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Ali, P. orcid.org/0000-0002-7839-8130, Allmark, P., Booth, A. orcid.org/0000-0003-4808-3880 et al. (3 more authors) (2021) How accurate and useful are published UK prevalence rates of intimate partner violence (IPV)? Rapid review and methodological commentary. *Journal of Criminal Psychology*, 11 (2). pp. 129-140. ISSN 2009-3829

<https://doi.org/10.1108/jcp-11-2020-0048>

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

Journal:	<i>Journal of Criminal Psychology</i>
Manuscript ID	JCP-11-2020-0048.R1
Manuscript Type:	Research Paper
Keywords:	intimate partner violence, domestic violence, screening, domestic violence, IPV screening, survey data

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Manuscripts

MANUSCRIPT DETAILS

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

ABSTRACT:

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

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

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

CUST_RESEARCH_LIMITATIONS/IMPLICATIONS_(LIMIT_100_WORDS) :No data available.

CUST_PRACTICAL_IMPLICATIONS_(LIMIT_100_WORDS) :No data available.

CUST_SOCIAL_IMPLICATIONS_(LIMIT_100_WORDS) :No data available.

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

IPV prevalence v2 Final

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

Journal of Criminal Psychology

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3 **ABSTRACT**
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5 **Purpose:** To estimate the prevalence of intimate partner violence (IPV) in the UK
6 general population and in the low-risk clinical population and to identify the
7 methodological challenges presented by this task.
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11 **Design:** Rapid review as defined by Grant and Booth (Grant and Booth, 2009) – it is
12 used under time or financial constraint to assess what is known using systematic review
13 methods.
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17 **Methods:** Data were extracted with the help of a predesigned tool and were synthesized
18 to answer the two study aims. Data were mixed quantitative and qualitative.
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21 **Results:** In the general population, crime survey data gave a range of past-year IPV
22 prevalence from 1.8-4.5%. This was higher in women than men (2.5-6.3% vs 0.9-
23 2.7%). In both the general and low-risk clinical population (i.e., that which is not
24 routinely screened for IPV), there was little data on pregnant women or gay men and
25 lesbians. No significant relationships between IPV and ethnicity were found. There
26 were methodological challenges. For example, different surveys used different
27 definitions of IPV and domestic violence, making it difficult to give an accurate
28 estimate. There were also problems with data accuracy.
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32 **Originality:** The research updates knowledge about IPV prevalence and adds to
33 knowledge about the challenges of judging such prevalence from current data.
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37 **Key words:** nurses, midwives, intimate partner violence, UK, official statistics
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4 INTRODUCTION

