DOI:
10.1080/09540261.2016.1201053

Document Version
Peer reviewed version

Improving mental health service responses to domestic and sexual violence

Journal:	*International Review of Psychiatry*
Manuscript ID	CIRP-2016-0046
Manuscript Type:	Review
Date Submitted by the Author:	05-May-2016
Complete List of Authors:	Trevillion, Kylee; Institute of Psychiatry, Health Service and Population Research Corker, Elizabeth; Newham Centre For Mental Health, Unit for Social and Community Psychiatry Capron, Lauren; Institute of Psychiatry Psychology and Neuroscience Department of Psychological Medicine, Section of Women\'s Mental Health Oram, Sian; King's College London, Section of Women's Mental Health
Keywords:	Domestic Violence, Mental Health, Perpetrators, Mental Health Services, Intervention

Title

Improving mental health service responses to domestic and sexual violence

Authors

1. *Kylee Trevillion, PhD; King's College London; Section of Women's Mental Health, PO31 King's College London, De Crespigny Park, London SE5 8AF; Telephone – 02078485061; Fax – 02072771462.

2. Elizabeth Corker, PhD, Unit for Social and Community Psychiatry, Newham Centre for Mental Health, London, E13 8SP; Telephone – 02075406755; Fax – 02075402976

3. Lauren E. Capron, MSc, King's College London; Section of Women's Mental Health, PO31 King's College London, De Crespigny Park, London SE5 8AF; Telephone – 02078485129; Fax – 02072771462.

4. Siân Oram, PhD, King's College London; Section of Women's Mental Health, PO31 King's College London, De Crespigny Park, London SE5 8AF; Telephone – 02078480708; Fax – 02072771462.

*Corresponding author – kylee.trevillion@kcl.ac.uk

K**eywords:** Domestic Violence; Mental Health; Perpetrators; Mental Health Services; Intervention.

Introduction

Domestic violence (DV) comprises physical, psychological and emotional, financial or sexual abuse, or controlling or coercive behaviours, against a current/former intimate partner or adult family member (Home Office, 2013b). DV is an important international public health problem and is associated with negative health outcomes among both women and men (Jonas et al., 2014, Buller et al., 2014, Hester et al., 2015). Evidence from general population surveys indicate that the prevalence of DV is comparable between men and women (Office for National Statistics, 2014). However, women are shown to be at greater risk of repeated abuse, of severe physical and sexual violence, and of violence that occurs in the context of controlling behaviours (Stark, 2006, Walby et al., 2015). A review of the rates of violence victimisation among men and women with severe mental illness highlight that women are at increased risk of victimisation compared to men (Khalifeh and Dean, 2010).

Systematic reviews report that a high proportion of mental health service users experience DV (Oram et al., 2013) and demonstrate a consistent relationship between mental disorder and DV, with a three-fold increased risk of depressive disorders and seven-fold increased risk of post-traumatic stress disorder (PTSD) among victims of DV (Trevillion et al., 2012b). Although the majority of evidence is drawn from cross-sectional studies, there is some research to suggest that the relationship between DV and mental disorder may be causal, including an observed dose response relationship between the severity of mental illness symptoms and the frequency and severity of abuse (Du Mont and Forte, 2014, Golding, 1999, Jones et al., 2001). Although longitudinal studies are fewer, they suggest a bidirectional relationship between mental disorder and DV, with mental disorders increasing vulnerability to DV (Trevillion et al., 2012b) and DV damaging mental health (Dekel and Solomon, 2006, Devries et al., 2013, Howard et al., 2013). Research also suggests a relationship between mental disorder and lifetime DV perpetration, although the association is less pronounced than that between mental disorder and DV victimisation (with a two-fold increase in risk of lifetime DV perpetration among both men and women with depression and anxiety disorders) and uncertainty regarding the role of potential mediators such as substance abuse, psychiatric symptoms, and treatment adherence (Oram et al., 2014).

Mental health professionals have an important role in responding to DV (Chapman and Monk, 2015), and several countries have introduced policies of routine enquiry for mental health services, including the UK (Department of, 2008), New Zealand (Agar and Read, 2002), and the US (Eilenberg et al., 1996). Yet, DV remains under-detected in mental health settings (Chapman and Monk, 2015,

Howard et al., 2010) and mental health service users report low levels of satisfaction with psychiatric services response to DV (Trevillion et al., 2014b). This paper reviews the evidence on mental health service responses to DV, including identifying, referring, and providing care for people experiencing or perpetrating DV. We searched Medline, PsychINFO and Embase on the 12th January 2016 for papers that reported on identifying and responding to DV in mental health care settings. Citation tracking was used to identify additional papers. Only papers published in English were included. The search date parameters were 2009 to 2016, updating a previously published review (Howard et al., 2010). DV was defined in line with the UK Home Office definition, and included physical, psychological and emotional, financial, and sexual abuse, and controlling or coercive behaviours (Home Office, 2013b).

Is domestic violence identified by mental health professionals?

