The *Lancet Psychiatry* Commission on intimate partner violence and mental health: advancing mental health services, research, and policy

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Executive Summary

Background

Intimate partner violence (IPV) is the most common form of violence worldwide and contributes significantly to the global burden of mental health problems. The *Lancet Psychiatry* Commission on Intimate Partner Violence and Mental Health met to consider progress in reducing IPV and its associated mental health harms (see panel 1), and to establish a roadmap for strengthening responses across mental health research, services, and policy. Mental health care is delivered predominantly through primary care globally, but to date the relationship between IPV and severe mental health problems, and how to address IPV within secondary mental health care, has been relatively neglected. We therefore focus mainly on the changes needed to address IPV within secondary mental health care. Our focus on mental health is pragmatic rather than exclusionary: we also recognise the need for broader change across multiple disciplines, systems, and institutions. This Commission comprises five parts, which are summarised briefly below, and the key messages arising from this Commission are provided in panel 2.

[Insert Panel 1 here]

Part 1: Evidence for associations between IPV and mental health problems

IPV is a gendered problem. Most victims of IPV are women - globally, an estimated 27% of women aged 15 years and older have suffered physical or sexual IPV - though high rates are also suffered by other groups, including sexual and gender minorities, people with disabilities, migrants, and people from minoritised ethnic or indigenous groups. There is a complex relationship between IPV and mental health; exposure to IPV in childhood or in adulthood increases the likelihood of developing a range of mental health problems and of suicidal ideation and suicide attempt, while the presence of mental health problems also makes individuals more vulnerable to being subjected to IPV. Children who are exposed to IPV are themselves at high risk of additional forms of abuse and neglect, and experiencing abuse or being exposed to IPV in childhood greatly increases risk for IPV as an adult - either as someone who experiences or who commits IPV. Those with diagnosed mental health problems are also more likely to commit IPV, though absolute rates are low, and this relationship appears to be partly mediated through substance misuse, with the incidence of violence higher where mental health problems and substance misuse co-occur. Research in this area is controversial: mechanisms still need to be elucidated, and there are concerns about the potentially stigmatizing consequences of examining the role of mental health problems in the perpetration of IPV, and that diagnoses such as borderline personality disorder pathologise women's responses to violence and oppression. However, associations appear to occur across the lifespan and relate to both the onset and the course of mental health problems.

Part 2: IPV across the life course

Although IPV is endemic, it is not inevitable: evidence points to several targets for prevention and intervention with individuals, families, communities, and societies. Some are stage-specific, such as parenting programmes to reduce child abuse and neglect, or schools-based programmes to address violence supportive norms and behaviours; others span several stages, or are relevant across the life-course, such as the prevention and treatment of substance misuse, and secondary or higher education for women.

Part 3: Measurement of IPV

Measuring the frequency, severity, and context of IPV, its co-occurrence with other forms of violence, and its impacts on mental health is challenging but important. Although significant strides have been

made in assessment methods for IPV, more needs to be done to advance measurement and harmonise data collection with collaboration across sectors; administrative data are fragmented and inconsistent between fields, professionals, and practitioners. The development of IPV measures should involve people with lived experience of IPV and of mental health problems to ensure their relevance, feasibility, and validity.

Part 4: Transforming the mental health system to address IPV

Survivors should be fundamental to the development and evaluation of support services, from grassroots survivor-led services to statutory mental health services. Mental health systems and providers can make a critical difference in IPV survivors' path to healing, but too often the opportunity to do so is unfulfilled, and some survivors experience mental health services as harmful and re-traumatising. Survivors and providers alike have called for urgent reform to enable pathways to safety, healing, health, and well-being for those experiencing IPV, including through the coproduction of trauma-informed approaches to care. All mental health professionals should have a good understanding of the gendered nature and dynamics of IPV, its impact on mental health, and the intersections of both IPV and mental health with other forms of oppression including racism, transphobia, disablism, and poverty. Mental health professionals must also be enabled to respond appropriately through training and continuous learning and organisational infrastructure and support. As mental health services can be difficult to access due to poor availability, financial or logistic constraints, especially for minoritised populations and those in low- and middle-income countries, efforts to integrate mental health care into primary health care, and to strengthen training of lay workers, and grassroots and user-led alternatives to mental health services are essential.

Part 5: Addressing gender inequality and societal responses to IPV

Primary prevention must sit alongside work to strengthen mental health service responses to IPV and should use an intersectional gendered lens, recognising that IPV interlocks with other forms of oppression. This includes addressing structural factors such as access to education, employment, and poverty reduction strategies; laws and policies that discriminate against women (e.g., divorce or child custody, property, and inheritance) and other groups at risk of IPV, such as people in same-sex relationships and gender minorities; the implementation and enforcement of anti-violence legislation; and policies to reduce harmful alcohol consumption. Moreover, in order to prevent IPV, societies should consider how violence supportive norms are located and the ways in which institutional and public structures condone or reinforce them; the risk of IPV appears highest in societies that are most unequal in their gender relations and where the use of violence generally, and the use of violence against women specifically, are accepted norms. The importance of context and wider societal issues on rates of IPV has been particularly apparent during the COVID-19 pandemic, which has seen, in many places a steep increase in reports of IPV. The mental health consequences of these increased rates of IPV, and potentially the reduced opportunities to access support and escape, are not yet apparent but will be important to investigate, alongside the mental health consequences of COVID-19 itself.

[Insert Panel 2 here]

Introduction

Intimate partner violence (IPV) is a public health crisis, with catastrophic impacts for individuals, families, and communities. It is the form of violence most commonly experienced by women globally and is associated with physical, mental, sexual, and reproductive health problems and with death due to homicide and suicide. IPV refers to any behaviour committed against a current or former intimate partner that causes physical, psychological, or sexual harm. As described in panel 3, it includes physical violence, emotional abuse, sexual violence, and controlling and coercive behaviours, with technology increasingly being used to facilitate abuse, including through abuse on social media and other online platforms, the installation of stalkerware on personal devices, and manipulation of 'smart' meters, locks, and cameras.[1,2]

The burden of IPV is suffered overwhelmingly by women and girls. Although women can be violent towards their current and former male and female partners, IPV is mostly committed by men against women. Globally, an estimated 27% of ever-partnered women aged 15 years and older report having experienced physical or sexual IPV in their lifetime;[3] there is high prevalence in low-, middle-, and high-income countries alike, although prevalence is highest in low-income countries. Age-disaggregated data show that women are often subjected to IPV from an early age: 24% of ever-partnered 15-19-year-old girls report having experienced physical or sexual IPV.[3] Data also show that exposure to IPV continues throughout the life course: although some studies have reported that prevalence declines with increasing age, finer analysis of exposure by type of IPV shows that this is limited to physical violence, with rates of non-physical types of abuse remaining stable across age groups.[4] Research also indicates that transgender individuals are at 2-3 times higher risk of physical and sexual IPV compared with cis-gender individuals,[5] and that prevalence of IPV may also be elevated for gay men and lesbians in comparison with heterosexual people.[6] Other axes of discrimination and marginalisation, such as indigenous[7,8] and migrant status, disability,[9,10] and poverty,[11-13] are also associated with increased risk of IPV.

[Insert Panel 3 here]

Several theoretical models exist that seek to explain IPV. Prominent among these for the past 25 years has been the ecological model, which proposes that violence results from factors operating at the individual, relationship, community, and societal levels. A recent update has sought both to capture the inter-connections between risk factors operating at different levels and to clarify which risk factors are indicators of broad underlying latent constructs.[14] Proponents of this model argue that gender inequality, the normalisation and acceptability of violence in social relationships, and poverty drive men's perpetration and women's risk of experiencing IPV (figure 1). Additionally, gender inequality and poverty increase the incidence of individual and relationship factors - poor mental health and substance misuse, childhood neglect and abuse, and poor communication and relationship conflict responses – that also increase risk of IPV. In this model, disability is suggested to further exacerbate risk factors, while individual and structural factors are intensified during conflict and post-conflict periods.[14]

Gender inequality is entrenched globally, with actual and threatened violence a means through which men's dominance and control over women is expressed and gender hierarchies are maintained.[15,16] Research suggests that the most violent men are more likely to express hypermasculine behaviours and gender-inequitable attitudes,[16] though the evidence on associations between such attitudes and IPV is mixed.[17] Social norms provide for both the reproduction and maintenance of attitudes regarding gender equity, gender power imbalances, and the acceptability of violence within interpersonal relationships. The relative importance of community versus individual attitudes, however, varies contextually, including in relation to other risk factors such as poverty and trauma.[14] Poverty increases IPV both

indirectly (by increasing the likelihood of experiencing other risk factors for IPV, including poorer educational outcomes,[18] childhood abuse and neglect,[13,19] and poorer mental health and substance misuse in adulthood) and directly (by increasing exposure to stressors, contributing to greater levels of conflict within households).[20,21]

As highlighted by the ecological model, experience of child maltreatment and exposure to IPV in childhood are strongly associated with either experiencing or committing IPV. Evidence consistently shows that women who experienced abuse in childhood or who were exposed to violence between their parents are more likely to be victimised by their partner, while men who have experienced these forms of maltreatment are more likely to use violence against their partner. Mental health problems and harmful substance use are associated with increased risk of both IPV victimisation and perpetration and are frequently comorbid. IPV drives mental health problems and substance misuse in women,[22,23] while mental health problems and substance misuse increase risk of experiencing IPV. Risk of committing IPV is higher among men who report harmful use of alcohol and drugs, and who have a diagnosis of one of a range of mental health disorders.

IPV occurs along a continuum of severity (frequency and types of acts) and combinations of forms used (physical, sexual, emotional, controlling behaviours). Some researchers in high-income countries draw a distinction between "intimate terrorism" (where violence is a mechanism to reinforce control over a partner)[24] and "situational violence" (where violence is a physical reaction to anger or frustration but is not motivated by control), the former arguably justifying more substantial interventions than the latter.[25] Another approach accounts for violence occurring along a continuum of escalation (frequency, severity, and combinations of violence used),[26] with the implication that different intervention points and tailored responses to patterns of abuse might be needed.

[Insert figure 1 here]

IPV has both direct and indirect impacts on health, including mental health. Hypothesised pathways between IPV and different forms of illness, disability, and mortality include direct pathways between physical violence, injury, disability, and death: globally, across countries with available data, 38% of all murdered women and 6% of murdered men between 1982 and 2011 were killed by an intimate partner.[27] Indirect pathways are likely to be mediated by biological stress responses; the use of alcohol, drugs, tobacco, and prescription medication to manage the consequences of abuse; and restricted help-seeking and decision-making.[27] The impacts of abuse appear to be cumulative: analyses using data from the World Health Organization's Multi-Country Study on Women's Health and Domestic Violence have highlighted that while all forms of IPV were damaging to physical and mental health, combined abuse – and, in particular, combined abuse involving sexual IPV – was associated with the highest levels of harm, including risk of suicidal ideation and suicide attempt.[28] The effects persist long after abuse has stopped.[28] Children are also harmed by exposure to IPV, having increased risk of anxiety and depression and poorer behavioural and educational outcomes compared to their unexposed peers.[29-32] Exposure to IPV places children at increased risk of experiencing or committing IPV in adolescence and adulthood. Studies in low-income settings have found that children exposed to IPV are less likely to be immunised against infectious diseases,[33] have increased risk of diarrhoeal and other diseases,[34] and have higher rates of child mortality than children not exposed to IPV.[35,36]

Stopping cycles of violence and abuse is estimated to decrease the prevalence of mental health problems by as much as a quarter. This *Lancet Psychiatry* Commission on Intimate Partner Violence and Mental Health aimed to consider evidence to identify and reduce the risk of IPV and its related harms, and to establish a roadmap for future work across mental health research, services, and policy. We have drawn on the best available evidence, identifying where evidence is incomplete or of poor quality. Overall evidence is generally from high-income countries, with less available from middle- and low-income

country settings. Furthermore, although IPV, as an expression of power inequality, interacts with age, class, disability, ethnicity, gender identity, indigenous status, migrant status, religion, and sexuality, too few studies of IPV and mental health take an intersectional approach.

Part 1: Evidence for associations between IPV and mental health problems

IPV as a risk factor for the development of mental health problems

IPV is associated with the occurrence of a range of mental health problems with varying degrees of severity and differing levels of impact on individuals' functioning.[37-39] Diagnoses of anxiety, depression, substance use disorder, post-traumatic stress disorder (PTSD), personality disorders, and psychosis, as well as self-harm and suicidality, are all more common among those who have experienced IPV than those who have not.[40] Although not all people exposed to IPV go on to experience mental health problems, associations between IPV and poor mental health have been reported for women,[41] men,[42] and transgender and non-binary people,[5,43] and across the lifespan from childhood[31] and adolescence[44] through to old age,[45] as well as during and after pregnancy.[46] Some research has suggested that individuals who experience IPV are likely to have more persistent mental health problems than those who have not experienced IPV.[47] Women are more likely to be victims of IPV than men,[27] and a larger proportion of women experience mental health problems related to IPV (assuming causality) than men.[48] This emphasises the importance of disaggregating data on associations between IPV and mental health outcomes by sex and by gender identity.

Different types of IPV have been shown to be associated with mental health problems, including physical aggression, sexual assault, verbal and emotional or psychological abuse, controlling behaviours, and coercive control.[49,50] There is emerging evidence around the adverse mental health impacts of technology-enabled IPV.[51] Different types of IPV commonly co-occur (as do mental health problems) and thus focusing on associations for specific types of IPV is probably unhelpful. Moreover, individuals exposed to more than one type of IPV might be at greatest risk for poor mental health outcomes,[52] particularly where multiple exposures include sexual IPV.[28] Chronic exposure to IPV has been shown to be associated with more severe mental health problems,[40] although this might at least be partly dependent on type of IPV.[53]

Although much of the existing research comes from high-income countries, evidence is accruing from low- and middle-income countries (LMICs) of associations between IPV and development of mental health problems.[40,54,55] For example, a study conducted across several LMICs found that experience of IPV was an independent risk factor for suicide attempts.[55] The mental health impact of IPV might be even greater in societies which have larger gender inequalities, where it may be more difficult to access support or escape harmful relationships. Indeed, the complex relationships between IPV and mental ill-health can be neither understood nor addressed without acknowledging the profound and interlocking effects of heteropatriarchy (the dominance of heterosexual and patriarchal norms in society) and other forms of oppression, including racism,[56] transphobia,[57] and disablism, as well as intersections with gender and poverty.[14,58]

Children who have experienced IPV in early life are more likely to have mental health problems than those who have not experienced IPV. Violence in childhood can have many forms, including being exposed to or experiencing physical, sexual, or emotional abuse, or neglect. Children who are exposed to violence between adults in their lives are at increased risk of developing mental health problems in childhood and adolescence[31] as well as in adulthood compared with their unexposed peers.[59] For example, Dube et al.[60] identified a positively graded risk for self-reported adult substance misuse and

depressed affect as the frequency of exposure to IPV during childhood increased in a US-based sample. Many adults who commit IPV are also violent, abusive and neglectful towards their children,[61,62] and this direct maltreatment has also been associated with increased risks for developing a wide range of mental health problems.[63] It is important to consider multiple risk factors for this violence, such as poverty, mental health problems of caregivers, low educational achievement, alcohol and drug misuse, having been maltreated oneself as a child, and family breakdown or violence between other family members.[64]

A history of child maltreatment (or exposure to IPV) has been shown to increase the risk of experiencing IPV in adulthood.[65,66] Therefore, childhood exposure to abuse and neglect could be compounded by experiences of IPV in adulthood and this harmful combination might further increase the likelihood of developing mental health problems. Longitudinal studies involving comprehensive prospective assessments are needed to disentangle the associations between these factors. One such study in a sample of women based in the UK, found that IPV in adulthood was associated with a doubled risk of experiencing a new onset of depressive disorder independent of exposure to physical abuse in childhood, but when women had experienced both IPV in adulthood and childhood physical abuse the risk of developing depression was even greater.[67] More research is needed to understand these associations, including survivor-led studies. Regardless, it remains clear that reducing IPV (whether exposure occurs directly as an adult, indirectly in childhood, or both) is likely to improve mental health outcomes.

