women, but it could also correlate with - or precipitate - an escalation of violence. Moreover, self-reports and official documentation of outcomes, such as improved relationships, may reflect coercive pressures by the perpetrator on the abused woman to report this. We will also consider any adverse outcomes from interventions where these are reported by study authors.

Outcomes will be further specified during the realist review and may include more proximal and distal outcomes in the context of developing CMO configurations.

#### Timing of outcome assessment

Intimate partner abuse can have short-term and long-term negative health consequences for survivors even after the abuse has ended (Campbell 2002), and these will be incorporated into our programme theory. Correspondingly, an intervention may result in some immediate positive outcomes, such as a reduction in physical violence, whereas other benefits, such as positive mental health effects, may take some time to be realised.

We have been previously unable to determine the optimal period of follow-up or outcomes trajectory (Rivas 2015). For the purposes of this review, and to conform with our previous work (Rivas 2015), we tentatively define short term as up to and including 12 months, medium term as more than 12 and up to 24 months, and long term as more than 24 months.

### Search methods for identification of studies in phase 3

The phase 3 literature search will be based on the searches reported in Appendix 1 of Rivas 2015 and Appendix 2 in this review. Where necessary, we will modify these searches to reflect changes in controlled vocabulary or database syntax. We will restrict our searches to English-language studies and to high-income country settings. We will consider any study excluded from the Rivas 2015 review but deemed relevant on the basis of this realist review, hence considering all studies from when databases began. In practice, there are unlikely to be any studies of intimate partner abuse interventions before 1980 (Dobash 1984).

We will also follow selected elements of the CLUSTER (**c**itations, **l**ead authors, **u**npublished materials, **s**cholar searches, **t**heories, **e**arly examples, **r**elated projects) approach (Booth 2013), which includes backwards and forwards citation checking, as well as kinship- and sibling-paper searches, and the 'search similar citations' function on PubMed for all papers relevant to our realist question that we accrue through the review.

#### Electronic searches

We will search the electronic sources listed below, to test the theory in this phase of the realist review, and to update the Rivas 2015 review.

- Cochrane Central Register of Controlled Trials (CENTRAL; current issue) in the Cochrane Library.
- MEDLINE Ovid (1948 to current).
- Embase Ovid (1980 to current).
- PsycINFO Ovid (1806 to current).
- PsycArticles America Psychological Association (1894 to current).
- ASSIA Cambridge Scientific Abstracts (1987 to current).
- CINAHL Plus EBCSCOhost (Cumulative Index to Nursing and Allied Health Literature; 1937 to current).

- Social Science Citation Index Web of Science (1970 to current).
- International Bibliography of Social Sciences ProQuest (1951 to current).
- Health Management Information Consortium Ovid (1979 to current).
- Maternity and Infant Care Ovid (1971 to current).
- *Cochrane Database of Systematic Reviews* (CDSR; current issue), part of the Cochrane Library.
- Database of Abstracts of Reviews of Effects (DARE; current issue), part of the Cochrane Library.
- UK Clinical Research Network Study Portfolio ( www.ukcrc.org/research-infrastructure/clinical-research-networks/uk-clinical-research-network-ukcrn).
- OpenGrey ( www.opengrey.eu).
- Dissertations & Theses ProQuest (1861 to current).
- UK Clinical Trials Gateway ( www.ukctg.nihr.ac.uk).
- WHO International Clinical Trials Registry Platform (ICTRP; www.who.int/ictrp/en).

All studies need to consider advocacy interventions for women who have experienced partner abuse.

#### Other resources

We will also search the following websites.

- WHO Violence and Injury Prevention ( who.int/topics/violence/en).
- Violence Against Women Online Resources ( vawnet.org/publisher/violence-against-women-online-resources).