Identifying service users who have experienced DV

In 2010, a review reported that mental health professionals were not routinely enquiring about DV and that DV was under-detected by mental health services (Howard et al., 2010). Research published since then suggests that levels of enquiry about DV remains low and that this negatively impacts on service users' disclosure and the identification of DV.

A UK survey of 131 psychiatric nurses' and psychiatrists' knowledge, attitudes and preparedness to respond to DV found that only 15% (n=20) reported routinely enquiring about DV (Nyame et al., 2013). As the sample did not include other mental health professionals, such as social workers and psychologists, it is not possible to infer if routine enquiry was low among all staff in this setting. A second UK survey conducted with 142 mental health professionals prior to DV training found that more than one-third never or seldom asked about DV with patients who presented with substance abuse or eating disorders and over 40% never or seldom asked patients with depression, anxiety, or psychotic disorders (Oram et al., unpublished). Research conducted in a US emergency department suggested that patients with substance use disorders were significantly less likely to be screened for experiences of DV, although no differences in screening rates were found for patients with other mental health disorders (Choo et al., 2010).

Research with service users similarly suggests low levels of enquiry about DV in mental health settings. In the USA, a cross-sectional survey of 158 male and 270 female mental health service users found that fewer than half had been asked about experiences of abuse by clinicians, with more

women (55%) than men (27%) reporting screening (Chang et al., 2011). Slightly more participants reported having been asked about physical (39%) and emotional (37%) than sexual violence (30%), although the differences were not statistically significant. In self-administered questionnaires, half of the female service users reported lifetime experiences of DV (50%; n=134) and one in eight (13%, n=34) reported having experienced DV in the past year. Lifetime DV was also reported by a fifth of male service users (18%; n=29) and past year DV by 6% (n=10). Findings highlight that mental health professionals are failing to identify DV, particularly among male service users. Research with women with severe mental illness (SMI) in Spain reported that that less than two-thirds of women with lifetime experiences of DV and only half of women with past year experiences of DV were identified by mental health services, with sexual violence also less likely to be detected than physical and psychological violence (Cases et al., 2014).

Identification of violence perpetration

There is a paucity of evidence on rates of detection of DV perpetration in mental health services. However, a recent cross-sectional survey conducted with 303 patients with SMI under the care of community mental health services in the UK found that one in ten disclosed lifetime perpetration of DV, of whom a third had been identified by mental health professionals (Khalifeh, 2015). The UK Home Office and the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness have also reported a failure of mental health services to assess risk of DV perpetration (Home Office, 2013a, University of Manchester), while an evaluation of UK perpetrator programmes highlighted that very few referrals to community perpetrator programmes come from mental health services (Kelly and Westmarland, 2015).

Service user disclosures of domestic violence

Mental health service users may experience multiple barriers to disclosing that they have experienced or perpetrated DV (Cases et al., 2014, Khalifeh et al., 2015, Trevillion et al., 2014b). However, evidence suggests that disclosure is facilitated by direct enquiry by health professionals (Khalifeh et al., 2015, Howard et al., 2010, Emerson Dobash et al., 2004, Posner et al., 2008).

Spangaro et al. (2010), for example, surveyed 363 women who attended US antenatal, drug and alcohol, or mental health services and who had been screened for DV as part of routine clinical assessments within the previous year. The sample included 122 women who had screened positive for experiences of DV and 241 who had screened negative. Fifty-six percent (67/120) women who had screened positive for IPV reported that this was the first time they had been asked about DV by

a health professional and 23% (27/120) reported that this was the first time they had disclosed the violence to anyone. Fourteen percent (34/240) of women who screened negative for DV disclosed to the researchers that they had experienced DV but had not disclosed this when screened. False negative responses were more likely among women attending mental health services (OR 12.2, 95% CI 3.3-46.1) or drug and alcohol services (OR 8.8, 95% CI 3.4-23.3) versus women attending antenatal clinics. No other variables were found to be significant predictors of false negative response. The authors suggested that the higher rates of false negative responses in drug and alcohol and mental health services may be due women exercising caution resulting from previous negative experiences within these services (Spangaro et al., 2010). Reasons for false negative responses included not viewing the abuse as sufficiently serious or frequent to report; fear of the perpetrator finding out; embarrassment and shame; and not feeling comfortable with the health professional.

A systematic review of qualitative studies reporting on mental health service users' experiences of disclosing DV similarly found that mental health services often failed to identify and facilitate disclosures of domestic violence and to develop responses that prioritised service user safety (Trevillion et al., 2014b). A study of 24 mental health service users, for example, identified multiple barriers to disclosure of DV (Rose et al., 2011). Service users described DV as a hidden problem: they did not necessarily recognise behaviours as abusive, perpetrators acted to isolate them from their friends and families and to prevent them from speaking privately to health professionals, while professionals failed to respond to signs of abuse. Professionals were described as focusing on diagnosing and treating the symptoms of mental illness, and as ignoring social and personal factors that contributed to these symptoms. Fear also emerged as a major theme: service users feared that they would not be believed or that disclosure would lead to further violence, to the disruption of family life and the involvement of social services, or could have negative impacts on their immigration status. Service users in this study also described feelings of shame and self-blame about their experiences of DV (Rose et al., 2011). Disclosure of DV may be particularly difficult for mental health service users as they are likely to have experienced discrimination in relation to their mental illness and this may discourage help seeking (Du Mont and Forte, 2014, Trevillion et al., 2012a). Interestingly, the UK qualitative study found that some service users reported a reluctance to access DV support services because of fears about disclosing their mental health status (Trevillion et al., 2012a). Research in the UK and Australia has highlighted that women with severe mental illness have difficulty accessing refuge services (Hager, 2011, Harvey et al., 2014).

