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Violence against women and mental health

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Violence against women is widely recognised as a violation of human rights and a public health problem. In this Series paper, we argue that violence against women is also a prominent public mental health problem, and that mental health professionals should be identifying, preventing, and responding to violence against women more effectively. The most common 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. We highlight that little research has been done on 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.

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This is the fourth in a Series of four papers on Women's mental health

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Introduction

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

The most common forms of violence against women are domestic violence and abuse and sexual violence. 35% 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 experienced repeated severe violence.[10] Worldwide, 39% of murders of women are committed by intimate partners or ex-partners (compared with 6% for male homicides), and higher rates (59%) are found in southeast Asia than worldwide (compared with 0.9% for male homicides).[11] Non-partner sexual violence is also endemic and has been experienced by 7% of women worldwide.[12] In England, the 2013–14 crime survey found that 2·2% (approximately 355 000) of women aged 16–59 years had experienced some form of sexual assault and 8·5% (1·5 million) had experienced domestic abuse in the past year.[13] When men are victims of interpersonal violence, this violence is more likely to be street or gang violence perpetrated by other men.[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 violence against women but will also be relevant to how mental health services can help men experiencing domestic and sexual violence. We aimed to review evidence on the association between violence against women and mental health, the identification of and response to violence against women by mental health services, and mental health interventions for victims and perpetrators of violence against women. Although violence against women takes many forms (including domestic violence, sexual violence [including in conflict zones and as a weapon of war], forced and early marriage, so-called "honour" crimes, female genital mutilation [FGM], and human trafficking), we focus on domestic and sexual violence as the most common forms of violence against women worldwide in this Series paper, and present emerging evidence on the mental health effects of human trafficking and FGM.

Definitions and concepts of violence against women

Domestic violence and abuse

Many countries provide a gender neutral definition of domestic violence and abuse. 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.[15] 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". However, domestic violence and abuse is recognised to disproportionately affect women and to be an expression of power inequality between men and women. Domestic violence and abuse is, therefore, a form of gender-based violence.[16] Some experts argue that evidence exists for distinctions between "situational violence" (domestic violence and abuse that is less frequent, less likely to escalate over time, and more likely to be mutual) and "intimate terrorism" (domestic violence and abuse characterised by a coercive pattern of physical violence, intimidation, and control).[17–19]

For more on the **US Department of Justice's definition on domestic violence** see https://www.justice.gov/ovw/domestic-violence

Research of domestic violence and abuse has often focused on incidents of physical violence, but this ignores the effect of repeated victimisation, sexual violence, emotional abuse, and controlling and coercive behaviour.[20] Women's experiences of high-frequency repeated domestic violence and abuse and other forms of violent victimisation have been further obscured by crime surveys, which typically cap repeated victimisation in reports.[21] This limitation highlights the need for a gendered perspective on analysis of violence.

Sexual violence

Although most domestic violence and abuse research has focused on physical violence, sexual violence can also be perpetrated by partners, and often research does not examine the relationship between the victim and perpetrator of sexual violence.[20] Partner and non-partner sexual violence are defined separately by WHO. Partner sexual violence is defined 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 non-partner sexual violence is defined as "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".[10] 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 to reduce the responsibility of perpetrators. In this context, many victims choose not to report their experiences or might not define what happened to them as an act of sexual violence.[22]

Other forms of violence against women

Sexual violence is common in the general population, as we mentioned previously, but is particularly highly prevalent in specific groups. For example, a study of survivors of human trafficking who were in contact with support services in England found that 95% of women trafficked for sexual exploitation, 54% of women trafficked for domestic servitude, and 21% of women trafficked for labour exploitation reported having been forced to have sex while trafficked.[23,24] Women make up over half of the estimated 20·9 million victims of human trafficking worldwide;[25] 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.[26] Women who have been trafficked are also likely to have experienced physical and sexual violence before trafficking and can remain vulnerable to victimisation after escape from exploitation;[23,24,27] similar findings have been found among female asylum seekers.[28,29]

