Intimate Partner Violence and Homicide: An Analysis of European Prevalence Studies and the Role of Mental Health in Domestic Homicide Reviews.

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Thesis Portfolio Abstract

Background: Intimate Partner Violence (IPV) is a major public health issue and is a common precursor to Intimate Partner Homicide (IPH). The United Nations (2025) has set goals to eliminate all forms of violence against women and girls by 2030. The current thesis aims to contribute to the growing body of research in this area.

Method: The systematic review and meta-analysis sought to synthesise all studies reporting past-year IPV prevalence among women in Europe and to provide up-to-date estimates. The review further sought to examine the definitions used to measure IPV and explore their impact on reported prevalence. The empirical paper aimed to explore the mechanisms of mental health (MH) within the perpetrator in IPH cases in England and Wales.

Results: 22 studies were included in the systematic review. A pooled prevalence of 12.1% for 'any IPV' among women in Europe was identified. The prevalence rates for IPV subtypes were 7.4% for physical IPV, 3.1% for sexual IPV, and 22.6% for emotional IPV. The empirical paper found that anxiety, psychosis or schizophrenia and neuro-cognitive disorders appeared to feature more in perpetrators, in cases where MH was likely to be linked to IPH perpetration (MH-IPH). Depression was also common among perpetrators. Care-giving roles and close relational dynamics were also further characteristics of MH-IPH cases.

Conclusions: There is significant heterogeneity in prevalence studies reporting IPV towards women, creating significant challenges in establishing confidently what the true rates are. IPV prevalence is best understood within the local country and cultural context. Whilst MH is commonly reported in perpetrators of IPH, it is not always a primary driver, and often patterns of abusive behaviour, conflict, and separation can be antecedents. Strengths, limitations, clinical implications, and directions for future research are discussed.

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List of Abbreviations

DA – Domestic Abuse

DV – Domestic Violence

DVA- Domestic Violence and Abuse

IPV – Intimate Partner Violence

IPH – Intimate Partner Homicide

VAW - Violence Against Women

DHRs – Domestic Homicide Reviews

MH – Mental Health

MHS – Mental Health Services

Declaration

This thesis portfolio includes and builds upon material previously submitted as part of the ClinPsyD Thesis Proposal.

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Chapter One: General Introduction

Intimate partner violence (IPV) is defined as abuse or aggression which occurs in the context of a romantic relationship. An intimate partner refers to a current or former partner or spouse, including a dating partner (CDC, 2024). IPV varies in severity, from one incident of violence to chronic and severe incidents occurring over a period of time. It can include acts of physical violence (strangling, punching, kicking, slapping, pushing), sexual violence (unwanted touching or sexual activity, forced sex), psychological abuse (belittling, humiliating, verbal abuse, threats), economic and financial abuse (restricting access to healthcare, education or resources such as housing or transport and taking control of money) (The World Health Organisation [WHO], 2022). IPV also includes coercive control, which is a pattern of behaviour used to dominate, intimidate and create fear and dependency in the victim (Stark, 2009), which is now recognised as a criminal offence under Section 76 of the Serious Crime Act (2015). Although not the focus of the present project, research is now developing into technology-facilitated IPV (TF-IPV), which has emerged as a significant and evolving form of abuse, through social media, and the use of tracking devices. Evidence highlights that this has harmful consequences, and there is a lack of understanding among frontline staff in TF-IPV, which creates challenges in addressing this form of abuse (Afrous, 2021).

IPV is the most common form of violence worldwide, contributing to physical, mental, reproductive and sexual health problems as well as death through homicide or suicide (Oram et al., 2022). IPV is considered a gendered phenomenon across research, in that most victims are female. Still, males can certainly also be IPV victims, and high rates are also prevalent among gender minority groups, those with disabilities, marginalised ethnic groups and migrants (Oram et al., 2022). The WHO (2025) report that violence against women remains one of the most enduring yet under-addressed human rights crises, with very little progress in the past two decades. IPV has disastrous effects on individuals, families, communities and the economy. These concerns are reflected within the United Nations (UN) 2030 Sustainable Development Goals, which include a call for the elimination of violence against women and girls (UN, 2025).

At the most extreme side of the continuum is intimate partner homicide (IPH), which is the killing of a current or former partner or spouse (Matias et al., 2020). Understanding the scale of the problem and the mechanisms that contribute to lethal violence is essential for informing prevention efforts, developing resources, shaping service responses, and advancing theoretical development.

The thesis portfolio examines IPV from two perspectives. Chapter two consists of a systematic review and meta-analysis of population-based studies across Europe that have collected prevalence data on IPV against women. Building on this, chapter three connects the gap between IPV and IPH. Chapter four contains the empirical study, which explores the function of mental health in cases of IPH, using Domestic Homicide Reviews from England and Wales. The study also explores recommendations for mental health services (MHS), presenting insights into organisational gaps and opportunities for prevention. The final chapter provides an integrated summary of the findings from both the systematic review and the empirical study. It further offers a critical appraisal of both studies and reflections on the research process. Both the clinical and theoretical implications are discussed, culminating in an overall conclusion.

CHAPTER TWO
Systematic Review

Prevalence of Intimate Partner Violence in Europe and Definitional Variance: A Systematic Review and Meta-analysis

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Chapter Two: Systematic Review

Abstract

Purpose: IPV against women is widely prevalent and has a significant impact on the health and well-being of women, along with substantial economic costs. Numerous population-based studies have collected data on IPV prevalence. However, they can differ substantially in their survey methodology and in the definition or measurement tools employed. The way IPV is defined will affect what is counted and, in turn, inform policy and investment. This systematic review and meta-analysis aimed to examine prevalence estimates of IPV against women in the past year across Europe. The review further assessed the different definitions used and their subsequent impact on reported prevalence.

Methods: A systematic literature search was conducted across five databases (PubMed, ASSIA, Scopus, Web of Science, and EBSCO). Twenty-two eligible studies met the inclusion criteria. Meta-analyses were performed to generate pooled prevalence rates for overall IPV and its subtypes. Further subgroup analyses explored how varying definitions shape prevalence rates.

Results: Across Europe, the pooled past year prevalence of 'any IPV' (physical, sexual and emotional) was 12.1%. Subgroup analyses showed prevalence estimates of 6.5% for combined physical and/or sexual IPV, 7.1% for physical IPV, 3.1% for sexual IPV and 22.6% for emotional IPV.

Conclusions: Although substantial heterogeneity across studies limits the interpretation of pooled estimates as a single European figure, the elevated prevalence across diverse populations demonstrates that the problem is both widespread and remains a significant public health concern that policymakers cannot overlook.

Keywords: Intimate Partner Violence, Domestic Violence, Prevalence, Definition, Europe

Introduction

The World Health Organisation [WHO] (2022) defines IPV as behaviour that causes physical, sexual or psychological harm within an intimate relationship by current and former spouses and partners. Acts include physical aggression, sexual coercion, psychological abuse and controlling behaviours. Although IPV is considered a gendered crime, mostly perpetrated by men (Women's Aid, 2024), it is important to acknowledge at the outset that men can be victims too. Men as victims have received less attention, yet still experience a wide range of abuse, underscoring the need for a separate focus in the research in this area (Isangha et al., 2026; Rehman et al., 2023). The present research focuses on IPV against women. Violence against women (VAW) is a violation of human rights and widely recognised as a global public health issue (Stöckl & Sorenson, 2024). Almost 1 in 3 women (30%) aged 15 and over have experienced physical and/or sexual violence at least once in their lifetime (UN Women, 2024). Most of this violence is IPV, with 27% of women aged 15-49 reporting physical and/or sexual violence by an intimate partner (WHO, 2024). Over the past two decades, IPV has declined very slowly, at an annual rate of 0.2% (WHO, 2025).

IPV exposure has been associated with adverse effects on mental health in women, including depression, post-traumatic stress disorder, anxiety, and suicidality (Lagdon et al., 2014; White et al., 2023). IPV has also been associated with poorer physical health outcomes in women and increased risk of developing diabetes, sexually transmitted infections, use of substances and the development of pain and chronic diseases (Stubbs & Szoeke, 2022). From a human rights and policy perspective, IPV violates a woman's rights to life, security and freedom (End Violence Against Women, 2022) and has high economic costs (Oliver et al, 2019; Peterson et al, 2018).

Prevalence studies are important for estimating the frequency with which a phenomenon occurs in a population. Collecting, analysing, and regularly producing reports on IPV data are the first steps in developing evidence-based initiatives to reduce VAW and girls (Sardinha et al., 2022; Maheu-Giroux et al., 2022). Population-based studies collecting IPV data from nationally representative samples have increased in the last decade. However, survey methods for measuring

IPV still show substantial variation (Sardinha et al., 2022). Maheu-Giroux et al. (2022) acknowledge the significant challenges researchers face in estimating the prevalence of IPV. These challenges include using different definitions or items to measure IPV subtypes (physical, sexual, emotional) and differences in women sampled (e.g. currently partnered, ever partnered, married women). Researchers also face difficulties due to the presence or absence of disaggregation by age or by the types of violence identified. Such issues lead to substantial differences in comparability across studies. To understand the extent of the problem and monitor progress in addressing VAW, studies now provide baseline estimates for the global, regional, and national prevalence of physical and/or sexual IPV (Barbier et al., 2022; Sardinha et al., 2022; White et al., 2023).

One of the key studies reviewing the prevalence of IPV was Hegarty & Roberts (1998). They acknowledged differences in reported prevalence rates across Australian studies, attributing them to the definitions used to measure IPV. Studies from the United States reported rates ranging from 5 to 20%, depending on the definition of IPV (Stark & Flitcraft, 1988, as cited in Hegarty & Roberts, 1998). For example, in terms of violence, at one end, studies might use a self-defined definition that includes numerous examples of behaviour considered violent; at the other, studies might include violence only if it meets the criteria for a criminal offence. Unsurprisingly, more restrictive definitions of violence are associated with lower prevalence rates (Hegarty & Roberts, 1998). These findings have significant policy implications, given that, at the national level, countries with limited or vague definitions may underreport IPV incidents. Moreover, at an individual level, unnecessarily restrictive definitions may mean that victims may not recognise their experiences as abuse or have access to appropriate support services. Researchers have argued for a broader, operationally defined definition of IPV to capture comparable prevalence rates and to reflect this complex phenomenon (Hegarty & Roberts, 1998).

Beyond the key study by Hegarty and Roberts (1998), several other authors have attempted to estimate prevalence rates for violence against women. Alhabib et al. (2009) systematically reviewed published worldwide prevalence studies on ‘domestic violence’ (DV) against women between 1995

and 2006. The authors did not compare definitions in their study but acknowledged the need to develop clearer definitions to enable cross-setting comparisons and to monitor changes in prevalence over time. Costa et al. (2015) later reported similar reflections for studies conducted across Europe on prevalence estimates for men and women. They acknowledge that rates vary due to study design and differences in IPV definitions, which preclude comparisons. IPV definitions vary widely, with some including only physical and or sexual IPV, and others considering emotional and economic IPV. Higher rates of IPV are reported when the definition is broad, including minor assaults, sexual and emotional/psychological abuse (Hegarty & Roberts, 1998). More recently, Sardinha et al. (2022) concluded that one in four (24%) ever partnered women aged 15-49 years had experienced physical or sexual violence at least once in their lifetime, and one in seven (13%) had experienced such violence in the past year. Authors also highlight the challenges posed by using varying definitions and measures to estimate IPV prevalence, which make comparisons across studies and countries difficult. Furthermore, the study was unable to capture information on psychological abuse due to variations in the definition and measurement of this type of abuse. Barbier et al. (2022) collated results from an EU-wide survey, finding the lifetime prevalence of physical (20%), sexual (8.4%) and psychological (48.5%) abuse among women was likely underestimated. The authors reiterate the need for a more comprehensive definition of IPV, having found that IPV is mainly a combination of at least two types of violence and is infrequently the experience of one type of violence. Studies exploring the prevalence of domestic homicide and non-partner sexual violence further highlight the difficulties with differing definitions and the importance of more inclusive definitions (Stockl et al., 2013; Abrahams et al., 2014). This indicates that variations in definitions are a common challenge across the field of violence research. Variations in operationalised definitions are a source of heterogeneity in prevalence research. Differences in behavioural acts, time frames and severity thresholds will significantly alter who is classified as experiencing IPV. To improve reporting and support for victims, studies must adopt comprehensive definitions of IPV and align with the data-collection methods used. Understanding how differences in definitions affect prevalence estimates will be important for improving the measurement of IPV.

