ABSTRACT
Domestic violence and abuse is a considerable international public health problem, which is associated with mental disorders in both women and men. Nevertheless, victimization and perpetration remain undetected by mental health services. This paper reviews the evidence on mental health service responses to domestic violence, including identifying, referring, and providing care for people experiencing or perpetrating violence. The review highlights the need for mental health services to improve rates of identification and responses to domestic violence and abuse, through the provision of specific training on domestic violence and abuse, the implementation of clear information sharing protocols and evidence-based interventions, and the establishment of care referral pathways. This review also highlights the need for further research into mental health service users who perpetrate domestic violence and abuse.

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Introduction
Domestic violence and abuse (DVA) 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 (Buller, Devries, Howard, & Bacchus, 2014; Hester, Ferrari, Jones, Williamson, Bacchus, Peters, et al., 2015; Jonas et al., 2014). Evidence from general population surveys indicate that the prevalence of DVA 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, Walby, Towers, & Francis, 2015). A review of the rates of violence victimization among men and women with severe mental illness highlight that women are at increased risk of victimization compared to men (Khalifeh & Dean, 2010).

Systematic reviews report that a high proportion of mental health service users experience DVA (Oram, Trevillion, Feder, & Howard, 2013) and demonstrate a consistent relationship between mental disorder and DVA, with a 3-fold increased risk of depressive disorders and 7-fold increased risk of post-traumatic stress disorder (PTSD) among victims of DVA (Trevillion, Oram, Feder, & Howard, 2012). Although the majority of evidence is drawn from cross-sectional studies, there is some research to suggest that the relationship between DVA 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 & Forte, 2014; Golding, 1999; Jones, Hughes, & Unterstaller, 2001). Longitudinal studies are sparse but they suggest a bidirectional relationship between mental disorder and DVA, with mental disorders increasing vulnerability to DVA (Trevillion Oram, et al., 2012), and DVA damaging mental health (Dekel & Solomon, 2006; Devries et al., 2013; Howard, Oram, Galley, Trevillion, & Feder, 2013). Research also suggests a relationship between mental disorder and lifetime DVA perpetration, although the association is less pronounced than that between mental disorder and DVA victimization (with a 2-fold increase in risk of lifetime DVA 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, Trevillion, Khalifeh, Feder, & Howard, 2014).

Mental health professionals have an important role in responding to DVA (Chapman & Monk, 2015), and several countries have introduced policies of
routine enquiry for mental health services, including the UK (Department of Health, 2008), New Zealand (Agar & Read, 2002), & the US (Eilenberg, Thompson Fullilove, Goldman, & Mellman, 1996). Yet, DVA remains under-detected in mental health settings (Chapman and Monk, 2015; Howard, Trevillion, & Agnew-Davies, 2010), and mental health service users report low levels of satisfaction with psychiatric services response to DVA (Trevillion Hughes, et al., 2014).

Aims and objectives

This paper extends a previous review that was conducted by our research team and published in this journal in 2010 (Howard et al., 2010). The previous review used a gendered lens to summarize evidence on the prevalence of DVA, its risk factors and health impacts, and how mental health services should respond. As the previous review presented clear data on the nature, extent, and health impacts of DVA, this review focuses on summarizing new evidence on how mental health services should best respond to DVA. The update extends the focus of the previous review by also examining service responses to DVA perpetration, which is increasingly a focus in service planning and clinical guidelines (NICE, 2014). We searched Medline, PsychINFO, and Embase using the following inclusion criteria: English-language primary research papers and reviews reporting qualitative or quantitative findings from observational or intervention studies that investigate mental health services’ identification and response to DVA. Citation tracking was used to identify additional papers. The previously published review was updated (Howard et al., 2010), examining studies published from 1 January 2009 to 12 January 2016; we referred to relevant reviews (Feder, Austin, & Wilson, 2008; Smedslund, Dalsbø, Steiro, Winsvold, & Clench-Aas, 2007) and the recent National Institute for Health and Care Excellence (NICE, 2014) guidelines to identify studies published on DVA perpetration prior to 2009. DVA 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 and abuse identified by mental health professionals?

Identifying service users who have experienced DVA

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

A UK survey of 131 psychiatric nurses’ and psychiatrists’ knowledge, attitudes, and preparedness to respond to DVA found that only 15% (n = 20) reported routinely enquiring about DVA (Nyame, Howard, Feder, & Trevillion, 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 DVA training found that more than one-third never or seldom asked about DVA 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, Capron, Trevillion, & Howard, 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 DVA, although no differences in screening rates were found for patients with other mental health disorders (Choo, Nicolaides, Jenkinson, Cox, & John McConnell, 2010).

