Violence against women and mental health

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Summary

Violence against women is widely recognised to be a violation of human rights and a public health problem. This article argues that violence against women is also a significant public mental health problem and that mental health professionals should be identifying, preventing, and responding to violence against women more effectively. English-language primary studies and reviews reporting on mental health service responses to domestic violence and other forms of violence against women were identified by searching Medline, EMBASE, and PsycINFO. Citation tracking and searches of the authors personal files were used to identify additional papers for inclusion. The commonest forms of violence against women are domestic abuse and sexual violence, and victimisation is associated with an increased risk of mental disorder. Despite clinical guidance on the role of mental health professionals in identifying violence against women and responding appropriately, poor identification persists and can lead to non-engagement with services and poor response to treatment. The review highlights that there has been little research in how to improve identification and treatment of victims and perpetrators in contact with mental health services but that mental health services could play a major role in primary and secondary prevention of violence against women.

Introduction

Violence against women (VAW) is a significant public health problem and a violation of human rights, impairing, in particular, women’s rights to life, to freedom from torture and other cruel, inhuman, or degrading treatment or punishment, and to the highest attainable standards of physical and mental health.\textsuperscript{1,2} International and national guidelines and position statements\textsuperscript{3-8} recognise that violence against women (VAW) is an important determinant of health for women and children and call for this significant public health issue to be identified and addressed by health services. In this review we demonstrate that VAW is also a public mental health problem. Mental health services internationally should therefore be identifying VAW, preventing further violence, and treating mental health consequences more effectively. Doing so requires mental health professionals to not only be aware of the impact of VAW on mental health and the effectiveness of potential treatments, but also to develop their understanding of the dynamics and complexities of abuse. In particular, professionals must guard against the risks of victim-blaming and of disempowering women already disadvantaged by the social determinants of VAW and mental disorders such as poverty and gender inequity.\textsuperscript{3,9}

The commonest forms of VAW are domestic violence and abuse (DVA), and sexual violence. Thirty five percent of women worldwide have experienced intimate partner violence or non-partner sexual violence. Although incidents of intimate partner violence are also experienced by men, women are more likely to have suffered repeated severe violence.\textsuperscript{10} Worldwide, 39% of murders of women are committed by intimate partners or ex-partners (compared with 6% for male homicides), and higher rates are found in southeast Asia (59%).\textsuperscript{11} Non-partner sexual violence is also endemic and has been experienced by 7% of women worldwide.2 In England, the 2013/4 crime survey found that 2.2% (approximately 355000) of women aged 16-59 had experienced some form of sexual assault and 8.5% (1.5 million) domestic abuse in the past year.\textsuperscript{13} When men are victims of interpersonal violence, this is more likely to be street or gang violence perpetrated by other men.\textsuperscript{14} However, the
structural inequalities experienced by people with mental disorders, particularly those with severe mental illness, intersect with gender inequality, and men with mental disorders are at increased risk of domestic and sexual violence compared with men in the general population. Mental health services therefore need to be aware of the interpersonal violence experienced and perpetrated by women and men and provide gender sensitive services to address it. This paper focuses on how mental health services can address VAW but will also be relevant to how mental health services can help men suffering from domestic and sexual violence. It aimed to review evidence on the relationship between VAW and mental health; the identification of and response to VAW by mental health services; and mental health interventions for victims and perpetrators of VAW. Although VAW takes many forms (including domestic violence, sexual violence (including in conflict zones and as a weapon of war), forced and early marriage, "honour" crimes, female genital mutilation, and human trafficking), this review focuses on domestic and sexual violence as the most common forms of VAW worldwide, and presents emerging evidence on the mental health impacts of human trafficking and female genital mutilation.

Box: Search strategy and selection criteria
References for this review were identified by searching Medline, Embase, and PsycINFO for English-language primary studies and reviews reporting on mental health service responses to domestic violence and other forms of violence against women. Search terms for violence against women were adapted from terms published in Cochrane protocols by Dalsbo et al and Ramsay et al. Searches were conducted for the period 2009 to 12th January 2016, updating a previously published review. Citation tracking using Web of Science and Google Scholar and searches of our personal files were used to identify additional papers.

