Appendix: Characteristics of included studies of review of screening women for intimate partner violence in healthcare settings

	Design; setting; country	Inclusion criteria; sample size; numbers analysed	Intervention (IG), comparison (CG)	Outcomes
Ahmad, 2009[25]	RCT; urban, hospital affiliated academic family practice clinic; Canada	Women aged >18 in relationship in past 12 months, able to read and write English. No of eligible recruited (%): 314/586 (53.6%). Total No analysed (No, % of women randomised) 280 (139, 89% IG; 141, 89% CG). Imputed figures (293 (144 IG; 149 CG)	Computer assisted screening for IPV, which included items from AAS and PVS embedded among items assessing range of health issues. "Yes" response to any IPV items was reported on 1 page risk report "possible partner abuse-assess for victimisation" that was provided to physicians. Relevant community resources were printed at end of report (IG). Standard medical care (CG)	1. Initiation of discussion about risk for IPV by participant or provider (discussion opportunity). 2. Detection of women at risk. Secondary: 1. Provider assessment of participant safety 2. Referrals 3. Advice for follow-up 4. Participant acceptance (exit survey). Data collected through audiorecording
Carroll, 2005[20]	Cluster RCT; 4 communities in Ontario, urban, suburban and rural practices where antenatal services offered; Canada	Family physicians, obstetricians, midwives seeing 10+ prenatal patients/ year. Women at 12-30 weeks' gestation; able to read and write English; able to provide consent. High obstetric risk excluded. No of eligible recruited (%): 253/273 (93%). Total No analysed (No, % of women randomised) 227: (98, 88% IG; 129, 91% CG)	Clinicians administered ALPHA tool face to face, which screened for 15 risk factors including IPV (IG). Usual antenatal care (CG)	Clinicians followed-up 1 month postpartum. All antenatal risk factors equally weighted in and considered "present" on basis of providers having "some" or "high" concern about risk factor. Family violence measured using 5 items, 1 of which directly assessed concern with current or past woman abuse
Humphreys, 2011[33]	RCT; 5 antenatal clinics; USA	Women aged >18, English speaking; <26 weeks pregnant; receiving antenatal care at one of participating clinics; not presenting for first visit. No of eligible recruited for baseline assessment (%): 410/524 (78%). 50/410 (12%). Total No analysed (No, % of women randomised) 46 (22, 88% IG; 24 96%, CG)	Computer-based assessment (to check eligibility based on AAS and randomise women) followed by Video doctor plus Provider Cueing before consultation. Their providers received printed cue sheet alert and suggested counselling statements. (IG). Computer based assessment (to check eligibility) with usual antenatal care (CG)	Short term assessment of outcomes (immediately after intervention and again after antenatal visit 1 month later; data collected from women). 1. Patient-provider discussion of IPV 2. Helpfulness of IPV discussion
Kataoka, 2010[22]	RCT; antenatal clinic of an urban general hospital; Japan	Women <25 weeks pregnant. No of eligible recruited (%): 328/355 (92%). Total No analysed (No, % of women randomised) 315 (155, 94% IG; 160, 98% CG)	Face to face screening by health provider using Japanese VAWS with brief counselling and community resource card on 3 occasions (IG). Self completed VAWS in interview room with resource cards available on 3 occasions (CG)	1. Prevalence Secondary outcomes: 2. Comfort level 3. Need to consult with nurse after screening (all participants completed questionnaire immediately after intervention)
Klevens, 2012a[24]	RCT; women's health clinics (obstetric, gynaecological and family planning) at a	Women aged >18. Women who did not speak English; were accompanied by their partner or child over 3 years; who were visually, hearing, or mentally	IPV screening by HCP using PVS, and if positive, HCP support (IG). ACASI IPV screening (PVS), and if positive, computer printout of locally available resources, A-CASI	1. Rates of IPV disclosure based on PVS 2. Screening mode preference 3. Impact of IPV screening