5 Domestic violence and abuse (DVA) is defined in the UK as: “*any incident or pattern*
6 *of incidents of controlling, coercive, threatening behaviour, violence or abuse between*
7 *those aged 16 or over who are, or have been, intimate partners or family members*
8 *regardless of gender or sexuality. The abuse can encompass, but is not limited to*
9 *psychological, physical, sexual, financial or emotional* (Home Office, 2013). This
10 definition also encompasses acts of ‘honour’ based violence, such as female genital
11 mutilation (FGM) [cutting] and forced marriage. DVA can manifest in several forms,
12 including child abuse, elder abuse and intimate partner violence (IPV). All these except
13 IPV can also take non-domestic forms whereas IPV involves only a current or former
14 intimate partner. The term IPV is also termed “partner violence” (Feder *et al.*, 2009).
15 While it is acknowledged that IPV men can also be subjected to IPV, it exists in
16 heterosexual as well as homosexual relationships and women can also perpetrate IPV,
17 most victims remain women and the intensity and severity of abuse experienced by
18 women is much greater.
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30 IPV can result in serious health impacts. For instance, according to World Health
31 Organization (WHO) approximately 42% of women who experience physical or sexual
32 IPV, sustain injuries as a result (Ahmad *et al.*, 2017). Sexual IPV can result in unwanted
33 pregnancy, miscarriage, sexually transmitted infections (STI) and other gynaecological
34 problems (Casique and Furegato, 2006; Black, 2011; Ali and McGarry, 2018).
35 Psychological effects of IPV may include fear, depression, low self-esteem, anxiety
36 disorders, headaches, obsessive-compulsive disorder, post-traumatic stress disorder,
37 disassociation, sleep disorders, shame, guilt, self-mutilation, drug and alcohol abuse
38 and eating disorders (Romito, Molzan-Turan and De Marchi, 2005; Plichta and Falik,
39 2011). IPV is also associated with harm to indirect victims, particularly other family
40 members, such as children (Ahmad *et al.*, 2017).
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50 Measuring the prevalence of IPV is challenging, as studies use different definitions,
51 examine different populations in different contexts and use a variety of methods and
52 questionnaires. The self-reporting nature of IPV can result in underrepresentation of the
53 true extent of IPV while the timing of enquiry can affect recall. Nevertheless, it is
54 estimated that the lifetime prevalence of IPV in women range from 13-31% in
55 community-based samples (general population) and from 13-41% in health service
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3 settings (clinical populations) (Romito, Molzan-Turan and De Marchi, 2005; Feder *et*
4 *al.*, 2009; Plichta and Falik, 2011; Ahmad *et al.*, 2017). In the UK, it was reported that
5 2.4 million adults, including 1.6 million women and 786,000 men, aged 16-74 years
6 experienced domestic abuse in 2018/19 (Office for National Statistics, 2020). It is
7 believed that in lesbian and bisexual women, IPV is experienced at a similar rate to
8 women in general (Hunt and Fish, 2008). Studies demonstrating the prevalence of IPV
9 in men are limited, however, the Office for National Statistics estimated that 4% of men
10 (between the ages of 16-74) experienced IPV in 2019 (Office of National Statistics,
11 2020). Similarly, between the year ending March 2016 and the year ending March 2018,
12 74% of victims of domestic homicide were female compared with 13% of victims of
13 non-domestic homicide (Office of National Statistics, 2020). Compared with
14 heterosexual men, 49% of gay and bisexual men have experienced one or more incident
15 of IPV (Guasp, 2012). IPV has cost implications and we know that for women affected,
16 estimated cost of providing increased public services and the lost economic output is
17 around £66 billion per year (Oliver *et al.*, 2019).
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30 Evidence suggest that there are several sociodemographic and clinical factors that
31 increase the risk of experiencing IPV. These include being female, aged 16-24 for
32 women or aged 16-19 for men, long-term disease or disability, mental health problems,
33 women separated from partners and pregnant women or women who have recently
34 given birth (Harrykisson, Rickert and Wiemann, 2002; Smith *et al.*, 2011; Trevillion
35 *et al.*, 2012; National Institute for Health and Clinical Excellence (NICE), 2014).
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41 Health and social care professionals including nurses, midwives, health visitors, social
42 workers and others are well placed to identify and treat IPV as they have access and
43 fairly intimate knowledge; as such, they have been tasked with doing so (Svavarsdottir
44 and Orlygsdottir, 2009; Bradbury-Jones, Clark and Taylor, 2017; Rossiter *et al.*, 2017)
45 and treating its consequences (Alhalal, 2018). One question that arises, therefore, is
46 when screening for IPV should be undertaken. At present, it is performed routinely only
47 in areas identified as high risk such as emergency departments, antenatal and postnatal
48 settings within the context of healthcare. Decisions about screening and intervention to
49 prevent IPV require accurate data on prevalence in the population in general and
50 amongst specific groups. The rapid review presented here examines the prevalence of
51 IPV in the general population in the UK and in clinical areas not identified as high risk.
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60 The research question for this review was, what is the prevalence of IPV: i) in the