Violence against women (VAW): definitions and concepts
Domestic violence and abuse (DVA)
Many countries provide a gender neutral definition of “domestic violence and abuse (DVA)”. For example, the UK Home Office states it is controlling, coercive or threatening behaviour, violence or abuse between people aged 16 or over, who are or have been intimate partners or family members, regardless of gender or sexuality“ which includes, but is not limited to psychological, physical, sexual, financial and emotional abuse. Similarly, the US Department of Justice defines domestic violence as a "pattern of abusive behaviour in any relationship that is used by one partner to gain or maintain power and control over another intimate partner" (https://www.justice.gov/ovw/domestic-violence). However, DVA is recognised to disproportionately affect women and an expression of power inequalities between men and women and, as such, to be a form of gender-based violence. Some argue that there is evidence for distinctions between “situational violence” – DVA that is lower in frequency, less likely to escalate over time, and is more likely to be mutual, and “intimate terrorism” - DVA characterised by a coercive pattern of physical violence, intimidation and control.

DVA research has often focused on incidents of physical violence, but this ignores the impact of repeated victimisation, sexual violence, emotional abuse, and controlling and coercive behaviour. Women's experiences of high-frequency repeated DVA and other forms of violent victimisation have
been further obscured by crime surveys, which typically cap repeated victimisation in reports. This highlights the need for a gendered perspective on analysis of violence.

**Sexual violence**

Although most DVA research has focused on physical violence, sexual violence may also be perpetrated by partners and research often fails to examine the relationship between the victim and perpetrator of sexual violence. Partner and non-partner sexual violence are defined separately by the World Health Organisation as “being physically forced to have sexual intercourse when you did not want to, having sexual intercourse because you were afraid of what your partner might do, and/or being forced to do something sexual that you found humiliating or degrading” and “when aged 15 years or over, being forced to perform any sexual act that you did not want to by someone other than your husband/partner”, respectively. Measuring the extent of sexual violence - which is often seen as shameful and stigmatising - presents a range of challenges. Myths about sexual violence - including that women who use alcohol or drugs are asking to be raped, that women provoke rape by the way they dress or act, and that rape is a crime of passion - are prevalent worldwide, and act to stigmatise and blame victims and reduce the responsibility of perpetrators. In this context many victims choose not to report their experiences or may not define what happened to them as an act of sexual violence.

**Other forms of VAW**

Sexual violence is common in the general population (see above) but is particularly highly prevalent in specific groups. For example, a study of survivors of human trafficking in contact with support services in England found that 95% women trafficked for sexual exploitation, 54% trafficked for domestic servitude, and 21% trafficked for labour exploitation reported having been forced to have sex while trafficked. Women make up over half of the estimated 20.9 million victims of human trafficking worldwide, where trafficking is defined as the recruitment and movement of people – most often by means such as deception, coercion, or the abuse of vulnerability – for the purposes of exploitation. Trafficked women are also likely to have experienced physical and sexual violence prior to trafficking and may remain vulnerable to victimisation after escape from exploitation; similar findings have been found among female asylum seekers.

Although families who practice FGM - procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reason – do not think of it as violence, FGM is internationally recognised as a form of VAW. It differs from most forms of violence against women in that, in practicing communities, it is promoted as a valued social and cultural norm and conducted routinely on almost all girls. It is estimated that at least 200 million women and girls in 30 countries have been subjected to FGM, and that over 3 million girls are at risk of FGM annually. The practice is most common in the western, eastern, and north-eastern regions of Africa, in areas of the Middle East (including Iraq and Yemen) and of Asia (including Indonesia), but is also found in Europe, Australia, and North America.

**Violence against women (VAW) and mental health**

*Domestic violence and abuse (DVA) and mental health*
There is evidence, at least for some conditions, that a bidirectional causal relationship exists between mental disorder and DVA. Longitudinal studies have demonstrated, for example, that DVA increases the likelihood of depression among women with no previous history of symptoms and there is also an association between depression and subsequent DVA; more than 10% of postnatal depression for example, may be potentially attributable to DVA. There has been limited longitudinal research into the relationship between DVA and other mental disorders, however, and more work is needed to disentangle the role of childhood abuse, which is associated with both mental disorder and DVA.