Although families who practise 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"[30]—do not think of it as violence, FGM is internationally recognised as a form of violence against women. It differs from most forms of violence against women in that it is promoted as a valued social and cultural norm and done routinely on almost all girls in practising communities.[30] At least 200 million women and girls in 30 countries are estimated to have been subjected to FGM, and more than 3 million girls are estimated to be at risk of FGM annually.[31] The practice is most common in the western, eastern, and north-eastern regions of Africa, and in areas of the Middle East (including Iraq and Yemen) and Asia (including Indonesia), but is also found in Europe, Australia, and North America.[31]

Violence against women and mental health

Domestic violence and abuse and mental health

Evidence shows, at least for some conditions, that a bidirectional causal association exists between mental disorders and domestic violence and abuse. For example, longitudinal studies have demonstrated an association between depression and subsequent domestic violence and abuse and also that domestic violence and abuse increases the likelihood of depression in women with no previous history of symptoms;[32] for example, more than 10% of postnatal depression might be potentially attributable to domestic violence and abuse.[33] However, longitudinal research into the association between domestic violence and abuse and other mental disorders is scarce, and more work is needed to disentangle the role of childhood abuse, which is associated with both mental disorders and domestic violence and abuse.[34]

Nonetheless, systematic reviews of predominantly cross-sectional studies report consistent relationships

between being a victim of domestic violence and abuse and having mental disorders across the diagnostic spectrum for men and women, but since women are more likely to be victims, the population attributable fractions (assuming causality) are higher for women than for men. One systematic review and meta-analysis[20] reported a three times increase in the likelihood of depressive disorders, a four times increase in the likelihood of anxiety disorders, and a seven times increase in the likelihood of post-traumatic stress disorder (PTSD) for women who have experienced domestic violence and abuse. Significant associations between intimate partner violence and symptoms of psychosis, substance misuse, and eating disorders have also been reported.[20,35–37] Because of a scarcity of primary data, systematic reviews have been unable to assess the associations between diagnosed mental disorders and specific types of domestic violence and abuse (eg, physical, sexual, psychological, and emotional abuse, and controlling and coercive behaviours). However, the results of a study by Pico-Alfonso and colleagues,[38] which compared three groups of women (non-abused, physically or psychologically abused, and psychologically abused), showed that although the two abused groups had a higher incidence and severity of symptoms of depression, anxiety, PTSD, and suicidal ideation than did non-abused women, no differences existed between the two abused groups. Similar findings have been reported elsewhere with respect to symptoms of depression, PTSD, and psychological distress,[39–41] suggesting that psychological domestic violence and abuse can be as detrimental to mental health as physical domestic violence and abuse.[38] Research that considers the specific effect of coercive and controlling behaviours on mental health is scarce, but in a study[42] of court-involved abused women, Dutton and colleagues showed that adverse mental health outcomes were independently associated with both coercive control and emotional abuse. Pico-Alfonso and colleagues[38] also reported a high degree of overlap between the types of abuse experienced: all the women who were subjected to physical violence also experienced 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 comorbidity.[40,41,43]

The prevalence of domestic violence and abuse victimisation is particularly high in people in contact with secondary mental health services—a survey of mental health-care service users in London reported that 70% of women (and 50% of men) had been domestic violence and abuse victims as adults, with many (27% of women, 10% of men) experiencing recent and current domestic violence and abuse.[44] The prevalence of domestic violence and abuse 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 attenders of general practitioner clinics a 17% prevalence of physical violence in the past year from a current or former partner was found for women.[45]

Some researchers have highlighted that psychiatric symptoms, although fulfilling criteria for a mental disorder using updated classifications, could be more usefully interpreted as understandable chronic anxiety about further abuse.[46,47] A meta-synthesis[47] of 14 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 health-care professionals from recognising abuse, while labels of mental illnesses minimised service users' experiences of abuse. Researchers and domestic violence sector advocates have similarly argued that pathologising and medicalising such symptoms obscures their meaning and might not be helpful in assisting victims to overcome symptoms and develop strategies to prevent further abuse.[48,49] Chronic experiences of abuse, particularly if abuse was also experienced in childhood and escape was not possible because of physical, psychological, family, or societal factors, can result in complex PTSD, a disorder first proposed by Herman.[50] Although not a category in DSM-5 (but might be included in ICD-11), complex PTSD is considered a useful concept by many working with chronically traumatised victims.[51]