### Final data synthesis

Data analysis and synthesis (through a meta-narrative) will show how the extracted data inform our understanding of the mechanisms for advocacy interventions. We will look for similarities and differences in CMOs and refine our initial theory. We will discuss tentative findings with each other and invite comments from our stakeholder group, leading to final adjustments to theory.
Data synthesis across stages will draw on:

- juxtaposition of sources in ways that might provide further insights;
- consolidation of sources when evidence about mechanisms and outcomes is complementary;
- reconciliation of sources where outcomes differ in comparable context;
- situation of sources where outcomes differ in different contexts; and
- adjudication of sources according to methodological strengths or weaknesses (Gough 2007; Pearson 2015; see also 'Strength and quality of the evidence' below).

We will describe the final realist theory using narrative and summary tables, a logic model and summary figure graphics, drawing insights from across the sources. We will write up the results according to the RAMESES Publication Standards For Realist Synthesis (Wong 2013a). We will provide data and extracts from published papers, and from our stakeholder group, to support our synthesis and developed theory in published reports on these. We will also use our theory to make recommendations for future research and practice.

### Missing data

Where there are gaps in the data, and we have been unable to fill these from further searches, we will use the Final data synthesis approaches in abductive reasoning to infer mechanisms from the data that are available, as a pragmatic approach. This could be tested in future research.

### Strength and quality of the evidence

We will assess studies used in the realist review on the basis of:

- relevance: whether the study addresses the theory under test; and
- rigour: whether the original researchers' inferences have sufficient weight to make a methodologically credible contribution to testing of the intervention theory.

We will use the concept of 'thickness' of the sources (Roen 2006), that is, the degree to which they offer explanatory insights on the developing theory and the factors shaping implementation processes. The criteria used to assess thickness are:

- detail of the description of relevance to our emerging theory;
- level of consideration of the relevant context and its influence;
- detail on potential mediators or moderators; and
- attempt to explain anomalous results and findings with reference to context and to data.

This assessment provides an indication of the quality of the evidence used to inform our theory rather than the studies or papers themselves; data of relevance to our review may form only a small part of a paper, rather than being its focus, so usual quality of evidence checklists would not be appropriate.

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## REFERENCES

### Additional references

**Access Economics 2004**
Access Economics. *The Cost of Domestic Violence to the Australian Economy: Part 1*. Canberra: Office for the Status of Women, 2004. [ISBN: 1–877–042–74–9; www.dss.gov.au/sites/default/files/documents/05_2012/cost_of_dv_to_australian_economy_i_1.pdf]

**Adams 2008**
Adams AE, Sullivan CM, Bybee D, Greeson MR. Development of the scale of economic abuse. *Violence Against Women* 2008;**14**(5):563–88. DOI: 10.1177/1077801208315529; PUBMED: 18408173

**Bair-Merritt 2014**
Bair-Merritt MH, Lewis-O'Connor A, Goel S, Amato P, Ismailji T, Jelley M, et al. Primary care-based interventions for intimate partner violence: a systematic review. *American Journal of Preventive Medicine* 2014;**46**(2):188–94. DOI: 10.1016/j.amepre.2013.10.001; PUBMED: 24439354

**Bell 2017**
Scottish Government. Domestic Abuse Recorded by the Police in Scotland, 2016-17. www.gov.scot/Publications/2017/10/3700 (accessed prior to 13 August 2018). [ISBN: 978–1–78851–235–0; www.gov.scot/Resource/0052/00526358.pdf]

**Black 2003**
Black CJ. Translating principles into practice: implementing the feminist and strengths perspective in work with battered women. *Affilia* 2003;**18**(3):332–49. DOI: 10.1177/0886109903254578

**Black 2011**
Black MC, Basile KC, Breiding MJ, Smith SG, Walters ML, Merrick MT, et al. *National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report*. Atlanta (GA): National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2011. [www.cdc.gov/violenceprevention/pdf/nisvs_report2010–a.pdf]