Nonetheless, systematic reviews of predominantly cross-sectional studies report consistent relationships between being a victim of DVA and mental disorders across the diagnostic spectrum for men and women, but as women are more likely to be victims, the population attributable fractions (assuming causality) are higher for women. One systematic review and meta-analysis reported a three-fold increase in the likelihood of depressive disorders, four-fold increase in the likelihood of anxiety disorders and a seven-fold increase in the likelihood of post-traumatic stress disorder (PTSD) for women who have experienced DVA. Significant associations between IPV and symptoms of psychosis, substance misuse and eating disorders have also been reported. Due to a lack of primary data, systematic reviews have been unable to assess the associations between diagnosed mental disorders and specific types of DVA (e.g. physical, sexual, psychological, and emotional abuse, and controlling and coercive behaviours). However, a study by Pico-Alfonso et al. which compared three groups of women (non-abused, physically/psychologically abused, and psychologically abused) found that while both abused groups had a high incidence and severity of symptoms of depression, anxiety, PTSD, and suicidal ideation than did non-abused women there were no differences between the two abused groups. Similar findings have been reported elsewhere in respect of symptoms of depression, PTSD, and psychological distress suggesting that psychological DVA can be as detrimental to mental health as physical DVA. Research considering the specific impact of coercive and controlling behaviours on mental health is limited, but in a study of court-involved abused women, Dutton et al showed that adverse mental health outcomes were independently with both coercive control and emotional abuse. Pico-Alfonso et al also reported a high degree of overlap between the types of abuse experienced: all the women who were subjected to physical violence also suffered from some form of psychological violence, with many also being sexually abused by their partners; research suggests that women who experience more than one form of abuse are at increased risk of mental disorder and co-morbidity.

The prevalence of DVA victimisation is particularly high in people in contact with secondary mental health services - a recent survey of mental healthcare service users in London reported that 70% of women (and 50% of men) had been DVA victims as adults, with many (27% of women, 10% of men) experiencing recent and current DVA. The prevalence of DVA in primary mental health care services such as primary care psychological therapy services in the UK (also known as IAPT – Improving Access to Psychological Therapy services) has not been investigated but in GP attenders a 17% prevalence of physical violence in the past year from a current or former partner was found for women.
Some have highlighted that psychiatric symptoms, while fulfilling criteria for a mental disorder using current classifications, may be more usefully understood as understandable chronic anxiety about further abuse. A recent meta-synthesis of fourteen studies reporting on mental health service users’ experiences of disclosure and response to domestic violence highlighted the limitations of the biomedical model as a key theme: service users explained that a focus on diagnosing and treating psychiatric symptoms often prevented healthcare professionals recognizing abuse, while labels of mental illnesses act to minimize service users’ experiences of abuse. Researchers and domestic violence sector advocates have similarly argued that pathologising and medicalising such symptoms obscures their meaning and may not help in assisting victims to overcome symptoms and develop strategies to prevent further abuse. Chronic experiences of abuse, particularly if abuse was also experienced in childhood and escape was not possible due to physical, psychological, family or societal factors, may result in “complex PTSD”, a disorder first proposed by Herman. Although not a category in DSMV (but may be included in ICD11), complex PTSD is considered a useful concept by many working with chronically traumatised victims.

There is some evidence that suggests that rates of physical and sexual IPV are lower in older women, but the prevalence of emotional and economic abuse and controlling behaviours are similar to those experienced by younger women, with similar rates of mental health problems. There is also preliminary evidence of an increased risk of DVA in women with dementia. The large literature on “carer abuse” may have ignored the possibility of historical abuse that started years before the onset of frailty and/or dementia.