Some evidence suggests that the prevalence of physical and sexual intimate partner violence is lower in older women than in younger women, but the prevalence of emotional and economic abuse and controlling behaviours in older women is similar to those experienced by younger women (for all adult ages), with a similar prevalence of mental health problems.[52] Also, preliminary evidence exists of an increased risk of domestic violence and abuse in women with dementia.[53] The large literature on carer abuse might have ignored the possibility of historical abuse that started years before the onset of frailty or dementia.[54]

Sexual violence and mental health

Research also suggests an association between sexual violence and mental disorders, but it generally does not distinguish between partner and non-partner violence. For example, an analysis of data from the cross-sectional Adult Psychiatric Morbidity Survey[55] suggests associations between sexual violence and drug and alcohol dependence. It estimated population attributable fractions 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 review of recent sexual violence against women with severe mental illness identified eight studies, with a median prevalence

of 10% (IQR 6–18%).[56] Again, people in contact with secondary care have a history of particularly high rates of sexual violence—the survey by Khalifeh and colleagues[44] reported a 61% (40% for rape or attempted rape) prevalence of adulthood sexual violence against 129 female patients, and the prevalence of past-year sexual violence was 10%.[44] 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 or strangers (for 77% of victims) with current or former partners reported for 47% of victims. After adjusting for sociodemographic differences, the odds of sexual violence against women with severe mental illness were six times higher for lifetime sexual violence (odds ratio [OR] 6, 95% CI 4–9) and three times higher for past-year sexual violence (OR 3, 1–6) than in women in the general population.[44] Similar findings were reported in a survey of female psychiatric patients in the Netherlands (past-year sexual harassment OR 3·6, 2·7–4·8, compared with women in the general population).[57]

Other forms of violence against women and mental health

Less is known about the association between other forms of violence against women and mental health. A small number of studies suggest that high levels of symptoms, including symptoms of depression, anxiety, and PTSD, 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.[23,24,27] Mental health problems appear to endure into the medium-term to long-term: a survey of Moldovan women who have been trafficked found that 55% of these women met DSM-IV criteria for mental disorder at an average of 6 months after returning to Moldova,[58] whereas 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 after escape.[23] Several studies have reported that the risk of mental health problems is increased by physical or sexual violence before and during trafficking; duration and severity of trafficking; and, after escape, unmet social needs, and poor social support.[58–60] Trafficked men also experience violence before and during trafficking, and studies suggest the prevalence is lower than among women who have been trafficked (42% *vs* 77% for physical violence while trafficked and 4% *vs* 66% for sexual violence while trafficked) and that trafficked men are less likely to report having been injured while trafficked (33% *vs* 67%).[23]

Although the physical health problems caused by FGM (including haemorrhage, urinary tract infection, dyspareunia, and obstetric complications) have been extensively documented,[61] less is known about its mental health consequences. Studies suggest, however, that women with FGM might be more likely to have a psychiatric diagnosis and to experience symptoms of anxiety, depression, somatisation, PTSD, and low self-esteem,[62–64] and that psychopathology can be associated with type of FGM (with higher risk for infibulation), event recollection, avoidant coping style, migration, and employment status.[63,64]

