Advocacy interventions for women experiencing intimate partner abuse: Evidence and implications for public health

Review Focus

Women (>15 years of age) experiencing/having experienced intimate partner abuse

Brief (<12 hours in duration) or intensive (>12 hours in duration) advocacy (e.g. safety planning, emergency housing and psychological care, etc.)

Usual care (e.g. typical shelter care)

Primary Outcomes: Incidence of abuse (physical, sexual, emotional, financial); psychosocial health (quality of life, depression, anxiety). Secondary Outcomes: Physical health (e.g. mortality, injury, chronic health disorders, etc.); psychosocial health (e.g. self-efficacy, self-esteem, alcohol or drug abuse, etc.); socioeconomic status; ‘proxy’ measures (e.g. the use of safety behaviours, refuges/shelters, counseling, etc.)

Review Quality Rating: 9 (strong) Details on the methodological quality are available here.

Considerations for Public Health Practice

This high quality review is based on randomized controlled trials of mostly moderate to poor methodological quality. Limited evidence illustrates positive results of:

- **intensive advocacy** on decreased **physical abuse** 12-24 months after women exited a shelter
- **prenatal brief advocacy** on reduced incidence of postpartum depression and minor abuse;
- **brief advocacy** in the emergency department on reduced perceived stress, and increased use of safety behaviours

the evidence is mixed on the impact of:

- **intensive advocacy** among women in shelters/refuges on emotional abuse, anxiety/psychological distress, and social support;
- **brief advocacy** on physical abuse, emotional abuse and quality of life among women in healthcare settings.

included studies did not evaluate:

- financial abuse, alcohol/drug abuse, attempted suicide, self-harm, physical health, or socio-economic measures;
- brief advocacy in shelter/refuge settings.

It remains unclear if women actively seeking help (e.g. Based on this review, public health programs should include and/or support:

- **intensive advocacy** for women in a shelter/refuge setting to decrease physical abuse; and,
- **brief advocacy** in the emergency department or legal setting to increase use of safety behaviours, although the amount of evidence is very limited. It is recommended that decision makers search for emerging evidence in this field regularly.

The current body of evidence cannot definitively recommend or reject the use of:

- **brief advocacy** to reduce sexual abuse, emotional abuse (during the prenatal period), overall abuse, postpartum depression, reduce perceived stress post traumatic stress disorder, and risk of homicide/work harassment;
- **intensive advocacy** to reduce emotional abuse, depression upon shelter discharge, anxiety, and emotional attachment, or to increase self-esteem, self-efficacy and independence from the abuser; and,
- **brief or intensive advocacy** interventions to improve quality of life.
Evidence and Implications