Equivalent research has not been conducted in relation to disclosure of DV perpetration. Khalifeh et al's UK study of mental health service users suggested, however, that disclosure is facilitated by direct enquiry ((Eckhardt et al., 2008, Khalifeh, 2015) and research elsewhere has suggested that perpetrators are unlikely to self-identify or seek treatment without assistance (Eckhardt et al 2008, Chapman and Monk 2015).

Are mental health professionals effective in documenting domestic violence?

Documentation of domestic violence victimisation

Research suggests that, once DV has been identified, incidents of abuse are inadequately documented (Cobo et al., 2010). A Spanish study conducted in a large urban hospital service reviewed all detected cases of DV experienced by women presenting to the service between January 2004 and December 2006 (Cobo et al., 2010). The study identified 412 women, all of whom presented with severe physical injury. In 13% (n=53) of cases, women had previously sought psychiatric care within the service. The study conducted a detailed analysis of 33 of these 53 cases and found that only half had any documentation of abuse in their clinical histories, with only 14 cases providing exact information about incidents. Where DV was documented, clinicians often used generic or euphemistic terms to describe violence, and very few cases contained information regarding the approach or intervention taken with regards to the violence (Cobo et al., 2010). Research elsewhere has similarly suggested that DV is infrequently addressed within treatment plans (Agar and Read, 2002, Trevillion et al., 2012a), and in the UK a survey of mental health professionals' behaviours in addressing DV found that only 27% of professionals reported that they provided information to service users after a disclosure (Nyame et al., 2013).

Documentation of domestic violence perpetration

Less is known about the documentation of DV perpetration by mental health professionals. However, a qualitative study conducted with mental health professionals in England found staff lacked confidence about when and how to share information about service users who perpetrated DV with other relevant professionals and with new partners (Hemmings et al., Submitted).

What are the barriers to mental health professionals identifying and responding to disclosures of domestic violence?

Research with mental health professionals suggests that barriers to enquiry about DV include a perceived lack of expertise (Salyers et al., 2004), a lack of rapport or a strong therapeutic

relationship with the service user (Currier et al., 1996), time constraints and competing demands on time (Hamberger and Phelan, 2004), the presence of partners during consultations, and fear of offending or re-traumatising service users (Emerson Dobash et al., 2004, Trevillion et al., 2012a). Male clinicians may be less likely to ask about DV than female clinicians (Nyame et al., 2013), although a lack of confidence and competency in how to appropriately identify and respond to DV is a barrier to both male and female clinician enquiry (Emerson Dobash et al., 2004, Klap et al., 2007).

In the UK, a qualitative study with 20 mental health professionals found that many did not feel confident or competent to examine experiences of DV in their practice (Emerson Dobash et al., 2004). They cited a lack of training in how to appropriately identify and respond to disclosures and a lack of clear care referral pathways as key barriers to enquiry. Some clinicians reported that it was easier to enquire about perpetration of violence, as it aligned with their routine risk assessments. In contrast, another UK qualitative study found that mental health professionals did not perceive they had sufficient skills and knowledge to enquire about DV perpetration (Hemmings et al., Submitted). In this latter study, clinicians reported that existing clinical risk assessments did not specifically refer to different types of DV risk (e.g. risk to ex-partners) and this resulted in inadequate assessment and identification of risk of harm. Concerns were also voiced regarding poor information sharing and a perceived lack of organisational recognition of DV perpetration and support to address this form of violence, including a lack of guidance and training provision (Hemmings et al., Submitted)

How can mental health services improve their responses to domestic and sexual violence?

The 2014 NICE guideline on DV highlighted the need for better evidence on interventions to provide effective support for healthcare professionals to identify and respond to DV and on the effectiveness of perpetrator programmes, domestic abuse recovery programmes, and psychological and interventions for people who have experienced DV (NICE, 2014). This review has identified a particular lack of evidence to support improved mental health service responses to DV, including interventions for mental health service users who are still experiencing abuse and for those who perpetrate DV. With regards to support for mental health service users who are experiencing ongoing abuse, evidence from non-psychiatric settings suggests that interventions which integrate DV advocacy and psychological therapies may lead to improvements in mental health symptoms and reductions in abuse (Kiely et al., 2010).