Risk factors for being a victim of violence against women

WHO uses an ecological model when considering risk factors for domestic violence and abuse. Risk factors operating at the level of the individual include young age,[65–67] disability,[68–70] poverty[67,71,72] (the increase in domestic violence and abuse since 2008 in England and Wales highlights the relationship between the economy and domestic violence and abuse),[21] witnessing domestic violence and abuse as a child, childhood abuse,[67,73,74] and substance abuse.[75] Although individual-level risk factors for sexual violence are likely to vary according to the context of the abuse, sexual violence is more likely to occur in young people, women, people with disability, and people experiencing or who have experienced poverty, sexual abuse in childhood, and substance abuse.[14,76] 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, and the complex pathways involved in being a victim of violence through the lifespan, and it also highlights potential prevention strategies (as we discuss in this paper). However, causal factors also occur at the level of the relationship (eg, partner with depression, substance misuse, patriarchal attitudes, or a history of being a victim of childhood abuse), community characteristics (eg, 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).[14,77–79]

Perpetration of violence against women by people with mental disorders

Mental disorders are associated with an increased risk of perpetrating violence, and, internationally, mental health policy focuses on assessment of the risk of violence to others. However, few studies have been done on the extent of the risk of domestic violence and abuse or sexual violence perpetration rather than violence in general, which has restricted our knowledge on the prevalence and risk of perpetration of these types of abuse. However, a systematic review[80] of predominantly cross-sectional psychiatric morbidity and population surveys found associations between all mental disorders and domestic violence and abuse perpetration in both men and women. Conclusions are restricted though, as most studies measured isolated incidents of physical violence rather than repeated severe violence. Additionally, potential confounding and mediating factors were not examined in the included studies; however, results from the

UN Multi-Country Cross-Sectional Study on Men and Violence in Asia and the Pacific[79] suggest that high levels of depressive symptoms might increase the 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 reviews of domestic homicides in England and confidential enquiries into homicides by people with mental illness has highlighted that domestic homicides are not infrequently perpetrated by male users of mental health services. 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.[81] 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.[82] Victims of domestic homicide often have a history of contact with mental health services as children or as adults.[83,84] Alcohol and substance misuse[85] and persecutory delusions[86,87] are often reported to be mediators of violence in people with severe mental disorders: these mediators have not been investigated in relation to domestic violence and abuse 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,[88] this treatment association has not been investigated in relation to domestic violence and abuse. Similar mechanisms might be important in the relation between domestic violence and abuse 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 absent, 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.[89] Långström and Grann[90] have reported an increased relative risk of psychiatric hospital admissions and severe mental illness in sexual offenders, and have postulated that psychiatric symptoms could trigger sexual offending. Severe mental disorders can also be associated with potential risk factors for sexual violence perpetration (including aggression, poor social skills, cognitive distortion, drug and alcohol misuse, and sexual violence victimisation).[90]

What can mental health professionals do?

International guidelines, including from WHO and the UK National Institute for Health and Care Excellence (NICE), recommend that mental health professionals should facilitate domestic violence and abuse disclosure as part of comprehensive clinical assessments, provide support and ensure safety, and treat physical and mental disorders in the context of any domestic violence and abuse (figure).[3,4,91,92] Although there is debate about the role of universal screening for domestic violence and abuse in the health-care system in generic services such as primary care or emergency departments,[93] the prevalence of being a victim of violence is so high in users of mental health services that clinical guidelines recommend routine inquiry in mental health services. There is a lack of evidence on whether the introduction of routine inquiry improves outcomes. The outcomes will depend on the nature of the response to disclosure; guidelines therefore stress that routine inquiry should only be introduced when professionals have been appropriately trained, and have protocols in place on interventions, particularly referral to specialist domestic violence and abuse services and access to trauma-informed interventions. Given the high prevalence of domestic violence and abuse and sexual violence, providers of mental health services 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 domestic violence and abuse and sexual violence experienced in childhood and adulthood as part of clinical assessment and ongoing care.[4,5,10] Routine inquiry needs to be carried out safely (ie, 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 inquiry.[4] 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-judgmentally to 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.[3,94,95] *The Lancet* 2015 series highlighted that the infrastructure of health systems and community services needs to change to address violence against women (figure). However, an editorial in the *American Journal of Psychiatry* suggested that mental health professionals themselves have to address their strong psychological barriers to addressing domestic violence and abuse and sexual violence, which can lead to pity and disdain of the victim, vilification of the abuser, and abdication of the roles of clinicians and researchers.[96]