Aim of the Review

To date, no recent papers have systematically reviewed the definitions of IPV or their subsequent impact on prevalence rates. This review will focus on extracting and comparing operationalised definitions of IPV across European studies and exploring how these definitions affect prevalence rates. Although large European surveys have reported a prevalence of 5.3% over the past year, with estimates ranging from 2.8% to 12% (Eurostat, 2024), they did not provide prevalence estimates for the IPV subtypes (physical, sexual, and emotional). Therefore, this review will also synthesise the prevalence rates of IPV among women in Europe, including the subtypes. The review will focus on 'past year IPV', which is key to enable exploration of current policy and information regarding IPV. Restricting the analysis to past-year IPV also reduces recall bias and enhances comparability across studies, providing a clearer picture of recent IPV rates. Previous studies have found higher rates of VAW in clinical populations, which are arguably not generalisable to the wider population (Alhabib et al., 2009). Therefore, the sample in this review will be restricted to population or community samples to improve the generalisability of the findings. Finally, the review will focus on women recruited only in Europe. Existing literature indicates that women experience IPV at disproportionality higher rates compared to men (EuroStat, 2024). Whilst men can be victims and experience a wide range of abuse, their experience and prevalence of such abuse merit a separate body of research (Isangha et al., 2026; Rehman et al., 2023).

Europe is a diverse continent with varying legal frameworks and cultural differences, likely resulting in significant heterogeneity in definitions and prevalence rates, as well as sufficient homogeneity in shared practices and developments regarding DV.

Review objectives

1. To quantify the past year prevalence of IPV against women across Europe.
2. To explore how varying definitions of IPV influence reported prevalence estimates across Europe.

Methods

The review protocol was written and uploaded to the Open Science Framework (https://doi.org/10.17605/OSF.IO/HMJST) on 25th October 2025. Amendments were made, and the document was updated on 25th January 2026. The analysis and review objectives were revised to accommodate enough studies and subsequent data, thereby enabling a meta-analysis. This systematic review followed the Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) guidelines (PRISMA, 2020; Page et al., 2021).

Eligibility Criteria

Studies were eligible if they were peer-reviewed primary research published in the English language, meeting all the following criteria:

- A cross-sectional, community or population-based survey design which could be generalised to the wider population.
- Female participants aged 15+, where the range of included ages suggested it was meaningful to generalise to the wider population
- Participants were recruited from a European nation as defined by the Council of Europe (2025).
- Participants were recruited from settings that supported population generalisability, for example, GPs or healthcare centres.
- Quantitative prevalence data were available for past-year IPV (last 12 months)
- A clear definition of IPV was provided, or a measure was used to estimate IPV prevalence.
- The violence was perpetrated by an intimate partner (current or former).

Studies were excluded if they did not meet the criteria above. In practice, this means that studies were excluded if they recruited from specific healthcare departments, where the sample was unlikely to be generalisable to the wider population (e.g., fracture clinics, A&E, perinatal populations). Additionally, we excluded studies that reported a recruitment window to assess IPV in

the context of the COVID-19 pandemic or were conducted in countries outside Europe. Studies which only reported lifetime prevalence or where the violence measured did not specify if the perpetrator was a partner or spouse were also excluded.

Search Strategy and Identification

Initial searches were conducted on the 6th of November 2025. Five databases were searched: PubMed, EBSCOhost, ASSIA, Web of Science and Scopus, using the search terms listed in Appendix B. A total of 1,042 articles were retrieved from the database searches and uploaded to Rayyan (Rayyan, 2022). Rayyan was used to remove duplicate articles. The primary author (CL) screened titles and abstracts for inclusion using the inclusion criteria. 87 articles were eligible for full-text review. 25% of full-text articles were screened by a second reviewer (HK) against the inclusion criteria. HK also screened 100% of eligible studies (*n*=22). Both authors agreed that the selected studies met the inclusion criteria.

Data Extraction

A data extraction template was created in Excel, piloted and refined before full data extraction. Extracted data included citation details (author, year), demographic details (age range, country, relationship status), methodology (sample size, sampling method, study design), type of IPV measured, the definition or measurement used and reported prevalence data on past-year IPV. The primary outcome was the prevalence of IPV, typically reported as a percentage (the number of females who had experienced IPV in the past 12 months). Prevalence estimates were extracted as reported or calculated when the raw numerator and denominator data were available.

Study Risk of Bias Assessment

The final articles selected for inclusion in the review underwent quality appraisal using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Prevalence Studies (Munn et al., 2020). The tool consists of nine questions, demonstrates high rigour, and addresses the most important methodological quality items in prevalence studies (Migliavaca et al., 2020; Munn et al., 2014). 32% of the included articles were also quality assessed by the second reviewer, HK. Any conflicts in

decisions were resolved through discussion. Further discussion with a third reviewer (RR) was sought for ambiguous or conflicting decisions about certain articles. The tool itself does not provide guidance on cut-offs or scores for assessing study quality; instead, it encourages reviewers to make their own decisions. Cutoff scores are not recommended because the critical appraisal questions are not equally weighted, and totalling "yes" responses does not provide an accurate indication of the problems within a study. Authors are encouraged to present results of all questions in a table rather than providing a summary score (Munn et al., 2020). The table is displayed in the results section of this paper.

Data Synthesis

To address the first research aim, studies were organised by the type of IPV prevalence data they reported, allowing pooling of estimates to generate overall prevalence figures for IPV and its specific subtypes (physical, sexual, and emotional). Several meta-analyses were conducted using the software JASP (JASP, 2025; Goss-Sampson, 2025). Random-effects models were used throughout to calculate pooled prevalence estimates, accounting for the likely heterogeneity across prevalence studies (Migliavaca et al., 2022; White et al., 2023). Prevalence rates and sample sizes were used to calculate effect sizes and standard deviations, which were then transformed using the logit transformation, the classic transformation recommended in the literature for proportions (Schwarzer & Rücker, 2022). A Restricted Maximum Likelihood (RML) model was used to estimate the between-study variance ($\tau 2$) (Langan et al., 2019), and the Hartung-Knapp adjustment was applied to produce more conservative confidence intervals (this is recommended when K is small, and heterogeneity is large (van Aert & Jackson, 2019). Despite its ubiquity, classifying the I^2 statistic, which estimates heterogeneity as low, moderate, or high, does not indicate the magnitude of effect size variation. Tau-squared ($\tau 2$) and 95% prediction intervals (PI) will be reported alongside the I^2 statistic, as they provide information on the extent of effect-size variability (Borenstein, 2024). The 95% PI provides estimates on where the true effects of future comparable studies are expected to fall.

To address the second research aim, examining how different definitions of IPV may affect prevalence rates, studies were grouped by their definitions of IPV. Because of the various instruments used to measure IPV and the considerable overlap among questionnaire items, studies were grouped by the violence concepts they measured. Table 1 presents the grouping of studies according to the definitions or measurement items used. These definitions were iteratively developed and are not based on any pre-existing empirical framework. Subgroup analyses were performed, and the Cochran's Q test was used to assess differences between subgroups (Borenstein & Higgins, 2013).

Given the substantial heterogeneity observed across studies, sensitivity analyses were conducted to assess the robustness of the subgroup-pooled prevalence estimates. Forest plots were used to identify studies with extreme prevalence rates that may influence the overall model. When an outlier was visually detected, the meta-analysis was re-run with the study removed. This indicated whether the findings were stable or dependent on a single study.

Table 1.

Subgroupings based on types of definition

Physical IPV Subgroups	
Moderate Behavioural Acts	Definitions or measures which lend themselves to being briefer, capturing 'moderate' behavioural acts of physical violence, e.g. 'hit, slapped, kicked, pushed'.
Severe Behavioural Acts	Definitions or measures which lend themselves to being longer, capturing more 'severe' behavioural acts of physical violence as well as moderate behavioural acts, e.g. 'hit, slapped, kicked, pushed' AND 'strangled, choked, burned, scalded, dragged, beaten up'.
Sexual IPV Subgroups	
Force Only	Definitions or measures which only captured physical force or attempted force, e.g. 'forced to have sex or perform sexual acts you did not want to'.
Force and Coercion	Definitions or measures which captured both force and coercion by threats, fear or intimidation, e.g. 'you had unwanted sex because you were afraid of what he might do if you refused', 'threatened or frightened into intercourse when you did not want to'.
Emotional IPV Subgroups	
Emotional Abuse Only	Studies which only measured the concept of emotional abuse were clustered together. This includes definitions or items with questions related to threats, insults, humiliation, intimidation.
Emotional Abuse and Control	Studies with definitions or measures which spanned a range of concepts, such as emotional abuse as defined above, as well as coercive control and/or economic control under emotional IPV, were clustered together. This

includes items related to withholding money, restricting access to economic items, jealousy, and preventing one from seeing friends or family.