**Bonomi 2009**
Bonomi AE, Anderson ML, Rivara FP, Thompson RS. Health care utilization and costs associated with physical and nonphysical-only intimate partner violence. *Health Services Research* 2009;**44**(3):1052–67. DOI: 10.1111/j.1475-6773.2009.00955.x; PMC2699921; PUBMED: 19674432

**Booth 2013**
Booth A, Harris J, Croot E, Springett J, Campbell F, Wilkins E. Towards a methodology for cluster searching to provide conceptual and contextual "richness" for systematic reviews of complex interventions: case study (CLUSTER). *BMC Medical Research Methodology* 2013;**13**:118. DOI: 10.1186/1471-2288-13-118; PMC3819734; PUBMED: 24073615

**Brownridge 2006**
Brownridge DA. Violence against women post-separation. *Aggression and Violent Behavior* 2006;**11**(5):514–30. DOI: 10.1016/j.avb.2006.01.009

**Campbell 1993**
Campbell JC, Humphreys JC. *Nursing Care of Survivors of Family Violence*. 2nd Edition. St Louis (MO): Mosby, 1993. [ISBN: 0–801–663–784]

**Campbell 2000**
Campbell M, Fitzpatrick R, Haines A, Kinmonth AL, Sandercock P, Spiegelhalter D, et al. Framework for design and evaluation of complex interventions to improve health. *BMJ* 2000;**321**(7262):694–6. [PMC1118564; PUBMED: 10987780]

**Campbell 2002**
Campbell JC. Health consequences of intimate partner violence. *Lancet* 2002;**359**(9314):1331–6. DOI: 10.1016/S0140-6736(02)08336-8; PUBMED: 11965295

**Campbell 2004**
Campbell JC. Helping women understand their risk in situations of intimate partner violence. *Journal of Interpersonal Violence* 2004;**19**(12):1464–77. DOI: 10.1177/0886260504269698; PUBMED: 15492060

**Carney 2012**
Carney MM, Barner JR. Prevalence of partner abuse: rates of emotional abuse and control. *Partner Abuse* 2012;**3**(3):286–335. DOI: 10.1891/1946-6560.3.3.286

**Colombini 2017**
Colombini M, Dockerty C, Mayhew SH. Barriers and facilitators to integrating health service responses to intimate partner violence in low- and middle-income countries: a comparative health systems and service analysis. *Studies in Family Planning* 2017;**48**(2):179–200. DOI: 10.1111/sifp.12021; PMC5518204; PUBMED: 28422291

**Davidson 2001**
Davidson LL, King V, Garcia J, Marchant S. What role can the health services play?. In: Taylor-Browne J editor(s). *What Works in Reducing Domestic Violence: A Comprehensive Guide for Professionals*. London: Whiting & Birch Ltd, 2001:95–122. [ISBN–10: 1–861–770–367]

**Dobash 1984**
Dobash RE, Dobash RP. The nature and antecedents of violent events. *British Journal of Criminology* 1984;**24**(3): 269–88. [APA PsycNet record: 1985–14778–001]

**Feder 2006**
Feder G, Ramsay J, Zachary MJ. Clinical response to women experiencing intimate partner abuse: what is the evidence for good practice and policy?. In: Roberts G, Hegarty K, Feder G editor(s). *Intimate Partner Abuse and Health Professionals: New Approaches to Domestic Violence*. Edinburgh: Churchill Livingstone, 2006:93–110. [ISBN: 0–443–074–933]

**Feder 2013**
Feder G, Wathen CN, MacMillan HL. An evidence-based response to intimate partner violence: WHO guidelines. *JAMA* 2013;**310**(5):479–80. [PUBMED: 10.1001/jama.2013.167453; PUBMED: 23925614]

**Felson 2005**
Felson RB, Ackerman JM, Gallagher C. Police intervention and the repeat of domestic assault. *Criminology* 2005;**43**(4): 563–88. DOI: 10.1111/j.0011-1348.2005.00017.x