There are several limitations to the current body of research on this topic that restrict the conclusions that can be drawn. First, much research in this area is cross-sectional and thus it is not clear whether the mental health problems developed after exposure to IPV or were present beforehand (although there are a few longitudinal studies[22,67,68,69]). Second, many studies do not control for potential confounders, such as history of childhood maltreatment, shared genetic vulnerabilities, or prior psychopathology or behavioural problems (although there are exceptions[70]). Third, the specificity of the findings on IPV and mental ill-health is difficult to ascertain as most studies focus on a single type of IPV or group all types of IPV together (Gibbs et al.[14] is a notable exception). More in-depth investigations are required considering survivor perspectives on the usefulness of such typologies. Fourth, it is difficult to capture the prevalence of exposure to IPV accurately because of the potential for non-disclosure (especially by men[71] and those in minoritised groups[72]) due to shame, fear of being judged or discriminated against, fear of retaliation, not being aware of available services, or not recognising that what was experienced constitutes IPV. This likely results in an underestimation of the degree of association between IPV and mental health problems. Finally, the generalisability of findings on IPV and mental ill-health is restricted because very few studies take an intersectional approach to data collection and analysis, particularly in relation to IPV occurring in non-heterosexual relationships, or where the adults involved have disabilities, or are trans, or come from minoritised ethnic or indigenous groups, different social classes, or geographical locations. Moreover, while the literature from different parts of the world suggests similar associations between IPV and mental ill-health,[40] the generalisability of findings from one location to another is likely to be limited by contextual factors that might differ between and within countries, such as cultural beliefs about partnerships, higher levels of violence within the wider community, poverty, natural disasters, health crises (including pandemics),[73] or ongoing wars, displacement or other traumatic experiences.

Mental health problems as a risk factor for experiencing IPV

Individuals who are experiencing mental health problems are at increased risk of being exposed to IPV. A meta-analysis[74] found that individuals diagnosed with a mental health problem were exposed to high

rates of IPV over the previous 1-3 years, with women reporting approximately double the rates of men. Although the evidence is sparse, estimates suggest that these rates of IPV exposure are around 2-3 times higher than those reported by people without mental health disorders.[75] Similarly, a systematic review of longitudinal studies found that women with depressive symptoms were at increased risk of experiencing IPV for the first time.[22] This could occur because abusive partners inflict violence when individuals with mental health problems are assumed to be less able to protect themselves (e.g., during certain psychotic states involving disinhibition or preoccupation with one's own thoughts). As discussed earlier, it is also possible that experiences of violence during childhood give rise to both the development of mental health problems and revictimisation via IPV in adulthood[65] and thus it could be these early experiences that are actually driving the associations seen between current mental health disorders and recent experiences of IPV. People who have been abused or neglected in childhood might be less likely to have a sense of what a healthy/non-abusive relationship looks like. Their self-worth might also have been eroded to the extent that they think they deserve to be treated in this way. Moreover, their experiences of the minimisation of violence - possibly as a means of coping, or due to the normalisation or endorsement of violence within their family or the wider society they live in – might lead them to think that the abuse is not really that bad. An illustration of this cycle of victimisation is provided in panel 4.

[Insert Panel 4 here]

Mental health problems as a risk factor for perpetrating IPV

Increased risks of IPV perpetration were reported for individuals diagnosed with depression, generalised anxiety disorder, and panic disorder compared to those without such diagnoses in a systematic review of mainly cross-sectional studies, with odds ratios in the range of 2-3.[76] Associations between depression, anxiety, and IPV perpetration were found in a Swedish population-based and sibling-control longitudinal study, which also reported increased risks for diagnoses of schizophrenia-spectrum disorders, bipolar disorder, and attention-deficit hyperactivity disorder among IPV perpetrators compared to non-perpetrators.[77] No association was found between autism and IPV perpetration. The association between diagnoses of schizophrenia-spectrum disorders and IPV perpetration was not present when compared with unaffected siblings,[77] suggesting that the link is confounded by familial factors (i.e., genetic and early environmental factors shared between individuals with schizophrenia and their siblings). The strongest associations of risk of IPV perpetration were found with alcohol and drug use problems, and substance misuse comorbidity increased risk in all diagnostic groups.[77] Although the strength of the association with mental health problems might be lower for IPV than for other forms of violence, these findings correspond with evidence that having a diagnosis of substance use, schizophrenia-spectrum, bipolar, or personality disorders increases the risk of perpetrating violence more generally.[78]

The connection between substance use and IPV perpetration is complex, and consideration of it should include environmental, situational, social, economic, and cultural contexts. Substances interact differently based on a person's physiology, psychology, gender, and the environments in which the substances are consumed. That said, there is literature that suggests alcohol use directly increases the risk for committing IPV based on the psychophysiological effects of alcohol.[79] Studies from high-, middle- and low-income countries support an association between alcohol and IPV, albeit with inconsistent findings on the degree and moderators.[77,80-82] The variability in associations might be due to multiple contextual factors (e.g., relationships, culture, gender roles, history of dispossession, experiences of discrimination) and methodological limitations (e.g., poor measurement, non-representative or non-comparable samples). The complexities of the interaction between substance use

and IPV make it challenging to determine the pathways behind the association. For example, alcohol might affect neurochemical systems that lead to aggressive behaviour, or alcohol might reduce effective communication, causing discord and eventually violence. Of course, mental health problems such as PTSD or depression could account for both substance misuse and aggressive behaviour. More research is needed to clarify these relationships and possible causal, mediating, and moderating pathways. However, given the consistent findings that there is a moderate effect size for the association between alcohol and IPV that remains even after adjustment for familial factors,[77,80] it is important to study these associations further in order to help reduce IPV. A recent treatment study in Zambia found that reductions in alcohol use were related to IPV reductions.[83]

It is important to note that the vast majority of individuals experiencing mental health problems are not violent, and that people with many mental health problems are more likely to experience than to commit IPV. In addition, the odds of perpetrating IPV for people with mental health problems are lower than those for historical factors, such as previous IPV, and at least as large as relationship factors, such as marital discord and attitudes condoning violence, suggesting that a multifactorial approach is required to understand why individuals commit IPV. From a dimensional perspective, psychological traits such as anger, hostility, and jealousy, have strong associations with IPV, which might be more prevalent in some individuals with mental health problems.[78]

Research is needed to explain the increased risks of committing IPV among some individuals who are experiencing mental health problems. Mechanisms may include symptoms directly leading to violence, such as paranoia, hostility, and anger. In addition, mental health problems increase likelihood of substance misuse, and specifically alcohol misuse, which in turn can increase risk of committing IPV. Other important explanations include familial confounding, in that there are shared genetic and early environmental risks for mental health disorders, substance use and violence.[77,84] A final possibility is that these heightened risks are due to higher rates of detection and arrest of people with mental health problems, although this might be counterbalanced by the police dropping charges disproportionately in these groups. There is not always a clear distinction between committing and experiencing IPV, with some individuals taking both roles.[85] People who both experience and commit violence have been suggested to have the greatest risk of developing mental health disorders.[86]

The potentially stigmatising nature of research on mental health problems and IPV

Research that addresses mental health problems and IPV needs to be attentive to the wider frameworks that are used to contextualise and explain these relationships so as not to embed simplistic assumptions about victimhood or pathologise particular groups of people.

Linking mental health problems with committing or experiencing IPV has the potential to perpetuate existing discriminatory behaviours and assumptions within society. In particular, the conflation of mental health problems and violence contributes to the stigmatisation of mental health problems and discrimination against people with mental health problems, and creates barriers to help-seeking.[87-89] It is crucial, therefore, to better communicate what is meant by the term risk and how this translates into actual numbers of individuals that either use IPV or are subjected to it. Despite increased relative risks (i.e., the probability of committing IPV in a group of individuals with a mental health problem compared to the probability in another group that does not have that mental health problem), the absolute risks (i.e., the risk of committing IPV over a period of time) are not high: a minority of people with mental health problems will perpetrate IPV (see table 1). However, it is important for clinicians to acknowledge that there is an association between mental health problems and violent behaviour, and the effective treatment of high-risk groups should be a priority for mental health services.[90]

[Insert table 1 here]

Minimising or denying any links between mental health disorders and IPV will probably lead to poorer risk assessment and treatments to address modifiable risk factors,[91] and might maintain or even increase IPV rates leading to greater perpetuation of stigma. Researchers can assist this endeavour by improving the evidence base around the association between mental health problems and committing IPV through conducting high quality epidemiological studies that have large, representative samples, longitudinal designs (where the timing of mental health problems and IPV can be ascertained), validated methods to identify mental health disorders and IPV, and adjustment for probable confounders (including familial factors).

The use of diagnostic categories in relation to IPV

Diagnostic categories for mental health problems (in the ICD and DSM classification systems) are commonly used by practitioners to describe symptom clusters to help understand causal relationships, prognoses, and treatments. However, they can also add to stigma and create a siloed view of the nature of mental health symptoms. In addition, several diagnoses (including those associated with both experiencing and committing IPV, e.g., borderline personality disorder,[92,93] antisocial personality disorder[94,95] and substance use disorders) can be highly gendered or racialised, and can produce and reinforce stigma. These diagnoses, some argue, might tell us more about societal and cultural assumptions concerning gender, violence, and trauma than they describe actual mental health problems.[96] It is argued that the diagnosis of borderline personality disorder, for example, pathologises women's responses to violence and other forms of oppression.[97]

Diagnoses can also produce an incomplete picture of individuals who have experienced IPV and present to services with comorbidity. For example, psychotic symptoms can occur in the presence of severe PTSD resulting from IPV, which can lead to difficulties in determining diagnosis, misdiagnosis, or practitioners focusing on one set of symptoms for treatment rather than considering all of a person's experiences.[98] Indeed, any time a mental health condition is diagnosed, we risk producing an incomplete picture and not taking into account comorbidity, environment, events, and other circumstances.

Additionally, diagnoses and mental health labels can be misused by abusive partners. For instance, people who commit IPV have been reported to sometimes label their victimised partner as mentally unwell to excuse their behaviour or as a means of psychological abuse or control (panel 5).

[Insert Panel 5 here]

Key knowledge gaps

Many gaps remain in our understanding of the relationship between IPV and mental ill-health, and research is crucial to improve services, interventions, and outcomes for both people who experience and those who commit IPV. If there is a causal relationship, then the biopsychosocial mechanisms through which IPV leads to the development and maintenance of mental health problems require thorough investigation to inform preventive interventions. The extent to which other factors (e.g., poverty, exposure to other forms of violence) contribute to the relationship between IPV and mental health problems requires clarification. An improved understanding of the factors across multiple levels (individual, family, relationships, and social, cultural, economic, and political structures) that might protect IPV survivors from adverse mental health consequences would also facilitate prevention.

Furthermore, it is important to understand potential risk factors among those who commit IPV (e.g., substance misuse) to identify and evaluate treatments that could reduce IPV.

Research is also needed on understudied groups, including those who are undocumented, indigenous, disabled, and sexual and gender minorities, or any other group that is marginalised or discriminated against. The use of qualitative methods may be particularly helpful in improving understanding of the experiences of IPV in these understudied groups. The association of IPV with other mental health problems, such as eating disorders and sleeping disorders, should be studied. Research into IPV and mental ill-health should consider the wider context within which IPV occurs, in relation to both other manifestations and experiences of violence and abuse, and the broader societal and political structures in which it operates, through the adoption of intersectional, multi-level and cross-national approaches. Greater integration of psychiatry and the social sciences may support such research. Finally, it is imperative that future studies are designed and conducted in collaboration with survivors (or are wholly survivor-led), to ensure lived experience perspectives are central to the research conducted.

Part 2: IPV across the life course

IPV occurs across the life course. In this section, we consider the developmental mechanisms that make IPV more or less likely to occur and suggest targets for prevention and intervention (figure 2). Most studies have been conducted in high-income countries, but we present evidence from low- and middle-income countries where possible.

[Insert figure 2 here]

The perinatal period (pregnancy and the first year postpartum)

IPV during pregnancy can be the precursor for the intergenerational transmission of mental health problems and the propensity to commit violence and thus might contribute to both the individual and global burdens of mental and physical health problems.[99] Evidence from animal, clinical, and brain imaging studies of trauma-exposed individuals show that exposure to traumatic stress in early life, including the intrauterine period, has serious consequences for mental[100] and physical[101] health, while epidemiological evidence shows that both people who experience and those who commit IPV are more likely to have been children of women who were abused during and after pregnancy.

Although there is conflicting evidence about whether IPV increases or decreases during pregnancy,[102] unplanned pregnancy in particular is associated with IPV (potentially reflecting reproductive coercion),[103] and IPV during pregnancy is associated with greater risk of mortality.[104] The World Health Organization found that the global prevalence of IPV during pregnancy ranged between 2 and 13.5%, with higher prevalences in Latin America and Africa, and substantial within-country variation.[105] A review of IPV during pregnancy in low- and middle-income countries[106] found prevalences between 2 and 35% for physical violence, between 9 and 40% for sexual violence, and 22 and 65% for psychological violence, but more higher quality research is needed.[107] The children of women subjected to IPV in the perinatal period are at risk for common and severe mental health problems and non-communicable diseases.[101] Women experiencing IPV in pregnancy have increased odds of experiencing obstetric complications, including emergency caesarean sections, instrumental delivery, pre-eclampsia or eclampsia, and untoward obstetric outcomes (prematurity and small for gestational age babies),[108] and these are themselves risk factors for mental health problems, neurodevelopmental problems, and cognitive deficits in their offspring. Children who develop mental health problems are also more likely

to be at risk of experiencing (and committing) abuse both in childhood and in adulthood and this impacts on subsequent generations.

Several other mechanisms might link IPV in the perinatal period with childhood mental health problems in the offspring. Systematic reviews of studies in high-income countries and those in low- and middle-income countries consistently find associations between IPV in pregnancy or postpartum and perinatal mental health problems in mothers,[68,69,106] including substance misuse.[109-112] It is well established that perinatal mental health problems and substance misuse are associated with a range of childhood adverse mental health and behavioural outcomes in the offspring.[68,69,106,113,114] A review of the mechanisms involved is beyond the scope of this report but these include the impact of stress in utero (see below) and the quality of the mother-infant relationship, which is impaired by postnatal depression in particular but also other adversities.[115] Stress in utero including that caused by mental health problems and IPV during the pregnancy does not inevitably lead to adverse outcomes in childhood, but is moderated by maternal sensitivity towards the child, poverty, persistent symptoms of mental health problems, and postnatal IPV.