**Sexual violence and mental health**

Research also suggests an association between sexual violence and mental disorder, but generally does not distinguish between partner and non-partner violence. Analysis of data from the cross-sectional Adult Psychiatric Morbidity Survey, for example, suggests associations between sexual violence and drug and alcohol dependence, and estimated PAFs for women of between 6% and 16% for non-consensual sexual intercourse and between 13% and 24% for contact abuse for the mental disorders assessed, assuming a causal relationship (which is problematic in such cross-sectional data). Our recent review of recent sexual violence against women with severe mental illness (SMI) identified eight studies, with a median prevalence of 10% (IQR 6%-18%). Again people in contact with secondary care have a history of particularly high rates of sexual violence - the survey discussed above reported a 61% (40% for rape or attempted rape) prevalence of adulthood sexual violence against 129 female patients and prevalence of past-year sexual violence was 10%. More than half of those who had experienced rape or attempted rape reported having attempted suicide as a result of their experiences. Perpetrators of sexual violence were most commonly acquaintances and strangers (77% of victims) with current or former partners reported for 47% of victims. After adjusting for socio-demographic differences, the odds of sexual violence against women with SMI were six-fold higher for lifetime sexual violence (OR 6, CI 4-9) and threefold higher for past-year sexual violence (OR 3, CI 1-6) compared to women in the general population. Similar findings were reported in a survey of female psychiatric patients in the Netherlands (past-year sexual harassment OR 3.6 (CI2.7-4.8) compared to women in the general population).

**Other forms of VAW and mental health**
Less is known about the relationship between other forms of VAW and mental health. A small number of studies suggest that high levels of symptoms including depressive, anxiety, and PTSD symptoms are found in women who have escaped their traffickers and are in contact with shelter services; psychotic disorders and substance use disorders are also found in trafficked people in contact with secondary mental health services. Mental health problems appear to endure into the medium- to long-term: a survey of Moldovan trafficked women found that 55% met DSM-IV criteria for mental disorder at an average of 6 months post-return to Moldova, while a survey of trafficked people in contact with shelter services in England found that 78% of women screened positive for depression, anxiety, or PTSD at an average of 16 months post-escape. Several studies report that the risk of mental health problems is increased by physical or sexual violence prior to and during trafficking; duration and severity of trafficking; and, after escape, unmet social needs and poor social support. Trafficked men also suffer violence prior to and during trafficking, studies suggest the prevalence is lower than among trafficked women (42% versus 77% for physical violence while trafficked and 4% versus 66% for sexual violence while trafficked) and that trafficked men are less likely to report having been injured while trafficked (33% versus 67%).

Although the physical health problems of FGM (including haemorrhage, urinary tract infection, dyspareunia, and obstetric complications) caused by FGM have been extensively documented, less is known about its mental health consequences. Studies suggest, however, that women with FGM may be more likely to have a psychiatric diagnosis and to experience symptoms of anxiety, depression, somatisation, post-traumatic stress disorder, and low self-esteem and that psychopathology may be associated with type of FGM (with higher risk for infibulation), event recollection, avoidant coping style, migration, and employment status.

**Risk factors for being a victim of VAW**

The World Health Organisation uses an ecological model when considering risk factors for DVA. Risk factors operating at the level of the individual include young age, disability, poverty (the increase in DVA since 2008 in England and Wales highlights the relationship between the economy and DV), witnessing DVA as a child, childhood abuse, and substance abuse. Although individual-level risk factors for sexual violence are likely to vary according to the context of the abuse, sexual violence is more likely in the young, women people with disability, poverty, sexual abuse in childhood, and substance abuse. Many of these risk factors are also risk factors for mental disorders, which emphasises the social determinants of both mental disorders and violence against women, the complex pathways involved in being a victim of violence through the lifespan, and also highlights potential prevention strategies (see below). However, aetiological factors also occur at the level of the relationship (e.g. partner with depression, substance misuse, patriarchal attitudes, and/or a history of being a victim of childhood abuse), community characteristics (e.g. high population density, unemployment and social isolation), and larger societal factors including health, educational, economic and social policies, cultural norms, gender disadvantage and social inequalities.

**Perpetration of VAW by people with mental disorders**
Mental disorders are associated with an increased risk of perpetrating violence, and, internationally, mental health policy has a focus on assessment of risk of violence to others. However there have been few studies of the extent of the risk of DVA or sexual violence perpetration rather than violence in general, which has limited our knowledge on the prevalence and risk of perpetration of these types of abuse. However, a recent systematic review of predominantly cross-sectional psychiatric morbidity and population surveys found associations between all mental disorders and DVA perpetration in both men and women. Conclusions are limited though, as most studies measured isolated incidents of physical violence rather than repeated severe violence. In addition, potential confounding and mediating factors were not examined in the included studies, though from the United Nations Multi-Country Cross-Sectional Study on Men and Violence in Asia and the Pacific suggest that high levels of depressive symptoms may increase risk of perpetrating physical, sexual, and emotional domestic abuse even after adjustment for substance misuse, witnessing and experiencing violence as a child, and participation in violence outside the home.