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

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

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39 MEDLINE, PsycINFO, Embase and Cochrane Library databases were searched on
40 18/10/2018 using the term “intimate partner violence” and synonyms, such as battered
41 women and spouse abuse combined with terms related to incidence, prevalence and
42 epidemiology. Two reviewers undertook study selection (Pallm and PA). Any queries
43 at the abstract or the full text stage were resolved through discussion.
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49 Studies were included if they:

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51 1) concerned IPV affecting men or women aged 16 and above; (below this age,
52 incidents are likely to be characterised differently, as, for example, child abuse);
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54 2) contained relevant data from the UK or its regions.
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56 3) were published in English;
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58 4) concerned victims (not perpetrators);
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3 5) were published from 1 January 2007 (for women) or any date (for men and sub-
4 groups of women by sexuality, pregnancy and ethnicity);
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7 6) concerned either: a) the general population; b) the low-risk clinical population; or c)
8 the high-risk clinical population serving exclusively pregnant or postnatal women (all
9 other high-risk groups were excluded)
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13 The last two criteria, b) and c), merit explanation. First, the differential dates for males
14 and females arose from this review being an update of earlier National Screening
15 Council (NSC) reviews which included figures up to 2007 but which only included
16 women. Second, the requirement for specific populations arose from the fact that
17 current National Institute of Clinical Excellence (NICE) public health guidance [PH50]
18 (National Institute for Health and Clinical Excellence (NICE), 2014) and a quality
19 standard [QS116] (National Institute for Health and Clinical Excellence, 2012) already
20 recommend routine DVA screening in specific areas such as alcohol and drug misuse,
21 children and vulnerable adults' services, and Emergency Departments. The focus of
22 this study was on clinical areas where such routine screening does not take place.
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31 We also examined the references and included studies in other systematic reviews.
32 None of these exactly corresponded to the specifications of our review but they were
33 used to verify inclusion of all relevant papers; this element of the search is shown on
34 the PRISMA chart in the four papers included from hand-searches.
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38 **Analysis**

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41 Quality appraisal of all reviewed papers was performed by 2 reviewers. The Appraisal
42 tool for Cross-Sectional studies (AXIS), a 20-item tool appraising introduction,
43 methods, results, discussion and an 'other' category was used to assess the quality of
44 the studies (Downes *et al.*, 2016). Police and Government data were not assessed for
45 quality; we comment further on this in the results and discussion sections. The
46 appraisals were used to assess the quality of the studies, but no studies were excluded
47 on the basis of quality. The decision not to impose limitations by study type or quality
48 was a function of the broad types of data sources that currently need to be drawn on by
49 researchers seeking prevalence data for IPV in the UK. We also comment on this further
50 in the results and discussion. Data were extracted by two reviewers using a tool that
51 included author, date, extractor initials, numbers, gender, sexuality, ethnicity,
52 pregnancy status and results.
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The data were primarily quantitative to answer the prevalence questions; however, qualitative commentary was also used to evaluate its usefulness and accuracy. The data were synthesized from the extraction tool prior to completion of a narrative analysis.

Ethics

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

Results

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

INSERT FIGURE 1 HERE

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

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

A) The General Population

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

Gender

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

Pregnancy

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

Sexual Orientation

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

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

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

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

Ethnicity

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

Other sub-population characteristics

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

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3 ***B) The Clinical Population*** 4

5 Two studies of HIV clinics show high incidence of IPV in their clinical populations,
6 between 29.4% (Warren-Gash *et al.*, 2016) and 52% (Dhairyawar *et al.*, 2013). GUM
7 clinics also showed high incidence of IPV (Sanmani, Sheppard and Chapman, 2013).
8 One of the studies showed a prevalence of 14.1% during present pregnancy, although
9 this corresponded to the prevalence for past-year IPV and, as such, pregnancy did not
10 seem to carry increased risk (Dhairyawar *et al.*, 2013). Outside of HIV clinics, one
11 study notes a higher prevalence rate of IPV in a current relationship for pregnant women
12 attending a termination of pregnancy clinic than for those attending antenatal clinic
13 (5.8% against 0.9%) (Wokoma *et al.*, 2014). Gynaecology clinics recorded prevalence
14 rates of between 24-19% (Johnson *et al.*, 2007).
15