**Garcia-Moreno 2006**
Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts CH, WHO Multi-country Study on Women's Health and Domestic Violence against Women Study Team. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *Lancet* 2006;**368**(9543):1260–9. DOI: 10.1016/S0140-6736(06)69523-8; PUBMED: 17027732

**García-Moreno 2015**
García-Moreno C, Hegarty K, Lucas d'Oliveira AF, Koziol-McLain J, Colombini M, Feder G. The health-systems response to violence against women. *Lancet* 2015;**385**(9977):1567–79. DOI: 10.1016/S0140-6736(14)61837-7; PUBMED: 25467583

**Gough 2007**
Gough D. Weight of evidence: a framework for the appraisal of the quality and relevance of evidence. *Research Papers in Education* 2007;**22**(2):213–28. DOI: 10.1080/02671520701296189

**Greenhalgh 2016**
Greenhalgh T, Macfarlane F, Steed L, Walton R. What works for whom in pharmacist-led smoking cessation support: realist review. *BMC Medicine* 2016;**14**:209. DOI: 10.1186/s12916-016-0749-5

**Heise 2002**
Heise L, García-Moreno C. Violence by intimate partners. In: Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R editor(s). *World Report on Violence and Health*. Geneva: World Health Organization, 2002:87–122. [ISBN: 92–4–154561–5; apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf;jsessionid=E26A1CD5EE2A406EEFC9D9C5C6489EF7?sequence=1]

**Henwood 2000**
Henwood M. *Domestic Violence: A Resource Manual for Health Care Professionals*. London: Department of Health, 2000.

**Holmes 2018**
Holmes MR, Richter FGC, Votruba ME, Berg KA, Bender AE. Economic burden of child exposure to intimate partner violence in the US. *Journal of Family Violence* 2018;**33**(4): 239–49. DOI: 10.1007/s10896-018-9954-7

**Holt 2015**
Holt S. Post-separation fathering and domestic abuse: challenges and contradictions. Child Abuse Review 2015; Vol. 24, issue 3:210–22. DOI: 10.1002/car.2264

**Home Office 2013**
Home Office. Domestic violence and abuse. www.gov.uk/guidance/domestic-violence-and-abuse (accessed prior to 13 August 2018).

**Howe 2009**
Howe D. *A Brief Introduction to Social Work Theory*. London: Palgrave Macmillan, 2009. [ISBN: 0–230–233–120]

**Ingram 2005**
Ingram JK. Statement to the UN on violence against women. web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTGENDER/0,,contentMDK:20779823~menuPK:336914~pagePK:64020865~piPK:149114~theSitePK:336868,00.html (accessed prior to 13 August 2018).

**Jagosh 2012**
Jagosh J, Macaulay AC, Pluye P, Salsberg J, Bush PL, Henderson J, et al. Uncovering the benefits of participatory research: implications of a realist review for health research and practice. *Milbank Quarterly* 2012;**90**(2):311–46. DOI: 10.1111/j.1468-0009.2012.00665.x; PMC3460206; PUBMED: 22709390

**Johnson 2015**
Johnson SD, Tilley N, Bowers KJ. Introducing EMMIE: an evidence rating scale to encourage mixed-method crime prevention synthesis reviews. *Journal of Experimental Criminology* 2015;**11**(3):459–73. DOI: 10.1007/s11292-015-9238-7

**Jones 2006**
Jones AS, Dienemann J, Schollenberger J, Kub J, O'Campo P, Gielen AC, et al. Long-term costs of intimate partner violence in a sample of female HMO enrollees. *Women's Health Issues* 2006;**16**(5):252–61. DOI: 10.1016/j.whi.2006.06.007; PUBMED: 17055378

**Kalra 2017**
Kalra N, Di Tanna GL, García-Moreno C. Training healthcare providers to respond to intimate partner violence against women. *Cochrane Database of Systematic Reviews* 2017, Issue 2. DOI: 10.1002/14651858.CD012423