The introduction of statutory domestic homicide reviews in England and confidential enquiries into homicides by people with mental illness has highlighted that domestic homicides are not infrequently perpetrated by male mental health service users. In one study, 14% of perpetrators of intimate partner homicide and 23% of perpetrators of adult family homicide in England and Wales had been in contact with mental health services in the year before the offence. For both types of homicide, men made up more than four-fifths of perpetrators. Also in England and Wales, a study of homicide-suicides similarly found that current or former partners were the victims in two thirds of cases (although homicide-suicides make up a relatively small proportion of intimate partner homicides) and that 12% of perpetrators had been in contact with mental health services in the year before the offence. Victims of domestic homicide also often have a history of contact with mental health services as children or as adults. Alcohol and substance misuse and persecutory delusions are often reported to be mediators of violence in people with severe mental disorders: this has not been investigated in relation to DVA perpetrated by people with mental disorders and should be considered in future research. Similarly, although treatment with antipsychotics and mood stabilisers is associated with reduced violent crime, this has not been investigated in relation to DVA. Similar mechanisms may be important in the relationship between DVA perpetration and mental disorders; future research should seek to investigate this.

Evidence on the perpetration of sexual violence by people with mental disorders is similarly lacking, although a review of risk factors for sexual violence perpetration did not find evidence for an association between perpetration and psychological symptoms measured using screening instruments. Langstrom et al. have reported an increased relative risk of psychiatric hospitalization and severe mental illness in sexual offenders and have hypothesised that psychiatric symptoms could trigger sexual offending. Severe mental disorders may also be associated with potential risk factors for sexual violence perpetration (including aggression, poor social skills, and cognitive distortion), or mental disorders may be associated with risk factors for sexual violence such as drug and alcohol misuse and sexual violence victimisation.

What can mental health professionals do?
International guidelines, including from the World Health Organization (WHO) and National Institute for Health and Care Excellence (NICE), recommend that mental health professionals should facilitate DVA disclosure as part of comprehensive clinical assessments, provide support and ensure safety, and treat physical and mental disorders in the context of any DVA. While there is debate about the role of universal screening for DVA in the health care system in generic services such as primary care or emergency departments, the prevalence of being a victim of violence is so high in mental health service users (as discussed above), clinical guidelines recommend routine enquiry in mental health services. There is limited evidence on whether the introduction of routine enquiry improves outcomes, and outcomes will depend on the nature of the response to disclosure; guidelines therefore stress that routine enquiry should only be introduced when professionals have been appropriately trained, and have protocols in place on interventions, particularly referral to specialist DVA services and access to trauma-informed interventions. Given the high prevalence of DVA and sexual violence, mental health service providers must include support for staff who have been victims; many staff will find this work emotionally challenging if it resonates with their own experiences. With these caveats, guidelines recommend that mental health professionals routinely ask about DVA and sexual violence experienced in childhood and adulthood as part of clinical assessment and ongoing care. Routine enquiry needs to be carried out safely (i.e. in private with the use of a professional interpreter if needed rather than family members) and mental health professionals need to know how to respond before implementing routine enquiry. When working with survivors of sexual violence, human trafficking, and FGM, mental health professionals should similarly ensure women have opportunities to be seen without partners, family members, or acquaintances present; provide access to independent interpreters; respond sensitively, compassionately, and non-judgementally disclosure; reassure women that they are believed and not to blame for their experiences; and offer information and practical support that responds to women’s concerns and respects their autonomy. The 2014 Lancet series highlighted that the infrastructure of health systems and community services need to change in order to address violence against women. However, a recent editorial in the American Journal of Psychiatry suggested that mental health professionals themselves have to address their strong psychological barriers to addressing DVA and sexual violence, which can lead to “pity and disdain” of the victim, and vilification of the abuser, and abdication of the roles of clinicians and researchers.

Figure 1: Addressing violence against women – necessary elements at the level of health providers, services and systems.

[Taken from Garcia-Moreno et al, 2014].