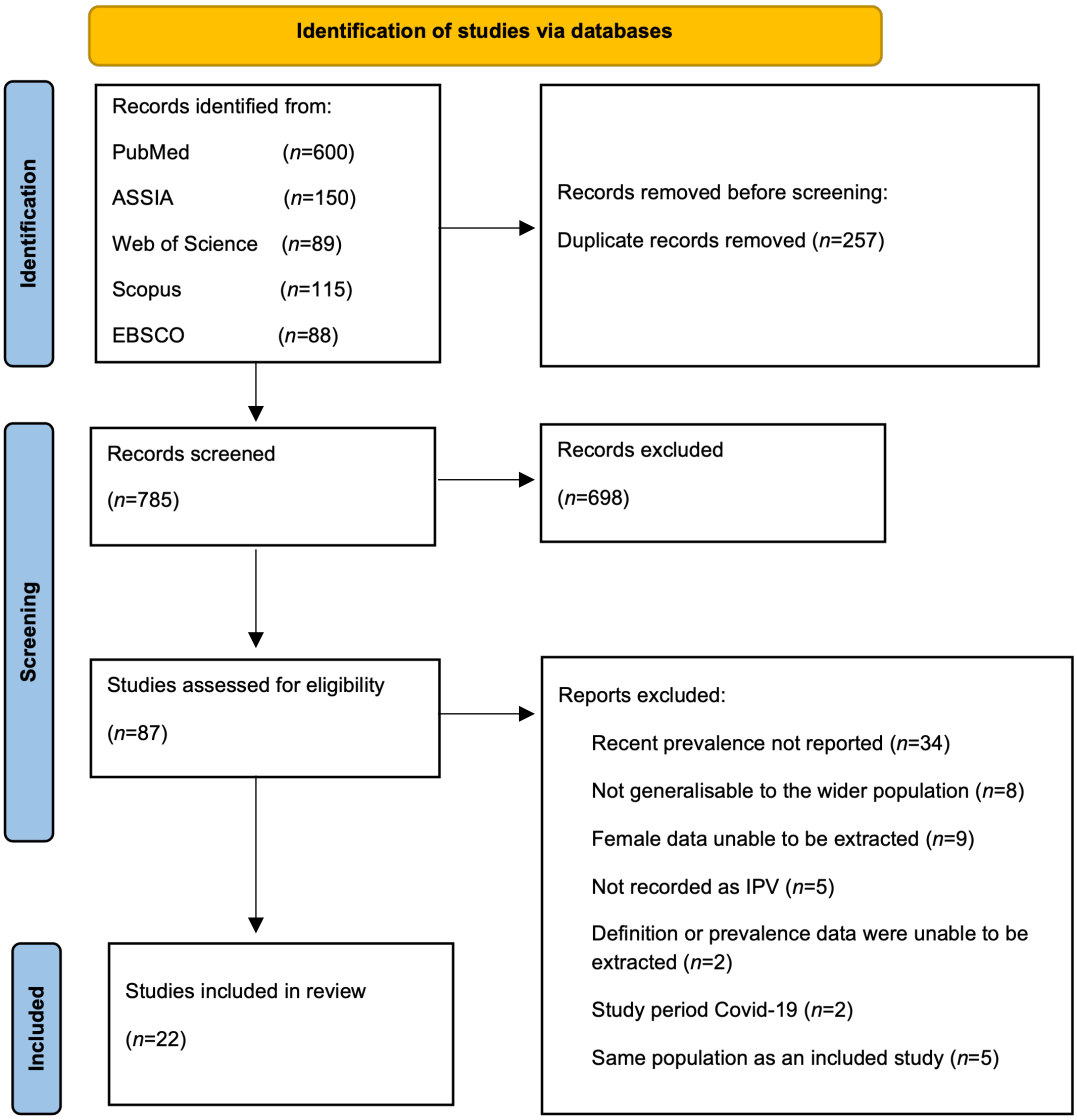
Results

Studies Included

Figure 1 illustrates the PRISMA flow diagram. Initial database searches yielded 1042 results. Removing 257 duplicates left 785 titles and abstracts to screen. 87 articles were eligible for full-text review. 27 studies met the inclusion criteria, but five were removed because they drew on the same population as another included study. Thus, 22 papers were included in the final sample.

Figure 1.

Prisma Flow Chart



Study Characteristics

Sample sizes ranged from 251 to 39,269, covering 141,764 women from at least 16 European countries or cities. Two multi-country studies (Costa et al., 2015; Ismayilova, 2015) contributed multiple effect sizes from distinct, non-overlapping populations. The recall period was IPV in the past 12 months. Data collection ranged from 2003 to 2018.

Measure of IPV

Measurement tools employed to capture data on IPV varied across studies, with four reporting the use of the Conflict Tactic Scale (CTS) (Straus et al., 1996), and the remaining 18 studies using other tools such as the VAW Instrument (VAWI), Index of Spouse Abuse (ISA) (Hudson &

McIntosh, 1981), domestic violence modules within national surveys or bespoke definitions. The definitions or measurement items used to assess IPV in each study are displayed in Appendix C because they could not be clearly presented in Table 2, which contains the study characteristics and prevalence rates.

Quality Assessment and Risk of Bias

Table 3 provides an overview of the quality assessment outcomes for all included studies, evaluated using the JBI critical appraisal checklist for studies reporting prevalence data. Overall, the primary source of potential bias relates to the adequacy and representativeness of the study samples. Studies were rated 'Yes with a caveat (Y*)' for question 5 if they used random sampling methods and included women from a wide range of ages. However, these studies often left out women who were institutionalised or homeless, especially when using household sampling. This increases coverage bias by excluding groups at higher risk of IPV (Sasseville et al., 2020; Yakubovich et al., 2021).

Most studies were rated as 'unclear' because they lacked sufficient information on subgroup response rates to assess coverage bias confidently, yet they indicated that certain populations of women were missing. For example, some studies captured a narrower age range (Dude, 2007; Alkan & Demir, 2025; Ismayilova, 2015; Laanpere et al., 2012) or recruited only from large cities (Garcia-Moreno et al., 2006; Costa et al., 2015; Burazeri et al., 2005). Excluding rural populations or younger or older women can result in reduced coverage of the country's wider population. These factors also reduce generalisability to the wider population. Three studies were confidently rated 'no' because they underrepresented subgroups in the data (Ruiz-Perez et al., 2018; Lövestad & Krantz, 2012; Khalifeh et al., 2013).

Regarding response rates (Question 9), Burazeri et al. (2005), Dude (2007), and Vives-Cases et al. (2011) reported good response rates or compared responders to nonresponders, earning a confident 'Yes' rating. Studies with survey weights and high response rates were rated Y* (Alkan & Demir, 2025; Khalifeh et al., 2013; O'Leary et al., 2008) because they made efforts to address non-response.

Several studies reporting low response rates did not provide details on non-responders, evidence of applying survey weights, or made any comparisons among groups of non-responders (Laanpere et al., 2012; Lövestad & Krantz, 2012; Nerøien & Schei, 2008). Other studies applied weights but did not make comparisons (Hasemi et al., 2025; Stockl & Penhale, 2015; Zorilla et al, 2009). Many others did not report details on the response rates at all, making it difficult to assess if the response rate was managed adequately and therefore rated as 'unclear' and indicating possible non-response bias (Costa et al, 2015; Gracia et al., 2023; Ismayilova, 2015; Sanz-Barbero et al., 2018). No studies were intentionally excluded from the analysis based on quality; however, the definition of violence used by Vives-Cases et al. (2011) did not align with any of the operational categories in the review, therefore, it could not be included in the pooled analyses.

Table 2.

Study Characteristics and Key Variables

Author / Year /Country/Region	Sample Size (Women)	Age of women	Relationship Status	Method of data collection	Measure or definition used to capture IPV	Past-year Prevalence
Alkan and Demïr, (2025) Turkey	*n*=6458	15-59	Married, in a relationship or had been previously in a relationship.	Household Survey. Face to face Interviews with trained researchers and questionnaires administered. Data collected in 2014.	Questions adapted from the WHO study titled 'multi-country study on women's health and domestic VAW'.	Emotional Violence in urban areas 26.17% Emotional violence in rural areas 20.87% Calculated Combined Emotional Violence: 24.5%
Burazeri et al. (2005) Tirana (capital city) of Albania	*n*=1039	25-65	Only married women included.	Structured questionnaire administered by an interviewer face-to-face. Women randomly selected from 2001 census. Data collected July – October 2003.	No validated measure. Definition: 'hit, slapped, kicked or physically hurt by husband' at least once in the past year.	Physical Violence: 37%

Costa et al., (2015) Six European countries measured from regions/large cities.	*n*=2026 women in total from across all sites Athens *n*=276 London *n*=298 Stuttgart *n*=318 Budapest *n*=356 Östersund *n*=370 Porto *n*=408	*18-64*	Single, cohabiting, separated/divorced.	Face-to-face interview with self-administered IPV questionnaire in Athens, Budapest, Porto and London (small proportion mailed in London and Porto). Stuttgart: mostly mailed with some face to face. Östersund: mailed. Data collection took 9 months, completed in May 2011.	Revised Conflict Tactics Scales (CTS2) – standardised across languages. Physical Assault (12 items) Psychological Aggression (8 items) Sexual Coercion (7 items)	Physical Assault: Athens 23.1% London 17.0% Stuttgart 13.5% Budapest 12.4% Östersund 9.9% Porto 8.5% Psychological aggression: Athens: 70.5% London: 64.9% Stuttgart 58.3%, Östersund 56.7% Porto 54.1% Budapest 46.4% Sexual Coercion: Stuttgart 25.3%, Porto 24.5% London 23.3% Athens 20.6% Östersund 9.2% Budapest 8.9%
Dude, 2007 Ukraine	*n*=3587	17-44	Ever married women.	Data drawn from the 1999 Ukraine Reproductive Health Surve. Face-to-face interviews.	No validated measure. Definition: 'kicked, hit, slapped, pushed or attacked with a weapon by a current or former sexual partner'	Physical violence: 7.2%
Garcia-Moreno et al. (2006) Data extracted for Serbia and Montenegro city	*n*=1191	15-49	Ever partnered women (married or lived with a partner).	Household surveys on women's health and experiences of violence in Belgrade (capital city). Female interviewers, face-to-face interviews using a standardised structured questionnaire. Data collected between 2000 and 2003.	Questions used in the WHO study Physical violence by an intimate partner (6 items) Sexual violence by an intimate partner (3 items)	Physical Violence 3.2% (CI 2.2-4.2%) Sexual Violence 1.1% (CI 0.4-1.8%) Any IPV (Physical or Sexual or both): 3.7% (2.6-4.8%)

Gracia et al. (2023) Spain	*n*=8824	18-96	Women who had been in an intimate relationship with a man.	Women interviewed in their homes using computer assisted personal interviews. Data collected in 2019.	Non-validated measure. Physical Violence (7 items) Sexual Violence (8 items) Psychological Violence (17 items)	Calculated Physical Violence: 0.9% Calculated Sexual Violence: 1.2% Calculated Psychological Violence: 6.2%
Hashemi et al. (2025) England	*n*=4120	16+	Ever-partnered women.	Household survey. Completed face to face by trained interviewers. Computer assisted personal interviewing and computer assisted self-completion. Data Collected May 2014 – September 2015	Adult Psychiatric Morbidity Survey. Questions adapted from the British Crime Survey and originally based on the CTS.	Any IPV in the past 12 months: 7.2% Any consisting of physical, sexual, economic and psychological abuse.
Ismayilova, (2015) 3 countries across Europe. Azerbaijan Moldova Ukraine	Azerbaija*n*=3932 Moldova *n*= 4053 Ukraine *n*= 1932	15-49	Married or cohabiting women (excluded formerly married women).	Demographic and Health Survey (DHS). Face to face interviews conducted by trained interviewers. Conducted in Azerbaijan - 2006 Moldova – 2005 Ukraine - 2007	Domestic Violence Module as part of the wider DHS survey. Physical Violence (7 items) Emotional Violence (3 items) Sexual Violence (2 items)	Azerbaijan Any type 10.5% Physical 8.4% Sexual 1.6% Emotional 4.7% Moldova Any type 21.8% Physical13.5% Sexual 2.2% Emotional 16.8% Ukraine Any type 16.7% Physical 7.0% Sexual 0.9% Emotional 15.4%