**Kelly 2015**
Kelly L, Westmarland N. *Domestic Violence Perpetrator Programmes: Steps Towards Change. Project Mirabal Final Report*. London: London Metropolitan University; Durham University, 2015. [www.nr–foundation.org.uk/downloads/Project_Mirabal–Final_report.pdf]

**Kiely 2010**
Kiely M, El-Mohandes AA, El-Khorazaty MN, Blake SM, Gantz MG. An integrated intervention to reduce intimate partner violence in pregnancy: a randomized controlled trial. *Obstetrics and Gynecology* 2010;**115**(2 Pt 1):273–83. DOI: 10.1097/AOG.0b013e3181cbd482; NCT00381823; PMC2917915; PUBMED: 20093899

**Koss 1991**
Koss MP, Koss PG, Woodruff WJ. Deleterious effects of criminal victimization on women's health and medical utilization. *Archives of Internal Medicine* 1991;**151**(2): 342–7. [PUBMED: 1992961]

**Kraemer 2002**
Kraemer HC, Wilson GT, Fairburn CG, Agras WS. Mediators and moderators of treatment effects in randomized clinical trials. *Archives of General Psychiatry* 2002;**59**(10):877-83. [PUBMED: 12365874]

**Kutin 2017**
Kutin J, Russell R, Reid M. Economic abuse between intimate partners in Australia: prevalence, health status, disability and financial stress. *Australian and New Zealand Journal of Public Health* 2017;**41**(3):269–74. DOI: 10.1111/1753-6405.12651; PUBMED: 28245514

**Monitor 2013**
Monitor. Closing the NHS funding gap: how to get better value healthcare for patients. www.gov.uk/government/publications/closing-the-nhs-funding-gap-how-to-get-better-value-healthcare-for-patients (accessed 16 December 2017).

**Mullen 1999**
Mullen PE, Pathé M, Purcell R, Stuart GW. Study of stalkers. *American Journal of Psychiatry* 1999;**156**(8): 1244–9. DOI: 10.1176/ajp.156.8.1244; PUBMED: 10450267

**NCIPC 2003**
National Center for Injury Prevention and Control. *Costs of Intimate Partner Violence Against Women in the United States*. Atlanta (GA): Centers for Disease Control and Prevention, 2003. [www.cdc.gov/violenceprevention/pdf/IPVBook–a.pdf]

**NCRVAWC 2009**
National Council to Reduce Violence against Women and their Children. *The Cost of Violence Against Women and their Children*. Greenway, Canberra (AU): Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), 2009. [ISBN: 978–1–921380–31–0; www.dss.gov.au/sites/default/files/documents/05_2012/vawc_economic_report.pdf]

**ONS 2018**
Office for National Statistics. Statistical bulletin: crime in England and Wales: year ending December 2017. www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingdecember2017 (accessed prior to 13 August 2018).

**Pawson 2003**
Pawson R, Boaz A, Grayson L, Long A, Barnes C. *Types and Quality of Knowledge in Social Care*. London: Social Care Institute for Excellence, 2003. [www.scie.org.uk/publications/knowledgereviews/kr03.asp]

**Pawson 2005**
Pawson R, Greenhalgh T, Harvey G, Walshe K. Realist review -- a new method of systematic review designed for complex policy interventions. *Journal of Health Services Research & Policy* 2005;**10**(Suppl 1):21–34. DOI: 10.1258/1355819054308530; PUBMED: 16053581

**Pawson 2006**
Pawson R. *Evidence-Based Policy: A Realist Perspective*. London: Sage Publications Ltd, 2006. [ISBN: 1–4129–1059–5]

**Pawson 2009**
Pawson R, Tilley N. Realist evaluation. In: Otto H-U, Polutta A, Ziegler H editor(s). *Evidence-based Practice: Modernising the Knowledge Base of Social Work?*. Opladen & Farmington Hills (MI): Barbara Budrich Publishers, 2009. [ISBN: 978–3–86649–121–2]