Interventions to improve service responses to DV

Two recently conducted reviews have considered the effectiveness of training in improving health service responses to DV: a scoping review of 38 intervention studies and a systematic review of nine randomised controlled trials from the US and Europe (Choi and An, 2016, Zaher et al., 2014). The reviews demonstrated that although guideline dissemination and training can be effective in improving health professionals' knowledge about DV, they do not create consistent and sustainable improvements in the identification and response to DV unless implemented along system support interventions and systemic change. Neither review included interventions for improving responses to DV in mental health settings. However, studies conducted in mental health settings support their conclusions that efforts to improve health service responses to DV must go beyond improving professionals' knowledge of DV. In the UK, for example, a cross-sectional survey of 131 psychiatrists and psychiatric nurses found that although psychiatrists reported significantly greater knowledge about the nature and impact of DV than did psychiatric nurses, they felt less ready to use their knowledge to assess and manage service users' experiences of abuse (Nyame et al., 2013). A pilot study conducted in UK Community Mental Health Teams (CMHTs) found, however, that an intervention which combined DV training for clinicians and the implementation of a referral pathway to DV advocacy for service users improved rates of identification and referral among mental health professionals in addition to improved self-reported DV knowledge, attitudes, and behaviours (Trevillion et al., 2014a). An evaluation of an intervention aimed at achieving organisation-wide changes in responses to DV at two UK mental health care organisations ("Promoting Recovery In Mental Health", http://www.kcl.ac.uk/ioppn/depts/hspr/research/CEPH/wmh/projects/A-Z/Promoting-Recovery-in-Mental-Health-(PRIMH).aspx) including through the development of DV policies and competency frameworks, mentoring managers and senior practitioners to become DV champions, delivering training to frontline professionals and train-the-trainers, is currently underway.

Interventions for service users experiencing domestic violence

Systematic reviews have identified evidence from randomised controlled trials of effective interventions for victims of DV and other forms of trauma, including CBT for PTSD (Warshaw et al., 2013, NICE, 2014). Findings suggest that useful components are likely to include psychoeducation about the causes and consequences of DV, attention to ongoing safety risks, development of cognitive and emotional skills to address trauma-related symptoms and other concerns, and a focus on survivors' strengths. There has been limited research, however, on interventions for mental health service users with experiences of DV. This review identified three relevant studies: two

before-and-after studies conducted in the USA and one quasi-experimental pilot study conducted in the UK (Frueh et al., 2009, Lu et al., 2009, Trevillion et al., 2014a). Although neither before-and-after study was aimed specifically for mental health service users with experiences of DV, both samples included participants with experiences of DV.

Frueh et al (2009) conducted a before-and-after study in two USA CMHTs to examine the effectiveness of an exposure-based manualised cognitive behavioural therapy (CBT) intervention for abused service users with PTSD and either schizophrenia or schizoaffective disorders (Frueh et al., 2009). Twenty service users participated in the intervention (15 women and five men), of whom 14 (70%) reported lifetime DV by an intimate partner or family member. The 11-week intervention comprised four group and eight individual sessions delivered alongside usual care and combined psycho-education, anxiety management, social skills and anger management training, trauma management and exposure therapy. Self-assigned ratings of mental health problems improved significantly among treatment completers (n=13) between baseline and three month follow-up ($p<0.001$). Clinician-assigned ratings of PTSD symptoms ($p<.001$) also improved, although there were no significant improvements in clinician-assigned ratings of depression and anxiety symptoms (Frueh et al., 2009). A second before-and-after study conducted in two US CMHTs examined the effectiveness of a trauma-focused (non-exposure based) manualised CBT intervention for abused service users with PTSD and either major depression, bipolar disorder, schizophrenia or schizoaffective disorders (Lu et al., 2009). 19 service users (11 women and eight men) participated; 7 (50%) of whom disclosed lifetime DV by an intimate partner or family member. The 12 to 16 week manualised CBT intervention comprised breathing training, psycho-education about PTSD, and cognitive restructuring, and was delivered through individual-therapy sessions alongside usual care (Lu et al., 2009). Among those who completed treatment (n=14), three and six months post-intervention assessments revealed significant improvements in clinician-assigned ratings of post-traumatic stress symptoms ($p<.001$) and other psychiatric symptoms ($p<.001$). Improvements were also observed for self-assigned ratings of depressive symptoms ($p<.050$) (Lu et al., 2009). Neither before-and-after study was developed specifically for mental health service users with experiences of DV (e.g. addressing immediately safety and risk issues) and findings cannot be extrapolated to those still experiencing abuse. Due to exclusion criteria, findings cannot also not be generalised to those with acute illness or those who are suicidal. Furthermore, as neither study included a comparison condition, it is difficult to determine if improvements in outcomes were the direct result of the intervention, of changes over time, or of usual treatment received. Consequently, the

effectiveness of CBT interventions (both exposure and non-exposure based) for mental health service users with experiences of DV remains uncertain.