Identifying victims of violence against women in mental health services

Despite the high prevalence of domestic violence and abuse among users of mental health services, a review[97]

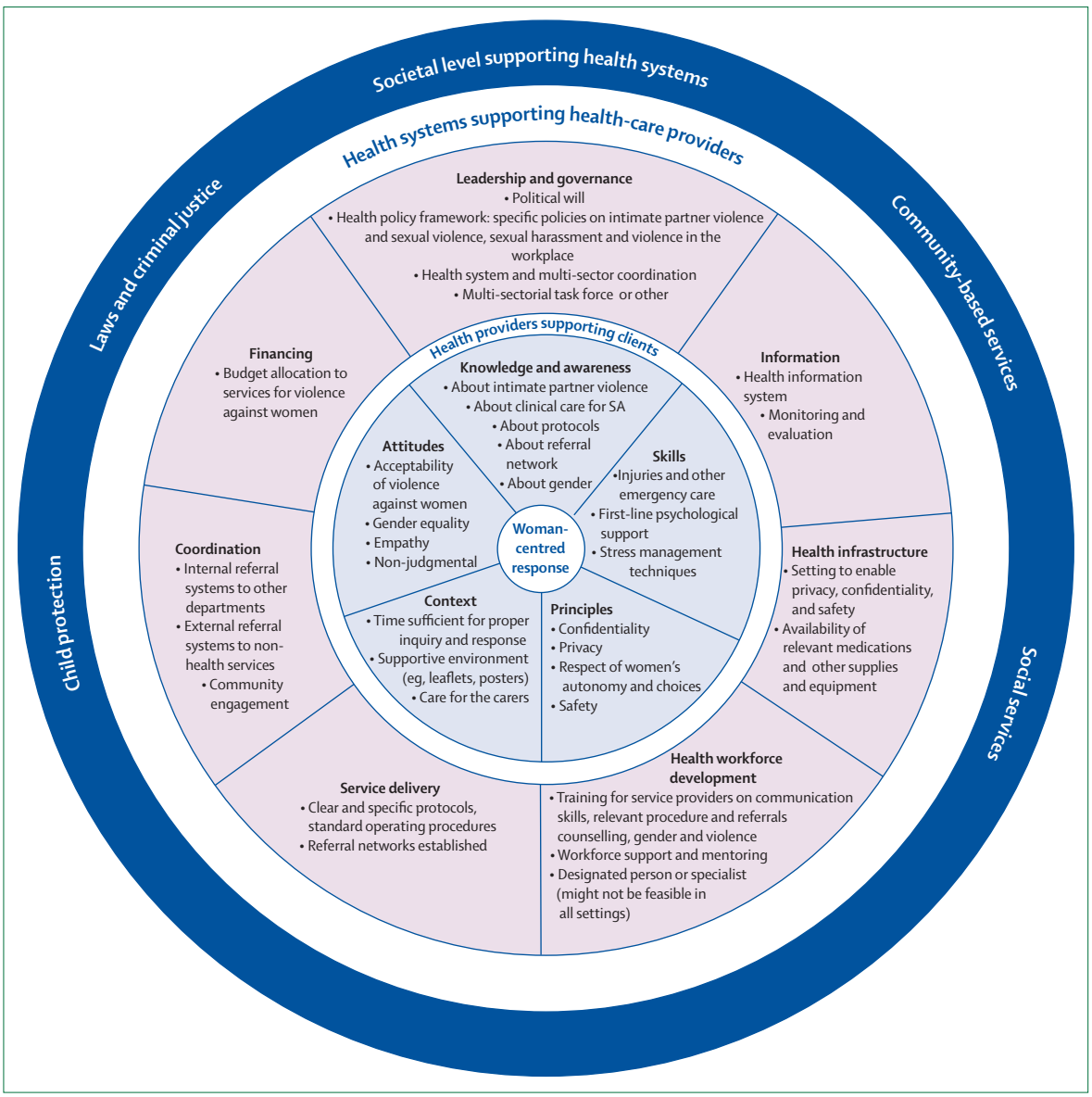

***Figure*: Necessary elements to address violence against women at the level of health providers, services, and systems**
This figure has been adapted from the original article by Colombini and colleagues[91] and the previously adapted figure by Garcia-Moreno and colleagues.[92] The original article is an open access article distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0), which permits unrestricted use, distribution, and reproduction in any medium. SA=sexual assault.