**Pearson 2015**
Pearson M, Chilton R, Wyatt K, Abraham C, Ford T, Woods H, et al. Implementing health promotion programmes in schools: a realist systematic review of research and experience in the United Kingdom. *Implementation Science* 2015;**10**:149. DOI: 10.1186/s13012-015-0338-6; PMC4625879; PUBMED: 26510493

**Phillips 2014**
Phillips J, Vandenbroek P. *Domestic, Family and Sexual Violence in Australia: An Overview of the Issues*. Canberra: Department of Parliamentary Services, 2014. [ISSN: 2203–5249; parlinfo.aph.gov.au/parlInfo/download/library/prspub/3447585/upload_binary/3447585.pdf;fileType=application/pdf]

**Plichta 2007**
Plichta SB. Interactions between victims of intimate partner violence against women and the health care system: policy and practice implications. *Trauma, Violence & Abuse* 2007;**8**(2):226–39. DOI: 10.1177/1524838007301220; PUBMED: 17545576

**Ramsay 2009**
Ramsay J, Carter Y, Davidson L, Dunne D, Eldridge S, Hegarty K, et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *Cochrane Database of Systematic Reviews* 2009, Issue 3. DOI: 10.1002/14651858.CD005043.pub2

**Rivas 2010**
Rivas C. "I don't feel like I'm in an abusive relationship": women's naming of their partner's abusive behaviours and how this may be affected by institutional definitions. *Psychology of Women Section Review* 2010;**12**(2):2–10.

**Rivas 2015**
Rivas C, Ramsay J, Sadowski L, Davidson LL, Dunne D, Eldridge S, et al. Advocacy interventions to reduce

or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *Cochrane Database of Systematic Reviews* 2015, Issue 12. DOI: 10.1002/14651858.CD005043.pub3

**Roe 2010**

Roe S. *Intimate Violence: 2008/09 British Crime Survey*. London (UK): Home Office, 2010.

**Roen 2006**

Roen K, Arai L, Roberts H, Popay J. Extending systematic reviews to include evidence on implementation: methodological work on a review of community-based initiatives to prevent injuries. *Social Science & Medicine* 2006;**63**(4):1060–71. DOI: 10.1016/j.socscimed.2006.02.013; PUBMED: 16574289

**Shalaunsky 1999**

Shalaunsky C, Ericksen J, Henderson A. Abused women and child custody: the ongoing exposure to abusive ex-partners. *Journal of Advanced Nursing* 1999;**29**(2):416–26. [PUBMED: 10197942]

**Signorelli 2012**

Signorelli MC, Taft A, Gomes Pereira PP. Intimate partner violence against women and healthcare in Australia: charting the scene. *Ciência & Saúde Coletiva* 2012;**17**(4): 1037–48. DOI: 10.1590/S1413-81232012000400025; www.scielo.br/scielo.php?script=sci_arttext&pid=S1413–81232012000400025

**Thomas 2008**

Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology* 2008;**8**:45. DOI: 10.1186/1471-2288-8-45; PMC2478656; PUBMED: 18616818

**Tirado-Muñoz 2014**

Tirado-Muñoz J, Gilchrist G, Farré M, Hegarty M, Torrens M. The efficacy of cognitive behavioural therapy and advocacy interventions for women who have experienced intimate partner violence: a systematic review and meta-analysis. *Annals of Medicine* 2014;**46**(8):567–86. DOI: 10.3109/07853890.2014.941918; PUBMED: 25211469

**US Office on Violence Against Women 2018**

Office on Violence Against Women. Domestic violence. www.justice.gov/ovw/domestic-violence (accessed prior to 13 August 2018).

**Vigurs 2016**

Vigurs CA, Schucan Bird K, Quy K, Gough D. *The Impact of Domestic Violence Perpetrator Programmes on Victim and Criminal Justice Outcomes: A Systematic Review of Reviews of Research Evidence*. Coventry: College of Policing, 2016.