16 A survey of 532 gay men attending a sexual health clinic in London defined IPV in
17 terms of negative behaviours, such as needing to ask permission to work or go shopping
18 as well as more blatant physical abuses (Bacchus *et al.*, 2017). The main result was that
19 of 532 men, 33.9% (95% CI 29.4-37.9%) experienced and 16.3% (95% CI: 13.0-19.8%)
20 reported carrying out negative behaviour.
21

22 Only one study explored the prevalence of IPV in primary health care clinics, namely
23 16 general practices in SW England (Hester *et al.*, 2015). Male patients (N=1368)
24 completed the questionnaire, which used the IPV definition as “negative behaviours”
25 (as in the Bacchus study reported above). For lifetime IPV, 22.7% of men reported ever
26 experiencing negative behaviour from a partner (feeling frightened, physically hurt,
27 forced sex, ask permission to go out, and so on); 7.6% reported experiencing any
28 negative behaviours in the past 12 months.
29

30 **Discussion** 31

32 This study aimed to explore how accurate and useful are published UK prevalence rates
33 of intimate partner violence (IPV) and lessons can be learned with regards to
34 completeness, accuracy, relevance, timeliness, relevance and consistency with other
35 studies.
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37 *Completeness* 38

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

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

Accuracy

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

Relevance and timeliness

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

Consistency with other studies

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

Study Limitations

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

CONCLUSION

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