Secondly, traumatic stress exposes fetuses and infants to high concentrations of cortisol, resulting in the activation of psychophysiological systems that leads to underlying difficulties in adaptation and mental health problems in later life.[108] Anxiety, depression, attention deficit hyperactivity disorder (ADHD) and conduct disorder have been shown to be more frequent in children born to mothers who experienced IPV during pregnancy.[108] Chronic activation of the corticolimbic circuit in the fetus impairs regulation of subcortical (amygdala and hippocampal) activation by the prefrontal cortex and greater stress exposure is associated with smaller grey matter volume.[101] These can lead to less efficient modulation of impulses and anxiety as well as greater vulnerability to new stimuli. These changes in fetal and infant brain structure are compounded by epigenetic changes, which affect the machinery that regulates gene expression. Epigenetic changes are associated with IPV,[116] as well as environmental and nutritional influences (such as the greater food insecurity often linked to IPV).[108] Exposure of the infant to a mother who becomes depressed in the postpartum period (40% mothers reporting IPV during pregnancy experience postpartum depression symptoms)[117] could also result epigenetic changes that in turn could lead to mental (emotional regulation and cognitive development) and physical impairments in the infant.[118] Research is required to characterise the role of cortisol itself and the neuroendocrine, epigenetic, and genetic regulation of the hypothalamic–pituitary–adrenal axis, and to see whether the stress of IPV experiences causes damage via the pathological response of the mother (e.g., depression or PTSD) or through direct antenatal effects of maternal stress hormones on the fetus.[119]

Studies testing theories of intergenerational violence transmission[120] have a high degree of methodological variability,[121] with a heavy reliance on measuring discrete acts of physical violence only, and scarce inclusion of measurement of the context and purpose of violent acts and of coercive control.[122] It is therefore difficult to draw any firm conclusions from these studies. The measurement of IPV and mental health is discussed further in Part 3.

Infancy and the pre-school period

IPV more than doubles the risk that a child will have significantly aggressive behaviour by four years of age.[123] Most infants and young children use aggression to express frustration and demands.[124] Aggression peaks during the second year of life and then diminishes but in a minority of children it persists.[124,125] Exposure to IPV seems to be particularly associated with the development of traits such as feeling no remorse, uncaring behaviours, and an inability to express emotion, which are later associated with persistent aggression.[126] Mechanisms involve both the child's temperament and the

family environment. The more maltreatment a child experiences, including exposure to IPV, the more persistent the aggressive behaviour.[127] At a population level, childhood experience of exposure to IPV or experiencing physical or sexual abuse doubles the risk of committing IPV in men and of experiencing IPV in women;[128] research is needed to understand protective factors in those who do not subsequently commit or experience IPV.

Severe parental stress has been shown to greatly increase the risk of their children experiencing abuse of all kinds, including exposure to IPV.[129] Parental stresses such as unemployment, poverty, food insecurity and postnatal depression might therefore increase the risk that child abuse or IPV occurs.[130] Children who experience abuse, neglect, or IPV are much more likely than their non-maltreated peers to have complex, overlapping neurodevelopmental problems.[131] Longitudinal research has shown that these neurodevelopmental problems tend to be noted before abuse and neglect in the life cycle,[132,133] leading to controversy about the causal role of early childhood adversity.[134] These findings, as well as behavioural genetic evidence,[131] are building a picture that neurodevelopmental symptoms in children and adults can increase parental stress[135] and potentially IPV.[136]

Children with neurodevelopmental problems such as ASD and ADHD are stressful to care for[137] and children with ASD are at higher risk of being abused and neglected.[138] This does not imply that the child is in any way responsible: no child should ever be subjected to maltreatment. Treatment of neurodevelopmental problems, in children and adults, is therefore an important target for the prevention of family stress and IPV. Neurodevelopmental problems are lifelong highly heritable conditions,[139] and there is emerging evidence that adults with ADHD are more prone to committing IPV.[136] Adults with neurodevelopmental problems who, in turn, have children with neurodevelopmental problems might find parenting particularly stressful.

Middle childhood and adolescence

During middle childhood (approximately 5-12 years of age), children are growing in autonomy and are increasingly exposed to influences outside the home, such as peers and school. Unsurprisingly, being exposed to IPV at home can be detrimental to children's performance at school and can be reflected in their behaviour. This can lead to them being labelled as a difficult child and to underperforming educationally[140,141] although, conversely, children experiencing abuse might strive for perfection and present as model pupils. Children exposed to IPV at home are deprived of many of the benefits of education, including the possibility of social mobility.[142] However, middle childhood affords an opportunity for schools to modulate factors that reduce the risk of IPV emerging in adolescence. Schools need to be a safe space for children and can purposively create an ethos that promotes gender equality and respectful relationships, and potentially influences values, attitudes and behaviour related to IPV.[143]

Adolescence is a period of transitions: from the relative security of a small primary school to a larger secondary school with new peers; the onset of puberty, which might be accompanied by the amplification of gender-restrictive norms, particularly for girls,[144] and the intensification of pressure to conform to gender roles; for many, experiencing their first sexual relationships; and becoming increasingly independent of parents and potentially more influenced by peers and intimate partners. IPV is common in adolescent dating relationships; the World Health Organisation estimates that globally approximately 24% of ever-partnered adolescent girls have experienced physical or sexual violence, or both, from an intimate partner.[3] The predictors of being subjected to IPV in adolescence are also predictors of other adverse outcomes, such as substance misuse, poor educational outcomes, risky sex, and adolescent pregnancy (and early parenthood).[142]

IPV in adulthood

The highest lifetime prevalence of physical or sexual IPV (or both) for women is between 25 and 44 years. The highest prevalence in the past 12 months is in adolescent girls and young women (15–24-years). IPV prevalence is higher in low-and middle-income countries than in high-income countries and the difference is starkest when considering past 12 months prevalence.[3] 31% of women 15 years and older surveyed worldwide reported physical or sexual IPV or sexual violence from a non-partner, and 6% reported sexual violence from a non-partner globally. As mentioned earlier, IPV is a common experience during pregnancy: analysis of surveys conducted in 19 countries between 1998 and 2007 found the reported prevalence ranged from approximately 2% in Australia, Cambodia, Denmark, and the Philippines to 13.5% in Uganda among ever-pregnant ever-partnered women, with prevalence generally higher in African and Latin American countries than in European and Asian countries.[105] Coercive control, controlling behaviours, and emotional abuse are less well measured and understood, but their importance has been highlighted by the #Me Too campaign, and its many national and regional adaptations.[145] Individual risk factors, such as previous exposure to trauma and violence, poor education and younger age interact with factors operating at the level of the relationship, community, and society.[146] The absence of proper sexual and reproductive health services, including modern contraception, abortion, and timely and quality antenatal and delivery care (including proper attention to the emotional changes) compounds the violence experienced by women during the reproductive years.

IPV can be part of a complex range of abuses experienced both in and out of the home. Higher education and work outside the home are hampered by sexual harassment (unwanted behaviour of a sexual nature), that causes severe losses in productivity, slows or stops women's advancement, and is associated with mental health problems.[147] As discussed below, unsafe public spaces,[148] lax implementation of protective legislation, delay in intervention to change societal views about women's rights and liberties (including sexual expressions), and absence of criminal recourse are macro-level factors that contribute to the perpetuation of IPV during adulthood.

IPV in older adults

IPV in older adults might exist as a long-standing abusive relationship with both partners growing old together. Abuse can also be a new experience in older people, including after changes in a partner's behaviour in the context of age-related pathologies such as Alzheimer's, stroke, or depression, or the establishment of a new relationship.[149,150] Frailty and dependence due to declining physical ability and cognitive function increase vulnerability to IPV, as do retirement, children leaving home, and menopause.[4] Intimate partner homicide-suicide, which is rare in the general population, is found at higher rates among older adults compared to younger people.[151] Analyses of news and police reports frequently highlight untreated depression in the perpetrator.[152]

IPV is associated with mental health problems in older women, including depression, anxiety, psychological distress, and substance misuse,[153-155] which might be exacerbated by prolonged exposure to violence.[4] Older women who have experienced prolonged and ongoing IPV report frustration, anger, helplessness, hopelessness, isolation and low self-esteem, while women whose experiences of abuse have ended might continue to experience psychological distress.[154]

In older adults, IPV is often treated as a subset of elder abuse, which typically considers abuse from an ageing and disease-based, rather than a relational, perspective.[156] Such an approach overlooks the particular experiences and needs of older adults, and also ignores the significance of gendered power within abusive relationships in later life.[154,157] Differences in both gender socialization and in attitudes towards service use might mean older women are less likely to self-identify, or seek help for experiences

of IPV. Older women might be more accepting of men's use of controlling and abusive behaviours[158] and have grown up in an era in which mental health problems and use of mental health services were more stigmatised. Women's refuges and other specialist services might not be appropriate to older women's needs, including an absence of provision for women with disability and mobility requirements. Other obstacles to help-seeking include poor physical and mental health, financial issues, poor social networks, and family worries.[4] Older adults might also experience loss of hope for change as a result of long-term exposure to IPV and fear loneliness.[149]

Part 3: Measurement of IPV

Accurate measurement underpins the evaluation of prevalence, incidence, risk, and severity IPV and related mental health problems, and the effectiveness and cost-effectiveness of interventions to prevent or reduce them. Numerous assessment tools and research instruments have been developed over the past three decades.[159,160] Specialised cross-national and national survey initiatives have captured data on IPV exposures (type, severity, timing, relationship status to the person committing violence) and health outcomes. These include the WHO Multi-Country Study on Women's Health and Domestic Violence,[27, 161] the National Intimate Partner and Sexual Violence Survey (NISVS) in the USA,[162] the Crime Survey for England and Wales in Europe[163] and the Personal Safety Survey in Australia.[164]

Despite this progress, IPV is often not included as an exposure or an outcome in mental health research. Challenges in measuring IPV include no consensus on how types of IPV, which can vary by severity and frequency, are combined into a pattern of behaviour to represent an individual's experience. There are also questions about the equivalency of measurement in diverse populations and subpopulations and across geographical, cultural and language boundaries. In clinical practice, although both DSM-5[165] and ICD-11[166] include codes for data collection regarding IPV, in practice, to our knowledge, these codes are not routinely used.

Tools developed for use in healthcare settings

A range of self-report questionnaires have been developed to measure IPV, most of which have focused on IPV victimisation.[167] The following measures have been used to determine prevalence of IPV, as criterion standards when assessing brief IPV assessment tools, and as outcome measures in intervention studies: the Conflict Tactics Scale CTS, 18 items),[168] the Revised Conflict Tactics Scale (CTS-2, 78 items),[169] a subsequent short form of the CTS-2 (20 items),[170] and the Composite Abuse Scale.[171-173] Brief self-report questionnaires or screening tools have been developed for use in clinical and research settings; the accuracy of these measures varies widely, with sensitivities for IPV in women ranging from 47% to 94% and specificities ranging from 38% to 95%.[174] Tools are being used for screening in some jurisdictions, however, three trials evaluating the effects of IPV screening of women did not show a reduction in the occurrence of IPV or improvement in health outcomes.[174]

Brief instruments have been developed for screening for IPV perpetration, as summarised by Davis and colleagues.[175] Whether the use of such tools is associated with improved outcomes for service users is unknown. While risk assessment of violence perpetration to "others" is routine within mental health assessments, it has tended not to focus on identification of risk to partners or ex-partners. Tools have also been developed to provide risk stratification for future IPV assault and intimate partner homicide (IPH). Such tools need to have very good predictive validity (i.e., identify individuals who are expected to assault or kill their intimate partners and those who are not). Graham and colleagues[176] identified 43 studies that collectively examined 18 different IPV or IPH assessment tools. Only a few – the ODARA (Ontario Domestic Assault Risk Assessment),[177] DA (Danger Assessment-20 item Revised Version),[178]

DVSI-R (Domestic Violence Screening Instrument Revised)[178] and the K-SID (Kingston Screening Instrument for Domestic Violence)[179] - had available data on internal consistency, interrater reliability, and validity (predictive, construct and concurrent). Differences in measurement of validity, outcomes, and length of time between IPV/IPH tool administration and measurement of outcomes make synthesis of study findings challenging. It has been argued that structured risk assessment tools in forensic settings can enhance the comprehensiveness, objectivity, and defensibility of expert opinion, and can be triangulated with other information on risk.[180] However, the validity of these tools in predicting outcomes is mostly weak to moderate where it is reported, so the tools need refinement using better designs for development, internal and external validation, and reporting a wider range of performance measures (including calibration). Such tools should be simple and scalable, and act as a support to clinical and professional decision-making.

Measurement of IPV in research settings

When measuring any aspect of IPV – victimisation, perpetration, or risk – it is important to consider the types of violence, the context, and the extent to which the perspectives of people with lived experience are incorporated. Tools have been criticised[41,181-183] for measuring conflict tactics as opposed to coercive tactics or normative use of violence[184] and concentrating mainly on physical abuse, with only limited measurement of sexual abuse and verbal aggression and excluding social isolation and harassment.[183] There is concern that not focusing on characteristics of IPV such as severity and repetition results in an apparent gender symmetry in experiencing and committing IPV.[183,184] Gender equivalence of the perpetration of violence is often the result of inclusion of isolated minor incidents, even though qualitative data suggest that self-defence is a common reason that women hit their partners.[183,185] Similar criticisms have been made of measures used in the assessment of intergenerational and family violence.[120,121]

To address these measurement limitations, Walby and colleagues[163,186] have utilised a nuanced measurement framework with finely graded distinctions in the severity and frequency of violence and coercion, that also include the consequences of these for victims. Walby and colleagues argue that counting repetitions as well as the number of victims is important in building a multi-faceted picture of IPV, including an understanding of how the impact of IPV differs by gender. If only the number of victims is counted, then the gender profile of IPV is distorted, suggesting that it is near gender-symmetrical. If the repetition of violent acts is included in the measure, the gender profile of IPV is shown to be asymmetrical, with acts of violence from men to women much more frequent and more severe than those from women to men. Further, when repetitions are counted, an increase in IPV during economic crises is made visible, an increase that is obscured if only the number of victims is counted.[163] Information on frequency and severity is essential to generating an accurate gender profile of IPV victimisation and perpetration, which is relevant to informing policy about the provision of targeted services.[163]

Some forms of abuse, including controlling and coercive behaviours, might be better identified by patterns and frequency over time than repetition. The Composite Abuse Scale (CAS) and the Composite Abuse Scale-Short Form (CAS-SF) provide a multi-dimensional measure of IPV and calculate the patterns and severity of abuse for an individual.[171-173] The WHO instrument is used widely in low- and middle-income countries. Designed for prevalence surveys (though also used in clinical research), it captures physical, sexual, and psychological abuse, and frequency and duration of abuse in the past 12 months and adult lifetime. It also measures some of the impacts including, for example, injuries, living in fear, and mental health.[161]

Measuring mental ill-health in IPV research

Measurement of mental ill-health should be embedded in research on IPV. Depression, anxiety, PTSD, and substance misuse have been the most measured mental health outcomes in observational and interventional studies, largely through self-report measures. Few studies have incorporated clinician administered semi-structured interviews to confirm psychiatric diagnoses.[41] More often, screening measures are used which assess symptoms rather than diagnosable disorders. There is also wide variation in the timeframe of measurement, from past week to past year, with many studies not specifying a timeframe at all, which is likely to affect estimates of the associations between IPV and mental health problems. Consensus on short, standardised measures that can be integrated into IPV research to measure, at a minimum, depression, anxiety, and PTSD symptoms, and substance misuse, is urgently needed.