Research with service users similarly suggests low levels of enquiry about DVA in mental health settings. In the US, 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 DVA (50%; n = 134), and one in eight (13%, n = 34) reported having experienced DVA in the past year. Lifetime DVA was also reported by a fifth of male service users (18%; n = 29) and past year DVA by 6% (n = 10). Findings highlight that mental health professionals are failing to identify DVA, particularly among male service users. Research with women with severe mental illness (SMI) in Spain reported that less than two-thirds of women with lifetime experiences of DVA and only half of women with past year experiences of DVA 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 DVA 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 10 disclosed lifetime perpetration of DVA, 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 DVA perpetration (Home Office, 2013a; University of Manchester, 2015), while an evaluation of UK perpetrator programmes highlighted that very few referrals to community perpetrator programmes come from mental health services (Kelly & Westmarland, 2015).

Service user disclosures of domestic violence and abuse

Mental health service users may experience multiple barriers to disclosing that they have experienced or perpetrated DVA (Cases et al., 2014; Khalifeh, Oram, Trevillion, Johnson, & Howard, 2015; Trevillion, Hughes, et al., 2014). However, evidence suggests that disclosure is facilitated by direct enquiry by health professionals (Howard et al., 2010; Khalifeh et al., 2015; Posner, Eilenberg, Friedman, & Fullilove, 2008).

Spangaro, Zwi, Poulos, and Man (2010), for example, surveyed 363 women who attended US antenatal, drug and alcohol, or mental health services and who had been screened for DVA as part of routine clinical assessments within the previous year. The sample included 122 women who had screened positive for experiences of DVA and 241 who had screened negative. Fifty-six per cent (67/120) of women who had screened positive for IPV reported that this was the first time they had disclosed the violence to anyone. Fourteen per cent (34/240) of women who screened negative for DVA disclosed to the researchers that they had experienced DVA 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) vs 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 to 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. These findings replicate those which were identified in the previous review (Howard et al., 2010).

A systematic review of qualitative studies reporting on mental health service users’ experiences of disclosing DVA similarly found that mental health services often failed to identify and facilitate disclosures of domestic violence and abuse and to develop responses that prioritized service user safety (Trevillion Hughes, et al., 2014). A study of 24 mental health service users, for example, identified multiple barriers to disclosure of DVA (Rose et al., 2011). Service users described DVA as a hidden problem: they did not necessarily recognize 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 DVA (Rose et al., 2011). Disclosure of DVA 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 & Forte, 2014; Trevillion, Howard, et al., 2012). Interestingly, the UK qualitative study found that some service users reported a reluctance to access DVA support services because of fears about disclosing their mental health status (Trevillion Howard, et al., 2012). Research in the UK and Australia has highlighted that women with severe mental illness have difficulty accessing refuge services (Hager, 2011; Harvey, Mandair, & Holly, 2014).
Equivalent research has not been conducted in relation to disclosure of DVA perpetration. Khalifeh et al.’s (2015) UK study of mental health service users suggested, however, that disclosure is facilitated by direct enquiry (Eckhardt, Samper, & Murphy, 2008; Khalifeh, 2015), and research elsewhere has suggested that perpetrators are unlikely to self-identify or seek treatment without assistance (Chapman & Monk, 2015; Eckhardt et al., 2008).

Are mental health professionals effective in documenting domestic violence and abuse?

Documentation of domestic violence and abuse victimization

Similar to the previous 2010 review (Howard et al., 2010), research suggests that, once DVA 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 DVA 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 DVA 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 DVA is infrequently addressed within treatment plans (Agar & Read, 2002; Trevillion Howard, et al., 2012), and in the UK a survey of mental health professionals’ behaviours in addressing DVA 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 and abuse perpetration

Less is known about the documentation by mental health professionals of DVA perpetration. 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 DVA with other relevant professionals and with new partners (Hemmings, Trevillion, Howard, & Oram, Submitted).