Khalifeh et al. (2013) England	*n*=11,503	16-59	Married, cohabiting, single, separated, widowed or divorced.	Computer assisted self-interviewing in person with interviewer on the interviewer's laptop. Private household survey. Data collected in 2008.	Domestic Violence, Sexual Victimisation and Stalking module administered. Physical IPV (7 items) Sexual IPV (2 items) Emotional IPV (4 items)	Any IPV 4.3% Physical IPV: 2.0% Sexual IPV: 0.4% Emotional IPV: 3.2% Any IPV classified as any physical, sexual or emotional violence.
Laanpere et al. (2012) Estonia	*n*=1966	16-44	Married/cohabiting, divorced, separated, single. (excluded pregnant women).	Self-administered postal questionnaires. Sample drawn from the Estonian women's health survey. Data collected in 2004.	Physical Violence: "had been exposed to threats of physical violence, pushed, shaken, something thrown at her, hit with something that caused/could have caused physical injury, threatened with a knife/gun/violent object" Sexual violence: "forced to have intercourse, threatened or frightened into having intercourse or forced to participate in other sexual acts"	Any type of IPV reported (physical or sexual)– 18.4% Physical – 17.2% Sexual 4.1% Both – 1.8%
Lövestad and Krantz (2012) Sweden	*n*=251	18-65	Married/cohabiting, boy/girlfriend, divorced, separated, single.	Postal Questionnaire. Random sample drawn by Statistics Sweden. Data collected January 2009.	A questionnaire based on the revised CTS. Physical Assault (11 items) Sexual Coercion (4 items)	Physical Assault: 8% Sexual Coercion: 3.2%
Nerøien & Schei (2008) Norway	*n*=2143	*20-55*	Ever partnered women (Married/Cohabiting/ previous partner).	Postal Questionnaires.	Questionnaire used from previous national studies in Nordic countries. Unclear if it is validated. Physical Violence (Mild/Moderate/Severe) Sexual Violence	Any IPV (Physical or Sexual): 5.5% Sexual Violence: 1%
Nybergh et al. (2013) Sweden	*n*=573 women	18-65	Ever partnered women (Married/Cohabiting/boy/girlfriend/previous partner).	Postal Questionnaire. Data collected January – March 2009.	The WHO's VAWI. Physical Violence (6 items) Sexual Violence (3 items) Psychological Violence (4 items)	Any IPV (Physical/Sexual/Emotional): 23.2% Physical Violence: 8.1 Sexual Violence: 3.0% Psychological Violence: 23.6%

O'Leary et al. (2008) Ukraine	*n*=558	18+	Married or cohabiting.	World Mental Health Composite International Diagnostic Interview (WMH-CIDI), Version 3 administered. Self-completed booklet. Data collected in 2002.	Partner Aggression defined as "Pushed, grabbed or shoved; threw something; slapped or hit"	Prevalence for aggression by spouse against respondent (woman): 12.7%
Ruiz-Perez et al. (2018) Andalusia (Region) in Spain	*n*=2293	18-75	Married/'Other' (e.g. not married)	Face to face interviews in the home by trained interviewers with questionnaires administered.	Questions adapted from a scale proposed by the World Health Organization Multi-Country Study on Women's Health and Life Events. Intimate partner violence measured with a set of three items asking whether the participants were abused physically (hit, slapped, pushed, etc.), psychologically (threatened, insulted, humiliated, etc.), or sexually (forced them into sexual activities) during the last 12 months.	Any IPV in women (Physical, emotional or sexual): 11% Physical IPV: 5.9% Emotional IPV: 9.4% Sexual IPV: 1.4%
Ruiz-Perez et al. (2017) Spain	*n*=10322	18-70	Married, separated, widowed, divorced, single.	Women recruited through primary health care centres. Women excluded if they were accompanied by a male partner. Self-administered questionnaire in envelope from physician. Confidentiality and anonymity guaranteed. Data collected 2006-2008.	Measure: Index of Spouse Abuse (30-items). Adapted and validated in Spain. Measures physical and psychological violence. Sexual violence is included under the physical subscale. Physical Violence (11 Items) Psychological Violence (19 Items	Any IPV in previous year (physical or psychological): 15.1% (CI 13.9% - 16.3%) Physical IPV: 8.9% (CI 7.9%-10%) Psychological IPV: 12.9% (CI 11.8-14%) Both physical and psychological IPV: 6.7% (CI 5.8%-7.6%)

Sanz-Barbero et al. (2018) 28 Countries Across Europe	*n*=39269	18-74	Ever-partnered women.	Data taken from the 2012 EU FRA-VAW survey. Face to face structured interviews conducted in women's homes. Sensitive questions administered via tablet for self-completion. Data collected March – September 2012.	Measured via standardized FRA-VAW questionnaire items. "Physical aggressions include to be pushed, slapped, grabbed, burned, thrown a hard object, beaten with a fist, tried to strangle, cut or stabbed, beaten her head against something. Sexual aggressions include to be forced or attempted to force her into sexual intercourse, made woman take part in any form of sexual activity when she did not want or when woman consented to sexual activity because she was afraid"	Physical and/or sexual IPV: 4.2% (95% CI 3.9-4.7)
Sanz-Barbero et al. (2019) Spain	*n*=8935	16+	Ever partnered women - had or have had a partner at some point in their lives.	Using data from the Spanish Macro survey on Gender Violence of 2014. Face to face interviews in people's homes by trained interviewers. Standardised questionnaire.	Following the "guidelines for the production of statistics on VAW: statistical surveys published by the United Nations." Severe and moderate physical violence Sexual violence Psychological violence Emotional violence Economic violence	Some form of IPV in last 12 months: 15.6% Physical IPV: 2.1% Sexual IPV: 1.7% Psychological IPV 15.2% (includes control-related, economic and emotional)
Stöckl and Penhale (2015) Germany	*n*=7257	16-86	Women currently in a relationship.	Uses a sample from a nationally representative survey undertaken in 2003. Face to face interviews, with self-completion questionnaires for IPV.	Physical and Sexual IPV measured using a modified CTS-2.	Physical or sexual violence or both in the past year combined calculated – 6.1%
Vives-Cases et al. (2011) Spain	*n*=13,094	16+	Unclear what the relationship status of women was.	Data from the Spanish National Health Survey 2006. Data collected via face-to-face	"Current IPV: this was measured using two questions. First, women were asked if they had suffered any kind of violence during the previous 12 months. If they answered 'yes'	Current IPV: 0.98%

				interviews in the home.	they were asked who the aggressor was" "Women who answered affirmatively to the first question and said that their male intimate partner was the aggressor were considered victims of IPV"	
Waltermaurer et al. (2013) Georgia	*n*=4302	15-44	Ever married women	Secondary analysis the 2010 women's reproductive health survey. Nationally representative survey. Survey was conducted in women's homes.	The experience of physical IPV was measured using the modified eight-item CTS.	Physical Violence: 1.6%
Zorrilla et al. (2009) Data from Madrid region in Spain	*n*=2136	18-70	Living with a partner or who had been in contact with an ex-parter in the previous year.	Telephone interviews during 2004 using computer assisted telephone interviewing.	Physical Violence measured based on the CTS. Psychological or Sexual Violence was measured using the module in the France National Survey of VAW.	Experienced 'some type' of IPV in previous year 10.1% (CI 8.9-11.5%). Physical Violence 2.4% (CI 1.8-3.1%) Sexual Violence 1.1% (CI 0.68-1.6%) Psychological Violence 8.6% (CI 7.4-9.8%)

Table 3.

Quality Assessment using the JBI Critical Appraisal Checklist for Prevalence Studies

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9
Alkan and Demïr. (2025)	Y	Y	Y	Y	U	Y	Y	Y	Y*
Burazeri et al. (2005)	Y	Y	Y	Y	U	U	Y	Y	Y
Costa et al. (2015)	Y	Y	Y	Y	U	Y	Y	Y	U
Dude, (2007)	Y	U	Y	Y	U	Y*	Y	Y	Y
Gracia et al. (2023)	Y	Y	Y	Y	Y*	Y	Y	Y	U

Garcia-Moreno et al. (2006)	Y*	Y	Y	U	U	Y	Y	Y	U
Hashemi et al. (2025)	Y	Y	Y	Y	Y*	Y	Y	Y	N
Ismayilova (2015)	Y	Y	Y	Y	U	Y	Y	Y	U
Khalifeh et al. (2013)	Y	Y	Y	Y	N	U	Y	Y	Y*
Laanpere et al. (2012)	Y	Y	Y	Y	U	Y*	Y	Y	N
Lövestad and Krantz (2012)	Y	Y	N	Y	N	Y	Y	Y*	N
Nerøien & Schei (2008)	Y	Y	Y	Y	U	Y*	Y	Y	N
Nybergh et al. (2013)	Y	Y	Y*	Y	U	Y	Y	Y	N
O'Leary et al. (2008)	Y	Y	Y	Y	U	Y	Y	Y	Y*
Ruiz-Perez et al. (2017)	Y	Y	Y	Y	U	Y	Y	Y	U
Ruiz-Perez et al. (2018)	Y	Y	Y	Y	N	Y	Y	Y	U
Sanz-Barbero et al. (2018)	Y	Y	Y	Y	U	Y	Y	Y	U
Sanz-Barbero et al. (2019)	Y	Y	Y	Y	Y*	Y*	Y	Y	U
Stockl and Penhale (2015)	Y	Y	Y	Y	Y*	Y	Y	Y	U
Vives-Cases et al. (2011)	Y	Y	Y	Y	Y*	N	Y	Y	Y
Waltermaurer et al. (2013)	Y	Y	Y	Y	U	Y	Y	Y	U
Zorilla et al. (2009)	Y	Y	Y	Y	Y*	Y	Y	Y	U

Note
Yes = Criterion met Y* = Yes with a caveat. No = Criterion not met Unclear = Insufficient Information
Questions 1-9
1. Was the sample frame appropriate to address the target population?
2. Were study participants sampled in an appropriate way?
3. Was the sample size adequate?
4. Were the study subjects and the setting described in detail?
5. Was the data analysis conducted with sufficient coverage of the identified sample?
6. Were valid methods used for the identification of the condition?
7. Was the condition measured in a standard, reliable way for all participants?
8. Was there appropriate statistical analysis?
9 Was the response rate adequate, and if not, was the low response rate managed appropriately?

Pooled Prevalence estimates for 'Any' Recent IPV and 'type' of IPV in women

Table 4 shows pooled prevalence estimates for any IPV and different types and combinations of IPV. Studies reporting 'any' form of IPV, consisting of physical, sexual and or emotional abuse, yielded a pooled estimate of 12.1%. Studies reporting the prevalence of combined physical and/or sexual IPV yielded a lower pooled estimate of 6.5%. Prevalence estimates varied across the subtypes of IPV types, with emotional IPV emerging as the most reported form of past-year victimisation. Physical IPV was less prevalent, and sexual IPV was reported the least frequently. All forms of IPV showed substantial between-study heterogeneity, reflected in the wide PIs. This indicates the wide dispersion in true prevalence for all types of IPV across women in Europe. Figures 2a to 2e display the forest plots, which provide a visual representation of heterogeneity across the included studies for each IPV domain.

Table 4.

Pooled prevalence estimates for any IPV, inclusive of different types and combinations of IPV

Outcome	*N*	*K*	Pooled prevalence (95% CI)	Q	Df	*p*-value	I^2 (%)	$\tau 2$	95% PI
Any IPV	7	9	12.1% (95% CI 7.8%-18.3%)	1312.58	8	*p*<.001	99.37	0.401	2.9%-39.1%
Physical and/or Sexual	5	5	6.5% (95% CI 2.9-13.9%)	687.68	4	*p*<.001	99.34	0.459	0.9%-35.3%
Physical IPV	16	23	7.4% (95% CI 4.9-11.0%	2969.43	22	*p*<.001	99.33	1.009	0.9%-40.1%
Sexual IPV	12	19	3.1% (95% CI 1.3-7.0%)	1564.52	18	*p*<.001	99.17	2.578	<0.1%-50.8%
Emotional IPV	10	17	22.6% (95% CI 12.7-37.0%)	4553.59	16	*p*<.001	99.84	1.832	1.5%-84.9%

Note
N number of studies included
K number of effect sizes included

Figure 2a.