Survivor priorities and perspectives on measurement in research

Measures administered in research settings often reflect researcher beliefs of what constitutes 'good' outcomes. These may not be shared by, or meaningful for, people with experience of IPV or mental health problems.[187,188] In addition, many survivors of IPV have been critical of the dominance of the biomedical model of mental disorders that emphasises symptoms but not why they are experienced.[189] When developing measures, thought is needed regarding whose definitions of successful outcomes are privileged.

Whereas clinical trials tend to measure a narrow set of health outcomes, those people using (as well as those delivering and funding) interventions often emphasize outcomes relating to function (e.g., quality of life) and wellbeing (e.g., self-efficacy) in addition to, or sometimes instead of improvements in health.[190] This mismatch between what is prioritised and what is measured in trials and other interventional studies might be due to the notion that outcomes valued by survivors (and other groups), such as empowerment and self-esteem, simply represent intermediate or surrogate endpoints - a step in the causal pathway between the exposure and the final outcome of interest, which is commonly recurrence or severity of abuse or a health outcome.[191] To ensure evidence produced from intervention studies is relevant, it is crucial that studies measure outcomes reflecting the priorities and expectations of survivors.[192] Also needed is the systematic monitoring of harms in IPV intervention trials as potential iatrogenic effects have been reported.[193-195]

Methods developed by mental health service user researchers to generate reliable and valid outcome measures from the perspectives of service users[187,196] could be adopted by researchers working with IPV survivors. The model involves participatory qualitative and psychometric methodology to explore survivors' experiences and perspectives and translate these into psychometrically robust outcome measures.[197]

Cross-cultural issues in measurement

The way IPV is conceptualised in any culture will crucially influence its recognition, assessment of risk, and linkage to care. Cultural norms might determine what can be measured in research or clinical settings. For example, disclosure of sexual IPV might be culturally sanctioned, affecting measurement of its impact on mental and physical health and as an intervention outcome.[198-200] Cultural norms might also determine how questions are asked, with implications for the translation and adaptation of Western tools. Measurement of psychological abuse and its differentiation from controlling behaviours may also

prove challenging across different cultures. The World Health Organization Multi-Country Study on Domestic Violence and Women's Health (WHO MCS) found such a high variation in the rates of psychological abuse between countries, as well as no cross-cultural consensus on the items constituting psychological abuse, that prevalence estimates were not published.[161] The authors revisited the data to identify meaningful thresholds that influence health outcomes and recommended the use of a continuum approach (i.e., a simple three-level intensity-based index) to advance cross-cultural measurement, recognising that emotional violence and controlling behaviours may mean different things in different cultures.[201]

Heise et al.[201] recommend enriching cross-cultural measurement through qualitative studies to understand how women experience different forms of violence, how they rate the severity of these acts and the emotional consequences, and their meaning in different cultures. To understand some of the cultural nuances in measurement, they recommend complementing qualitative investigation with quantitative studies to determine different ideal cut-points on measures of IPV and mental health, across countries and populations, and extending such investigation to clinical populations and women seeking help from social services. It is also important to understand the cultural context into which people are being asked to disclose abuse, including whether legal protections exist for those who have experienced or are experiencing IPV, and potential adverse consequences of disclosure.

In low literacy contexts, and in some cultural groups, measurement of IPV and mental health might need to be interviewer-led rather than self-administered. Survivors with low literacy levels might also have difficulty comprehending items on a questionnaire or scale.[202] The use of Audio Computer-Assisted Self-Interviews (ACASI) to facilitate disclosure among women with low literacy has had mixed results. Higher rates of disclosure of IPV in face-to-face interviews in one study was suggested to be due to the presence of a non-judgemental and empathic interviewer and the perceived likelihood of therapeutic benefits and referral for further support and care.[203]

Improving coordination and cooperation in data collection across sectors

Improved coordination and cooperation in data collection on violence is important, because multiple agencies (e.g., health services, specialist services, criminal justice, welfare services) need to act to reduce and end violence.[204] It is also crucial that researchers and policymakers gather data aligned with their specific remit. Currently, there are differences in the definition and operationalisation of definitions of IPV across and within disciplines and sectors. Some variation is due to the different priorities of agencies, which is appropriate, but some variation is merely legacy and serves little useful purpose. Where the conceptualisation and measurement of violence cannot be fully aligned across fields, they should at least be translatable. Progress may be aided by making reference to the legitimacy generated by international legal instruments from which UN agencies draw authority, even though the WHO, UN Office for Drugs and Crime (UNODC), UN Women, and the UN Statistics Commission have some differences in approach. Utilising core minimum information within and across sectors would both facilitate cooperation and deepen understanding.[186,205] Sex and gender identity should be mainstreamed throughout measurement.[206]

Greater coordination would also allow for learnings from “big data”. Data mining of electronic health records (EHRs), for example, will enable finer analysis of the associations between IPV and mental health problems (if information about IPV is recorded),[207] the temporal identification of mental health sequelae, and identification of high-risk women, men, and gender minorities for targeted preventive interventions,[208] thereby supporting improvements in the clinical response to IPV.[209,210] Similarly, machine learning models applied to administrative data records of IPV samples might be beneficial in

identifying high-risk women, men, and gender minorities for targeted preventive interventions, based on risk models' predictions of sexual violence victimisation in other high-risk non-IPV samples.[208]

Mainstreaming IPV within mental health research

Despite the long-standing association of IPV with mental ill-health, and recent evidence that psychological treatments for anxiety might be more effective among women who have experienced IPV,[211] IPV remains too often unmeasured in mental health research. Traditionally, observational mental health research has either excluded IPV or asked only one or two questions about it, impeding investigation of causal associations and mechanisms. As new population cohorts are established, it is essential that IPV is measured comprehensively.

Future trials of mental health interventions should measure IPV as a potential moderator of treatment response. Information should be gathered on the sex and gender identity of people experiencing and committing IPV, and outcome data should be routinely disaggregated by sex and other variables, including gender identity, disability, and migrant status.[212] Heterogeneity in outcomes - measured across trials for people who experience IPV, either as adult victims, children living with abuse, or those who commit abuse - has hampered the process of gaining a comprehensive picture of the effectiveness of interventions for IPV, when delivered to different populations or in different environments, and for comparing different interventions delivered to the same population.[188,191,213] The development of core outcome sets as a means of harmonising measurement of outcomes across different studies and, increasingly, contexts is gaining momentum through the COMET initiative.[214,215] Several core outcome sets have been developed in relation to specific mental health conditions,[216-218] and one study is underway in the UK to develop a core outcome set for targeted psychosocial interventions delivered to children and families with experience of domestic abuse.[219] Work is needed to guide decisions on what to measure at the interface between IPV and mental ill-health. IPV researchers can look to the mental health field, which is more advanced with respect to the development of core outcome sets and service user leadership, to guide measurement in the context of both research and clinical practice.

Part 4: Transforming the mental health system to address IPV

Trauma and violence are often invisible within mental health policy, frameworks, services, training, and research, hiding the connections between IPV and poor mental health across the life course.[220-222] The prevalence of IPV among mental health service users is high,[75,223] and many more survivors of IPV are unable to access to mental health services.[224] The dominance of medical models of mental illness[225] and the standardisation of psychological interventions can lead to the organisation of treatment along diagnostic categories[221] and an inattention to individuals' lived experiences and contexts.[195,221] Thus, mental health services too often concentrate on what is "wrong" with service users affected by IPV and what treatment they might need rather than what has happened to them and how they might best be supported (see panel 6). Compounding these problems, many mental healthcare providers know little about the dynamics of IPV and how it affects mental health, in particular women's mental health. Furthermore, although the need for survivor-centred and gender-sensitive mental health services has been clearly articulated, such services are rarely provided.[226,227] There is a need for a greater focus within mental health services on respectful care, good communication skills through gender-sensitive and trauma-informed approaches to addressing IPV.[220,225,228]

[Insert Panel 6 here]

Responding individually to all members of the family when IPV is occurring

Survivors

Universal screening for IPV is generally not recommended,[229] but because mental health problems might be associated with, or worsened by, violence, all patients should be asked about experiences of violence, including IPV, within the context of a mental health assessment. Any healthcare provider asking about IPV should be trained in how to ask safely and respond appropriately to a disclosure. Information for providers, including examples of how to respond during interactions with patients, is available online,[221,230-232] including a curriculum for mental health providers developed by the World Psychiatric Association.[233] Guidelines developed by the WHO include a special focus on mental health responses for non-specialist primary care providers.[220] Although this and other guidance has generally focused on women subjected to violence by men,[231] the principles are mostly relevant to anyone with these experiences, including children and young people, women in same-sex relationships, men, and gender minorities.

Panel 7 summarises good practice principles for recognising and responding safely to those who have experienced IPV. These principles align with "LIVES", WHO's recommended first-line response to disclosures of IPV: 1) *Listen* to the service user, with empathy, and without judgement; 2) *Inquire* about and respond to their needs and concerns; 3) *Validate* experiences, and assure them they are not to blame; 4) *Enhance* safety, discussing a plan to protect them and their children from harm; and 5) *Support* and follow-up, helping them to connect to information, services, and social support.[230]

[Insert Panel 7 here]

A meta synthesis exploring what survivors want from health professionals echoes the LIVES response and reinforces the need for a patient-centred and trauma-informed approach to care.[234] In addition, this synthesis suggests the importance of "CARE" (Choice and control, Action and Advocacy, Recognition and understanding, and Emotional connection). Harms experienced by survivors where such an approach is not enacted include re-traumatisation and feeling ignored, disrespected, dismissed, silenced, and more afraid.[234-236] Mental health services that are predicated upon power relations and conditions of coercion and control can re-enact abusive relationships,[237,238] causing survivors to feel re-traumatised rather than supported through their contact with services.[239,240] For example, the use of coercive treatment, such as seclusion, restraint, and forced medication, in inpatient settings can cause re-traumatisation.[238] Less research has been conducted on the impacts of subtler forms of coercion in community settings, such as around the management of disclosure and pressure to comply with treatment. There is, however, a substantial body of discursive literature by survivors and trauma experts that explores the harms caused by subtler forms of coercion. Psychiatrist Judith Herman, for instance, has famously argued that "help" is always harmful when it takes power away from the survivor, thus mimicking the original trauma.[222]

Trauma-informed approaches require a transformation of community, outpatient, and inpatient mental health services.[239] The implementation of trauma-informed approaches through staff training and organisational redesign can reduce the use of coercive treatment in both adolescent[241] and adult inpatient settings.[242] Yet, the principles of trauma-informed approaches (see table 2) are sometimes highlighted in mental health policies without guidance or evidence to inform the organisational or health systems change needed for implementation.[221,228,243] Applying these principles requires that both providers and the environment in which mental healthcare is delivered are sensitive and responsive to the pervasiveness and potential impacts of trauma.[230] All who interact with service users, including non-clinical staff, should be trained in the importance of non-discrimination and avoidance of stigma.[230,231]

There needs to be recognition that any person may have experiences of violence currently or in the past, and that interactions with the healthcare system can lead to possible revictimisation, re-traumatisation and additional harm.[244] For the provider, this means being aware that a broad range of signs and symptoms can be associated with exposure to IPV.[230] For example, the service user who repeatedly cancels visits and then seeks mental health care after hours from the emergency department, might be experiencing IPV. In all instances, it is important that information about a service user's mental health is not collected solely from partners (who might be controlling and abusive). Revictimisation of survivors of IPV can occur at the provider level (e.g., responding to a disclosure of IPV in way that is blaming or judgemental) or the team level (e.g., having to retell their story) or the systems level (e.g., having a triage system where the service user is asked in front of other service users about the reason for seeking care or restraining practices on inpatient wards). Hence the importance of a health systems approach integrating actions at the individual, provider and organisational level.[245,246]

[Insert table 2 here]

Digital technologies are increasingly used in responding to IPV, especially safety decision aids to reduce IPV. Qualitative research conducted in Australia suggested that survivors find these acceptable and that digital interventions might be able to provide support that is similar to face-to-face support.[235] Although these online interventions have mixed evidence of effectiveness,[247,248] they have come to the fore during the COVID-19 pandemic, when delivery of some face-to-face support has been suspended. Remote delivery of care has provided new opportunities but also presents challenges in some areas, including with regards to risk assessment. In some countries, there has been a shift to telephone-delivered safety protocols for IPV situations, realising that access may be limited as the perpetrator might be monitoring or own the phone (see panel 8). Guidance includes finding out the location of the patient, checking that the call has not been placed on loudspeaker, and checking that the person is alone and safe to talk using yes/no questions. Patients who are not alone should be advised to hang up and report that it was a wrong number and that they will be called back later. Code words should be established to indicate that a situation is no longer safe and that the call should be ended.[249,250]

[Insert Panel 8 here]

Although IPV is associated with increased risk of mental health problems, mental health problems are not an inevitable consequence of exposure to IPV and not all survivors will require psychological interventions. Moreover, there is no single intervention that will suit all survivors. Where indicated by assessment, survivors should have access to appropriate therapeutic counselling, and peer support if available, to support longer-term healing. Appropriate interventions may include trauma-focused and non-trauma focused cognitive behavioural therapies (CBT).[233] A Cochrane systematic review and meta-analysis[195] of 33 randomised controlled trials of integrative (n=11), humanistic (n=9), CBT (n=6), and third-wave CBT (n=4), and other psychological-orientated interventions (n=3) showed that these therapies work to some extent in the context of IPV. The studies were mostly from high-income countries (19 USA, three Iran, two Australia, two Greece, and one China, India, Kenya, Nigeria, Pakistan, Spain and UK). Psychological therapies ranged from two to 50 sessions and were delivered by a variety of staff (social workers, nurses, psychologist, community health workers, family doctors and researchers). The therapies showed a probable reduction in depression (SMD -0.24, 95% CI -0.47 to -0.01, four trials, 600 women, moderate-certainty evidence) and anxiety (SMD −0.96, 95% CI −1.29 to −0.63; four trials, 158 women; low-certainty evidence). However, it is important to note that these studies involve a mix of different therapies provided in widely varying contexts thus limiting the comparisons that can be made between them.

A systematic review and meta-analysis[211] of 15 randomised controlled trials from eight LMICs (Kenya, South Africa, Zimbabwe, Uganda, Cambodia, Pakistan, India, and Iraq) reported that anxiety (SMD -0·31, 95% CI 0·04 to 0·57) showed a greater response to intervention among women reporting IPV versus those who did not report IPV.[211] No differences were seen in this review with PTSD, depression or psychological distress, although all individual studies had some effect on one of these common mental disorders.[211] Interventions ranged from trauma-informed (cognitive processing, habituating traumatic memories, focusing on traumatic experiences or debriefing) to those with a more practical focus (problem-solving, behavioural activation, or coping skills).

Thus, while psychological therapies can improve the mental health of women experiencing IPV, it is unclear if women's ongoing needs for safety, support, and holistic healing from complex trauma are being addressed. Systematic reviews and meta-analysis[195,251,252] have shown that advocacy (empowerment, safety information and referrals) interventions, typically provided by specialist IPV services, can help women in terms of both safety and recovery. Greater integration is needed between specialist IPV and mental health services to respond to survivors' needs.[243] Innovative models for addressing survivors' needs in an integrated way should be developed, including the delivery of psychological therapies by specialist services.[253]

More evidence is required to establish what types of intervention best serve women and infants during pregnancy and the postnatal period. An RCT conducted in the USA of an intervention combining a structured abuse assessment and six home visitor-delivered empowerment sessions integrated into home visits reported significant reductions in IPV from baseline that were maintained at 2 years postpartum.[254,255] Preconception interventions might reduce risk of intergenerational violence transmission,[91] ideally starting in adolescence but also equipping women in relationships with support, where pregnancies are planned, and to prevent reproductive coercion.