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3 particularly the crime surveys used in official data, should use a consistent definition
4 of IPV and related violence and collect data using these consistent definitions. In
5 addition, such data should include categories of pregnancy and sexual orientation.
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9 Finding the data to answer even the broad-brush question of the extent of IPV in the
10 UK population is constrained by problems of definition. Crime surveys provide the best
11 data but use inconsistent definitions and terminology. Police data presents additional
12 problems of quality. Parsing the data further to consider gender is reasonably
13 straightforward as this is routinely collected in all cases. Ethnicity data are also
14 routinely collected in England and Wales but not Scotland and Northern Ireland. Very
15 little routine data relates to sexuality or to pregnancy. Crime survey data could be
16 improved through the use of consistent subcategories of domestic violence, to include
17 IPV. IPV data would also benefit from the consistent use of categories of interest,
18 particularly those in the so-called protected characteristic groups.
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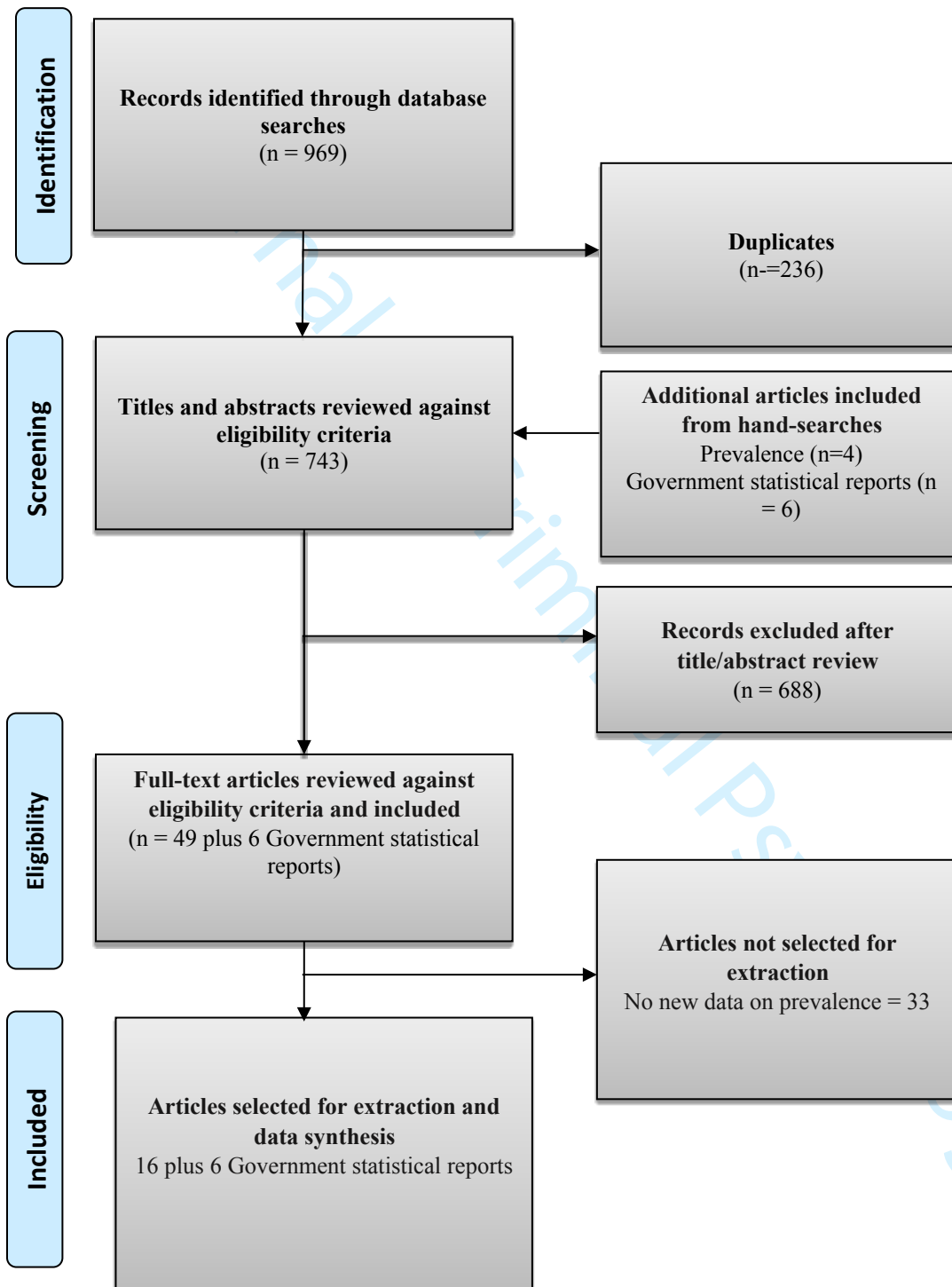
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IPV Prevalence PRISMA CHART FIGURE 1

Figure 1: PRISMA CHART

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

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

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

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

* = Domestic Abuse or Domestic Violence (all other figures are for IPV or "partner violence"). For definitions see "Purpose of this review, above"