Forest Plot of Pooled Prevalence for 'Any IPV'

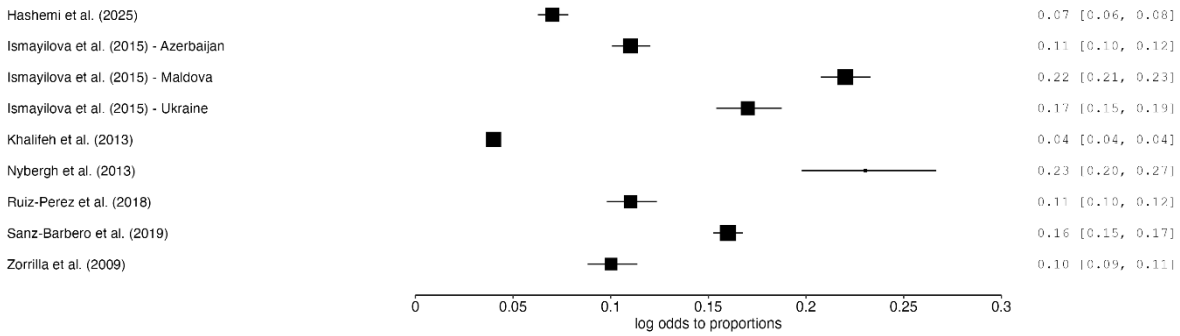


Figure 2b.

Forest Plot of Pooled Prevalence for 'Physical and/or Sexual IPV'

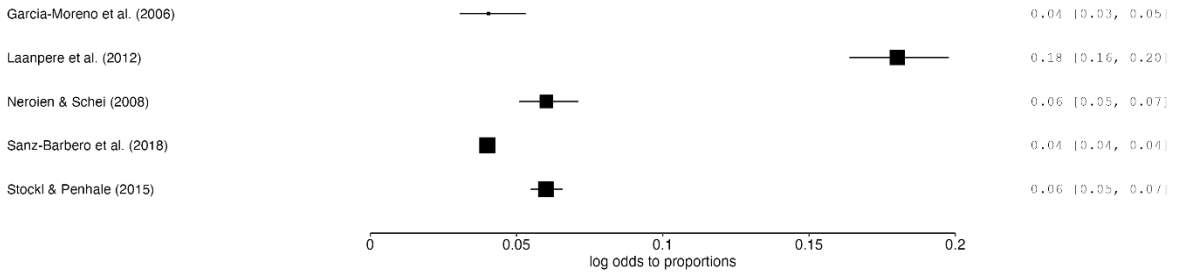


Figure 2c.

Forest Plot of Pooled Prevalence for Physical IPV

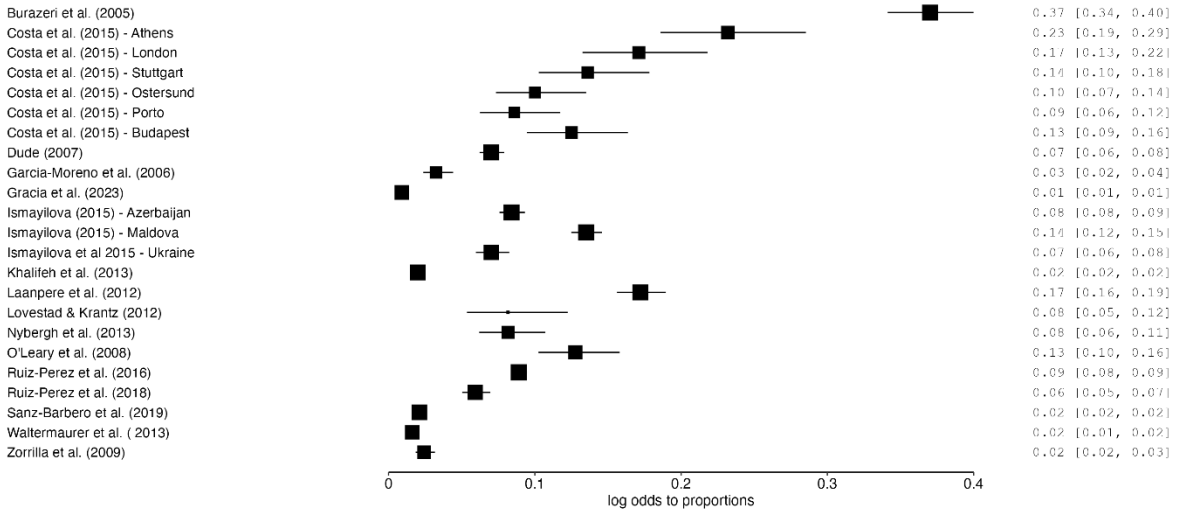


Figure 2d.

Forest Plot of Pooled Prevalence for Sexual IPV

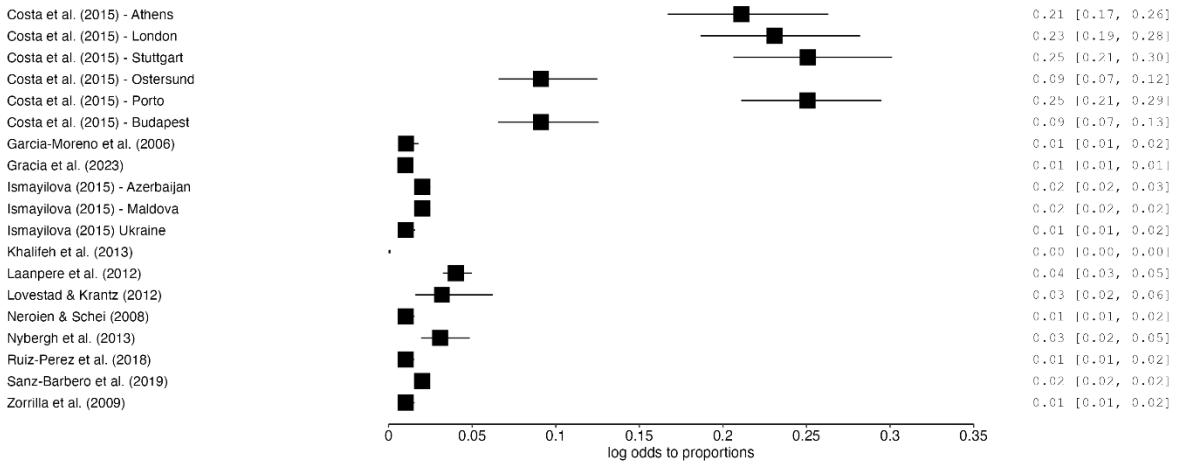
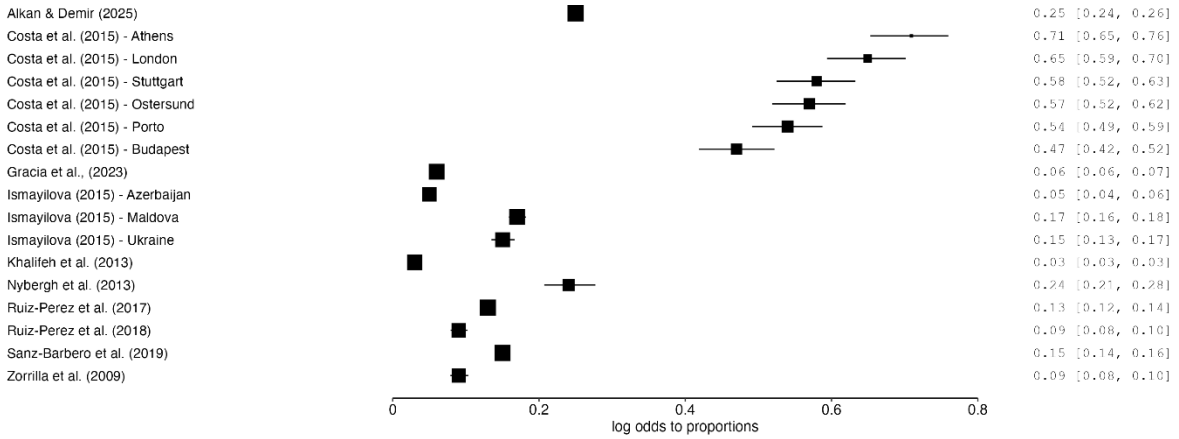


Figure 2e.

Forest Plot of Pooled Prevalence for Emotional IPV



Subgroup Analyses by Definition

Table 5 displays the pooled prevalence across IPV types and definitional subgroups. Definitional variation did not significantly affect pooled estimates for physical IPV (Q=3.27, p=.070). However, both sexual and emotional IPV had prevalence rates which differed depending on how they were defined (Q=4.17, p=.041 and Q=12.75, p<.001, respectively). Broader definitions for sexual IPV yielded higher prevalence rates than narrower ones. For emotional IPV, definitions that consisted of 'emotional abuse only' yielded a higher estimate of prevalence than definitions encompassing 'emotional abuse and control'.

Table 5.

Pooled prevalence estimates across IPV type and definitional subgroups

Outcome	*N*	*K*	Pooled prevalence (95% CI)	I² (%)	τ2	95% PI

Physical IPV						
Moderate	5	5	13.3% (95% CI 4.8%-31.8%)	99.31	0.796	1.0%-69.9%
Severe	11	18	6.2% (95% CI 3.9%-9.8%)	99.22	0.956	0.8%-35.6%
Sexual IPV						
Force Only	4	6	1.3% (95% CI 0.9%-1.9%)	80.40	0.111	0.5%-3.3%
Force and Coercion	8	13	4.4% (95% CI 1.3%-14.3%)	99.42	3.499	<.01%-76.9%
Emotional IPV						
Emotional Abuse Only	5	12	32.6% (95% CI 18%-51.7%)	99.7	1.552	2.7%-89.4%
Emotional Abuse and Control	5	5	8.1% (95% CI 3.5%-17.3%)	99.67	0.491	1%-42.5%

Note:
N number of studies included
K number of effect sizes included

Sensitivity Analyses

The forest plot (Figure 3a) indicated that one study, Costa et al. (2015), was yielding higher estimates of sexual IPV from four different countries. Sensitivity analyses confirmed there were no differences between groups when Costa et al. (2015) was removed from the analysis (Q=0.01, p=.940). The pooled prevalence for the 'Force Only' subgroup remained as 1.3% (95% CI [0.9%-1.9%], I^2=80.4%, 95% PI [0.5%-3.3%]) and the 'Force and Coercion' subgroup reduced from 4.4% to 1.3% (95% CI [0.2%-7.1%], I^2=98.99%, 95% PI [<0.1%-43.7%]).

Costa et al. (2015) also yielded higher estimates for emotional IPV (Figure 3b). Sensitivity analyses confirmed the difference was no longer significant when Costa et al. (2015) was removed from the analysis (Q=2.17, p=.140). The pooled prevalence rate reduced from 32.6% to 14.1% (95% CI [7.2%-25.8%], I^2=99.42%, 95% PI [2.3%-54.1%]) for the 'Emotional Abuse Only' subgroup and remained at 8.1% (95% CI [3.5%-17.3%], I^2=99.67%, 95% PI [1%-42.5%]) for 'Emotional abuse and Control' subgroup.