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

Research with mental health professionals suggests that barriers to enquiry about DVA include a perceived lack of expertise (Salyers, Evans, Bond, & Meyer, 2004), a lack of rapport or a strong therapeutic relationship with the service user (Currier, Barthauer, Begier, & Bruce, 1996), time constraints and competing demands on time (Hamberger & Phelan, 2004), the presence of partners during consultations, and fear of offending or re-traumatizing service users (Rose et al., 2011; Trevillion Howard, et al., 2012). Male clinicians may be less likely to ask about DVA than female clinicians (Nyame et al., 2013), although a lack of confidence and competency in how to appropriately identify and respond to DVA is a barrier to both male and female clinician enquiry (Klap, Tang, Wells, Starks, & Rodriguez, 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 DVA in their practice (Rose et al., 2011). 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 DVA perpetration (Hemmings et al., Submitted). In this latter study, clinicians reported that existing clinical risk assessments did not specifically refer to different types of DVA 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 organizational recognition of DVA 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 previous review identified limited evidence on the effectiveness of interventions for DVA in mental health settings (Howard et al., 2010). This still appears
to be the case, and the 2014 NICE guidelines highlight the need for evidence-based interventions on how health services can identify and respond to DVA, on the effectiveness of perpetrator programmes and domestic abuse recovery programmes for people who have experienced DVA (NICE, 2014). This review has also identified a particular lack of evidence to support improved mental health service responses to DVA, including interventions for mental health service users who are still experiencing abuse and for those who perpetrate DVA. With regards to support for mental health service users who are experiencing ongoing abuse, evidence from non-psychiatric settings suggests that interventions which integrate DVA advocacy and psychological therapies may lead to improvements in mental health symptoms and reductions in abuse (Kiely, El-Mohandes, El-Khorazaty, & Gantz, 2010).

**Interventions to improve service responses to DVA**

Two recently conducted reviews have considered the effectiveness of training in improving health service responses to DVA: a scoping review of 38 intervention studies and a systematic review of nine randomized controlled trials from the US and Europe (Choi & An, 2016; Zaher, Keogh, & Ratnapalan, 2014). The reviews demonstrated that, although guideline dissemination and training can be effective in improving health professionals’ knowledge about DVA, they do not create consistent and sustainable improvements in the identification and response to DVA unless implemented along system support interventions and systemic change. Neither review included interventions for improving responses to DVA in mental health settings. However, studies conducted in mental health settings support their conclusions that efforts to improve health service responses to DVA must go beyond improving professionals’ knowledge of DVA. 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 DVA 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 DVA training for clinicians and the implementation of a referral pathway to DVA advocacy for service users improved rates of identification and referral among mental health professionals, in addition to improved self-reported DVA knowledge, attitudes, and behaviours (Trevillion, Byford, et al., 2014). An evaluation of an intervention aimed at achieving organization-wide changes in responses to DVA at two UK mental healthcare organizations (‘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 DVA policies and competency frameworks, mentoring managers and senior practitioners to become DVA champions, delivering training to frontline professionals, and train-the-trainers, is currently underway.

**Interventions for service users experiencing domestic violence and abuse**

Systematic reviews have identified evidence from randomized controlled trials of effective interventions for victims of DVA and other forms of trauma, including cognitive behavioural therapy for post-traumatic stress disorder (NICE, 2014; Warshaw, Sullivan, & Rivera, 2013). Findings suggest that useful components are likely to include psychoeducation about the causes and consequences of DVA, 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 DVA. This review identified three relevant studies: two before-and-after studies conducted in the US and one quasi-experimental pilot study conducted in the UK (Frueh et al., 2009; Lu et al., 2009; Trevillion Byford, et al., 2014). Although neither before-and-after study was aimed specifically for mental health service users with experiences of DVA, both samples included participants with experiences of DVA.

Frueh et al. (2009) conducted a before-and-after study in two US CMHTs to examine the effectiveness of an exposure-based manualized 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 DVA 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 3-month follow-up \((p < 0.001)\). Clinician-assigned ratings
of PTSD symptoms ($p < 0.001$) 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) manualized CBT intervention for abused service users with PTSD and either major depression, bipolar disorder, schizophrenia, or schizoaffective disorders (Lu et al., 2009). Nineteen service users (11 women and eight men) participated; seven (50%) of whom disclosed lifetime DVA by an intimate partner or family member. The 12–16 week manualized CBT intervention comprised breathing training, psychoeducation about PTSD, and cognitive restructuring, and was delivered through individual-therapy sessions alongside usual care (Lu et al., 2009). Among those who completed treatment ($n = 14$), 3- and 6-months post-intervention assessments revealed significant improvements in clinician-assigned ratings of post-traumatic stress symptoms ($p < 0.001$) and other psychiatric symptoms ($p < 0.001$). Improvements were also observed for self-assigned ratings of depressive symptoms ($p < 0.050$) (Lu et al., 2009). Neither before-and-after study was developed specifically for mental health service users with experiences of DVA (e.g. addressing immediately safety and risk issues) and findings cannot be extrapolated to those still experiencing abuse. Due to exclusion criteria, findings also cannot be generalized 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 DVA remains uncertain.