Little is known about the impact of mental health interventions on preventing or reducing IPV. A systematic review of studies evaluating the impact of mental health treatments on the prevention or reduction of IPV in LMICs identified just seven studies, all conducted in middle-income countries, but concluded there was promising initial evidence for the effects of interventions for depression in reducing IPV.[256] An RCT conducted in the USA found that a CBT intervention for PTSD and depression symptoms reduced IPV victimisation among female survivors of interpersonal violence.[257] A cognitive-behavioural, modular, flexible, multi-problem, transdiagnostic treatment model that was evaluated in a trial for women who reported moderate or higher levels of IPV and their male partners with hazardous alcohol use in Zambia reduced IPV and hazardous alcohol use.[83] Given epidemiological evidence for an association between mental health problems and IPV victimisation, this may be an important focus for future research and intervention.

Children

Children's exposure to IPV is often recognised because their mothers are identified as experiencing IPV. However, children and adolescents with emotional and behavioural problems should also be assessed for exposure to IPV.[32,193] As with adult survivors, it is important to see the child or adolescent alone once they are of an appropriate age and developmental stage to be interviewed; for example, when they are able to speak in sentences.[246,258] Open-ended questions such as "how do the people in your family get along?" are useful in beginning the discussion. Providers must be sensitive to the struggles that children face in reconciling their feelings about parents in the context of abuse, and support children to know that they are not alone in their experiences and have permission to talk to providers about what has happened to them.

In countries with child protection systems, it is generally the role of child protection workers to investigate the possibility of child maltreatment and children's exposure to IPV. Mental health providers should ask about children's exposure to IPV to the extent needed to determine whether there is reason to suspect such experiences. Children should not be subjected to intensive interviews about IPV or other types of maltreatment when child protection workers have the mandate of investigating possible exposure. It is essential that mental health providers collaborate both with child protection services in determining risk to the child and to any parent who is a survivor, and with the non-abusive parent.

Children might need specific interventions together with or separately from their caregivers, but this should be determined by a thorough assessment and not simply because of exposure to IPV: not all children experience impairment.[259] Preventing children's exposure to IPV before they experience negative outcomes should be a priority; when interventions focus on reducing the impairment associated with IPV, there should be ongoing efforts to prevent recurrence of children's exposure to violence. Providers should work to increase support for parent survivors of IPV in their efforts to keep their child safe.

A wide range of interventions have been developed to improve mental health outcomes among children exposed to IPV; these vary in terms of their therapeutic strategy, focus, format and mode of delivery, and whether they are selective or indicated.[213] Although the evidence base remains underdeveloped, there is some suggestion that mother-and-child and child-focused therapies (including psychotherapeutic interventions, parenting skills and training, and advocacy plus psychoeducation[213]) improve child behavioural and mental health outcomes, although replication is needed. A recent review has suggested that interventions involving mothers and children working both separately and jointly across sessions might be associated with greater improvements across a range of outcomes.[260] Several shortcomings remain. Although interventions are typically offered based on children's exposure to IPV, rather than on type or severity of difficulty, it is clear that no one intervention is effective in reducing all outcomes associated with exposure to IPV.[213]

Furthermore, evidence is lacking for children who are living with ongoing abuse. There is evidence that interventions targeting families experiencing or at risk of child maltreatment, such as home visitation and parenting programmes, which may include but not explicitly target families experiencing IPV, can improve child outcomes.[193,261] However, the benefit of these broader interventions might be attenuated for families experiencing IPV.[262] This could be because IPV is backgrounded relative to other adversities such as parental mental health and substance use,[263] or because parents traumatised by IPV need help in addressing their own experiences before being able to engage effectively in child focused interventions.[264,265] Children experiencing mental health problems for which there are evidence-based interventions (for example, depression), should be offered treatment but the provider should be knowledgeable about the impact of trauma and be able to assess whether the child is experiencing ongoing exposure to IPV or other types of maltreatment. Cohen et al[266] offer some practical strategies for the delivery of trauma-focused cognitive behavioural therapy to children living with ongoing abuse, including implementing safety modules at the beginning rather than the end of treatment, focusing on sharing the child's awareness and experiences of IPV, and addressing maladaptive cognitions rather than mastering past memories of trauma, and working to help the child discriminate between real dangers and generalised fears.

Perpetrators

Efforts to reduce IPV must address perpetrators' use of abusive behaviours, including how to support mental healthcare providers to identify and respond to the perpetration of IPV,[267,268] drawing on lessons learned from efforts to improve responses to IPV victimisation.[269,270] Good practice guidelines exist to improve healthcare responses to the use of IPV, including for service users with mental health or drug and alcohol problems.[269] Key principles include that healthcare providers have a duty of care not only to service users but, where those service users use IPV, to their current and former partners and to their children (see panel 9). The role of the healthcare provider is to help the service user within the context of a multi-agency support network, maintaining the safety of those affected by abuse as a priority. When enquiring about the use of IPV, healthcare providers should be aware that people who commit IPV often deny or minimise behaviour, therefore enquiry might have to be persistent and probing. When asking about a history of violence, healthcare providers should ask specifically about violence towards partners, ex-partners, family members, and any children involved, and document any disclosure.

[Insert Panel 9 here]

Responses should include an acknowledgement of disclosure and, while conveying that abusive behaviour is unacceptable, reassurance that help is available. Working with people who commit IPV requires a consistent message that IPV is unacceptable, a belief that change is possible and desirable, and the demonstration of empathy without collusion: part of the aim of treatment should be to enable service users to take more responsibility and accountability for their abusive behaviours. Motivational interviewing approaches to engage people who commit IPV prior to specialist referral to behaviour change programmes have demonstrated increases in programme attendance, compliance and completion.[271,272] Motivational interviewing techniques[273] enable people, who will vary in their readiness to change, to weigh up their situation and options, and to form action plans that meet their personal priorities, tailored to their Stage of Change (pre-contemplation, contemplation, preparation, action and maintenance).

Providers working with perpetrators with mental health problems should determine whether there are potentially modifiable clinical risk factors for IPV that could be addressed, while being clear that neither mental illness nor substance misuse are excuses for violent behaviour. These include, for example, emotional dysregulation; overvalued jealousy and paranoia; delusions or hallucinations that might lead to violence; irritability (e.g., in depression, or PTSD-related hyper-arousal and hyper-reactivity); impulsivity; substance misuse, and alcohol misuse.[274] Clinical responses might include talking therapies for underlying traumas and emotional regulation, antipsychotics for delusional beliefs and command hallucinations, and interventions for substance or alcohol misuse. Randomised controlled trials of antipsychotic medications have shown a reduction of violence in those treated whose psychotic symptoms decreased, which suggests that some psychotic symptoms might play a role in committing violence.[275] This evidence was based on all violent outcomes, which were mainly non-domestic assaults, but may generalise to IPV.

Ongoing interventions for people who commit IPV typically follow one of three treatment modalities: cognitive behavioural, feminist, or psychodynamic therapy.[276,277] There is limited evidence for the effectiveness of these interventions in reducing violence among people who commit IPV generally and among people who commit IPV and who have mental health problems specifically.[231,278] This evidence deficit should be addressed as a matter of priority. Cognitive behavioural and motivational interviewing therapies delivered in conjunction with alcohol treatment programmes have been identified as promising interventions in high- and low-income settings but need more rigorous evaluation.[83,278,279]

It is essential to acknowledge the complexity of IPV. Not all people experiencing IPV want to separate from their abusive partner, and some people who do separate remain in contact, for example in the context of a parenting relationship. There is little evidence to inform safe practice for professionals working with individuals in this context.[280,281] Relationship-level interventions have proven effective where these were grounded in gender theory.[282-284] A systematic review of six randomised controlled trials of couples therapies showed some effectiveness.[281] However, healthcare providers should be aware that couples' interventions might be dangerous in relationships where one partner is afraid of the other.[281] Where violence is normative or situational, working with couples to improve communication and conflict resolution skills, as mediators of IPV, may be promising. The use of a curriculum with couples to support equitable, nonviolent relationships in Rwanda and Nepal, found that programmes in both sites supported greater communication and conflict resolution skills and a sense of unity and shared power among couples.[285] The findings suggest the value of couples programming within the context of an enabling environment with highly trained facilitators.

What assists practitioners to be ready to address IPV?

Providers need to be supported in this work through undergraduate and in-service training, and ongoing organisational support, supervision, and reflective practice. Training without reinforcement, referral pathways, and organisational change appears to be insufficient. A Cochrane review of randomised and quasi-randomised controlled trials of domestic violence education interventions for healthcare professionals suggested there is some, albeit weak, evidence that training can contribute to improved attitudes and knowledge about IPV.[286] Evidence for improvements to actual responses – including the use of safety planning identification, and documentation of IPV – was weak and inconsistent and the sustained effect of training on these outcomes was uncertain.[286]

System-level interventions

A cluster trial in primary care conducted in the UK found that training provided by domestic violence advocates from specialist charitable organisations, a computerised prompt to remind clinicians to ask about IPV where service users presented with indicators of abuse (such as depression), and a referral pathway for those needing IPV advocacy or counselling, improved rates of identification and referral for support for women experiencing IPV.[287] Evidence suggests this model of intervention is sustainable and scalable and is likely to be cost-effective.[288,289] Similar findings, with improved rates of identification and improvements in mental health and decreased abuse, have been reported in pilot interventions modified for secondary mental healthcare services in the UK.[290] However, a recent cluster trial in the Netherlands found no improvement in rates of identification despite changes in knowledge and attitudes following training, possibly due to the training not being carried out in the context of an integrated intervention or referral pathway with the domestic violence sector.[291] Cluster trials of systemic integrated interventions in mental health settings in the UK, and other countries, are therefore urgently needed to support commissioning of such interventions.

Even if identification is improved, no system level intervention trial for individuals experiencing IPV has demonstrated improvements in mental health outcomes to date. Training by itself is unlikely to address problems such as the inadequacy of generic risk assessment in identifying risk of IPV severity and intimate partner homicide or filicide, unclear information sharing requirements and protocols, and the absence of a broad organisational commitment to addressing IPV. The establishment of links between healthcare providers and specialist domestic violence services is clearly important and recommended.[292] Research is needed to establish how best to improve actual outcomes, including clear measurement of fidelity of integration of co-located third-sector services within secondary care.

The importance of organisational support was highlighted by a systematic review of 47 qualitative studies of how health practitioners are enabled to address IPV.[293] Providers who collaborated within a team and worked within a health organisational system that was supportive were more likely to want to participate in identifying and responding to IPV.[293] Also important was that providers had tried a service-user centred approach and received positive feedback on this from service users, resulting in providers trusting that the health setting was an appropriate place in which to address IPV. Finally, the review showed increased engagement among providers who had a personal commitment to addressing IPV, either because of their personal experience or because of their human or child rights or feminist lens, areas which were not often addressed in training. Many providers will have experienced IPV, and support should include training for managers. While professionals often erroneously are not considered to be traumatised themselves, and while they benefit from this in appearing well-adjusted, it also denies an important part of their experience that can enhance their practice if used carefully.[294,295] A recent study showed that providers with their own personal experience of IPV were more likely to attend training and provide more effective care for survivors.[296]

Supervision and reflective practice are useful when doing this challenging work; questions that providers might wish to consider as part of regular reflective practice and to enhance trauma-informed approaches to IPV are provided in panel 10.[297]

[Insert Panel 10 here]

Enhancing the organisation of mental health services to meet the needs of families experiencing IPV

The readiness of mental health services to address IPV varies from there being little or no acknowledgement in mental health policy or practice of the underlying role of IPV in mental health problems, through to recognising the need for individualised, survivor-centred and trauma-informed approaches and what infrastructure is required to support the response to IPV[298] (see table 3).

[Insert table 3 here]

Improving organisations' understanding of the interrelationships between IPV and mental health problems, and the need for trauma-informed approaches to care, is essential. While many mental health services reference trauma-informed approaches, in practice there is still little attention on addressing the system-wide changes needed.[270] These encompass strengthening leadership and governance, providing care in environments that are private and safe (corridors, lighting, women-only inpatient corridors, private spaces, posters), implementing clear policies and procedures, and ensuring co-ordination of care (with roles defined, referral pathways mapped, and reduction of waiting times).[245] At an individual level, there is often poor recognition that even within the context of trauma-informed approaches, there may be a need to tailor the response to the specific type of violence and abuse experienced.[240] Enabling change requires a focus on building relationships across teams and services for a shared understanding of mental health and IPV frameworks,[299] supported by clinical champions.[243] Reflecting on the organisation, including through survivor voices, clinical audits, staff input and feedback, environment and workflow patterns and assessment of culture, values and beliefs within the mental health service, can identify the transformations needed.[300] This may include reflection on how mental health practitioners use their own power and privilege, bringing their own frameworks to individuals which can disturb the interaction between the practitioner and survivor, the arbitrary uses of power and inflexibility within services, and iatrogenic harm (including unavailability of services).

An important omission from some definitions of trauma-informed approaches to care is that services are co-produced with and led by service users; survivors themselves are instrumental in bringing about change (see panel 11). Similar to the early development of the Recovery Movement, in which mental health service users played an active role in advocating for change and redesigning services,[301] the development and embedding of trauma-informed approaches often has survivors working as clinicians, researchers, peer workers and trainers to communicate what trauma-informed approaches are and why they are needed.[295] Doing so should not require survivors to carry all the emotional labour around using their experience to inform service development. Instead, involvement should be empowering and liberating, creative and joyful, amplify the voice of survivors and promote self-care,[302] including by facilitating access to trauma-informed peer support.[303]

[Insert Panel 11 here]

Globally, however, many countries have few if any healthcare professionals trained in mental health,[304] let alone in trauma-informed or survivor-centred approaches to care. Almost half the world's population lives in countries where, on average, there is one psychiatrist to serve 200 000 or more people, and other mental health care providers trained in the use of psychosocial interventions are even scarcer. It is imperative that overall access to and quality of mental health services be strengthened. Efforts to integrate mental health care into primary health care and enhance the mental health care skills of primary care providers, such as the Mental Health Gap Action Programme (mhGAP),[305] are essential, and should include improving the identification of, and response to, IPV.

WHO has published several interventions that have demonstrated effectiveness in reducing symptoms of common mental health disorders in randomised controlled trials in low- and middle-income settings and can be delivered by trained and supervised non-specialists. For example, Problem Management Plus is a brief, transdiagnostic psychological intervention, comprising problem management and other strategies that can be delivered in individual or group format. It has been formally tested in violence-affected communities in Kenya and Pakistan, which included women with a history of domestic violence, and was shown to be effective in reducing depression and anxiety symptoms and improving daily functioning (i.e., ability to communicate, get around, care for oneself, complete work/household chores, and participate in society).[306,307] Self-Help Plus is an innovative, facilitator-guided, group-based transdiagnostic, stress-management intervention that uses pre-recorded audio and an illustrated self-help guide to communicate stress management techniques to groups of up to 30 people. It both prevented the onset of mental disorders and resulted in meaningful reductions in psychological distress at 3 months among South Sudanese female refugees, including those who had experienced IPV.[308,309]

Key knowledge gaps

High-quality evidence is needed to improve mental health interventions and service responses to IPV. To date, there is little research evaluating interventions for mental health service users who experience IPV. Trials in other settings suggest useful components are likely to be strengths-focused, develop cognitive and emotional skills to address trauma-related symptoms, and include psychoeducation about IPV and attention to safety.[270] Too little is known about how mental health services should assess, identify, and respond to mental health service users who commit IPV, including how to intervene to reduce risk, and whether and how culturally appropriate mental health interventions might help to reduce IPV. Future intervention targets could include risk factors (e.g., medication for persecutory delusions, psychological interventions, and treatment of comorbid alcohol and substance misuse), modifiable of which, when coupled with action to ensure the safety of potential victims, might be

expected to reduce use of IPV among mental health service users for whom the use of abusive behaviours appears linked to these factors. Insufficient evidence exists about how best to prevent children's re-exposure to IPV[310] and on interventions that are safe, appropriate and effective for children who live with ongoing abuse. Few studies of interventions delivered to adults who have experienced or who use IPV quantify the effects of reduced IPV on children's health and well-being.[193,311] In all research on IPV, studies need to be conducted with greater rigour. Studies often have inadequate sample sizes, high attrition rates, no meaningful controls, or no control group at all, or are missing information on long-term outcomes, or do not examine mediators and moderators sufficiently. Longitudinal research that can look at cumulative effects of different forms of violence across the life course and identify opportunities for early intervention is also needed.