Identifying victims of VAW in mental health services

Despite the high prevalence of DVA among mental health service users, a review in 2010 found that only 10-30% of DVA victims are identified by mental health professionals internationally. Qualitative studies have reported several barriers to routine enquiry by professionals, including a lack of confidence and competence in facilititating and managing disclosures, lack of DVA knowledge and understanding (e.g. of the power dynamics of DVA relationships involving coercive control), and
lack of clarity about the role of mental health professionals in addressing DVA. A meta-synthesis of qualitative studies involving mental health service users found that DVA victims want mental health professionals to acknowledge and/or validate their disclosures of domestic violence in a non-judgemental and compassionate manner. Some service users reported that their disclosures were not taken seriously and they felt blamed by professionals, which was unhelpful and associated with persistent symptoms (see also above). Lack of acknowledgement was felt to be compounded by limited opportunities for service users to discuss the DVA during consultations, which they felt focused exclusively on diagnosing and treating psychiatric symptoms, preventing them from recognizing the extent of abuse, receiving appropriate care, and minimizing their experiences. Responses that addressed their safety concerns were valued but service users were fearful that mental health professionals’ responses to the violence sometimes can place them at risk of further harm (e.g. if the perpetrator hears about the DVA disclosure), or dismissal by services if they do not leave the partner. Mental health professionals may fail to understand that choosing to remain in an abusive relationship may be based on a strategic risk: benefit analysis which includes financial concerns, concern that they will be seen as too ill to care for their children, short-term losses such as the family home and a father and network for the victim’s children, stigma, hope (not always unfounded) that the perpetrator will change, and an awareness that the perpetrator may stalk the victim and cause more severe violence. Indeed women are at greatest risk of homicide in the months immediately following separation.

Adulthood sexual violence is also under-detected in mental health services. Studies conducted with female mental health service users in Brazil, Sweden and the UK report that between 12% and 43% of those who had suffered sexual violence had told a health professional about their experiences47. In a Swedish study, sexual violence was less likely to be identified by mental health services than was either physical or emotional abuse. Female mental health service users in India who had experienced sexual coercion – 60% of whom reported having told no one about their experiences - explained that their reasons for non-disclosure included fears of being blamed and of further violence from the perpetrator, resignation, and believing that abuse happened to all women. Research to explore barriers to identifying and responding to sexual violence within mental health settings is lacking, although a small qualitative study conducted in Australia found staff reported personal discomfort with the issue and felt ill-equipped to respond to disclosures due to a lack of training and guidance, including with regards to containing distress and making referrals to sexual assault services.

There is little evidence on the extent to which either human trafficking or FGM is identified in mental health settings. Although UK research has shown that trafficked people have come into contact with mental health services while being exploited, providing mental health professionals with opportunities to identify, refer safely, and provide care while facilitating escape from the trafficking situation. A survey of NHS staff working in areas in which five or more trafficked people had been identified by police in the previous year found that one in eight mental health professionals reported that they thought they may have encountered at least one victim of trafficking in their clinical practice, but they lacked knowledge and confidence in how to respond appropriately and safely. A cohort study, using clinical informatics, found that in half the cases (n=95), mental health professionals were the first healthcare professional to become aware that their patient was a
potential victim of trafficking; of the other trafficked adults in this cohort had been identified as trafficking victims by others and were frequently referred by primary care and emergency departments, though maternity care was also an important route into mental healthcare for trafficked women. Compared with other adults in contact with the same mental health provider trafficked adults were more likely to be detained and had longer admissions. Trafficked people may find it difficult to disclose their experiences, due to fear, feelings of shame and guilt, and the impact of trauma on their recall of events. In addition trafficked people may not recognise that the abuse they are experiencing is trafficking, and may not trust healthcare professionals due to their fear of retribution by the traffickers.

Improving mental health service responses to violence against women (VAW)

There is evidence internationally that guideline dissemination and training in isolation do not create consistent, sustainable improvements in identification and response to VAW and research into strategies to improve the integration of DVA and other forms of VAW into the “core business” of mental health services is needed. There are trials of systemic interventions to improve identification and response to DVA in primary care, but a recent systematic review reported no trials in mental health settings and highlighted the need for more than training to improve identification. In non-mental health settings, ongoing integrated training, support and advice (e.g. from DVA advocates) for health professionals in addressing DVA improves health professionals’ facilitation of disclosure and improves professionals’ subsequent response. However, one study in maternity services reported potential and actual harm occurring after the introduction of routine enquiry, including breaches of confidentiality which could lead to the perpetrator finding out about the disclosure with consequent violence, and failure to document evidence, limiting women’s ability to access civil and legal remedies.