Figure 3a.
Forst Plot for Sexual IPV Subgroups

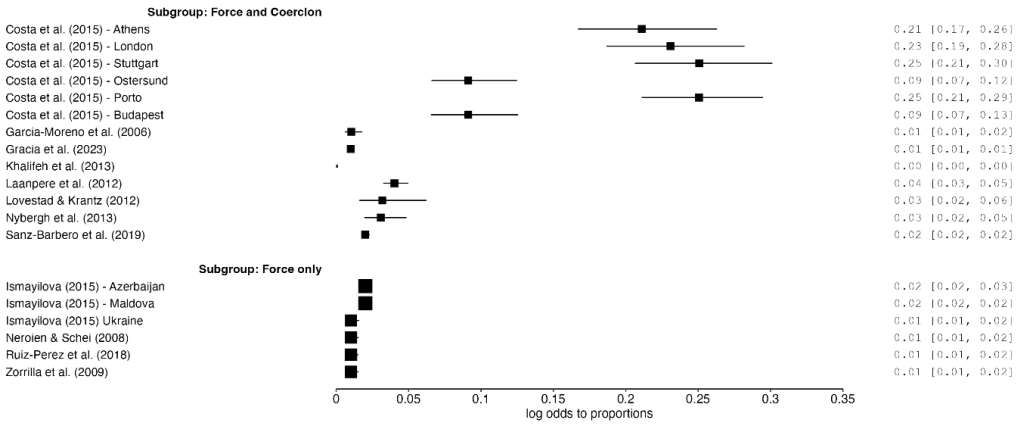
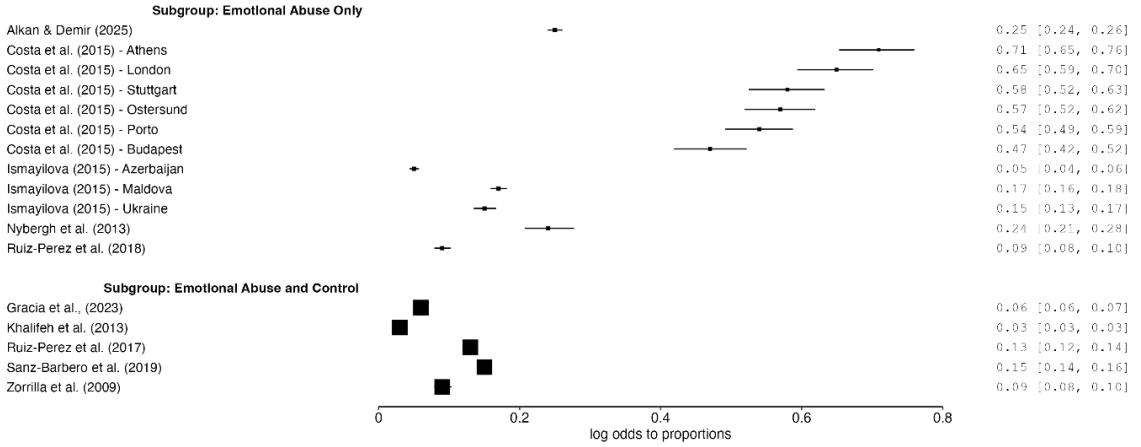


Figure 3b.

Forst Plot for Emotional IPV Subgroups



Discussion

The systematic review and meta-analysis aimed to examine the prevalence of IPV among women in Europe and to explore how differences in definitions may affect reported prevalence rates. The findings demonstrate that IPV remains widely prevalent, with considerable variation across types of violence experienced.

The pooled past-year prevalence for 'any IPV' encompassing physical, sexual, and emotional types of abuse was 12.1%. This is higher than previous survey findings, which reported a prevalence of 5.3% across Europe (Eurostat, 2024). In addition, global studies have reported higher rates of 24.2% (White et al., 2023).

Studies reporting prevalence combining 'physical and/or sexual abuse' yielded estimates of 6.5% in this study. Similarly, Sardinha et al. (2022) reported estimates of 4-7% across western, eastern, and central Europe in women aged 15-49, which captured data on physical and sexual IPV. In contrast, the worldwide estimate was higher, at 13%. Mostly higher-income countries, including central and western Europe, yielded the lower estimates. In contrast, regions such as Africa, Asia, and Oceania reported the highest past-year prevalence, which likely inflated worldwide estimates. The authors note that several countries with higher estimates are countries affected by conflict (Sardinha et al., 2022). Furthermore, economic insecurity, gender inequitable attitudes, societal stigma and inadequate support services limit a woman's ability to leave abusive relationships (Sardinha & Nájera Catalán, 2018). This may explain why estimates are higher in other regions of the world.

In relation to the subtypes of IPV, emotional IPV emerged as the most prevalent form at 22.6%, followed by physical IPV at 7.4% and sexual IPV at 3.1%. The patterns are similar to those of White et al. (2023), who also found emotional violence to be most prevalent and sexual violence the least prevalent.

The Impact of Definitions

A second aim of the review was to examine how definitions of IPV influence reported prevalence. The pooled estimates in this study found that broader IPV definitions, which included emotional IPV, increased IPV prevalence, whereas narrower definitions excluding emotional IPV yielded lower prevalence. This is similar to a recent EU survey, reporting that 17.7% of women had experienced physical violence or threats and/or sexual violence in their lifetime, which increased to 31.8% when psychological violence was included (Eurostat, 2024).

The analyses then examined how differences in the conceptualisation of violence influence prevalence estimates for each subtype. Physical IPV did not show statistically significant differences between moderate and severe definitional classifications. This may indicate that physical acts are more consistently operationalised across studies. Furthermore, there could be less ambiguity across cultures in recognising physical abuse.

For sexual IPV, studies which included both acts of 'force and coercion' in their measure yielded prevalence estimates over three times higher (4.4%) than those defining sexual IPV as acts of 'force only' (1.3%). This may suggest that broader definitions encompassing coercive acts yield higher prevalence rates than narrower definitions. Excluding sexual coercion likely leads to underestimations of sexual IPV. However, one study (Costa et al., 2015) contributed disproportionately high estimates for sexual IPV. Sensitivity analyses revealed that after removing this study, the 'force and coercion' subgroup estimate dropped from 4.4% to 1.3%, and there was no longer a meaningful difference between the two subgroups based on the definition used for sexual IPV ("force only" vs 'force and coercion'). The observed difference in the primary analysis was mainly due to this study.

Similarly, definitions of emotional IPV restricted to emotional abuse, threats, intimidation and humiliation only, yield substantially higher prevalence (32.6%) than definitions which include emotional abuse with controlling behaviours (8.1%). This may reflect differences in severity thresholds or in cultural recognition of emotional harm and/or control. Again, Costa et al. (2015) inflated the pooled prevalence for the 'emotional abuse only' subgroup. Removing the study reduced the prevalence from 32.6% to 14.1%, and the subgroup difference was also no longer significant. Costa et al. (2015) used the CTS to measure emotional IPV. The CTS captures a range of emotionally abusive acts, some of which might not be recognised as emotional abuse, e.g., stomping out of the room. Using this measure may have yielded the higher estimates.

The prediction intervals for all three subtypes were wide, again indicating that the actual prevalence greatly varies across Europe. Emotional IPV, however, had a very large prediction interval, ranging from 1.5% to 84.9%. Jewkes (2010) also found that the prevalence of emotional abuse can range from 9% to 70%. Emotional abuse is more pervasive and diverse than discrete acts of physical and sexual abuse, encompassing a range of mechanisms, including threats, manipulation, verbal abuse, social isolation, withholding earnings and coercive control all which erode a person's self-worth (Günnur Karakurt et al., 2025) There is also variation in acts of emotional abuse in different cultures and the way victims perceive emotional abuse (Jewkes, 2010). Defining or operationalising emotional abuse has been challenging (Stern et al., 2019). Threats, insults and humiliation may be more common or more likely to be disclosed than coercive behaviours, which are described as patterns and appear more subtle (Stark, 2009).

Overall, the findings demonstrate that the choice of definition for each subtype of violence can shape IPV prevalence estimates. However, the variation among studies does not appear entirely attributable to definitional variation, and certain studies (such as Costa et al., 2015) can also substantially influence rates, likely due to other factors. There is no consistent pattern across the literature. This further highlights the importance of definitional clarity and standardisation in IPV research. Inconsistent operationalisation will continue to drive heterogeneity, limiting the comparability of estimates across studies. Furthermore, the interpretation of pooled estimates should

consider the varying strength of evidence and potential sources of bias, such as whether studies have adequate population coverage and have considered the characteristics of non-responders, as these characteristics could differ from those of those who do respond.

Heterogeneity

Across all models, heterogeneity was high (I^2 range 80.4%-99.84%), indicating substantial variability in IPV research in Europe, reflecting real differences between studies rather than sampling error. The $\tau 2$ values (range 0.4-3.4) further show that the heterogeneity in effect sizes across studies is large, with studies reporting widely different prevalence rates. The wide prediction intervals further suggest that the actual prevalence of IPV across Europe can vary substantially from the pooled estimate. Therefore, the pooled estimates must be interpreted cautiously, at most as averages across highly diverse contexts rather than as universal prevalence rates. The dispersion and between-study variance likely reflect fundamental differences in how IPV is measured, defined and experienced across different countries and contexts. This is a longstanding challenge in IPV research, due to the various factors that influence reported prevalence rates, such as sampling frames, survey methods employed, measurement tools, and sociocultural norms and the acceptability of disclosure. Previous studies have found higher disclosure rates in face-to-face interviews than in other methods, such as telephone or survey interviews (Alhabib et al., 2009; Jansen et al., 2004).

Strengths and Limitations

The review offers an up-to-date picture of IPV prevalence across Europe while highlighting how definitional differences and subtypes of violence shape reported rates. By systematically synthesising relevant studies, this allowed for pooling of estimates that capture variation across physical, sexual, and emotional IPV. Importantly, the review provides current evidence that can now inform policymakers, guiding more effective policy responses.

However, the review is not without limitations. Firstly, Munn et al. (2015) acknowledge that systematic reviews of prevalence data are often complicated by substantial methodological and definitional heterogeneity, which can make statistical pooling inappropriate or misleading. This challenge was evident in the present review, where variation in IPV definitions, measurement tools,

and sampling frames likely contributed to vast differences in reported prevalence. The high heterogeneity and a small number of studies further limit precision; the single pooled estimates cannot fully represent IPV prevalence across Europe. Secondly, the review relied on the availability and quality of existing studies and surveys reporting on VAW, including the measures used. Not all surveys are based on recent data; therefore, the data is arguably outdated. Despite the availability of several population-based surveys, data remains unavailable for several other geographical regions. Thirdly, all estimates collected in the studies relied on women to self-report their experiences of being subjected to IPV. Given the sensitive nature of the topic, accurate prevalence estimates are likely to be higher (Sardinha et al., 2022). Most studies included in the current review also note self-report bias among their limitations, acknowledging that rates are likely underestimated overall. Furthermore, there was a risk of coverage and non-response bias among studies, and common exclusions of women with cognitive impairments or who live in institutions. Excluding certain populations also suggests that prevalence rates are likely to be underestimated. Lastly, the review included only peer-reviewed studies in English, potentially missing eligible studies in grey literature or other languages.

Clinical, Social and Policy Implications

Given the widespread prevalence of IPV, a collective effort is required from health, criminal justice, security, education and society to cooperate and promote social change (Oram et al., 2022). At a societal level, social norms which condone forms of IPV and male control over women need to be challenged. Gender inequality is a root cause of IPV and is highest in societies which are more unequal in gender relations and where VAW is acceptable (Oram et al., 2022). Interventions which do not promote problematic alcohol use in men, commonly associated with an increase in IPV perpetration against women, should be prioritised, and the media should promote gender equitable, non-violent relationships (Devries et al.,2013). Furthermore, priority is needed across all stages of the system, from designing services with survivor input, enhancing public understanding of IPV and how to stop it, to empathetic, supportive interactions between practitioners and clients (Oram et al., 2022).

