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Psychiatrists, Paediatrics and Child Health, Nursing, and Physicians (Faculty of Forensic Medicine), the British Psychological Society and British Psychoanalytical Society, Women's Aid and Refuge, the National Rape Crisis Network, the Survivors Trust, the Association of Chief Police Officers, and Prison, Probation and Youth Justice Services.

The challenge lies in turning guidelines into practice. As part of the VVAPP, a pilot was established in a number of adult mental health trusts to introduce routine clinical enquiry about violence and abuse in assessment and care planning as part of the care programme approach, focused on those with severe mental illness associated with childhood victimisation. The role of psychiatrists in this pilot and its evaluation, and the national implementation to follow, will be instrumental in helping recovery. The question is whether a similar approach in child and adolescent mental health services would produce better outcomes for children and young people.

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Making a difference. Invited commentary on . . . Effects of domestic violence and sexual abuse on mental health

When I qualified in 1987, I was appalled to learn that the vast majority of the on-call forensic medical examiners who examined women subjected to serious sexual assault and rape in the Metropolitan Police area were men. I was subsequently involved in the establishment of an on-call rota of women doctors who were prepared to examine victims of sexual violence. Nowadays, services deliver holistic non-judgemental intervention, particularly in sexual assault centres. These centres are specialist services providing 24-h forensic examinations, other medical and psychological services and aftercare in a secure and sensitive setting (Lovett *et al*, 2004; Kelly *et al*, 2008). This model is now being extended.

There was little in my training that covered the mental health effects of abuse and traumatisation, despite it being known that domestic violence, rape and sexual assault, sexual exploitation and childhood physical, emotional and sexual abuse can have life-long effects on the physical and mental health of the victims. Indeed, it was rare that questions about such traumas were even asked. We know, however, that such trauma leads to significant morbidity (Golding, 1999). Golding reported that the weighted mean prevalence of mental health problems among battered women was 47.6% in 18 studies of depression, 17.9% in 13 studies of suicidality, 63.8% in 11 studies of post-traumatic stress disorder, 18.5% in 10 studies of alcohol misuse and 8.9% in 4 studies of drug misuse.

Although many survivors recover spontaneously, treatment of clinically significant psychopathology is essential. The general practitioner has an important role in identifying those requiring formal treatment and ensuring follow-up is carried out. Post-traumatic stress disorder management guidelines (National Collaborating Centre for Mental Health, 2005) indicate that those affected should be offered trauma-focused psychological

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treatment (cognitive–behavioural therapy or eye movement desensitisation and reprocessing), regardless of the time since the traumatic event. If there is no marked improvement, clinicians should consider an alternative psychological therapy and/or medication. Antidepressants are recommended for prominent depressive symptoms or a distinct depressive illness. Short-term use of hypnotics and anxiolytics may be beneficial for hyperarousal in the immediate aftermath of the traumatic event. Management may be more complex in individuals with repeat traumatisation, when referral to a specialist centre should be considered.

Fortunately, progress has been made, although it seems that despite all the recent government initiatives, there still remains ignorance in relation to domestic and sexual violence. I often act as an expert witness in criminal trials where a woman defendant reports her experience of domestic abuse, often supported by other documentary evidence. At times I am surprised by other experts who, at best, ignore the potential impact of domestic abuse on the woman or, at worst, fail even to obtain a history of her experiences. For women who offend and who direct violence towards others, psychological antecedents of that violence are often overlooked. Despite personality disorder no longer being a diagnosis of exclusion, my experience indicates that it often is. We do not have the language to describe the effects on individuals of chronic, sustained neglect and trauma when those effects lead to a damaged scarred personality, apart from indicating that the individual has a personality disorder. Yet it is this very diagnosis that is often responsible for the focus on the aggression, rather than its antecedents, when considering potential sentencing options.

The Victims of Violence and Abuse Prevention Programme (VVAPP) aims to assist professionals and services to identify and respond to the needs of individuals affected by a broad range of abusive experiences. It is essential that the life-course perspective and whole-system approach advocated by the VVAPP is embraced, given that such experiences affect many aspects of an individual's functioning and health, not just their mental health. At present, we fail many of those who come into contact with services, as we do not recognise their needs.

The introduction of the Mental Health Trusts Pilot Collaboration Project is to be welcomed. The project has been established to develop and pilot a protocol for routine exploration in mental health services assessment and care planning about sexual and domestic violence and abuse, experienced as a child and/or as an adult. It is essential that, when identified, victims are offered the appropriate support and interventions. Thus, this recognition has to be extended beyond mental health services, given the pervasive damage that can be caused by abuse experiences. Mental health services have a long way to go in this regard and can learn from third-sector providers who are less likely to try to fit those presenting to such centres into convenient 'silos'.

The VVAPP is an ambitious attempt to tackle some of the more complex and damaging difficulties that our society faces. We need to recognise the fundamental principles underlying this programme, to train staff accordingly and to be facilitated in providing appropriate interventions. It is essential to ensure that this body of work leads to fundamental change rather than a few isolated areas of good practice.

Despite the significant effects of domestic and sexual violence and abuse on women, and the associated cost both to society and the individuals concerned, awareness remains low among mainstream health service practitioners about these issues, leaving survivors of such experiences in the dark. Often, they are not identified. The VVAPP is aimed at changing our practice, and the lives of those affected by violence.

Declaration of interest

F.M. was a member of the Adults Sexually Victimised in Childhood Expert Group for the VVAPP.

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