A small pilot in community mental health teams in South London suggests that DVA advocates integrated within teams, in addition to dedicated time for training, improve rates of identification of DVA and outcomes for individual victims with fewer unmet needs and lower levels of abuse at 3 months follow-up. Echoing findings that improving mental health service responses to DVA requires more than training, an audit conducted in New Zealand found that although the proportions of child and adulthood sexual and physical abuse included in formulations and treatment plans increased after the introduction of a trauma policy and training programme, actual interventions remained low.

Identification of perpetrators of VAW in mental health services

There is limited evidence on the extent to which poor detection of perpetrators of DVA and sexual violence occurs in mental health services. However, a recent qualitative study with mental health professionals has highlighted the lack of enquiry about DVA perpetration specifically (with most professionals asking about violence in general and not asking about ex-partners, even though risk of lethal violence increases after separation), perceived inadequacy of current risk assessment (as generic risk assessments do not specifically refer to different types of DVA) and lack of clarity on information sharing. Homicide-suicides have also recently been reported to be commonly preceded by relationship breakdown and separation, with most perpetrators male (88%), most victims female (77%); 62% of perpetrators had mental health problems.
In England, the National Confidential Inquiry into Homicides, and the Home Office, report a failure of mental health professionals to assess for DVA perpetration risk,$^{86,118}$ despite a clear responsibility of mental health services to identify potential IPV perpetrators within current risk assessment frameworks. Although there has been less research on how to respond to mental health service users who disclose DVA perpetration, there is extensive guidance on how to address risk of violence, which includes consideration of safety of the victim.

**Interventions for victims of VAW**

There is a large evidence base on mental health interventions for all the mental disorders associated with violence against women, but little is known on how effective psychological or pharmacological interventions are for victims of violence where the violence has not been disclosed, or where the violence is not the focus of the intervention. A Cochrane review of 70 trials (4761 participants) of psychological interventions for PTSD found that there was some evidence (though from generally low quality trials) that trauma focused CBT and eye movement desensitisation and reprocessing (EMDR) are superior to non-trauma focussed CBT between one to four months following treatment.$^{119}$

The evidence base on psychological interventions specifically designed for survivors of DVA is growing, and systematic reviews find that CBT based interventions and cognitive processing may be associated with improved PTSD and depressive symptoms in survivors no longer in abusive relationships.$^{4,120}$ Although a systematic review finds some support for the effectiveness of advocacy and CBT interventions in reducing physical and psychological DVA (too few studies were identified to assess effectiveness in reducing sexual DVA), few studies have examined whether interventions are helpful in reducing psychological symptoms among women still subject to abuse.$^{121}$ However, the few studies which integrate DVA advocacy and psychological interventions in women at risk of continuing abuse report both improvements in depressive symptoms and reductions in abuse,$^{122-124}$ including improvement in birth outcomes for women in the perinatal period.$^{122,124}$ It is not yet clear which modes of delivery are most effective and whether interventions can be delivered effectively to women with different levels of risk of abuse, including diverse and marginalised groups.$^{4}$

Evidence on psychological interventions for survivors of sexual violence is also inconsistent. A systematic review of 20 studies found some evidence for the efficacy of EMDR and trauma-focused CBT (TF-CBT) for PTSD, depression, and other psychological problems commonly experienced by sexually assaulted women, again from low quality studies.$^{125}$ However, the Cochrane review of treatment for PTSD found no differences between TF-CBT and other therapies that were not specifically trauma focused for women who had experienced sexual assault or abuse.$^{119}$ Since the publication of these reviews, a cluster trial of an adapted group cognitive processing therapy intervention versus individual psychosocial support for Congolese survivors of sexual violence has demonstrated effectiveness in reducing symptoms of post-traumatic stress, depression, and anxiety in a low-income, conflict-affected setting.$^{126}$ As with research on interventions for DVA, women with recent or ongoing experiences of sexual violence are excluded from the majority of intervention trials.
No research to evaluate interventions to support the psychological recovery of either trafficked women or women who have experienced FGM was identified in this or in previous reviews; \(^{27, 127}\) future research should test interventions in these survivor groups. Until then, care should be provided in line with guidelines for working with victims of trauma.\(^3\)

