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Routine enquiry about violence and abuse is needed for all mental health patients

I am pleased that Brooker and colleagues have highlighted their finding of poor recording of sexual violence and abuse in care programme approach (CPA) documentation in England.[1] It seems timely to highlight the international developments in this area, which are of relevance for staff seeing patients with mental disorders in general, not only patients receiving CPA support.

It is now well established that people with mental disorders are more likely to have been victims of violence and abuse (and/or to have witnessed it as children) than the general population, and that they continue to be at increased risk of being a victim of violence.[2,3,4] The World Health Organization (WHO) has a violence prevention strategy (http://www.who.int/violence_injury_prevention/violence/en/), and both the WHO and the World Psychiatric Association[5] have highlighted domestic and sexual violence as major determinants of mental ill health; a competency-based curriculum has recently been published for medical students and psychiatrists.[6] In the UK, the National Institute for Health and Care Excellence (NICE) public health guideline PH50 has recommended routine enquiry about experiences of domestic violence in mental health settings, and NICE clinical guideline CG89 recommends that childhood maltreatment is considered when assessing a range of physical, sexual and emotional problems. Violence and abuse, including physical, sexual and emotional abuse, are sadly still highly prevalent and, as England's Chief Medical Officer has argued, general practitioners and mental health professionals need to routinely ask people with mental health problems about current and historical violence and abuse.[3] However, routine enquiry alone is not enough; services need to train professionals so they know how to ask and respond sensitively and have protocols in place for appropriate care when violence or abuse is identified. In addition, there is a small but growing evidence base on the association between mental disorders and perpetration of domestic violence and abuse; therefore, domestic violence and abuse perpetration also need to be identified by mental health professionals for comprehensive risk assessment.[7]

Declaration of interest

L.M.H. was a member of the steering group at the World Psychiatric Association which wrote the competency-based curriculum,[6] and was a member of the NICE PH50 guideline development group.

1 Brooker CGD, Tocque K, Brown M, Kennedy A. Sexual violence and abuse and the care programme approach. *Br J Psychiatry* 2016; **209**: 359–60.

2 Khalifeh H, Johnson S, Howard LM, Borschmann R, Osborn D, Dean K, et al. Violent and non-violent crime against adults with severe mental illness. *Br J Psychiatry* 2015; **206**: 275–82.

3 Davies SC. *Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence.* Department of Health, 2014.

4 Anderson F, Howard L, Dean K, Moran P, Khalifeh H. Childhood maltreatment and adulthood domestic and sexual violence victimisation among people with severe mental illness. *Soc Psychiatry Psychiatr Epidemiol* 2016; **51**: 961–70.

5 World Psychiatric Association. *WPA Position Paper on Intimate Partner Violence and Sexual Violence Against Women.* WPA, 2016.

6 World Psychiatric Association. *The World Psychiatric Association (WPA) International Competency-Based Curriculum for Mental Health Care Providers on Intimate Partner Violence and Sexual Violence against Women.* WPA, 2016.

7 Oram S, Khalifeh H, Howard LM. Violence against women and mental health. *Lancet Psychiatry* 2017; **4**: 159–70.

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International suicide rates versus adequate treatments

Thornicroft and colleagues recently reported on the undertreatment of people with major depressive disorder (MDD) in 21 countries.[1] Their conclusions suggest that better diagnosis and treatment of major depression worldwide, particularly in low-income countries, should improve health outcomes. Such improvements should contribute, in particular, to reducing rates of suicide, which are closely associated with MDD.[2]

Accordingly, we considered relationships between the reported national rates of treatment for MDD overall or for identified cases who wanted treatment,[1] versus annual suicide rates as reported by the World Health Organization.[3] In data available from 12 countries of greater versus 8 of lesser wealth listed by Thornicroft *et al*,[1] annual suicide rates averaged 9.48 (95% CI 6.80–12.2) *v.* 5.31 (2.23–8.40) respectively per 100 000 ($t = 2.27$, $P = 0.04$). Rates of minimally adequate treatment of identified MDD cases differed correspondingly: 48.2% (40.9–55.5) *v.* 28.7% (14.0–43.4) among those who wanted treatment ($t = 3.01$, $P = 0.008$), and 23.4% (19.6–27.3) *v.* 7.36% (3.35–11.4) for MDD cases overall ($t = 6.28$, $P < 0.0001$). Moreover, there was a strong, direct, linear correlation between greater rates of treatment (by either measure) and higher suicide rates ($r_s = 0.644$, $P = 0.005$; slope for rates of treatment of those wanting it: 0.154 (0.049–0.260), $t = 3.09$, $P = 0.006$).

These observations are sobering in indicating: (a) surprisingly low observed rates of minimally adequate treatment for MDD, especially in less affluent countries, and (b) absence of lower suicide rates with greater rates of treatment. However, we propose that the various numerical estimates involved are susceptible to errors of ascertainment. Notably, the relatively low reported suicide rates in less affluent regions may, at least partly, reflect incomplete reporting. Low observed rates of treatment, instead, probably reflect complex differences that may include ascertainment errors, less access to care (lower clinician density and economic factors) and cultural factors, between relatively wealthy and poor countries. Efforts to reduce morbidity and mortality, including reduction of suicide risks, by improving recognition and treatment of MDD are highly laudable. However, their demonstration may require relatively challenging, within-region outcome measures, such as valid comparisons of suicide rates before versus after interventions aimed at improving clinical care.

1 Thornicroft G, Chatterji S, Evans-Lacko S, Gruber M, Sampson N, Aguilar-Gaxiola S, et al. Undertreatment of people with major depressive disorder in 21 countries. *Br J Psychiatry* 2017; **210**: 119–24.

2 Tondo L, Baldessarini RJ. Suicidal behavior in mood disorders: response to pharmacological treatment. *Curr Psychiatry Rep* 2016; **18**: 88–99.

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