In the UK, a quasi-experimental pilot study found that mental health service users with past year experiences of DV who received a multi-faceted DV intervention reported reductions in frequency and severity of DV and improved social inclusion and quality of life (Trevillion et al., 2014a). The intervention was delivered in five community mental health teams: three intervention teams and two controls (treatment as usual). 35 service users participated (34 women and one man); 28 in the intervention group and seven in the comparison group. The intervention comprised DV training for mental health professionals, the implementation of a direct referral pathway, integrated DV advocacy for service users (i.e. signposting to relevant support agencies, and specialist emotional and practical support including safety planning), and an information campaign within the mental health teams to raise awareness about DV. The intervention was delivered alongside usual care, with integrated advocacy delivered by two DV advocates seconded from a local DV service.

At three months follow-up, the 27 participants who received the intervention reported significant reductions in the frequency and severity of violence ($p<.001$); improvements in quality of life outcomes ($p<.010$) and perceived social inclusion ($p<.050$) (Trevillion et al., 2014a). Clinician referrals to independent DV advocates also increased, as did referrals to local multi-agency risk assessment conferences (meetings in which information is shared on high risk DV cases between representatives of the local police, health, child protection, housing practitioners, domestic violence advocates, and other specialists from the statutory and voluntary sectors). Economic evaluation showed that the total costs of the intervention averaged £1,213 per service user. The total cost of services used (including use of health, social, and criminal justice services) increased among participants in both the intervention and control arms between baseline and follow-up, with slightly greater costs observed in the intervention group (mean difference £962). Although requiring further testing in a larger study, findings therefore indicated that improvements in outcomes may be generated at relatively small additional cost (Trevillion et al., 2014a). Due to the small sample size of the comparison group (n=7), between-group analyses were not conducted and the effectiveness of this DV advocacy intervention remains uncertain. Findings also cannot be extrapolated to service users with more acute illness or to those who had not experienced DV in the past year.

Interventions for service users who perpetrate domestic violence

Large, robust studies to test the effectiveness of interventions for people who perpetrate DV are lacking, with many of the studies conducted to date lacking a comparison group, having relatively small sample sizes, suffering high rates of attrition, and lacking follow-up beyond the intervention (NICE, 2014). Within this limited evidence base, there is a particular lack of information on the effectiveness of interventions for perpetrators with mental health problems, for whom risk of violence may be increased by mental health symptoms (for example, hostility and suspiciousness during a psychotic episode) and by drug and alcohol use. Future interventions for DV perpetration may benefit from including strategies that target modifiable risk factors (such as medication for persecutory delusions, psychological interventions for mental disorders, and treatment of comorbid alcohol and substance misuse) and manage potential risks of harm. Effective interventions could potentially improve the health of perpetrators in contact with mental health services, reduce levels of violence, and help ensure the safety of potential victims.

Discussion

Key findings

Over the past decade, international and national bodies have called for improved awareness and responses to DV across the health sector, including mental health services (World Health Organization, 2013, NICE, 2014, Stewart and Chandra, 2016, Davis, 2014). Policies have been introduced in several countries implementing routine enquiry about DV in mental health settings, although a systematic review of DV screening in a range of healthcare settings found there was insufficient evidence to conclude that routine enquiry improved mortality or morbidity (Feder et al., 2009). Despite these efforts, mental health services often fail to adequately address DV. This review suggests that many mental health professionals do not ask about DV and that service users do not readily disclose DV in the absence of direct enquiry. DV is under-documented and, when recorded, often lacks detail. There has been little consideration of how mental health services should assess, identify, and respond to service users who perpetrate DV and preliminary evidence suggests considerable gaps in professionals' knowledge and confidence to respond.

Findings from this review suggest that spontaneous disclosure is uncommon among people who have experienced or perpetrated DV, but that disclosure is facilitated by clinician enquiry. Even when asked, people experiencing abuse may be reluctant to disclose - often due to fears about the potential consequences of disclosure. When asking about DV, mental health professionals should discuss the limits of confidentiality and potential implications of disclosures with service users. Service users who disclose experiencing DV should be reassured that their disclosure will be taken

seriously and reassured that they are not to blame for what has happened to them. However, the review also identified that mental health professionals lack knowledge and confidence to respond safely and appropriately to DV. In the absence of training and clear referral pathways enquiry about DV can have adverse consequences for service users, in particular service users may be placed at risk by enquiry if the perpetrator finds out about a disclosure (Becker and Duffy, 2002). The review therefore highlights a mismatch between practice in mental health services and the needs of service users who are experiencing or perpetrating abuse. Future efforts to improve mental health service responses to DV should note the review's findings that although DV training can be effective in enhancing mental health professionals' knowledge and awareness of DV, it is unlikely to improve practice unless accompanied by clear care referral pathways.

Particularly little attention has been given to how mental health services should address the perpetration of DV by mental health service users. Findings from a small number of studies suggest that although disclosure of DV perpetration may be facilitated by direct enquiry, there is a need for guidance and organisational support to assist mental health professionals in assessing, identifying, and responding to risk of DV perpetration, including with regards to information sharing and treatment approaches. Research to address key evidence gaps is therefore urgently needed, including with regards to the barriers and facilitators to enquiry and disclosure of DV perpetration, the validity of general violence risk assessment tools in identifying risk of DV, and the effectiveness of domestic violence perpetrator programmes and intervention approaches for DV perpetrators with mental health problems. The review has also identified a need for research on interventions that specifically address the needs of mental health service users with experiences of DV (including managing ongoing risk of violence), building on the growing evidence base of non-specific interventions for mental health service users with experiences of trauma.