in 2010 found that only 10–30% of domestic violence and abuse victims are identified by mental health professionals internationally. Qualitative studies have reported several barriers to routine inquiries by professionals, including a lack of confidence and competence in facilitating and managing disclosures, lack of domestic violence and abuse knowledge and understanding (eg, of the power dynamics of domestic violence and abuse relationships involving coercive control), and lack of clarity about the role of mental health professionals in addressing domestic violence and abuse.[98,99] A meta-synthesis[47] of qualitative studies involving users of mental health services found that domestic violence and abuse victims want mental health professionals to acknowledge 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 (as we discussed). An absence of acknowledgment was felt to be compounded by few opportunities for service users to discuss the domestic violence and abuse during consultations, which they felt focused exclusively on diagnosing and treating psychiatric symptoms, preventing them from recognising

the extent of abuse, receiving appropriate care, and minimising 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 (eg, if the perpetrator hears about the domestic violence and abuse disclosure), or dismissal by services if they do not leave the partner. Mental health professionals might fail to understand that choosing to remain in an abusive relationship could be based on a strategic risk–benefit analysis that includes financial concerns, concerns that they will be seen as too ill to care for their children, short-term losses such as loss of the family home and a father and network for the victim's children, stigma, hope (not always unfounded) that the perpetrator will change,[98,100] and an awareness that the perpetrator might stalk the victim and cause more severe violence. Indeed, women are at greatest risk of homicide in the months immediately following separation.[101,102]

Adulthood sexual violence is also underdetected in mental health services. Studies of female users of mental health services 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 experiences.[44,103,104] In a Swedish study,[104] sexual violence was less likely to be identified by mental health services than was either physical or emotional abuse. Female users of mental health services 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.[105] Almost no research has been done to explore the barriers to identify and respond to sexual violence within mental health settings, although a small qualitative study done in Australia found that staff reported personal discomfort with the issue and felt ill-equipped to respond to disclosures because of insufficient training and guidance, including with regards to containing distress and making referrals to sexual assault services.[106]

Little evidence exists 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,[27,107] providing mental health professionals with opportunities to identify, refer safely, and provide care while facilitating escape from the trafficking situation. A survey of National Health Services' 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 might have encountered at least one victim of trafficking in their clinical practice, but they did not have enough knowledge and confidence in how to respond appropriately and safely.[107] A cohort study[108] that used clinical informatics found that in half the cases (n=95), mental health professionals were the first health-care professionals to become aware that their patient was a potential victim of trafficking. The other trafficked adults in the cohort had been identified as trafficking victims by others and were frequently referred by primary care and emergency departments, although maternity care was also an important route into mental health care for women who have been trafficked. Compared with other adults in contact with the same mental health provider, trafficked adults were more likely to be detained and had longer admissions.[88] Trafficked people can find it difficult to disclose their experiences because of fear, feelings of shame and guilt, and the impact of trauma on their recall of events. Additionally, trafficked people might not recognise that the abuse they are experiencing is trafficking, and might not trust health-care professionals because of their fear of retribution by the traffickers.[94,109]

Improvement of responses by mental health services to violence against women

Evidence internationally shows that guideline dissemination and training in isolation do not create consistent, sustainable improvements in identification and response to violence against women,[110,111] and research into strategies to improve the integration of domestic violence and abuse and other forms of violence against women into the core business of mental health services is needed. Trials have been done of systematic interventions to improve identification and response to domestic violence and abuse in primary care, but a systematic review[111] reported no trials in mental health settings and highlighted the need for more than just training to improve identification. In non-mental health settings, ongoing integrated training, support, and advice (eg, from domestic violence and abuse advocates) for health professionals in addressing domestic violence and abuse improves health professionals' facilitation of disclosure and improves professionals' subsequent response.[111,112] However, one study[113] in maternity services reported potential and actual harm occurring after the introduction of routine inquiry, including breaches of confidentiality, which could lead to the perpetrator finding out about the disclosure with consequent violence, and failure to document evidence, restricting women's ability to access civil and legal remedies.