**Walby 2009**

Walby S. The cost of domestic violence: up-date 2009. www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CDMQFjAB&url=http://www.lancaster.ac.uk/fass/doc_library/sociology/Cost_of_domestic_violence_update.doc&ei=qKFVU7GwHoug7AbWl4DoDg&usg=AFQjCNG0joG5UNkUYhuqA4s6VZfsOtijOw&bvm=bv.65058239,d.ZGUk (accessed 16 December 2017).

**Watts 2002**

Watts C, Zimmerman C. Violence against women: global scope and magnitude. *Lancet* 2002;**359**(9313):1232–7. DOI: 10.1016/S0140-6736(02)08221-1; PUBMED: 11955557

**Westmarland 2013**

Westmarland N, Kelly L. Why extending measurements of 'success' in domestic violence perpetrator programmes matters for social work. *British Journal of Social Work* 2013; **43**(6):1092–110. DOI: 10.1093/bjsw/bcs049

**WHO 2013a**

World Health Organization, London School of Hygiene, Tropical Medicine. South African Medical Research Council. *Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence*. Geneva: WHO, 2013. [ISBN: 978–92–4–156462–5; apps.who.int/iris/bitstream/handle/10665/85239/9789241564625_eng.pdf?sequence=1]

**WHO 2013b**

World Health Organization. *Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines*. Geneva: World Health Organization, 2013. [ISBN: 978–92–4–154859–5; apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf?sequence=1]

**Williamson 2017**

Williamson PR, Altman DG, Bagley H, Barnes KL, Blazeby JM, Brookes ST, et al. The COMET Handbook: version 1.0. *Trials* 2017;**18**(Suppl 3):280. DOI: 10.1186/s13063-017-1978-4; PMC5499094; PUBMED: 28681707

**Wilson 1993**

Wilson M, Daly M. Spousal homicide risk and estrangement. *Violence and Victims* 1993;**8**(1):3–16. [8292563]

**Wong 2012**

Wong G, Greenhalgh T, Westhorp G, Pawson R. Realist methods in medical education research: what are they and what can they contribute?. *Medical Education* 2012;**46** (1):89–96. DOI: 10.1111/j.1365-2923.2011.04045.x; PUBMED: 22150200

**Wong 2013a**

Wong G, Greenhalgh T, Westhorp G, Buckingham J, Pawson R. RAMESES publication standards: realist syntheses. *BMC Medicine* 2013;**11**:21. DOI: 10.1186/1741-7015-11-21; PMC3558331; PUBMED: 23360677

**Wong 2013b**

Wong G, Westhorp G, Pawson R, Greenhalgh T. *Realist Synthesis: RAMESES Training Materials*. London (UK): The RAMESES Projects, 2013. [www.ramesesproject.org/media/Realist_reviews_training_materials.pdf]

**Wong 2017**

Wong G, Westhorp G, Greenhalgh J, Manzano A, Jagosh J, Greenhalgh T. *Quality and Reporting Standards, Resources, Training Materials and Information for Realist Evaluation: The RAMESES II Project. Health Service and Delivery Research, No. 5.28*. Southampton (UK): NIHR Journal Library, 2017. [ISSN: 2050–4349; www.ncbi.nlm.nih.gov/books/NBK459059/]

**Wood 2015**

Wood L. Hoping, empowering, strengthening: theories used in intimate partner violence advocacy. *Journal of Women and Social Work* 2015;**30**(3):286–301. DOI: 10.1177/0886109914563157; journals.sagepub.com/doi/pdf/10.1177/0886109914563157

* *Indicates the major publication for the study*

# APPENDICES

## Appendix 1. Glossary

**Active ingredients**: those elements of an intervention that have an effect on the target population (intended or unintended, helpful or not).

**Backward citation tracking**: identifying and screening for inclusion additional studies of interest from the reference lists of included studies.

**Complex intervention**: complex interventions are those in which the causal pathway is dependent on interacting components between the intervention and the intermediate and final outcomes.