Mental health professionals are working with service users who are experiencing - or have experienced - domestic violence and with those who have perpetrated this form of abuse. The consequences of DV can be devastating, and missed opportunities to identify and support people who experience - or use - this form of violence can have serious consequences for mental health and for risk of harm. Services must ensure that their staff are supported to identify and respond appropriately based on the best available evidence, including through the provision of specific training on DV and implementation of clear information sharing protocols and referral pathways.

References

AGAR, K. & READ, J. 2002. What happens when people disclose sexual or physical abuse to staff at a community mental health centre? *International Journal of Mental Health Nursing,* 11**,** 70-79.

BECKER, J. & DUFFY, C. 2002. Women drug users and drugs service provision: Service level responses to engagement and retention. . *Briefing Paper 17–22.* London: Home Office.

BULLER, A. M., DEVRIES, K. M., HOWARD, L. M. & BACCHUS, L. J. 2014. Associations between intimate partner violence and health among men who have sex with men: a systematic review and meta-analysis. *PLoS Med,* 11**,** e1001609.

CASES, J. G., USAOLA, C. P., AGUADO, F. G., GIRONÉS, M. L., TRINCADO, M. R. & LIRIA, A. F. 2014. Prevalence and characteristics of intimate partner violence against women with severe mental illness: A prevalence study in Spain. *Community mental health journal,* 50**,** 841-847.

CHANG, J. C., CLUSS, P. A., BURKE, J. G., HAWKER, L., DADO, D., GOLDSTROHM, S. & SCHOLLE, S. H. 2011. Partner violence screening in mental health. *General hospital psychiatry,* 33**,** 58-65.

CHAPMAN, A. & MONK, C. 2015. Domestic violence awareness. *American journal of psychiatry,* 172**,** 944-945.

CHOI, Y. J. & AN, S. 2016. Interventions to Improve Responses of Helping Professionals to Intimate Partner Violence A Quick Scoping Review. *Research on Social Work Practice,* 26**,** 101-127.

CHOO, E. K., NICOLAIDIS, C., JENKINSON, R. H., COX, J. M. & JOHN MCCONNELL, K. 2010. Failure of intimate partner violence screening among patients with substance use disorders. *Academic emergency medicine,* 17**,** 886-889.

COBO, J., MUÑOZ, R., MARTOS, A., CARMONA, M., PÉREZ, M., CIRICI, R. & GARCÍA-PARÉS, G. 2010. Violence against women in mental health departments: Is it relevant for mental health professionals? *Revista de Psiquiatría y Salud Mental (English Edition),* 3**,** 61-67.

CURRIER, G. W., BARTHAUER, L. M., BEGIER, E. & BRUCE, M. L. 1996. Training and Experience of Psychiatric Residents in Identifying Domestic Violence. *Psychiatric Services,* 47**,** 529-530.

DAVIS, S. 2014. Annual Report of the Chief Medical Officer 2013: Public Mental Health Priorities-Investing in the Evidence. *London: Department of Health*.

DEKEL, R. & SOLOMON, Z. 2006. Marital relations among former prisoners of war: contribution of posttraumatic stress disorder, aggression, and sexual satisfaction *Journal of Family Psychology,* 20**,** 709-712.

DEPARTMENT OF, H. 2008. Refocusing the Care Programme Approach: policy and positive practice guidance. London: Department of Health.

DEVRIES, K. M., MAK, J. Y., BACCHUS, L. J., CHILD, J. C., FALDER, G., PETZOLD, M., ASTBURY, J. & WATTS, C. H. 2013. Intimate partner violence and incident depressive symptoms and suicide attempts: a systematic review of longitudinal studies. *PLoS Medicine,* 10**,** e1001439.

DU MONT, J. & FORTE, T. 2014. Intimate partner violence among women with mental health-related activity limitations: a Canadian population based study. *BMC public health,* 14**,** 1.

ECKHARDT, C. I., SAMPER, R. E. & MURPHY, C. M. 2008. Anger disturbances among perpetrators of intimate partner violence clinical characteristics and outcomes of court-mandated treatment. *Journal of Interpersonal Violence,* 23**,** 1600-1617.

EILENBERG, J., THOMPSON FULLILOVE, M., GOLDMAN, G. R. & MELLMAN, L. 1996. Quality and Use of Trauma Histories Obtained From Psychiatric Outpatients Through Mandated Inquiry. *Psychiatric Services,* 47**,** 165-169.

EMERSON DOBASH, R., DOBASH, R. P., CAVANAGH, K. & LEWIS, R. 2004. Not an ordinary killing - just an ordinary guy: when men murder an intimate woman partner. *Violence Against Women,* 10**,** 577-605.