A small pilot study[99] in community mental health teams in south London, UK, suggests that domestic violence and abuse advocates integrated within teams, in addition to dedicated time for training, improves the identification of domestic violence and abuse and outcomes for individual victims with fewer unmet needs and lower levels of abuse at 3 months' follow-up. Echoing findings that improving responses by mental health services to domestic violence and abuse requires more than training, an audit conducted in New Zealand found that although the proportions of childhood 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.[114]

Identification of perpetrators of violence against women in mental health services

Evidence on the extent to which poor detection of perpetrators of domestic violence and abuse and sexual violence occurs in mental health services is scarce. However, a qualitative study[115] of mental health professionals has highlighted the lack of inquiry about domestic violence and abuse 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 domestic violence and abuse), and need for greater clarity on information sharing.[116] Homicide-suicides have also been reported to be commonly preceded by relationship breakdown and separation, with most perpetrators male (88%) and most victims female (77%); 62% of perpetrators had mental health problems.[82]

In England, the National Confidential Inquiry into Homicides[117] and the Home Office[83] reported that mental health professionals did not assess for domestic violence and abuse perpetration risk, despite a clear responsibility of mental health services to identify potential intimate partner violence perpetrators within risk assessment frameworks. Although less research has been done on how to respond to users of mental health services who disclose domestic violence and abuse perpetration, extensive guidance exists on how to address risk of violence, which includes consideration of safety of the victim.

Interventions for victims of violence against women

A large evidence base exists 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 when the violence has not been disclosed, or when the violence is not the focus of the intervention. A Cochrane review[118] of 70 trials (4761 participants) of psychological interventions for PTSD found some evidence (although from generally low-quality trials) that trauma-focused cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) are superior to non-trauma-focused CBT between 1 and 4 months following treatment.

The evidence base on psychological interventions specifically designed for survivors of domestic violence and abuse is growing, and systematic reviews have found that CBT-based interventions and cognitive processing might be associated with improved PTSD and depressive symptoms in survivors no longer in abusive relationships.[4,119] Although a systematic review[120] found some support for the effectiveness of advocacy and CBT interventions in reducing physical and psychological domestic violence and abuse (too few studies were identified to assess effectiveness in reducing sexual domestic violence and abuse), few studies have examined whether interventions are helpful in reducing psychological symptoms in women still subject to abuse. However, the few studies that integrate domestic violence and abuse advocacy and psychological interventions in women at risk of continuing abuse report both improvements in depressive symptoms and reductions in abuse,[121,122] including improvement in birth outcomes for women in the perinatal period.[121,122] The methods of delivery that are most effective and whether interventions can be delivered effectively to women with different levels of risk of abuse, including diverse and marginalised groups, are not yet clear.[4]

Evidence on psychological interventions for survivors of sexual violence is also inconsistent. The results of a systematic review[123] of 20 studies found some evidence for the efficacy of EMDR and trauma-focused CBT for PTSD, depression, and other psychological problems commonly experienced by sexually assaulted women, again from low-quality studies. However, the Cochrane review[118] of treatment for PTSD found no differences between trauma-focused CBT and other therapies that were not specifically trauma focused for women who had experienced sexual assault or abuse. Since the publication of these reviews,[118,123] results of a cluster trial[124] of an adapted intervention group of cognitive processing therapy versus individual psychosocial support for Congolese survivors of sexual violence have showed effectiveness in reducing symptoms of post-traumatic stress, depression, and anxiety in a low-income, conflict-affected setting. As with research on interventions for domestic violence and abuse, women with recent or ongoing experiences of sexual violence are excluded from most intervention trials.