Trauma-informed approaches provide an opportunity to strengthen mental health service responses to IPV, but their implementation and sustainability should be studied. Future research on increasing access to quality mental health care to address IPV should include studies on the effectiveness of scalable psychological interventions and on different ways of delivering high quality mental health services. Interventions and research that are co-designed with survivors are more likely to meet the needs of those with lived experience.[312] Ongoing survivor involvement is therefore needed in service development and evaluation, including through research studies that are themselves trauma-informed as well as survivor-led. This could be through testing increases in the mental health capacity of primary care providers, using lay providers, using digital and m-health technologies to deliver psychological interventions, and greater integration of mental health and IPV services.

Part 5: Addressing gender inequality and societal responses to IPV

There are multiple causes of IPV, but gender inequality is a root cause. Gender inequality is manifested at all levels, from the relationship and family to economics, politics, civil society, and in how institutions respond to matters at a structural level.[313] The risk of IPV appears highest in societies that are most unequal in their gender relations and where the use of violence against women is an accepted norm. Within mental health, disciplines such as Psychiatry and Psychology have their own norms that, if unexamined, risk replicating the misuse of power against people, particularly women and others who are discriminated against, who have experienced IPV. Through changing gender norms and cultures of violence, and with the support and engagement of multiple systems – including mental health systems - it is possible to transform practices to promote gender equality, improve rights for women and for minoritised groups, and reduce IPV.

Gender inequality and IPV

Violence is both a cause and consequence of inequality in society. Inequalities drive violence against all disadvantaged people, including, but not only, women and girls.[314] Gender inequality intersects with other disadvantages based on social class, ethnicity, religion, sexuality, gender identity, citizenship, disability, and age. The intersection of these inequalities is associated with complex patterns of violence, and resistance to violence, with IPV part of a complex range of abusive experiences for women and disadvantaged or minoritised groups.

Although historically and cross-culturally societies vary in the extent of gender inequality and violence, the gendered inequalities that underpin IPV can be found in all social systems and social institutions. IPV can be decreased by reducing gendered inequalities in the economy, polity, and civil society, and multiple institutions are relevant to efforts to prevent IPV. For example, gendered economic inequalities are correlated with higher prevalences of IPV,[315,316] gendered inequalities in the ownership of land and other property increase IPV;[317] and women with less access to employment and home ownership are

more likely both to be subjected to IPV and to experience IPV that is more frequent and more severe.[26,186] Similarly, gendered inequalities in politics and civil society are associated with higher rates of IPV: countries with higher rates of women in parliament have lower rates of femicide,[318] the acceptability of IPV is lower in countries in which women contribute to the development of cultural institutions and to public debate,[319] and countries with stronger feminist movements have more robust policies to prevent violence against women.[320] Gendered welfare provision, including but not limited to specialised violence-against-women services, also reduces IPV,[321] decreasing the vulnerability of potential victims and increasing resilience. Greater access to public housing increases victims' capacity to leave a violent partner; women who rent from public authorities report lower rates of IPV than those who rent privately.[26,186]

The pervasiveness of gender-stereotyped and violence-supportive norms within society

Norms and beliefs supporting violence against girls and women are commonly held and include male dominance and privilege; male rights to assert power over women; male use of physical discipline to correct female behaviour and ward off future transgressions; use of certain types of violence in conflict; sexual intercourse as a man's right with a romantic partner; male sexual activity (and sometimes rape) as a marker of masculinity; and female provocation as a justification for violence.[322] Men's gender-inequitable attitudes and hypermasculine behaviours are not consistently related to their use of IPV, and there can be considerable diversity in men's perpetration of IPV at the individual level even in highly patriarchal and gender inequitable contexts.[14,17] However, research with a population-based sample of South African men points to the clustering of violent behaviours and the performance of heterosexual masculinities, with the most violent men expressing hypermasculine attitudes and behaviours.[16] Men's endorsement of sexist, hetero-patriarchal, or sexually hostile attitudes is an important predictor of their use of IPV.[14] Research on cognitive distortions in offenders has also highlighted themes such as victim-blaming and male entitlement to use violence.[323] Women and girls might be expected to tolerate violence to preserve the family unit or be held responsible for men's sexual urges. Although such norms might be more prominent in some cultures, this should not be used as a vehicle for 'othering' and racism; extreme tropes around virginity, female sexuality, and motherhood can be found in every culture and social class. Even within one society, there can be many sub-cultures or micro-cultures where violence might be culturally endorsed, especially if these groups are male dominated and have gender-restrictive norms (such as college fraternity groups, military settings, and sports).[324] Research suggests that very violent men are often strongly influenced by their peers.[325]

Gender-stereotyped and violence-supportive norms and attitudes permeate our social ecology, woven into language, popular culture, mass communication, and institutions. This can lead to misleading and harmful social norms being repeated, reinforced, and psychosocially embedded, shaping attitudes, social scripts, expectations, and life chances. Historical representations of women as 'passive' and 'incidental' still chime in contemporary life and gender-based violence is mainstreamed throughout culture and media, with the continued use of tropes about love being linked to violence (e.g., the teen fiction series Twilight); representations of women as sexual objects; depictions of women as ambiguous about sexual consent (e.g. Poldark, 2016); portrayals of women being harmed for 'transgressing' social norms (e.g., The Godfather); the use of violence against women in film (e.g., Fatal Attraction); and music which objectifies women or appears rape supportive (e.g., Blurred Lines). Women continue to be sexually commodified within advertising, music videos, and elsewhere with an increasing and harmful proliferation of sexualised images of girls.[326] Young people have also been more exposed to increasingly violent pornography, associated with gender-based violence and distorted perceptions of sexual relationships.[324,327] There are disturbing trends in the portrayal with the media of alcohol, gun culture, hyper-masculinity, restrictive gender norms, and the normative use of force to resolve problems – all risk factors associated with IPV[328] - as 'glamorous', 'aspirational' or 'entertaining'.

Cultural and institutional responses to IPV are often also gender-biased. Media reporting of IPV, including intimate partner homicide, is frequently sensationalist, victim-blaming, or justifying of violence.[329] There is often an over-focus on the negative consequences on people who commit IPV, rather than the impact upon the people who have been subjected to it. This erasure is amplified for those not 'stereotypically' affected by violence, such as men, gender minorities, people in same-sex relationships, and older adults, and for people with disabilities and from minoritised ethnic or indigenous groups, contributing to the failure to recognise and help these groups as victims of violence. Whilst there have been incremental gains in legislation to protect victims of IPV, conviction rates remain poor and the use of harmful stereotypes in courts is highly concerning.[330] Furthermore, research has illustrated how the legal system does not consider how IPV increases vulnerability of suicide amongst victims as well as risk of murder; with implications for the response of health and legal services in the identification and protection of victims and for the conviction of perpetrators.[331]

A critical eye on our disciplines: norms within psychiatry and psychology

Disciplines such as psychiatry and psychology are not immune to structural inequalities or social norms and have not always examined their own practices or histories. Historians and social scientists claim, however, that these disciplines have roots in practices which minimised or denied violence,[332] pathologised difference, particularly around racial heritage,[333,334] and reinforced classism and patriarchal norms, rather than seeing social oppression as pathogenic.[335] Mental health systems have perpetuated stereotypes and, at times, been used as an instrument of social and political control (e.g. political prisoners, unmarried mothers, ‘conversion’ therapy for homosexuality). Although no branch of medicine sits outside its cultural milieu, mental health research and practice has arguably been particularly vulnerable, at times, to exploitation by social and political power structures, with negative consequences for both service users and the profession.

Although many people benefit from using mental health services, it is essential to acknowledge this painful ancestry and to reflect on how harmful norms continue to shape responses to people who have suffered trauma and abuse. There are contemporary debates about aspects of mental health practice which variously interface between protection and coercive control. Whilst uncomfortable, this warrants serious attention, as services can repeat and perpetrate serious harms.[336] Further, traditional models of mental health problems might potentially endorse victim-blaming and pathologise ways of responding to victims of violence, e.g., that traumatised victims of violence are ‘mentally ill’ so their disclosures are unreliable. This view of victims has often intersected with the legal system, where narratives about unreliable testimony can be used to discredit victims.[337]

In the wake of contemporary influential social movements, such as #MeToo, #TimesUp, #BlackLivesMatter, and #EveryonesProblem, it is timely for mental health services to reflect upon and change organisational and professional cultures. Social movements voicing the concerns and demands of those often excluded from power have a long history in realising change. There is an urgent need for structural and societal shifts towards recognising and responding to IPV; developing richer and textured psychosocial perspectives; and mental health services realising their role in socio-cultural change regarding violence. Although the primary institution focused on by this Commission is mental health services, we recognise that this needs to occur across institutions. For example, the Law now incorporates a more sophisticated understanding of ‘coercive control’ but much more needs to be done to enhance the public, police, and judiciary’s understandings of the nature and impacts of this and other forms of abuse.

Promoting social change.

Ecological perspectives on violence prevention allow consideration of how social structures can mobilise and collaborate for change across cultures and contexts. In short, this involves everyone in collective effort. Health, criminal justice, security, faith, education, and civil society must act together to promote sustainable social change, shifting the cultural consensus away from violence supportive norms and towards gender equality.[338] IPV needs higher priority through all stages of the system from strategic decisions to designing services with survivors; to improving public understandings about IPV and how to stop it; to the micro-interactions practitioners have with clients (which must include empathy, belief, psychosocial support and referral to other services).

This also involves mental health and other services taking a clear stance that violence is unacceptable and working together to reduce the social determinants of health inequality and improve gender and 'race' equality indicators such as women's income, educational attainment, occupational status, and labour market participation and equal pay. Oram et al.,[231] for example, suggest roles for mental health professionals' in promoting and protecting women's rights to be free from IPV and other forms of gender-based violence. They advocate that such professionals should go beyond traditional forms of intervention to raise awareness of the effects of violence on mental health; challenge cultural norms within mental health services and wider society; identify and respond to violence experienced and committed by users of mental health services; and advocate the funding of specialist services. Advocates should also consider whether and how changes in the wider policy environment might contribute to reductions in IPV; increasing the price of alcohol has, for example, been endorsed by the WHO as the most cost-effective and targeted public health intervention to reduce alcohol-related harm.[339]

Gender-transformative interventions: a promising evidence base

To prevent violence, we need to reduce the prevalence of factors known to increase risk (e.g., poverty, gender inequality, scarcity of services) and enhance those that 'protect' from IPV (e.g., secondary education, economic empowerment, reducing child abuse). RESPECT Women: A framework for preventing violence against women was developed by WHO, with UN Women, in 2019 and is endorsed by 12 other UN agencies and bilateral partners.[340] It aims to convey in a simple way a process for and the evidence for prevention to policy makers. It identifies seven strategies which make up Respect: *R*elationship skills strengthened, *E*mpowerment of women (economic, social and psychological), *S*ervices ensured (health, legal/judicial, social welfare), *P*overty reduced, *E*nvironments made safe (schools, workplace, public spaces), *C*hild and adolescent abuse prevented, *T*ransformed attitudes, beliefs, and norms. The quality of the evidence for each of these 7 strategies is summarised and specific programmatic examples provided, with a focus on LMICs.[341] An important strategy is transforming gender attitudes, beliefs and norms addressed below.

A wide spectrum of gender-transformative interventions exist that aim to prevent IPV, ranging from small-scale interventions with groups of individual men to interventions that aim to transform social norms.[283,342-345] Rigorous evaluations are lacking, but evidence suggests that gender-transformative interventions (i.e., which explicitly address the norms, behaviours, and relations associated with masculinity rather than just specific behaviours or attitudes) can play an important role in violence prevention.[345,346] Successful programmes to transform norms are delivered by trained and well-supported staff over sustained periods; are participatory; engage multiple stakeholders, support critical dialogue about gender relationships (e.g., by explicitly examining norms and behaviours, including around gender binaries, gendered power relations, and homophobia[347]); and improve communication and shared decision-making within families.[344] Some methods of behaviour and attitude change involve

group mobilisation to challenge 'pluralistic ignorance' where people tend to overestimate the group support for harmful attitudes. However, interventions must be appropriately tailored: some men who commit violence will often feel entitled to commit violence, or feel they are able to violate social norms, or believe that there are not consequences to committing violence. Thus, interventions should be context specific, constructively engage community leadership structures and the police, health, and social services, be backed by legal and policy shifts, and receive sustained funding. Addressing the precarious funding situation for services which work to prevent IPV, and its associated harms is vital. Awareness-raising campaigns are unlikely to be as effective as standalone interventions:[283] change needs scaffolding across the social infrastructure, with an emphasis on prevention.[344] Recent evaluation of a global prevention programme has reaffirmed that poverty, patriarchal privilege and norms are key drivers in violence against women and girls.[14] Longitudinal, high quality ethnographic research is needed to develop effective and safe interventions which reduce the vulnerabilities caused by poverty and understand the nuances in experiences of inequality, exploitation and abuse.

Increasing the momentum for change – collective determination and continuous action

Understanding of IPV is changing due to the collective activism of those traditionally excluded from power. Over several decades, feminist activism has demanded that IPV is re-framed and recognised as a public health issue and that its roots in gender inequality are understood and addressed, forcing a societal shift away from the hidden or tolerated nature of abuse and towards prevention and recognition that violence is not inevitable. Though there are continuing challenges and struggles, there are also increasing commitments at the international and regional levels to end violence (see panel 12).

[Insert Panel 12 here]

Commitments in words must be matched by deeds, and while there is evidence of improvements, including the expansion of legal prohibitions against IPV, there is still a long way to go.[348] There is now, for example, legal recognition of coercive control in England and Wales, and the UK government has committed to ending violence against women and girls. Yet, specialist IPV services in the UK have seen reductions in public funding, including those services for racially minoritised women which were already under-funded.[349] There are concerns that even under the new UK Domestic Abuse Act[350] women with insecure immigration status will face major barriers to escaping violence and will lack rights and protections in law.[351] The South African government are currently consulting on a bill to amend the Domestic Violence Act 116 of 1998, with plans to extend the definition of domestic violence to include the abuse of an elder or the exposure of a child to a violent domestic environment, and to recognise entry into a victim's workplace without consent as a specific act of abuse (e.g., stalking and harassment) that can be presented in court application proceedings.[352] However, concerns have been raised that victims might be exposed to retaliatory harm from perpetrators because of a provision that would make it mandatory for adults who become aware of domestic violence to report this to either a social worker or the police or risk a fine or imprisonment. Legislative progress in Canada has included amendments to the Divorce Act[353] to address family violence, and Justice Canada has been developing resources to assist family law lawyers in working with clients experiencing this form of violence. However, there is still an urgent need for healthcare and social services as well as safe housing for those experiencing IPV, particularly in rural and remote areas and Indigenous communities.