**Interventions for perpetrators of VAW**

Evidence is lacking on the effectiveness and appropriateness of DVA perpetrator programmes for people with mental disorders, and these programmes receive few referrals from mental health services.\(^{128}\) However, interventions for modifiable risk factors (such as medication for persecutory delusions, psychological interventions, and treatment of co-morbid alcohol and substance misuse) while ensuring safety of the potential victim, may be expected to improve health and reduce violence for DVA perpetrators in contact with mental health services whose VAW perpetration appears linked to these factors.

**Violence against women: a public mental health approach to prevention**

Mental health professionals have an important role in protecting women’s rights to be free from gender based violence, and can employ primary, secondary, and tertiary measures to reduce the risk of VAW. As substance misuse, particularly excessive alcohol consumption, contributes to DVA and sexual violence, mental health professionals could argue for a reduction in hazardous levels of drinking as recently recommended by the Chief Medical Officer.\(^{129}\) Engagement in primary prevention could also involve mental health professionals raising awareness about the impact on mental health and intergenerational violence experienced by women and children and challenging cultural norms within mental health services as well as wider society. Secondary prevention of VAW (i.e. reducing the impact and harms of VAW that has already occurred) will involve identifying and responding to domestic, sexual, and other forms of VAW experienced or perpetrated by mental health service users. Identification and treatment of perpetrators may prevent future violence and would also improve victims' health: risk assessment should include a focus on risk of DVA and sexual violence to ex-partners (as well as current partners) and family members. Safeguarding and supporting children exposed to and/or witnessing VAW could reduce the likelihood of these children becoming victims or perpetrators of VAW, reducing risk of VAW for future generations. Mental health professionals can also contribute to the prevention of VAW at the tertiary level by advocating for funding for specialist services such as DVA advocates, sexual assault referral centres (SARCs), FGM clinics, and post-trafficking support. Increasing access to mental health services is an important secondary and tertiary preventive measure: despite evidence that mental disorder increases the risk of DVA victimisation and perpetration, and that experiencing DVA increases risk of mental disorder, effective mental health treatments are not available for most people globally.\(^{130, 131}\)

**Implications for future research**

States are obliged to prevent violence against women and to protect victims and should provide funding for research and services that is commensurate with the cost of violence against women to the health and wellbeing of women and of future generations. The Istanbul Convention, for example, requires that States take the necessary legislative and other measures to ensure that
victims of all forms of violence against women have access to healthcare, social and specialist support services; that services are adequately resourced; and that professionals are trained to assist victims to make appropriate referrals. Yet, and as highlighted in this review and elsewhere in this issue, and by the World Health Organization’s (WHO) global plan of action to strengthen health system responses to violence against women and children, appropriate mental health research and service provision is lacking. As indicated in the review above, and by the National Institute of Health and Care Excellence (NICE) and WHO, research into interventions for both victims and perpetrators of DVA and sexual violence are still needed; there have been only a few trials to date for victims of DVA or sexual violence with mental disorders, and no trials for mental disorders in victims of other forms of violence against women such as trafficking and FGM. Similarly there have been no trials of perpetrator programmes or other interventions for DVA perpetrators who have mental disorders and/or misuse substances. Research needs to be informed by more longitudinal studies into all forms of violence against women (rather than focusing solely on incidents of physical violence), including measures of impact of the violence, which could identify potential mechanisms that could be addressed by tailored interventions. New cohort studies should include measures of the range of mental disorders and symptoms, in addition to depression. Research is also needed to establish how often "non-engagement" with mental health services, and poor treatment response, is due to perpetrators limiting access to health professionals and undermining treatment offered. To what extent is treatment failure or treatment resistance due to VAW that has not been identified? It is striking that DVA and other forms of violence are rarely measured or identified in trials of mental health interventions even though they is likely to be important moderators of response. We hope that in future, there will be better integration of violence against women in studies investigating the epidemiology of mental disorders and their treatment.
References