No research that assesses interventions to support the psychological recovery of either women who have been trafficked or women who have experienced FGM was identified in this Series paper or in previous reviews;[24,125] 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 violence against women

Evidence on the effectiveness and appropriateness of programmes for domestic violence and abuse perpetrators with mental disorders is absent, and these programmes receive few referrals from mental health services.[126] However, interventions for modifiable risk factors (such as medication for persecutory delusions, psychological interventions, and treatment of comorbid alcohol and substance misuse), while ensuring safety of the potential victim, might be expected to improve health and reduce violence for domestic violence and abuse perpetrators in contact with mental health services whose

perpetration of violence against women 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 violence against women. Since substance misuse, particularly excessive alcohol consumption, contributes to domestic violence and abuse and sexual violence, mental health professionals could argue for a reduction in hazardous levels of drinking, as recommended by the Chief Medical Officer.[127] Engagement in primary prevention could also involve mental health professionals raising awareness about the effect on mental health and intergenerational violence experienced by women and children, and challenge cultural norms within mental health services as well as the wider society. Secondary prevention of violence against women (ie, reducing the effect and harm of violence against women that has already occurred) will involve identifying and responding to domestic, sexual, and other forms of violence against women experienced or perpetrated by users of mental health services. Identification and treatment of perpetrators could prevent future violence and would also improve victims' health: risk assessment should include a focus on risk of domestic violence and abuse and sexual violence to ex-partners (as well as current partners) and family members. Safeguarding and supporting children exposed to or witnessing violence against women, or both, could reduce the likelihood of these children becoming victims or perpetrators of violence against women, reducing the risk of violence against women for future generations. Mental health professionals can also contribute to the prevention of violence against women at the tertiary level by advocating for funding for specialist services, such as domestic violence and abuse advocates, sexual assault referral centres, FGM clinics, and post-trafficking support. An increase of the access to mental health services is an important secondary and tertiary preventive measure: despite evidence that mental disorders increase the risk of domestic violence and abuse victimisation and perpetration, and that experiencing domestic violence and abuse increases risk of mental disorder, effective mental health treatments are not available for most people globally.[128,129]

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. For example, the Istanbul Convention requires that States take the necessary legislative and other measures to ensure that victims of all forms of violence against women have access to health-care, social, and specialist support services; that services are adequately resourced; and that professionals are trained to assist victims to make appropriate referrals.[2] Yet, as highlighted in this Series paper and elsewhere in this Series, and by WHO's global plan of action to strengthen health-system responses to violence against women and children,[130] appropriate mental health research and service provision is lacking.[131] As indicated in the review done for this Series paper, and by NICE and WHO,[3,4] research into interventions for both victims and perpetrators of domestic violence and abuse and sexual violence is still needed; only a few trials have been done for victims of domestic violence and abuse or sexual violence with mental disorders, and no trials have been done for mental disorders in victims of other forms of violence against women, such as trafficking and FGM. Similarly, no trials have been done of perpetrator programmes or other interventions for domestic violence and abuse perpetrators who have mental disorders or misuse substances, or both. 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 restricting access to health professionals and undermining treatment offered. To what extent is treatment failure or treatment resistance due to violence against women that has not been identified? It is striking that domestic violence and abuse and other forms of violence are rarely measured or identified in trials of mental health interventions even though they are likely to be important moderators of response. We hope that in the future there will be better integration of violence against women as a factor in studies that investigate the epidemiology of mental disorders and their treatment.

Search strategy and selection criteria

We identified the references for this Review 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. We adapted the search terms for violence against women from terms published in relevant Cochrane protocols. We did searches from Jan 1, 2009, to Jan 12, 2016, updating a previously published review by some of the authors of this Series paper. We identified additional papers by citation tracking using Web of Science, Google Scholar, and searches of our personal files.

Contributors
SO and LMH conceived and developed the idea. SO and HK conducted the review. SO and LMH drafted the manuscript, and HK edited before all authors approved the final version.

Declaration of interests
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