	public hospital; USA	impaired; women who had no access to telephone or were over 36 weeks pregnant were excluded. No of eligible recruited (%): 126/228 (55%). Total No analysed (No, % of women randomised) 102 (36, 78% IG; 66, 83% CG)	encouragement to show HCP her results and HCP encouragement to contact IPV services if woman shared results. ACASI IPV screening (PVS), if positive for IPV, short video clip provided support and encouraged help seeking, and computer-printed list of available IPV resources (2 A-CASI arms combined as CG)	(pos/neg reactions) 4. Referral outcomes At 1 week follow-up telephone call, women asked to report: recall of receiving services list; share it with anyone; contact with services. At 3 months, local IPV advocacy staff asked to report records of any contact from participants
Koziol-McLain, 2010[23]	RCT; one emergency department; New Zealand	Women aged >18; presenting to ED during selected shifts. Acute presentations precluding informed consent; functional or organic impairment based on clinician assessment; emergency health needs; non-English speaking or entered study during previous visit excluded. No of eligible recruited (%): 399/983 (41%). Total No analysed (No, % of women randomised) 344 (167, 84% IG; 177, 88.5% CG)	Standardised 3 item IPV screen incorporating PVS and Abuse Assessment Screen, statements about unacceptability of violence, risk assessment, and referral (IG). Usual emergency care (CG)	3 months after index ED visit women had face to face structured follow-up interview. 1. Violence by (ex) partner in past 3 months Secondary: 1. Safety behaviours 2. Resource use Charts of eligible participants abstracted to collect data including documentation of IPV; not reported as comparison
MacMillan 2006[19]	Quasi-RCT; emergency departments, family practices and women's health clinics; Canada	Women aged 18-64, at site for own health visit, able to separate themselves from accompanying individuals, able to speak and read English, able to provide consent. Those too ill excluded. No of eligible recruited (%): 2461/2602 (94%). Total No analysed (No, % of women randomised (varied by tool)) 2339 (788, 92% IG; 741, 96% CG1; 810, 97% CG2 (CAS))	Face to face screening by HCP using 1 of 2 screening instruments randomly determined. Any disclosure became part of clinical encounter and women were offered usual care (IG). Computer based screening using PVS and WAST randomly ordered (CG1). Written screening using PVS and WAST randomly ordered (CG2)	1. 12-month prevalence based on instrument compared to CAS 2. Extent of missing data 3. Women's preference for screening approach
MacMillan, 2009[26]	RCT; 12 primary care sites (family practices, community health centres), 11 acute care sites and 3 specialty care sites (obstetrics/ gynaecology); Canada	Women aged 18-64; had male partner in past 12 months; presented for own healthcare visit; able to separate self from individuals with them; living within 120 km of site; able to speak and read English; able to provide consent. Those too ill excluded. No of eligible recruited (%): 6743/8293 (81%). Total No analysed (No, % of women randomised with positive screen result) 411 (199, 57% IG; 212, 59% CG)	Women self-completed WAST; if woman screened positive this information was provided to her clinician before healthcare visit. Subsequent discussions or referrals were at discretion of HCP. After visit, women completed CAS (IG). Women self completed WAST and CAS after visit (CG)	Followed up baseline (<14 days), 6, 12, 18 months after intervention (collected through self-report by women). 1. Recurrence of IPV (CAS) 2. Quality of life (WHO Quality of Life-Bref)
Rhodes, 2002[32]	Quasi-RCT; urban university hospital	English speaking women and men; aged 18-65; presented for emergency care with	Women completed computer based screen which included other lifestyle and behavioural	1. Screen positive data in IG assessed from computer responses

	emergency department; USA	non-urgent complaint, triaged into lowest 2 categories of 5-level system. Those in pain, blind, overtly psychotic, or unable to read were excluded. No of eligible recruited (%): 470/542 (87%) 322 were women (69%) Total No analysed (No, % of women randomised) 322 (170, 100% IG; 152,100 % CG). 80% of all charts reviewed to establish rates of documentation by clinicians	risks. Patients then offered computer printout to take with them including list of individualised resources. Results on one page computer printout were attached to patient's ED chart. This included prompt to assess for IPV if one or more IPV questions were answered positively. Resources for IPV support in hospital and community were listed on prompt (IG). Usual care (CG)	2. Documentation by physicians assessed by blinded chart review
Rhodes, 2006[27]	RCT; 2 EDs: urban academic medical centre serving publicly insured African-American inner city pop; suburban community hospital serving privately insured suburban white population; USA	Consenting women aged 18-65; triaged as medically non-emergent. No of eligible recruited (%): 1281/2165 (59%) Total No analysed (No, % of women randomised) 871 (421, 66% IG; 450, 70% CG)	Self administered computer based health risk assessment (Promote Health Survey), generated health recommendations for participants and alerted physicians to health risks, including IPV. If women answered "yes" to any of 8 IPV assessment items, then report generated for physician had prompt "Possible partner violence: assess for current abuse" and suggested referral options. Usual ED care (CG)	Data collected through audio recording of consultations (primary method): 1. Discussion of IPV 2. Disclosure of IPV to HCP 3. Provision of domestic violence services. Data also abstracted from medical records and collected directly from participants
Trautman, 2007[21]	Quasi-experimental control study; adult urban ED of large university hospital serving primarily socioeconomically disadvantaged, population; USA	Women aged >18; presented to the ED for medical treatment. Acute or critically ill presentation; illiteracy; impaired mental status, disorientation or apparent intoxication; would not separate from their partner; or already enrolled were excluded. No of eligible recruited (%): 1005/1395 (72%). Total No analysed (No, % of women randomised) 1005 (411, 100% IG; 594, 100% CG)	Self administered computer based health survey including 4 items about IPV. If woman answered yes to any of 4 IPV assessment items, 2 reports were generated. 1 copy was attached to woman's medical record to alert treating staff and second copy was placed in box for social work referral (IG). Self administered computer survey with no IPV items, and usual care (current ED policy recommending IPV screening) (CG)	Immediate abstraction of data from medical records: 1. Rates of enquiry 2. Detection 3. Referral 4. Service rates

Legend: RCT=randomised controlled trial; IG=intervention group; CG=comparison group; ALPHA=Antenatal Psychosocial Health Assessment; AAS=Abuse Assessment Screen; VAWS=Violence Against Women Screen; ACASI = Audio computer-assisted self-interview; PVS=Partner Violence Screen; WAST=Woman Abuse Screening Tool; CAS=Composite Abuse Scale; ED=emergency department.