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

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

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Executive summary

Part 1: Introduction

Intimate partner violence (IPV) is the most common form of violence worldwide and contributes substantially 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 the prevalence of IPV and associated mental health harms, and to establish a roadmap for strengthening responses across mental health services, research, and policy. Mental health care is delivered predominantly through primary care globally, but the relationship between IPV and severe mental health problems, and how best to address IPV within secondary mental health care, have been 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, and we also recognise the need for broader change across multiple disciplines, systems, and institutions.

Part 2: 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 and girls aged 15 years or older have experienced physical or sexual IPV—but high rates of IPV are also experienced by other groups, including sexual and gender minorities, people with disabilities, migrants, and people from marginalised ethnic or Indigenous groups. The relationship between IPV and mental health is complex. Exposure to IPV in childhood or adulthood increases the likelihood of developing a range of mental health problems, suicidal ideation, and attempting suicide. The presence of mental health problems also makes individuals more vulnerable to experiencing IPV. Children who are exposed to IPV are at high risk of additional forms of abuse and neglect, and experiencing abuse or being exposed to IPV in childhood greatly increases the risk of both experiencing and perpetrating IPV as an adult. People with diagnosed mental health problems are more likely to commit IPV mechanisms still need to be elucidated, and there are concerns about the potentially stigmatising consequences of examining the role of mental health problems in the perpetration of IPV, as well as concerns that diagnoses such as borderline personality disorder pathologise women's responses to violence and oppression. However, associations between mental health problems and experiencing or perpetrating IPV appear to occur across the life course and relate to both the onset and the course of mental health problems.

Part 3: IPV across the life course

Although IPV is endemic, it is not inevitable. Evidence points to several targets for prevention and intervention in individuals, families, communities, and societies. Some are stage specific, such as parenting programmes to reduce child abuse and neglect, or school-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 support for secondary or higher education for women.

Part 4: Measurement of IPV

Measurement of the frequency, severity, and context of IPV, its co-occurrence with other forms of violence, and its effects on mental health is challenging but important. Although substantial strides have been made in assessment methods for IPV, more needs to be done to advance measurement and to harmonise data collection via collaboration across sectors. Administrative data are fragmented and inconsistent between fields, professions, and practitioners. The development of IPV measures should involve people with lived experience of IPV and of mental health problems to ensure that the measures generated are relevant, feasible, and valid.

Part 5: Transformation of the mental health system to address IPV

Survivors should be fundamental to the development and assessment of support services at every level, from

Lancet Psychiatry 2022; 9: 487–524

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Part 5: Transformation of the mental health system to address IPV

Survivors should be fundamental to the development and assessment of support services at every level, from grassroots survivor-led services to statutory mental health services. Mental health systems and providers can make a crucial 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 retraumatising. Survivors and providers alike have called for urgent reform to enable pathways to safety, healing, health, and wellbeing 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, the effects of IPV on mental health, and the intersections of both IPV and mental health with other forms of oppression including racism, transphobia, ableism, and poverty. Mental health professionals should be enabled to respond appropriately through training and continuous learning, and should be able to count on organisational infrastructure and support. Because mental health services can be difficult to access as a result of poor availability and financial or logistic constraints (especially in marginalised populations and for people in low-income and middle-income countries), efforts to integrate mental health care into primary health care, to strengthen training of lay workers, and to provide grassroots and user-led alternatives to mental health services are essential.

Part 6: Addressing gender inequality and societal responses to IPV

Primary prevention should sit alongside work to strengthen mental health service responses to IPV and should be informed by an intersectional approach that recognises that IPV interlocks with gendered and other forms of oppression. Structural factors that need to be addressed include access to education, employment, and poverty-reduction strategies, laws and policies that discriminate against women (eg, those surrounding divorce, child custody, property ownership, and inheritance) and other groups at risk of IPV (including people in same-sex relationships and gender minorities), the implementation and enforcement of anti-violence legislation, and policies to reduce harmful alcohol consumption. Moreover, to prevent IPV, societies should consider how violence-supportive norms are located and how institutional and public structures condone or reinforce these norms. The risk of IPV is highest in societies that are most unequal in their gender relations and in which the use of violence generally, and the use of violence against women specifically, are accepted norms. The importance of context and wider societal issues in IPV has been particularly apparent during the COVID-19 pandemic, which has resulted in a steep increase in reports of IPV internationally. The mental health consequences of these increased rates of IPV, and potentially the reduced opportunities to escape and access support, are not yet apparent but will be important to investigate, alongside the mental health consequences of COVID-19 itself.

Key messages

• Exposure to intimate partner violence (IPV), whether in adulthood or in childhood, increases the likelihood of developing a range of mental health problems, and 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.

• Reducing IPV is very likely to improve mental health outcomes, irrespective of whether exposure occurs directly in adulthood, indirectly in childhood, or both.

• Some people with mental health problems are more likely to commit IPV compared with people without mental health problems, although absolute rates are low and people with mental health problems are more

likely to experience than to commit IPV. Treatment studies have shown that reductions in alcohol use are associated with reductions in IPV generally, and reductions in IPV severity particularly, with implications for both provision of mental health services and social policy.

• IPV causes early exposure to stress, including in utero, which results in difficulties coping with stressors during the life course, increased risk of mental health problems, and neurodevelopmental impairments that contribute to intergenerational transmission of violence. Preconception interventions might reduce the risk of intergenerational transmission of violence and improve mental health outcomes.

• Severe parental stress (eg, caused by IPV, poverty, or food insecurity) increases the risk of children experiencing maltreatment, including exposure to parental IPV. Reducing parental stress, whatever the cause, might help to reduce the prevalence of violence in the population.

• Schools have an opportunity to reduce the risk of IPV, through purposively creating an ethos that models gender equality and respectful relationships.

• Mental health services should address IPV by using approaches that are gender sensitive, trauma informed,
and coproduced with survivors.

• 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 done in private by trained practitioners who work within a clear referral network.

• WHO's LIVES principles for first-line response to IPV can help providers to recognise and respond to IPV.
Responders should listen with empathy and without judgement, enquire about needs and concerns, validate
experiences, enhance safety, and support people by connecting them to information, services, and social support.

• Children and adolescents with emotional and behavioural problems should be assessed for exposure to IPV. They might need specific interventions together with or separately from their caregivers, but this need should be established based on a thorough assessment.

• 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.

• Improved coordination and cooperation across sectors (eg, academia, policy, health services, specialist services, criminal justice services) are needed in terms of both data collection for IPV and core indicators and outcomes to assess interventions to reduce IPV, which should reflect the priorities and expectations of survivors.

• The risk of IPV seems to be highest in societies that are most unequal in terms of gender relations and where violence against women is an accepted norm. There is a growing evidence base suggesting that gender transformative interventions can effectively prevent IPV.

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