FEDER, G., RAMSAY, J., DUNNE, D., ROSE, M., ARSENE, C., NORMAN, R., KUNTZE, S., SPENCER, A., BACCHUS, L., HAGUE, G., WARBURTON, A. & TAKET, A. 2009. How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening

programme? Systematic reviews of nine UK, National Screening Committee critieria. *Health Technology Assessment.13(16)()(pp iii-113), 2009.Date of Publication: March 2009.*, iii-113.

FRUEH, B. C., GRUBAUGH, A. L., CUSACK, K. J., KIMBLE, M. O., ELHAI, J. D. & KNAPP, R. G. 2009. Exposure-based cognitive-behavioral treatment of PTSD in adults with schizophrenia or schizoaffective disorder: a pilot study. *Journal of anxiety disorders,* 23**,** 665-675.

GOLDING, M. J. 1999. Intimate Partner Violence as a Risk Factor for Mental Disorders: A Meta-Analysis. *Journal of Family Violence,* 14**,** 99-132.

HAGER, D. 2011. Finding Safety. provision of specialised domestic violence and refuge services for women who currently find it difficult to access mainstream services: disabled women, older women, sex workers and women with mental illness and/or drug and alcohol problems as a result of domestic violence.

HAMBERGER, K. L. & PHELAN, M. B. 2004. Spousal abuse in psychiatric and mental health settings. *Domestic Violence Screening and Intervention in Medical and Mental Health Care Settings.* New York: Springer Publishing Company.

HARVEY, S., MANDAIR, S. & HOLLY, J. 2014. Case by case: refuge provision in London for survivors of domestic violence who use alcohol and other drugs or have mental health problems. London: AVA (Against Violence & Abuse) and Solace Women's Aid.

HEMMINGS, S., TREVILLION, K., HOWARD, L. & ORAM, S. Submitted. Mental health professionals' experiences of identifying and responding to domestic violence perpetration by mental health service users: a qualitative study.

HESTER, M., FERRARI, G., JONES, S., WILLIAMSON, E., BACCHUS, L., PETERS, T. & FEDER, G. 2015. Occurrence and impact of negative behaviour, including domestic violence and abuse, in men attending UK primary care health clinics: a cross-sectional survey. *BMJ open,* 5**,** e007141.

HOME OFFICE 2013a. Domestic Homicide Reviews: Common Themes Identified as Lessons to be Learned. London: Home Office.

HOME OFFICE 2013b. Information for local areas on the change to the definition of domestic violence. London: Home Office.

HOWARD, L. M., ORAM, S., GALLEY, H., TREVILLION, K. & FEDER, G. 2013. Domestic violence and perinatal mental disorders: a systematic review and meta-analysis. *PLoS Med,* 10**,** e1001452, doi:10.1371/journal.pmed.1001452.

HOWARD, L. M., TREVILLION, K. & AGNEW-DAVIES, R. 2010. Domestic violence and mental health. *International Review of Psychiatry,* 22**,** 525-534.

JONAS, S., KHALIFEH, H., BEBBINGTON, P., MCMANUS, S., BRUGHA, T., MELTZER, H. & HOWARD, L. M. 2014. Gender differences in intimate partner violence and psychiatric disorders in England: results from the 2007 adult psychiatric morbidity survey. *Epidemiology and psychiatric sciences,* 23**,** 189-199.

JONES, L., HUGHES, M. & UNTERSTALLER, U. 2001. Post Traumatic Stress Disorder (PTSD) in Victims of Domestic Violence. A Review of the Research. *Trauma Violence & Abuse,* 2**,** 99-119.

KELLY, L. & WESTMARLAND, N. 2015. Domestic violence perpetrator programmes: Steps towards change. Project Mirabal final report. London, England: London Metropolitan University. Retrieved from https://www. dur. ac. uk/resources/criva/ProjectMirabalfinalreport. pdf.

KHALIFEH, H. 2015. *Violent and non-violent crime against people with severe mental illness.* UCL (University College London).

KHALIFEH, H. & DEAN, K. 2010. Gender and violence against people with severe mental illness. *International Review of Psychiatry,* 22**,** 535-546.

KHALIFEH, H., ORAM, S., TREVILLION, K., JOHNSON, S. & HOWARD, L. M. 2015. Recent intimate partner violence among people with chronic mental illness: findings from a national cross-sectional survey. *The British Journal of Psychiatry,* 207**,** 207-212.

KIELY, M., EL-MOHANDES, A. A., EL-KHORAZATY, M. & GANTZ, M. G. 2010. An integrated intervention to reduce intimate partner violence in pregnancy: a randomized trial. *Obstetrics & Gynecology,* 115**,** 273-283.

KLAP, R., TANG, L., WELLS, K., STARKS, S. & RODRIGUEZ, M. 2007. Screening for domestic violence among adult women in the United States. *J Gen Intern Med.,* 22**,** 579-84.