**Cluster searching**: systematic use of several search techniques to identify papers or other research outputs for a single study. These may be directly related ('sibling' outputs) or indirectly related ('kinship' outputs).

**Controlling behaviours**: behaviours used by an abuser that are intended to create inferiority dependency by isolating a person from sources of support, exploiting them for personal gain, depriving them of their independence and possibility of resistance and escape, and regulating everything they do.

**Coercive control**: involves the use of abusive acts in ways that create anticipatory fear in the woman and a feeling that she is under constant surveillance. It leads the woman to internalise the abuser's rules, acquiescing to them and following them, even when out of his sight, for fear of further abuse. The abuser's threats of physical abuse can become as effective as actual physical acts, reducing the outward evidence that could help the woman to access help.

**Forward citation tracking**: identifying and screening for inclusion additional studies of interest that cite an included study since publication.

**Kinship output**: an output that is related indirectly to another. Kinship outputs may be linked theoretically or contextually (including by provenance) or may be linked to a common antecedent study.

**Mechanisms of effect**: the processes by which the active ingredients or components of an intervention are 'activated'.

**Moderators**: these may be a property of the intervention itself or a result of the context of its delivery; for example, the people who deliver it, the setting of delivery, other features of the context in which it is delivered, and other responses to the resources offered by the intervention in a specific context to a specific group of people.

**Mediators**: the steps in the chain of events (or intermediate outcomes) that occur between an intervention and the final outcomes.

**Sibling output**: an output from the same study as an original paper of interest.

## Appendix 2. Medline search strategy

1 Battered Women/
2 Domestic Violence/
3 Spouse abuse/
4 battered women.tw.
5 (abus$ adj3 partner$).tw.
6 (abus$ adj3 wom#n$).tw.
7 (abus$ adj3 spous$).tw.
8 ((wife or wives) adj3 batter$).tw.
9 ((wife or wives) adj3 abuse$).tw.
10 (violen$ adj3 partner$).tw.
11 (violen$ adj3 spous$).tw.
12 (violen$ adj3 (date or dating)).tw.
13 or/1-12
14 exp child abuse/
15 child$ abus$.tw.
16 (child adj3 abus$ adj3 sex$).tw.
17 or/14-16
18 13 not 17
19 Women/
20 Females/
21 (woman or women or female$).tw.
22 (adolescen$ or teen$).tw.
23 Adolescent/
24 or/19-23
25 Advocacy.tw.
26 exp Patient Advocacy/
27 exp Consumer Advocacy/
28 mentor$.tw.
29 exp Mentors/
30 exp Crisis Intervention/
31 Crisis Intervention.tw.
32 exp Patient Advocacy/
33 exp Consumer Advocacy/
34 exp Counseling/
35 counsel$.tw.
36 Social Work/
37 social work$.tw.
38 exp Risk Assessment/
39 risk assessment.tw.
40 exp Social Welfare/
41 social welfare.tw.
42 Social Support/
43 social support.tw.
44 help seeking.tw.
45 information giving.tw.
46 giving information.tw.
47 (giv$ adj3 information).tw.
48 advice giving.tw.
49 ((give or giving) adj3 advice).tw.
50 Patient Education as Topic/
51 exp Health Education/

52 patient educat$.tw.
53 health educat$.tw.
54 exp Safety/
55 safety.tw.
56 womens health.tw.
57 Women's Health/
58 or/25-57
59 18 and 24 and 58

## CONTRIBUTIONS OF AUTHORS

Carol Rivas (CR) had the idea for the study and wrote the first draft of the protocol. CR will be the lead reviewer and the guarantor of the review.

Carol Vigurs contributed substantially to further drafts of the protocol and will be the second reviewer.

## DECLARATIONS OF INTEREST

Carol Rivas - none known.

Carol Vigurs - none known.

## SOURCES OF SUPPORT


### Internal sources

- None, Other.

### External sources

- None, Other.