In the UK, a quasi-experimental pilot study found that mental health service users with past year experiences of DVA who received a multi-faceted DVA intervention reported reductions in frequency and severity of DVA and improved social inclusion and quality-of-life (Trevillion Byford, et al., 2014). The intervention was delivered in five community mental health teams: three intervention teams and two controls (treatment as usual). Thirty-five service users participated (34 women and one man); 28 in the intervention group and seven in the comparison group. The intervention comprised DVA training for mental health professionals, the implementation of a direct referral pathway, integrated DVA 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 DVA. The intervention was delivered alongside usual care, with integrated advocacy delivered by two DVA advocates seconded from a local DVA service.

At 3-months follow-up, the 27 participants who received the intervention reported significant reductions in the frequency and severity of violence ($p < 0.001$); improvements in quality-of-life outcomes ($p < 0.010$) and perceived social inclusion ($p < 0.050$) (Trevillion Byford, et al., 2014). Clinician referrals to independent DVA advocates also increased, as did referrals to local multi-agency risk assessment conferences (meetings in which information is shared on high risk DVA 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 £1213 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 indicated that improvements in outcomes may be generated at relatively small additional cost (Trevillion Byford, et al., 2014). Due to the small sample size of the comparison group ($n = 7$), between-group analyses were not conducted, and the effectiveness of this DVA advocacy intervention remains uncertain. Findings also cannot be extrapolated to service users with more acute illness or to those who had not experienced DVA in the past year.

**Interventions for service users who perpetrate domestic violence and abuse**

Large, robust studies to test the effectiveness of interventions for people who perpetrate DVA 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. 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 (NICE, 2014). Indeed, the recent NICE (2014) review on healthcare interventions for DVA identified only one study targeted at reducing DVA perpetration among men seeking treatment within mental health settings; the remainder of the studies were conducted with men and women within criminal justice settings or community services. The study was a pilot intervention conducted in the US to address DVA perpetration among 23 alcohol-treatment seeking men in a community mental health team (Schumacher, Coffey, Stasiewicz, Murphy, Leonard, & Fals-Stewart, 2011). Eleven men were randomized to the intervention and 12 to the comparison group; 16 female partners agreed to participate in the study to provide collateral reports of DVA incidents. Men randomized to the intervention received a 90-min Motivational Enhancement Therapy session (incorporating principles of Motivational Interviewing), self-help handouts, and a list of DVA support services. Men in the comparison group received only a list of DVA support services. At the 2-week post-intervention assessment, men in the intervention arm reported significantly greater help-seeking behaviours than men in the comparison group. Nevertheless, at the 3- and 6-month assessments no significant differences were observed in rates of DVA perpetration between the groups, and no change was observed in self- and partner-reports of relationship satisfaction. Interpretation of these results is, however, difficult due to the small sample size and significant attrition at the 3- and 6-month assessments (~ 50% of participants were lost to follow-up). Future interventions for DVA 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 co-morbid alcohol and substance misuse) and manage potential risks of harm (Hiday, 1997; Witt, Van Dorn, & Fazel, 2013). 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

Over the past decade, international and national bodies have called for improved awareness and responses to DVA across the health sector, including mental health services (Davis, 2014; NICE, 2014; Stewart & Chandra, 2016; World Health Organization, 2013). Policies have been introduced in several countries implementing routine enquiry about DVA in mental health settings, although a systematic review of DVA 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 DVA. This review suggests that many mental health professionals do not ask about DVA and that service users do not readily disclose DVA in the absence of direct enquiry. DVA is underdocumented 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 DVA, and preliminary evidence suggests considerable gaps in professionals’ knowledge and confidence to respond.

Findings from this review suggest 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 DVA, mental health professionals should discuss the limits of confidentiality and potential implications of disclosures with service users. Service users who disclose experiencing DVA 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 DVA. In the absence of training and clear referral pathways, enquiry about DVA 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 & 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 DVA should note the review’s findings that, although DVA training can be effective in enhancing mental health professionals’ knowledge and awareness of DVA, 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 DVA by mental health service users. Findings from a small number of studies suggest that, although disclosure of DVA perpetration may be facilitated by direct enquiry, there is a need for guidance and organizational support to assist mental health professionals in assessing, identifying, and responding to risk of DVA 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 DVA perpetration, the validity of general violence risk assessment tools in identifying risk of DVA, and the effectiveness of domestic violence perpetrator programmes and intervention approaches for DVA 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 DVA (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 both service users who have experienced DVA and service users who have perpetrated this form of abuse. The consequences of DVA 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 DVA and implementation of clear information sharing protocols and referral pathways.

Disclosure statement

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

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