ND = No data

APMS = Adult psychiatric morbidity survey

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

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1	Reviewer 1	
2	However, the study is not appropriately	We used the term rapid review in accordance
3	described - it is titled and described in the	with an older definition, that of Grant and
4	title and the methods as a 'rapid review' and	Booth in 2009. This is less specific than that
5	reference is made to Nunn in BMC;	described by Cochrane whose
6	however, this article refers to scoping	recommendations we would now follow. We
7	reviews - which I think this is what the	have addressed this in the design section.
8	present review is. A rapid review uses a	
9	specific and more comprehensive	
10	methodology as described by the Cochrane	
11	Library. Therefore. the authors should	
12	clarify this, decide which it is and justify and	
13	explain accordingly.	
14	In Table 1 reference is made to APMS but	The APMS reference is clarified in the text, on
15	this is not explained in full anywhere else in	page 8. The table title is changed.
16	the text. Also, Table 1 needs a much more	
17	explicit title as it is quite hard to understand	
18	what the table is telling the reader - or	
19	maybe more explanation in the le	
20	Reviewer 2	
21	It does, however, need to make a much	See below – section on Discussion.
22	stronger case for exactly how it contributes	
23	to the literature, and how it addressed its	
24	second research aim.	
25	Abstract	
26	Please give some more detail on the 'low	These points are now addressed.
27	risk clinical population '	
28	Please give some examples of	
29	methodological challenges, and define	
30	rapid review	
31	Results – what about the clinical	
32	population?	
33	Originality – original how?	
34	Introduction	
35	p.4 – line 23 – Please provide some	This section has been substantially amended
36	references to support these	with a removal of some repetition. The
37	Sentence structure is also confusing and	references required are now earlier (from the
38	would benefit from being re-written with	paragraph beginning "Measuring the
39	more clarity	prevalence of IPV is challenging."
40	p4 – line 34 – Please give some examples	This is now covered in the paragraph beginning
41	of types of injuries. It might also be worth	"IPV can result in serious health impacts".
42	noting that the psychological effects can	
43	long-term result in further health problems	
44	as well	
45	p5 – line 3 – Please give some further detail	A sentence has been added for clarification just
46	on what exactly is defined as a clinical	before the Methods section.
47	population	
48	p5 – line 17 – I think the comment in	In this article we do not have any particular
49	domestic homicide is too brief. It the	focus on homicide. Here it is used mainly to
50	authors wish to discuss this (which I think is	reinforce the point that women suffer IPV to a
51		greater extent than men.
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useful) – please give some more detail on this	
p5 – line 44 – this paragraph appears to be mostly a repetition of the same one above?	Yes – we have removed it.
p6 – line 7 – A consideration of how this group of professionals might be particularly useful for this as they can theoretically identify victims who are not themselves disclosing IPV would be good. Overall, I think this point should be stressed throughout.	Sentence altered to make this point PLUS some changes to the discussion.
p6 – Please write RQs in present tense	The research question is set out in the paragraph before the Methods section. In addition, tense changes are made in the Methods-design subsection.
p6 – Please give some more detail on what is meant by a clinical population in this context. Were high risk groups excluded?	A short phrase in parenthesis has been added – there is also some clarification in the abstract.
p7 – Some further comment on the utility of including a quality measurement (if not informing study inclusion) necessary	A small change is made in the section headed “Analysis”. A more significant change, the addition of a paragraph, is made in the results section.
Results	
Overall, I would like more of an engagement with the research aim of ‘usefulness’ in the results, as this is key for this review. I would also like further engagement with the study quality of the reviews here. This is briefly discussed in the ‘discussion’, but I think it is warranted further comment in the results, too.	This is done, particularly in the paragraph headed “In terms of the quality of the research ...”
p10 – line 21 – Who were the perpetrators in the other instances?;	Sentence altered – adding “the other perpetrators were men who were former or current partners”
line 25 – Where is this quote from?	“made to feel worthless” – reference added.
p10 – line 40 – I think some comment on the potential for reduced reporting rates among these groups; lack of trust in societal institutions etc would be useful	A sentence is added to the discussion.
p11 – Line 30 – Some comment on cause and effect would be useful on the topic of mental disorders – isn’t this data mainly in line with the consequences of IPV?	Sentence and reference added in the section headed “Other sub-population characteristics”.
Discussion	
The discussion needs to engage much more with how the review addressed the second RQ, and also specifically outline (I would recommend using sub-headings for this) how the review addressed lessons learned in terms of completeness, accuracy, relevance, timeliness, and relevance. Currently this is largely missing,	The two-part research question is set out in the section just above “Methods”. As such, we believe you are referring to the population in clinical areas not identified as high risk. In line with this we have structured the discussion around subheadings of completeness, accuracy and so forth. Under three of the headings (Completeness, Accuracy and Relevance/timeliness) we have added specific

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