Moreover, the global COVID-19 pandemic is providing sobering evidence of how inequalities and vulnerabilities are magnified during times of social and economic crisis. Evidence suggests that IPV and child maltreatment have increased during the pandemic;[354,355] rates might increase further if post-COVID-19 austerity increases as recession forces women and minoritised groups out of the labour

market, increasing inequalities yet further and rendering them more vulnerable to IPV.[356] Post-pandemic planning at the national and international level must use this opportunity to address existing inequalities and enhance access to prevention and response services for IPV.

Overall conclusions

Understanding of the associations between IPV and mental ill-health, and how to prevent and respond to IPV and its associated mental health harms, has greatly improved in the past decade, but gaps remain. In this Commission, we have appraised the available evidence and made recommendations both to improve this evidence base and to act upon what is already known. Our ambition is to prevent IPV and, in doing so, to decrease the prevalence of mental health problems in society. With scientific effort, coordinated action, and political will, there are not only opportunities for change, but an imperative to do so.

Contributions
LMH developed the original idea for this Commission. FC, PC, CGM, SF, HLF, KH, EH, LMH, HM, HLMac, LKM, SO, DR, MR, KR, SS, AS, DT, and SW attended Commission meetings to discuss structure and content. HLF led the drafting of content on evidence for associations between IPV and mental health; authors of this section also included CA, FC, SF, and DR. HM led the drafting of content on IPV across the life course; authors of this section also included PC, MH, SBO and MR. SW and SS led the drafting of content on measurement of IPV: authors of this section also included PC, CGM, EH, KH and AS. KH led the drafting of content on transforming the mental health system to address IPV; authors of this section also included CGM, EH, HLMac, LKM, SO, AS, and DT. KR led the drafting of content on societal norms and IPV; authors of this section also included SW. All authors contributed to the first and second drafts of the manuscript. SO and HLF led the revision of the final draft, with all authors contributing to the final revision of the manuscript.

People who identified as Survivors of IPV were involved in all stages of the Commission's work. There were a number of Commission Authors who were recruited in part because of their expertise in both clinical or academic aspects of IPV and also having some form of lived experience. Based on feedback from a number of authors, both people who identified as Survivors and those who did not, several strengths and limitations of the Commission's involvement strategy were identified. A significant strength was that survivor colleagues were involved in all stages of the Commission's work and contributed as authors with professional expertise in addition to lived experience. This strength was also linked to a limitation of the approach which was that the survivors involved were mostly there in professional capacities and so were not able to speak to the range of life experiences that many victims of IPV face, including the full range of forms of social and economic marginalisation. Of particular note is that while the Commission's scope is international, there were no survivor authors from low- and middle-income countries, although efforts were made to include some of these voices in the document. A further identified strength is that a number of survivor authors felt that their contributions were welcomed, and they felt fully included in all aspects of the Commission's work. However, there was also feedback which suggested that for some there was limited scope for all Commission authors to be openly reflective about their motivations for participation in this work and so the burden for self-disclosure fell disproportionately on those with lived experience. This ties in with a broader hope noted by a number of survivor authors which is that the sterling work started by the Commission in making space for survivor perspectives can be developed further in future initiatives, particularly in thinking through the optimal structures and methods to enable knowledge to be meaningfully co-produced. IPV

and other forms of violence can be better understood and ameliorated through scientific inquiry; however ongoing stigma around the topic and a culture that privileges analytic distance in academic circles can create false binaries between experts and victims that in turn privileges particular forms of knowing.

Conflicts of Interest

HLMac was a member of the Guideline Development Group for the World Health Organization Clinical and Policy Guidelines on Responding to Intimate Partner Violence and Sexual Violence Against Women and HLMac received funds from the Public Health Agency of Canada as Project Lead for the Violence, Evidence, Guidance, Action (VEGA) Project.

SO, MR and CGM were members of the Steering Committee for the World Psychiatric Association Curriculum on Intimate Partner Violence and Sexual Violence. LMH was a professional member of the NICE guideline (PH50) on preventing and reducing violence.

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Panels

***Panel 1*: Methodology and approach used in preparing this Commission**

- This Commission was instigated by the Violence Abuse and Mental Health Network (VAMHN – http://www.vamhn.co.uk). VAMHN is an interdisciplinary research network, funded by UK Research and Innovation, that aims to understand, prevent, and reduce the impact of domestic abuse and sexual violence on mental health. It brings together experts with different ways of thinking about violence, abuse, and mental health – some with lived experience of these issues, others with expertise from the work they do – through the provision of engagement, capacity building, and funding opportunities.

- The initial consultation meeting for this Commission took place in June 2019, in which individuals from a variety of backgrounds with interests or expertise in intimate partner violence and mental health met to discuss progress and remaining challenges in the field, and to establish a roadmap for strengthening responses across mental health research, services, and policy.

- Commission authors span a range of disciplines, including applied health research, behavioural science, child and adolescent psychiatry, epidemiology, forensic psychiatry, general psychiatry, neuroscience, paediatrics, primary care, psychology, public health, service user research, and sociology, and include survivor-researchers and survivor-practitioners.

- This Commission presents a synthesis of the evidence – academic, clinical, and experiential - considered important by its authors as a group of international experts (from Australia, Canada, India, Malaysia, Peru, South Africa, Switzerland, UK, and USA).

- We have used evidence from systematic reviews where appropriate and draw also on conceptual work across a range of disciplines. We have performed database searches to identify the most recent evidence as required, and considered guidelines produced by national and international bodies.

- Some of the topics addressed by this Commission are under-researched and we draw attention to the strength of evidence (acknowledging that what is considered "strong" evidence varies across disciplines) and key knowledge gaps throughout.

- Quotes from survivors from Australia and the UK who are participants in research or are involved in research advisory or co-production work are included throughout this Commission.

***Panel 2*: Key messages**

1. Reducing IPV (whether exposure occurs directly as an adult, indirectly as a child, or both) is very likely to improve mental health outcomes.
2. Exposure to IPV (whether in adulthood or in childhood) increases the likelihood of developing a range of mental health problems, while those with mental health problems are at greater risk of exposure to IPV. These associations appear to occur across the lifespan, are rooted in gender and other intersecting inequalities, and relate to both the onset and course of mental health problems.
3. Some people with mental health problems are also more likely to commit IPV, though absolute rates are low and individuals with mental health problems are more likely to experience than to use IPV. Treatment studies have found that reductions in alcohol use are related to reductions in IPV generally, and with reductions in IPV severity particularly, with implications for both provision of mental health services and social policy.
4. IPV causes early exposure to stress including in utero, which results in difficulties coping with stressors during the life course, an increased risk for mental health problems, and neurodevelopmental impairments that contribute to the intergenerational transmission of violence. Preconception interventions might reduce the risk of intergenerational transmission of violence and improve mental health outcomes.
5. Severe parental stress (e.g., IPV, poverty, food insecurity) increases the risk of children experiencing maltreatment, including exposure to parental IPV. Reducing parental stress, whatever the cause, might contribute to the reduced prevalence of violence in the population.
6. Schools have an opportunity to modulate factors that reduce the risk of IPV, through purposively creating an ethos that models gender equality and respectful relationships.
7. Mental health services should address IPV using approaches that are gender-sensitive, trauma-informed, and coproduced with survivors.
8. Universal screening for IPV is not recommended, but because mental health problems might be associated with or worsened by violence, all mental health service users, especially women and gender and sexual minorities, should be asked about experiences of violence, including IPV, within the context of a mental health assessment. Assessments should be carried in private by trained practitioners who work within a clear referral network.
9. The World Health Organization's LIVES principles for first-line response to IPV are useful for providers in recognising and responding to IPV. They include: 1) Listen with empathy and without judgement; 2) Inquire about needs and concerns; 3) Validate experiences; 4) Enhance safety; and 5) Support through connecting to information, services, and social support.
10. Children and adolescents with emotional and behavioural problems should be assessed for exposure to IPV; they may need specific interventions together with or separately from their caregivers, but this should be determined by a thorough assessment and not simply based on exposure to IPV.
11. Measurement of IPV should be improved in future mental health research, including as a potential moderator of treatment response in intervention studies, and in new population cohorts.
12. Greater coordination and cooperation across sectors (e.g., academia, policy, health services, specialist services, criminal justice services) are needed with regards to both data collection on IPV and of core indicators and outcomes to evaluate interventions to reduce IPV, which should reflect the priorities and expectations of survivors.
13. The risk of IPV appears highest in societies that are most unequal in their gender relations and where the use of violence against women is an accepted norm. There is a growing evidence base that suggests that gender transformative interventions can be effective in preventing IPV.

***Panel 3*: Forms of intimate partner violence**

Physical violence – includes acts such as slapping, hitting, kicking, beating, and choking.

Sexual violence – includes sexual contact and behaviour that occurs without explicit consent, including rape, attempted rape, sexual touching, and forcing a person to perform sexual acts.

Emotional (psychological) abuse – includes insults, belittling, humiliation, intimidation, threats to harm, and threats to take away children.

Controlling behaviours – acts designed to make a person subordinate or dependent, including isolating a person from family and friends, monitoring a person's movements, and restricting a person's access to financial resources, employment, education, or healthcare.

Coercive behaviours – a continuing act, or pattern of acts, of assault, threats, humiliation, intimidation, or other abuse used to harm, punish, or frighten a person.

***Panel 4*: Survivor's account of how her childhood experiences impacted on her adult relationships**

"Personally, to survive my childhood, I learned to doubt my own experiences to maintain the adults in the light of caring individuals. It was safer to question my behaviours than theirs. I couldn't control them, but I could control myself, so I thought I must be wrong in thinking or doing such and such since they said so. I used that same strategy when in a relationship with my abusive partner. The pattern of self-doubt carried on in my adulthood and still makes me more vulnerable to IPV. In my life, I have had more experiences of disempowerment than empowerment, so whenever the former shows up, it has more weight. It is a lifetime's work to shift the balance. For the cycle of abuse to stop, one has to have more positive healthy relational experiences than abusive ones to create the new norm."

Caroline

***Panel 5*: Survivor's account of abusive partner labelling her as mentally unwell**

"I have experienced a violent partner accusing me of being mentally unwell. They used a few different methods: (1) Instilling fear, by lying and telling me that other people thought I was 'crazy', 'bipolar', 'schizophrenic'. (2) Disarming the appropriate fight/flight response by accusing me of being a pathological liar in order to create a shield for themselves. (3) Shifting their shame towards me. He spat on my face, the smell of his bloody, unhygienic spit made me gag and seek the toilet to throw up. He then used my eating disorder (anorexia/bulimia) against me to belittle and shame me further. This deflected me from being able to shame his abusive behaviours.

Through my partner's accusation of mental illness, he made me understand that no one would believe me regarding his abuse because society reduces people with mental illnesses as disconnected from the collective reality. I feared that if I shared my experience of abuse, I would be automatically discredited and disbelieved on the grounds of poor mental health, so I kept quiet. I didn't want to trade the gaslighting of my partner for the gaslighting of a more powerful system, the psychiatric system, where whatever I said would be used as proof of me lacking mental capacity. He could only weaponise mental illness because of the stigma attached to it. It worked. It was as powerful a tactic as his physical abuse."

Caroline

***Panel 6*: Survivor's account of pathologisation by mental health services**

"I wish mental health practitioners would stop judging us as survivors and see us for how strong and resilient and courageous we are. I fought the hardest to protect myself and my family from being murdered and I should be seen as a hero for that not pathologised by a mental health system that sees me as a problem and a victim."

Cina

***Panel 7*: Good practice principles for recognising and responding to those who have experienced IPV**

- **Prioritise safety.** Safety includes emotional and cultural safety and goes beyond absence of injury. Service users who are at ongoing risk of harm have different support needs to service users whose safety is assured – and professional support should never be withheld until a service user is "safe" or has left a relationship. Focus on increasing the choices available to the service user and remember that risks increase at the point of separation.

- **Listen with empathy and respond to the service user's needs.** Communication should be empathetic and non-judgmental, acknowledge the complexity of IPV, and respect the service user's concerns and decisions. The approach should involve shared decision-making, which respects individual competence of the service user and where they are in recognising violence.

- **Make the limits of confidentiality clear.** Service users should be informed of what to expect, including with regards to mandatory reporting legislation, which might require healthcare providers to contact child protection services when a child is being exposed to IPV.

- **Ensure privacy.** Enquiry about IPV should take place in private (i.e., not in the presence of a partner, relative, or child beyond infancy) and follow a phased approach, beginning first with the service user's presenting concerns followed by inquiries about well-being and relationships, including safety. General open-ended questions that can lead to more specific questions about IPV include: "How are things at home?" "How do you and your partner get along?" "Are you sometimes afraid of your partner?".[230]

- **Assess safety.** Ongoing enquiry about safety is imperative, working collaboratively with the service user to protect them and any children involved, and following safeguarding procedures where appropriate. Questions to ask include "is it safe for you to go home?", "what are you afraid might happen?", "what has [the abuser] threatened?"; and "what about threats to the children?". Risk indicators for greater severity and risk of harm include separation, obsessive jealousy, control of daily activities, strangulation, sexual assault, escalation of physical violence and use of weapons.

- **Ask about children**. Children are often exposed to IPV, and it is important to also ask about their safety and well- being. Survivors are often fearful of disclosing abuse in case their children are removed: providers should strive to help children stay with the non-abusive parent, and to work with that parent to keep the child safe.

- **Document enquiry, disclosure, and safety assessment.** Records should include a clear statement of who experienced IPV, who committed IPV, information about the frequency and severity of abuse, and any symptoms or injuries observed. Use the service user's words when recording disclosure and ensure that records are kept secure.

- **Support safety planning.** Discuss where the service user would go in an emergency, who they would contact and what would they take with them.

- **Share resources and information.** Discuss what IPV resources and services are available in the local context or online, assisting service users to explore preferences including their ability and comfort to access specialist IPV services.

- **Integrate knowledge of IPV into treatment and support.** This can be done at all levels of clinical practice - from how providers formulate and diagnose, choice of therapeutic approach, write letters, advocate for service users (e.g., letters of support for housing), and interact with service users on an ongoing basis.

***Panel 8*: Survivor's account of using services remotely during the COVID-19 pandemic**

"Being able to access my doctor via Telehealth during COVID was a life saver for me as I have been housebound due to my mental health issues since March 2020. Of course, going in person is much better when doctors are looking after your mental health issues but that is not always possible.

It took away a lot of the stress and anxiety worrying if I could actually physically get there. My doctors were patient and sympathetic and nothing was rushed. I have also been accessing my DV counsellor through Telehealth (every 2 weeks) and that has been invaluable."

Fiona

***Panel 9*: Survivor's account of the importance of services for people who commit IPV**

"I would like to see less wait times and an increase in access to services for perpetrators. Wait times may cost lives, the quicker we can work to change the behaviour, the quicker we can lower the risk for victims and future victims."