Women will likely be accessing healthcare services, considering the impact IPV has on the physical and mental well-being of women (Spencer et al., 2024). Healthcare services should be

equipped to identify, support, and refer women who have been subjected to IPV (Devries et al., 2013). All patients undergoing a mental health assessment should be asked about their experiences of violence, including IPV (Oram et al., 2022). Health-care providers should be trained to enquire about IPV safety and to respond appropriately to disclosures (Oram et al., 2022). The LIVES framework for good practice principles for recognising and responding appropriately is outlined in the WHO's first-line response to disclosures of IPV (WHO, 2014). Moreover, responding to disclosures of perpetration of IPV by perpetrators involves reassurance that help is available whilst conveying that abusive behaviour is not acceptable (Oram et al., 2022). Nevertheless, healthcare professionals need to feel supported by their organisation to confidently identify and respond to IPV (Hegarty et al., 2020).

Future Research

Devries et al. (2013) argue that the "gold standard" measure of IPV exposure involves asking about a range of specific acts of violence because this avoids participants making subjective decisions on whether their experiences are classed (or even recognised) as "abuse" or not. However, this approach, of course, relies on the validity and meaningfulness of the behavioural examples offered as representations of IPV. Previous studies have also shown that face-to-face methods (Alhabib et al., 2009) and the use of trained interviewers to collect IPV data increase participants' willingness to disclose (Jansen et al., 2004). Thus, survey design and interviewer training will play an essential role in increasing disclosure rates, although these approaches require additional resources and investment (Jansen et al., 2004). Future prevalence studies should seek to employ these methods to strengthen the evidence base and improve the quality of IPV measurement and disclosure rates.

IPV includes a broad spectrum of behaviours, which also vary in levels of severity. Despite more severe acts appearing less common in literature, they remain harmful and impactful. Whilst all types of IPV matter and are classified by subtypes, the severity within those subtypes is equally important, and each requires attention and possibly different responses. Researchers should consider reporting prevalence by both type and severity where possible. Although severity could be difficult to classify, distinguishing between high-impact severe acts of violence and broader behavioural indicators could help policymakers understand the full spectrum of IPV.

Historically, measuring IPV consisted of capturing prevalence on physical violence, and researchers urged for the definition to be broadened to include sexual and emotional violence (Hegarty & Roberts, 1998). Over time, prevalence rates have captured physical and sexual violence towards women (Sardinha et al., 2022), indicating movement in the right direction. However, emotional IPV was excluded from a recent paper that reported worldwide prevalence estimates because of variations in definitions, measurement, and non-standardisation across surveys and countries. The authors acknowledge that the WHO is working to address these challenges (Sardinha et al., 2022). Emotional IPV appears more widely prevalent than physical or sexual IPV (White et al., 2023). Emotional abuse is associated with significant long-term adverse effects on the well-being of survivors (Spencer et al., 2024). Therefore, future research should seek to operationalise the definition of emotional violence and collect data on all subtypes of IPV against women, to truly understand the magnitude of the problem. Greater consistency in behavioural definitions and the use of validated measures is essential to improve comparability across European studies and accurately monitor trends in past-year IPV rates over time.

Furthermore, several studies in the review captured data on women of reproductive age, limiting data on older women over 65+. Violence against older women is prevalent (Pathak et al., 2019), and there is a need for better quality data on violence experienced by older women (Meyer et al., 2020). Furthermore, there is limited specific research on males as victims of IPV (Rehman et al., 2023) and those in same-sex relationships (Aguiar, 2025). Future research should continue to explore IPV in these populations and develop specific intervention strategies for those populations.

Conclusion

Overall, the findings show that IPV towards women is still a significant issue across Europe, regardless of the differences in study context or how IPV is defined or measured.

Emotional IPV is a significant and widespread problem. The high heterogeneity and wide prediction intervals indicate that the actual prevalence varies dramatically across European populations of women. In some cases, IPV rates are substantially higher than policymakers may

account for. These data imply that current policies may underestimate the scale of IPV, and that definitional and methodological inconsistencies may risk obscuring its true extent.

Given the variability, estimates should be interpreted carefully and not as a single actual prevalence rate; they reflect an average across highly diverse contexts. These pooled estimates offer a helpful summary but do not replace local or specific regional prevalence rates. Policymakers should therefore not presume uniform regional rates and interpret their own regional data alongside local data and context.

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Chapter Three: Bridging Chapter

The systematic review outlined in chapter two provided pooled estimates of IPV prevalence against women in Europe. The review further compared different definitions of IPV subtypes and discussed their impact on reported prevalence rates. The findings showed that IPV remains widespread across Europe, with emotional IPV being the most prevalent form of IPV. Previous IPV, including acts of physical, sexual, and emotional violence, encompassing threats of harm and controlling behaviours, are well-known risk factors for escalation to IPH (Spencer and Stith, 2018). A recent Welsh case illustrates this escalation. In 2025, a man ferociously attacked his estranged wife after a period of separation and stalking. As this is a 'first instance' court decision, we must rely on journalistic reporting to understand the story (Thomas & Griffiths, 2026). This indicates that the couple were married in 2017, but that IPV characterised their subsequent married life. When the female victim confided in a work colleague about her experiences and then became emotionally close to this work colleague, the husband's jealousy increased. He was reported to have begun to spy on his wife at the care home in which she worked, and the victim reported concerns about the risk her husband posed to her. The relationship ultimately ended in April 2025, but after this, the husband appeared to make desperate efforts to rekindle it, being reported to have become 'overtaken with jealousy' and 'obsessed'. Ultimately, the victim's murder was noted to be a highly planned event, whereby the perpetrator had visited the area several times in advance to plan his attack and purchased knives in advance. The prosecution's case noted that 'such was the ferocity of the attack on her that the knife was broken during the assault'. Whilst the media reporting does not identify the details, it is notable that after the incident, the man was detained under the Mental Health Act, but then subsequently charged with, and convicted of, her murder.

Unfortunately, such cases are not terribly unusual, and this case has not been chosen because of its exceptional nature, but because it is the most recent of many similar cases published in the mainstream press shortly before the submission date of this thesis portfolio. Yet, describing such a case at the individual level is important, since it clearly illustrates both the serious need to better understand how to prevent IPV and, in particular, the transition between IPV and IPH. The potential

role of mental health difficulties is an important locus for further understanding. Whilst previous research has identified multiple risk factors, existing studies appear to report the descriptive statistics of mental health conditions within perpetrators (Bracewell et al., 2022; Chantler et al., 2019; MacInnes et al., 2023). Far less attention has been given to how these difficulties are conceptualised and understood, leaving a critical gap in the literature. The empirical study, therefore, aims to add to the growing body of literature by exploring how mental health can feature in IPH cases and how it may link to the fatal act of homicide. The project further explores the recommendations made to MHS within DHRs.

CHAPTER FOUR
Empirical Study

Domestic Homicide Reviews: An Exploration into Perpetrator Mental Health in Intimate Partner Homicide Cases in England and Wales

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Chapter Four: Empirical Study

Abstract

Purpose: Mental health is often reported among perpetrators of domestic homicide (DH). The current study aimed to explore the function of mental health (MH) in cases of intimate partner homicide (IPH) in England and Wales.

Methods: 115 domestic homicide reviews (DHRs) were retrieved from the DHR library on the government website. Quantitative content analysis was applied, converting written information into numerical codes. Based on the information reported within the DHR, perpetrator MH was grouped into 'likely linked' and 'unlikely linked' to the homicide. Effect sizes further supported descriptive statistics and chi-square tests, identifying trends in the data.

Results: Patterns of previous abuse towards the victim, stalking, harassment and coercive control were more frequent in cases where MH was less likely to be linked to the homicide. Anxiety was more common in cases where MH was likely to be linked to the homicide (p=.022). Psychotic/schizophrenic disorders (p=.047) and neuro-cognitive disorders (p=.044) were less common, but when present, were likely to be linked to the homicide, with small to moderate effects. Depression/Low Mood was common among perpetrators and reported in 84 DHRs.

Conclusions: Despite MH problems commonly reported in DHRs among perpetrators, this study suggests that MH was not consistently a significant feature or primary driver of IPH, and cases of severe mental illness were rare. The results suggest there are likely multiple pathways to homicide, with some involving prior abuse and conflict and others where MH vulnerability is present, alongside other relational and situational factors. Mental Health Services (MHS) require improvement to better identify and respond to domestic abuse (DA).

Keywords: Intimate Partner Homicide, Intimate Partner Abuse, Mental Health, Domestic Homicide Review, Domestic Abuse Related Death Review

Introduction

Globally in 2020, 47,000 women and girls were killed by their intimate partner or other family members, equating to a death every 11 minutes. Whilst most victims were from African and Asian continents, 2600 victims were from Europe (United Nations Office on Drugs and Crime, 2021). In England and Wales, 178 women were murdered by their male intimate partner over a three-year period (Office for National Statistics, 2025), equating to almost five deaths per month.

To reduce the rate of domestic/family-related deaths, England and Wales introduced Domestic Homicide Reviews (DHRs) through the introduction of the Domestic Violence, Crime and Victims Act (DVCVA) in 2004. However, the requirement for reviews under s. 9 of this Act did not enter into force until 2011. DHRs represent a multi-agency review process aimed at developing learning for services and improving prevention and intervention strategies. Such reviews followed the similar introduction of Domestic/Family Violence Death Reviews, which emerged in 1990 in the USA (Bugeja et al., 2015).

The definition of a DH is when a victim is killed by a current or former intimate partner, a family member, or another person living in the same household at the time of the homicide (Home Office, 2016). A DHR will occur in a situation where the 'death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect' by either (a) 'a person who they were related or with whom they were or had been in an intimate personal relationship' or (b) 'a member of the same household' (Legislation, 2013). DHRs in England and Wales were later renamed Domestic Abuse Related Death Reviews following a 2024 law change to recognise deaths from domestic abuse-related suspected suicides (Lambeth Council, 2024). Throughout this review, however, they will be referred to as DHRs.

Whilst the DHR process was a significant development, it also inevitably focused on the most serious and extreme behaviours, i.e. those leading to homicide. In this context, it is therefore essential to note a further key legislative development: the Domestic Abuse Act (DAA) of 2021, which was the first legislation to create a specific definition of domestic abuse. This defined 'domestic abuse' as behaviour which is violent, threatening, coercive or controlling and abuse which is physical, sexual,

economic, psychological, emotional or other (Legislation, 2021). The broader definition of DA has been important in the practice of DHRs, since it provides a more transparent framework of DHR eligibility between agencies, but also clarifies that DHRs can and should focus on homicide where this has occurred in the context of recurrent patterns of behaviours, meaning that DHRs are not limited to situations where death has followed a single severe incident.

The DHR process involves organising a local DHR panel comprising staff from multi-agency services (Police, Probation, Healthcare, Councils), who collate information about the victim, the perpetrator, and the circumstances leading up to the death. DHRs are conducted to examine the circumstances leading up to the DH, identify lessons learnt, and improve multi-agency responses to aid prevention and reduce future risk. Ultimately, an independent author (who may also lead the panel discussions) is appointed to write a report based on this learning process, which is produced with close regard to statutory guidance (Home Office, 2016). This statutory guidance also places expectations on Local Authorities to publish DHRs, and the government has established a DHR library (https://homicide-review.homeoffice.gov.uk/) to support this.