LU, W., FITE, R., KIM, E., HYER, L., YANOS, P. T., MUESER, K. T. & ROSENBERG, S. D. 2009. Cognitive-behavioral treatment of PTSD in severe mental illness: pilot study replication in an ethnically diverse population. *American Journal of Psychiatric Rehabilitation,* 12**,** 73-91.

NICE 2014. PH50: Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. London: National Institute for Health and Care Excellenec.

NYAME, S., HOWARD, L. M., FEDER, G. & TREVILLION, K. 2013. A survey of mental health professionals' knowledge, attitudes and preparedness to respond to domestic violence. *Journal of Mental Health,* 22**,** 536-543.

OFFICE FOR NATIONAL STATISTICS 2014. Chapter 4 - Intimate Personal Violence and Partner Abuse. Crime Statistics, Focus on Violent Crime and Sexual Offences 2012/13. London: Office for National Statistics.

ORAM, S., CAPRON, L., TREVILLION, K. & HOWARD, L. unpublished. Promoting Recovery in Mental Health: Evaluation of an Intervention to Improve Mental Health Service Responses to Domestic and Sexual Violence.

ORAM, S., TREVILLION, K., FEDER, G. & HOWARD, L. M. 2013. Prevalence of experiences of domestic violence among psychiatric patients: systematic review. *British Journal of Psychiatry,* 202**,** 94-99.

ORAM, S., TREVILLION, K., KHALIFEH, H., FEDER, G. & HOWARD, L. 2014. Systematic review and meta-analysis of psychiatric disorder and the perpetration of partner violence. *Epidemiology and psychiatric sciences,* 23**,** 361-376.

POSNER, J., EILENBERG, J., FRIEDMAN, J. H. & FULLILOVE, M. J. 2008. Quality and use of trauma histories obtained from psychiatric outpatients: a ten year follow-up. *Psychiatric Services,* 59**,** 318-21.

ROSE, D., TREVILLION, K., WOODALL, A., MORGAN, C., FEDER, G. & HOWARD, L. 2011. Barriers and facilitators of disclosures of domestic violence by mental health service users: Qualitative study. *British Journal of Psychiatry,* 198**,** 189-194.

SALYERS, M. P., EVANS, L. J., BOND, G. R. & MEYER, P. S. 2004. Barriers to assessment and treatment of posttraumatic stress disorder and other trauma-related problems in people with severe mental illness: clinician perspectives. *Community Ment Health J.,* 40**,** 17-31.

SPANGARO, J., ZWI, A. B., POULOS, R. & MAN, W. 2010. Who tells and what happens: disclosure and health service responses to screening for intimate partner violence. *Health & social care in the community,* 18**,** 671-680.

STARK, E. 2006. Commentary on Johnson's "Conflict and Control: Gender Symmetry and Asymmetry in Domestic Violence". *Violence Against Women,* 12**,** 1019-1025.

STEWART, D. E. & CHANDRA, P. 2016. Intimate partner violence and sexual violence against women: WPA curriculum. Presidential work http://www.wpanet.org/: World Psychiatric Association.

TREVILLION, K., BYFORD, S., CARY, M., ROSE, D., ORAM, S., FEDER, G., AGNEW-DAVIES, R. & HOWARD, L. 2014a. Linking abuse and recovery through advocacy: an observational study. *Epidemiology and psychiatric sciences,* 23**,** 99-113.

TREVILLION, K., HOWARD, L. M., MORGAN, C., FEDER, G., WOODALL, A. & ROSE, D. 2012a. The Response of Mental Health Services to Domestic Violence: a qualitative study of service users' and professionals' experiences. *Journal of the American Psychiatric Nurses Association,* 18**,** 326-36.

TREVILLION, K., HUGHES, B., FEDER, G., BORSCHMANN, R., ORAM, S. & HOWARD, L. M. 2014b. Disclosure of domestic violence in mental health settings: a qualitative meta-synthesis. *Int Rev Psychiatry,* 26**,** 430-444.

TREVILLION, K., ORAM, S., FEDER, G. & HOWARD, L. M. 2012b. Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. *PLoS ONE*.

UNIVERSITY OF MANCHESTER The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015: England, Northern Ireland, Scotland and Wales Manchester: University of Manchester.

WALBY, S., TOWERS, J. & FRANCIS, B. 2015. Is Violent Crime Increasing or Decreasing? A New Methodology to Measure Repeat Attacks Making Visible the Significance of Gender and Domestic Relations. *British Journal of Criminology***,** azv131.

WARSHAW, C., SULLIVAN, C. M. & RIVERA, E. A. 2013. *A systematic review of trauma-focused interventions for domestic violence survivors*, National Center on Domestic Violence, Trauma & Mental Health.

WORLD HEALTH ORGANIZATION 2013. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization.

ZAHER, E., KEOGH, K. & RATNAPALAN, S. 2014. Effect of domestic violence training Systematic review of randomized controlled trials. *Canadian family physician,* 60**,** 618-624.

Declaration of interest

The authors report no conflict of interest. The authors alone are responsible for the content and writing of this paper.