Jasmine

***Panel 10*: Practitioner reflective questions (adapted from Short et al.[297])**

- What kinds of power and privilege do I have? How do these shape my life and world view?
- Have I considered how experiencing trauma and violence might have contributed to the development of the presenting complaint/reason for referral?
- How do his/her/their coercive and controlling behaviours constrict her/him/their or her/his/their children's lives and her/his/their ability to do what she/he/they wants to do, including ability to engage in any mental health care plans?
- What do I know about what safety strategies she/he/they previously tried, how these worked, if services were helpful, her/his/their partner's reactions, and what if any access she/he/they has to financial, family, social and cultural supports?
- Are she/he/they and her/his/their family experiencing systemic barriers, (no stable housing, limited access to money and transport, poverty, language barriers and dismissive racist responses from services)? How is this impacting her/him/them and her/his/their children and family's safety and wellbeing?
- Who is working with her/his/their partner? What strategies are in place to support him/her/them and address his/her/their use of violence?
- Comprehending all of this, what actions can I take as a 'safety ally', as part of my treatment plan?
- How and with whom will I review whether what we are doing is supporting safety for her/him/them and her/his/their children and family?

***Panel 11*: Survivor's perspective on survivor-involvement**

"I may not have the years of family violence training you do. I may not have a PhD, but I have lived it, I have survived it. I don't want to be viewed as someone who is damaged or traumatised. I want to be viewed as someone who has something of value and importance to contribute."

Jasmine

***Panel 12*: Key international commitments to ending IPV and other forms of gender-based violence**

- 1945 - The United Nations is established to foster better international collaboration and it has enshrined gender equality in its charter.
- 1976 – The United Nations Development Fund for Women (UNIFEM) established to provide technical and financial assistance for programmes and strategies to promote women's human rights, political participation, and economic security.
- 1979 - The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) is adopted as the most comprehensive international instrument to protect the human rights of women. The convention legally bound signatory governments to end discrimination against women in public and private life, including the family. It also aimed to achieve equality between women and men — both legally and in everyday life
- 1993 - The UN Declaration on the Elimination of Violence against Women provides a framework for national and international action to address violence against women.
- 1993 – The International Conference on Human Rights recognizes women's rights as human rights, including the right to live a life free of violence.
- 1994 -The International Conference on Population and Development's Programme of Action recognises the importance of women's sexual and reproductive rights as central to everyone's welfare.
- 1994 – The Belém do Pará Convention adopted by the Inter-American Commission of Women of the Organization of American States, the first legally binding international treaty that criminalises all forms of violence against women, especially sexual violence.
- 1995 – The Declaration and Plan of Action of the Fourth World Conference on Women in Beijing includes a chapter on violence against women and one on women and armed conflict.
- 2003 - The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (the Maputo Protocol) established by the African Union to guarantee comprehensive rights to women, including the end of female genital mutilation and other traditional practices harmful to women.
- 2010 - UN Women established to exclusively champion women's rights and includes reference to the right to live free of violence and coercion.
- 2012 - The Istanbul Convention (Council of Europe, 2012) commits to improve gender equality, recognising violence against women as both a cause and consequence of inequality, reaching across Europe and to international states.
- 2015 - The Sustainable Development Goals (2015) set the goal of eradicating violence towards women and girls globally by 2030.
- 2016 – The World Health Assembly endorses the Global Plan of action to strengthen the role of the health system to address violence, in particular against women and girls and against children.
- 2017 - The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) launches recommendation number 35 on gender-based violence against women, updating general recommendation number 19. The updates include expanding the understanding of violence to include violations of sexual and reproductive rights and defining the different levels of liability of States for acts and omissions committed by its agents or those acting under its authority to protect women and girls and ensure access to remedies for survivors.

Figure legends

***Figure 1*: Drivers of intimate partner violence (reproduced from Gibbs et al.[14])**

***Figure 2*: Intimate partner violence and mental health problems: risk factors (blue) and targets for intervention (green) across the lifespan (orange)**

Table 1. Absolute rates and relative risks of men with and without mental health problems committing IPV.

	Absolute lifetime rates of committing IPV % (IQR)	**Relative risks of committing IPV OR (95% CIs)**
No diagnosis of mental health problems	4 (3-7)[a]	n/a
Alcohol use disorder	-	7.0 (6.6-7.5)[b]
Depression	18 (15-22)[a]	2.9 (2.7-3.2)[b,c]
Drug use disorder	-	7.7 (7.2-8.3)[b]
Generalised anxiety disorder	20 (19-23)[a]	3.2 (2.5-4.4)[a]
Personality disorder	-	4.3 (3.8-4.9)[b]
Post-traumatic stress disorder	22 (18-28)[a]	1.8 (1.0-3.2)[a]
Panic disorder	14 (13-19)[a]	2.5 (1.7-3.6)[a]

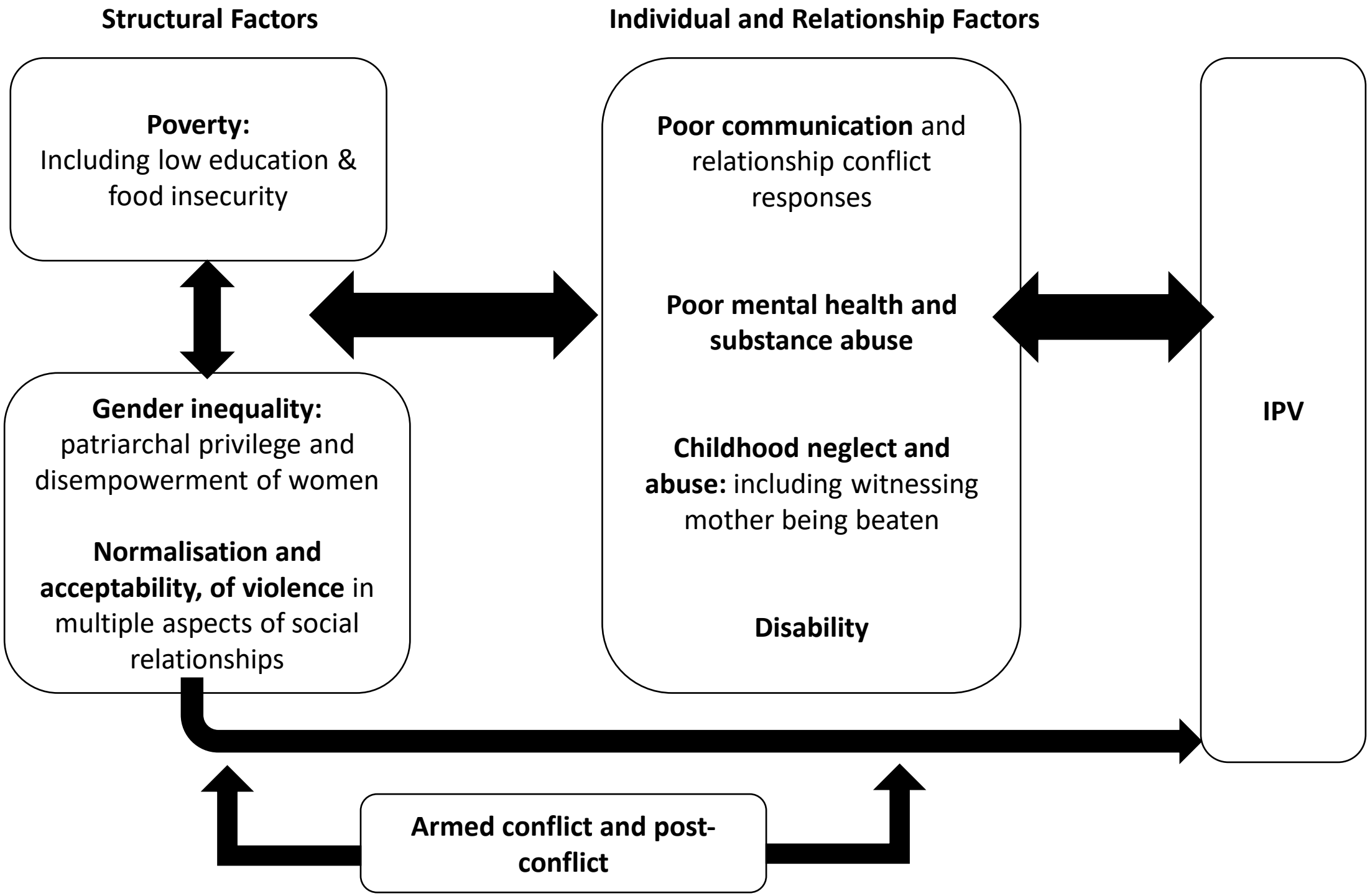
Notes: Modified from [a]Oram et al.[76], [b]Yu et al.[77], and [c]Fazel et al.[78]. IQR = interquartile range. OR=Odds ratios (odds of committing IPV compared to the general population). – indicates that estimate is not available. Estimates for drug and alcohol use disorders are based on hazard ratios adjusted for socio-demographic factors.

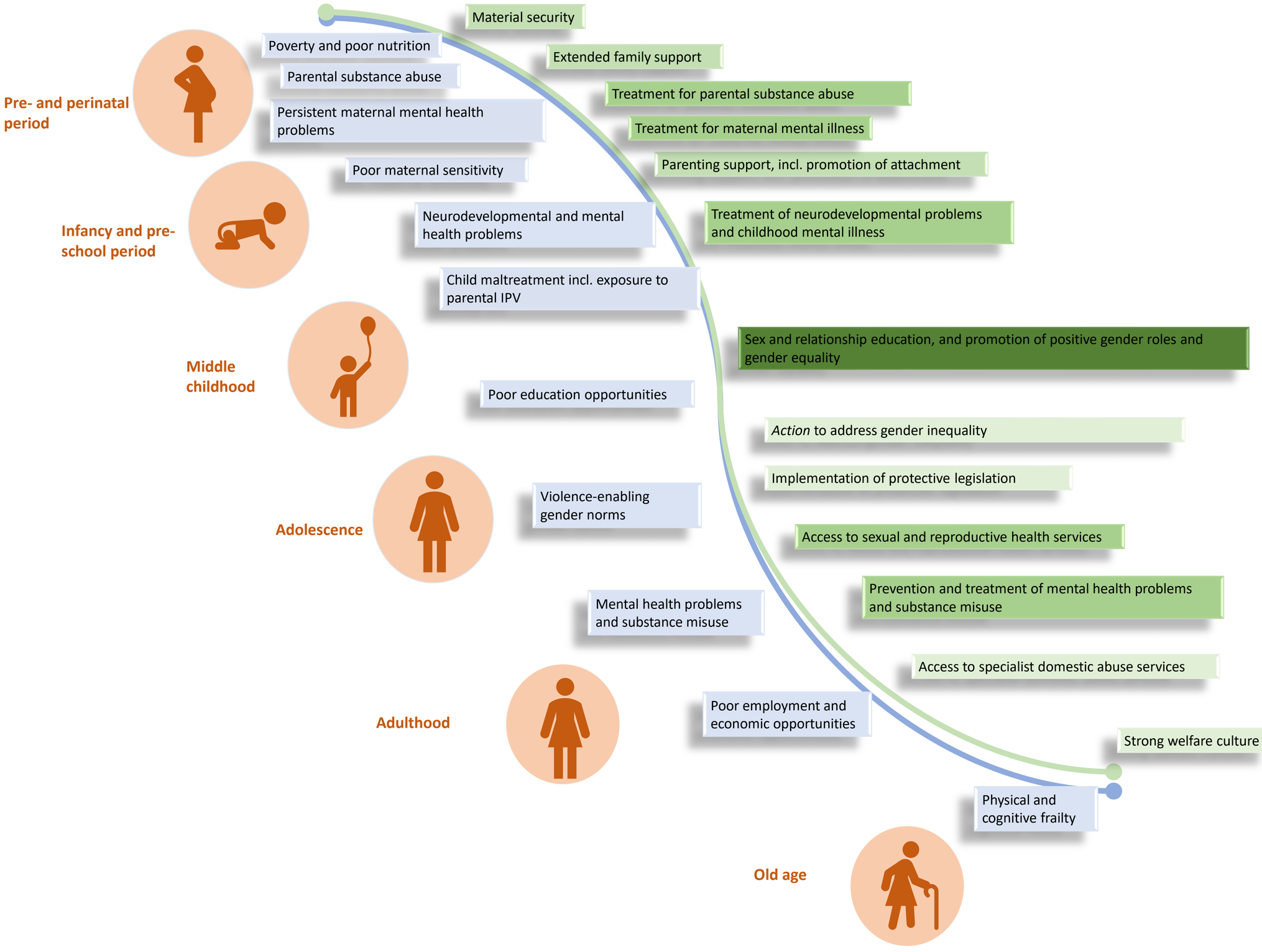
Table 2. Guiding principles of Trauma-Informed Care and implementation[242,244]

Principles	**Description**	**How it might be experienced by the person**
Safety	Throughout the organisation, staff, and the people they serve feel physically and psychologically safe.	"The most important thing is that I feel safe when getting help"
Trustworthy & Transparency	Organisational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, service users, and family members of those receiving services.	"The trust I had before was so badly betrayed, it is hard for me trust things will be different this time."
Peer Support & Mutual self-help	These are integral to the organisational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.	"Being around other women who have been through what I have been through makes me feel understood"
Collaboration & Mutuality	There is true partnering and levelling of power differences between staff and service users and among organisational staff from direct care staff to administrators. There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organisation recognises that everyone has a role to play in a trauma-informed approach. One does not have to be a therapist to be therapeutic.	"I feel like we are working together and nobody is taking over yet, which is different."
Empowerment, voice & choice	Throughout the organisation and among the service users served, individuals' strengths are recognised, built on, and validated and new skills developed as necessary. The organisation aims to strengthen the staff's, service users', and family members' experience of choice and recognise that every person's experience is unique and requires an individualised approach. This includes a belief in resilience and in the ability of individuals, organisations, and communities to heal and promote recovery from trauma. This builds on what service users, staff, and communities have to offer, rather than responding to perceived deficits.	"I am learning how to speak my mind for the first time in a long time."
Cultural, historical & gender issues	The organisation actively moves past cultural stereotypes and biases (e.g., based on sex, gender identity, gender inequality, sexual orientation, race, ethnicity, age, geography), offers services that are cognisant of gender power differentials and promote service users' autonomy, dignity and self-determination leverages the healing value of traditional cultural connections, and recognises and addresses historical trauma.	"I am taken seriously as a whole person here, not just treated as a victim."

Table 3. Readiness of mental health services to address IPV

None	No acknowledgement of the underlying role of IPV and sexual violence in mental health problems in policy or practice
Low	Policy and practice documents discuss generic trauma informed care but does not specify role of IPV or sexual violence in mental health problems nor train staff specifically in these areas
Medium	Policy and practice documents do include discussion of IPV, gender and safety issues. Training includes identification and response to IPV, trauma informed care principles, gender, and safety issues.
Moderate	A change process has implemented IPV policy and practice and train staff on IPV, gender trauma and safety issues. The organisation recognises that everyone has a role to play in addressing IPV through a trauma-informed approach
Strong	Throughout the organisation and among the clients served, individuals' strengths are recognised, and partnerships are strong. The organisation aims to share power, encourage choice, and recognize that every person's experience requires an individualised approach to addressing IPV.


Structural Factors
Individual and Relationship Factors
Poverty:
Including low education & food insecurity
Gender inequality:
patriarchal privilege and disempowerment of women
Normalisation and acceptability, of violence in multiple aspects of social relationships
Poor communication and relationship conflict responses
Poor mental health and substance abuse
Childhood neglect and abuse: including witnessing mother being beaten
Disability
IPV
Armed conflict and post-conflict



Key to institutions responsible tor interventions

Policy and politics

Welfare and social services

Health and social services

Education