<table>
<thead>
<tr>
<th>What’s the evidence?</th>
<th>Implications for practice and policy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Physical Abuse (6 studies)</strong>&lt;br&gt;• Brief advocacy (single, 30 min. session) in a prenatal care setting decreased minor abuse (<strong>SMD -0.45</strong>, 95% CI -0.83 to -0.07) (1 study).&lt;br&gt;• Intensive advocacy led to the end of physical abuse among women exiting shelters or refuges at 12-24 months follow-up (<strong>OR 0.43</strong>, 95% CI 0.23 to 0.80) compared to usual care (2 studies).&lt;br&gt;• No impact using brief advocacy with women recruited from public health clinics or severely abused pregnant women.</td>
<td><strong>1. Physical Abuse</strong>&lt;br&gt;• Public health may consider providing intensive advocacy to women in domestic violence shelters/refuges to reduce physical abuse in the medium to long term (12-24 months).&lt;br&gt;• Brief advocacy may be supported in healthcare settings for pregnant women, however&lt;br&gt;• Public health decision makers should not rely on healthcare setting-based brief advocacy as a means to reduce physical abuse among non-pregnant women.</td>
</tr>
<tr>
<td><strong>2. Emotional Abuse (4 studies)</strong>&lt;br&gt;• Brief advocacy in a prenatal setting decreased emotional abuse (<strong>SMD -0.72</strong>, 95% CI -1.11 to -0.34) (1 study). However, another study found no impact.&lt;br&gt;• No impact using intensive advocacy for women exiting shelters at 12 months or brief advocacy delivered in public health clinics.</td>
<td><strong>2. Emotional Abuse</strong>&lt;br&gt;• Public health decision makers should not rely on: intensive advocacy among women exiting shelters or brief advocacy in the prenatal period to reduce emotional abuse.</td>
</tr>
<tr>
<td><strong>3. Sexual Abuse (1 study)</strong>&lt;br&gt;• No impact using a single, 30 min. brief advocacy session in a prenatal setting.</td>
<td><strong>3. Sexual Abuse</strong>&lt;br&gt;• Evidence is inadequate for public health decision makers to support/reject the use of brief advocacy to reduce sexual abuse in the prenatal period.</td>
</tr>
<tr>
<td><strong>4. Combined Physical &amp; Emotional Abuse (2 studies)</strong>&lt;br&gt;• No impact with brief OR intensive advocacy on overall abuse.</td>
<td><strong>4. Combined Physical &amp; Emotional Abuse</strong>&lt;br&gt;• Public health should not rely on brief or intensive advocacy to decrease overall abuse.</td>
</tr>
<tr>
<td><strong>5. Quality of Life (3 studies)</strong>&lt;br&gt;• Women receiving brief advocacy during prenatal care had higher scores on 3/8 quality of life indicators: physical functioning (<strong>SMD 0.50</strong>, 95% CI 0.12 to 0.88); role physical (<strong>SMD 0.41</strong>, 95% CI 0.03 to 0.78); and, role emotional (<strong>SMD 0.56</strong>, 95% CI 0.18 to 0.94).&lt;br&gt;• No impact with intensive advocacy provided to women exiting shelters (2 studies).</td>
<td><strong>5. Quality of Life</strong>&lt;br&gt;• Evidence is inadequate for public health decision makers to support or reject the use of brief OR intensive advocacy to positively impact quality of life indicators.</td>
</tr>
<tr>
<td><strong>6. Depression (3 studies)</strong>&lt;br&gt;• Women receiving brief advocacy during prenatal care experienced less postpartum depression (<strong>OR 0.23</strong>, 95% CI 0.10 to 0.57) (1 study).&lt;br&gt;• No impact with intensive advocacy on depressive symptoms at 12 months among women exiting shelters (2 studies).</td>
<td><strong>6. Depression</strong>&lt;br&gt;• Evidence is inadequate for public health decision makers to support or reject the use of brief OR intensive advocacy to reduce depressive symptoms; however, a single study suggests that brief advocacy for pregnant women decreases the incidence of postpartum depression.</td>
</tr>
<tr>
<td><strong>6. Anxiety/Psychological Distress (4 studies)</strong>&lt;br&gt;• Brief advocacy provided in the emergency department (ED) led to lower levels of perceived stress at 4 months follow-up (<strong>SMD -0.62</strong>, 95% CI -1.18 to -0.06) (1 study).&lt;br&gt;• No impact with intensive advocacy on measures of anxiety/psychological distress (3 studies).</td>
<td><strong>7. Anxiety/Psychological Distress</strong>&lt;br&gt;• In settings where public health has contact with women seeking emergency health services, it should support brief advocacy to reduce perceived stress, while acknowledging the findings are limited to a single study.&lt;br&gt;• But, should not promote intensive advocacy over usual shelter care/services to decrease anxiety/psychological distress among women living in a domestic violence shelter/refuge setting.</td>
</tr>
<tr>
<td><strong>7. Psychosocial Health (3 studies)</strong>&lt;br&gt;• Evidence was mixed on the impact of intensive advocacy</td>
<td><strong>8. Psychosocial Health</strong>&lt;br&gt;• Evidence is inadequate for public health decision...</td>
</tr>
</tbody>
</table>
Intimate partner violence (IPV) is a violation of human rights and a serious public health issue in Canada that occurs across socio-demographic lines. Estimated yearly economic costs of violence against women in Canada ranged from $1.5 to $4.2 billion per year.\(^1\) IPV is associated with increased risk of physical injury; chronic health problems; mental health issues (including suicide, depression, post traumatic stress disorder, and substance (ab)use); and, social problems impacting other relationships and the ability to participate in education and the workforce.\(^2,3\) As well, children who are exposed to IPV are at greater risk for mental health concerns, criminal behaviour, and perpetrating or being the victim of IPV.\(^2,3\) In particular IPV occurring during pregnancy has substantial health risks for women and their unborn children.\(^2,3\) In Canada, approximately 6.2% of women aged 15 and over in Canada reported having experienced IPV over a 5 year period in 2009.\(^4\) This number is similar for men who are victims of IPV (6%), however women report more serious violence than men.\(^4\) Income, education, minority and immigrant status are not associated with experiencing IPV, making this a population-wide health issue straddling multiple and varied demographics.\(^4\) Because, 7 out of 10 Canadian victims of IPV choose to seek support from sources outside of the criminal justice system, and only 3 in 10 contact a formal service such as a counsellor or psychologist,\(^4\) it is necessary to consider a variety of intervention strategies.

**Why this issue is of interest to public health in Canada**

Intimate partner violence (IPV) is a violation of human rights and a serious public health issue in Canada that occurs across socio-demographic lines. Estimated yearly economic costs of violence against women in Canada ranged from $1.5 to $4.2 billion per year.\(^1\) IPV is associated with increased risk of physical injury; chronic health problems; mental health issues (including suicide, depression, post traumatic stress disorder, and substance (ab)use); and, social problems impacting other relationships and the ability to participate in education and the workforce.\(^2,3\) As well, children who are exposed to IPV are at greater risk for mental health concerns, criminal behaviour, and perpetrating or being the victim of IPV.\(^2,3\) In particular IPV occurring during pregnancy has substantial health risks for women and their unborn children.\(^2,3\) In Canada, approximately 6.2% of women aged 15 and over in Canada reported having experienced IPV over a 5 year period in 2009.\(^4\) This number is similar for men who are victims of IPV (6%), however women report more serious violence than men.\(^4\) Income, education, minority and immigrant status are not associated with experiencing IPV, making this a population-wide health issue straddling multiple and varied demographics.\(^4\) Because, 7 out of 10 Canadian victims of IPV choose to seek support from sources outside of the criminal justice system, and only 3 in 10 contact a formal service such as a counsellor or psychologist,\(^4\) it is necessary to consider a variety of intervention strategies.

**Other quality reviews on this topic are available on** [www.healthevidence.org](http://www.healthevidence.org)

**Suggested citation**


---

This evidence summary was written to condense the work of the authors of the review referenced on page one. The intent of this summary is to provide an overview of the findings and implications of the full review. For more information on individual studies included in the review, please see the review itself. The opinion and ideas contained in this document are those of the evidence summary author(s) and healthevidence.org. They do not necessarily reflect or represent the views of the author’s employer or other contracting organizations. Links from this site to other sites are presented as a convenience to healthevidence.org internet users. Healthevidence.org does not endorse nor accept any responsibility for the content found at these sites.

The production of this evidence summary was funded with support from the Public Health Agency of Canada. The views expressed herein do not necessary represent the views of the Public Health Agency of Canada.