DHR Demographics and Patterns

The above repository of DHRs has provided a natural opportunity for research, which has begun to analyse DHRs more closely to identify demographics, risk factors, patterns and learning. In one of the earlier comprehensive studies, Chantler et al. (2019) analysed 141 DHRs and found that 86% of perpetrators were male, 49% had a mental health diagnosis, and mental health services were most likely to be involved. Benbow et al. (2019) also thematically analysed 30 DHRs involving adults aged 60 or older, finding that age was not a significant factor in DH. Still, four themes emerged: a history of DA, financial issues, substance use and mental illness of the perpetrators. Other researchers have begun to examine subpopulations within DHRs. Chantler et al. (2022) examined how minoritisation was documented in 95 DHRs and argued that statutory services should improve the recording of cultural background, avoid cultural stereotypes, use trained interpreters, and draw on specialist knowledge from Black/minoritised domestic violence and abuse (DVA) services. More recently, Munro and Dangar (2025) have examined incidents of non-fatal strangulation or suffocation

in 32 domestic abuse-related deaths by suicide. They found that DHRs in suicide cases were not doing enough to uncover, assess and improve responses to disclosures of non-fatal strangulation and suffocation. Furthermore, Dheensa et al. (2025) explored the overlap between cancer and DH, finding that cancer may mask indicators of DA and professionals working with patients and their families should remain vigilant and hold a low threshold for concern.

Other areas of research have focused on the quality of information reported within DHRs. Gunby et al. (2025) examined 46 DHRs, finding that DHRs describe long histories of abuse and gaps in service response, yet rarely address the intersectionality and dynamics of gender and race that shape a victim's experiences. They argue this limits the quality of recommendations and hinders the opportunity to understand domestic homicide cases fully. Similarly, Chantler et al. (2024) found a lack of information on protected characteristics from services in DHRs, and that equality, diversity, and inclusion were scarce in the 24 DHRs they sampled.

Perpetrators of DH

Focusing on perpetrators specifically, several common factors and vulnerabilities have been identified across studies, including MH, a history of violent behaviour, alcohol problems and substance misuse (Chantler et al., 2019; Bridger et al., 2017; Home Office, 2024; MacInnes et al., 2023; Sharp-Jeffs & Kelly, 2016). In 66 adult family homicide (AFH) cases, Bracewell et all. (2021) reported 53% of perpetrators had a MH diagnosis, documented substance use (60.6%) and alcohol misuse (62.1%), again with the majority being male. A review of 263 DHRs related to intimate partner homicide (IPH) also found that perpetrator MH was a key factor in DH and stalking behaviour featured in many cases (Chopra et al., 2022). Baker et al., (2026) recently analysed IPH and IPH-suicide cases, identifying themes of separation, loss, dependency and mental health and suicidality, which had different meanings across different ages (younger vs older couples). Collectively, literature indicates that MH concerns have consistently featured among perpetrators of DH.

MacInnes et al. (2023) reviewed 189 DHRs, finding that 64.5% of perpetrators had accessed mental health services (MHS) and 43.5% had a history of self-harm, suicidal ideation, or suicidal behaviour. These findings appear broadly with Button et al. (2017), who found that offenders charged

with DH were five times more likely to have suicidal warning markers compared to other offenders. Furthermore, one of Bridger et al.'s (2017) main findings from 188 DHRs and information from police databases was that 40% of male perpetrators of IPH were experiencing suicidal ideation, had attempted self-harm, or attempted suicide. They suggest that identifying suicidal indicators could help predict and prevent IPH. Collectively, these findings strongly suggest that MH difficulties are prevalent among perpetrators of DH. Despite these associations, the mechanisms linking MH to DH remain poorly understood.

Mood (namely depression) and anxiety disorders appear to be the more commonly reported MH conditions among perpetrators (Chantler et al., 2019; MacInnes et al., 2023; Sharp-Jeffs & Kelly, 2016). In Canada, perpetrators with depression were likely to be older, express suicidal ideation and intent, display signs of sexual jealousy and have witnessed DV as a child (Cheng & Jaffe, 2019). In Australia, authors analysing the role of depression in IPH concluded that exploring depression amongst perpetrators on its own has limited value and should be considered alongside other personality risk factors and contextual factors (Lawler et al., 2023). Historic literature also found that certain MH conditions (anxiety, depression and panic disorder) appeared to feature among perpetrators of violence and were associated with increased odds of DV (Oram et al., 2013). Interestingly, personality disorder (PD) has been less commonly reported. Collison and Lynam's (2021) meta-analysis found PD to significantly correlate with IPV perpetration, particularly antisocial PD and borderline PD (BPD). Currently, no literature to date has considered the role of PD in perpetrators of IPH in England and Wales.

Learning from DHRs

Another key feature and purpose of DHRs is to highlight lessons to be learnt and to identify service recommendations to reduce and prevent DH. The Home Office analysed 50 DHRs, identifying themes to review in existing practices, raise awareness of DA, improve how information is recorded and shared, and enhance staff training (Home Office, 2024). Other studies have also examined recommendations for adult safeguarding agencies (Chantler et al., 2024) and criminal justice services (Gunby et al., 2025).

Montique (2019) analysed 84 DHRs from London. They highlight several recommendations for practice regarding MH, including staff training to identify and improve risk assessment and to respond appropriately to disclosures of DA, which are similar to previous recommendations (Home Office, 2013; Home Office, 2016; Sharp-Jeffs & Kelly, 2016). Other recommendations included improving policies on DA, conducting joint assessments involving addiction services, and increasing the involvement of relatives in MH and risk assessments (Sharp-Jeffs & Kelly, 2016). Montique (2019) further identified recommendations, including conducting carer assessments when caring roles and responsibilities are identified; the need for integrated working across services; appropriate handovers of perpetrator or victim MH records; discussions with internal safeguarding leads when DA is identified; and appropriate referrals to specialist DA services. Chantler (n.d.)'a review of 58 DHRs led to similar recommendations. Authors also report that MH and substance use services should prioritise DVA interventions and staff training to develop professional curiosity or skills to engage in conversations about DVA (Chantler et al., n.d.). They also acknowledge that healthcare professionals may hold unhelpful assumptions about service users, which can create barriers to responding sensitively (Chantler et al., n.d.).

Research Gaps

In short, whilst there are numerous recommendations arising from reviews of DH literature, the extent of implementation is unclear (Jones et al., 2024). Moreover, recommendations drawn from reviews concerning DHRs may be geographically specific (e.g. Montique (2019) or outdated (e.g. Sharp-Jeffs & Kelly's (2016)). In addition, simply collating recommendations from reviews does not help in understanding the mechanisms linking MH and DH.

Existing literature has identified demographic, behavioural, and risk factors among victims and perpetrators (Bracewell et al., 2021; Chantler et al., 2019). Whilst there is a presence of MH conditions being elevated among perpetrators, they have not explored further how MH features in the pathways leading to DH, and the relationship between the two is complex (Montique, 2019). Authors suggest further research should explore subsets of victims and perpetrators and better understand the link between MH and DH (Almomen et al., 2022; Chantler et al., 2019). To date, no research has

examined the possible mechanisms underlying perpetrator MH and DH in England and Wales. The purpose of this study is to focus on a subset of male perpetrators reflecting the gendered nature of DH. The study will focus on the primary subtype IPH, specifically cases in which MH concerns have been documented, and will explore the mechanisms underlying the association between MH and IPH. Additionally, whilst some reviews have previously identified recommendations for MHS, it is essential to examine and update the recommendations DHRs have made for these services.

Study Aims

Aim 1: To examine the possible mechanisms through which MH difficulties are linked to the perpetration of IPH by men.

Aim 2: To identify the recommendations made for MHS within DHRs involving IPH.

Methodology

Design

The study addressed the study objectives using quantitative content analysis (QCA). This approach includes a structured, transparent process that enables researchers to quantify qualitative data by converting written information into numerical codes. This process supports the identification of patterns, frequencies, and trends (Riffe et al., 2019). QCA was the most suitable approach when using DHRs as a data source, as these are heterogeneous written documents that vary in quality and depth. QCA enables the identification of patterns in perpetrator characteristics and MH indicators that may contribute to mechanisms underlying IPH.

DHR Sample

Data were collected from the DHR library, available on the government website at https://homicide-review.homeoffice.gov.uk/. Using the website's filter feature, DHRs were filtered accordingly to identify relevant reviews. This process used the inclusion and exclusion criteria highlighted in Table 6.

Table 6.

Inclusion and exclusion criteria for selecting DHRs to analyse

Inclusion criteria	Exclusion criteria
Intimate Partner Homicide	Adult Family Homicide
Male perpetrator	Other forms of homicide, such as parricide
MH identified in the perpetrator (Adjustment Disorder, Anxiety, Depression, Psychosis, Personality Disorder, Panic, PTSD, Self-harm, Suicidal thoughts, suicide attempts, Alzheimer's or Dementia, other)	Female perpetrators
	DHRs with more than 1 victim or perpetrator

Filtered results left a total of 231 DHRs, which were downloaded on 23rd August 2024. Resources would not have permitted reviewing all DHRs, so we aimed to review 115, i.e., half. To reduce selection bias, these were identified through assigning each DHR a number and identifying 115 DHRs using a random number generator (https://www.random.org/). A formal power calculation was not required for this study, as the number of available DHRs determined the sample size. Authors judged the sample size appropriate for quantitative analysis and manageable within the timescales of a doctoral programme.

Data Collection

CL developed a coding framework and data extraction template after screening a sample of 30 DHRs. The process was simultaneously inductive and deductive, allowing codes to emerge from the data, whilst also drawing on prior literature and evidence-based risk assessment tools, to identify relevant variables. MH diagnoses were coded and categorised according to the 11th revision of the International Classification of Diseases (ICD-11) (World Health Organisation [WHO], 2025). CL also referred to the Domestic Abuse Stalking and Honour-based Violence risk assessment (DASH) (Safe Lives, 2023), the Domestic Abuse Risk Assessment (DARA) (College of Policing, 2022), and Monckton Smith's (2019) eight-stage timeline to DH to identify additional IPH-relevant variables. Most variables were nominal and dichotomous. Other variables, such as 'age', were continuous and 'ethnicity' or 'sentencing' had multiple options. Dichotomous variables were typically coded as

'Present' if there was descriptive information or evidence within the DHR of a particular variable, as defined within the coding framework. Absence of such a variable was coded as 'Not Present'. Existing definitions from the literature were used to define codes where possible. The primary researcher defined other codes when definitions from previous literature were unavailable. The full coding framework is available on the Open Science Framework (https://doi.org/10.17605/OSF.IO/2KGWN). A summarised version of the coding framework, including the key variables in this paper, is displayed in Appendix D. In total, CL read 102 DHRs and 13 executive summaries in full and extracted and coded the data in Microsoft Excel. The data collected included demographics and characteristics of the perpetrator and victim, relationship characteristics, history of violence and abuse, risk factors for DVA, MH and MH service contact, and substance use. Single agency recommendations for MHS were also recorded.

Inter-rater Agreement

A separate sample of 30 DHRs, selected at random from the 115-sample, was coded independently by CL and KB to assess inter-rater agreement and the applicability of the coding framework. Coders were blinded to one another's coding. After the first 10 DHRs were coded, coders met to discuss initial discrepancies, clarify ambiguous variables and refine definitions. Coding then continued for the full pilot phase. Definitions were agreed upon, revised and updated before full coding. Variables that appeared more nuanced in the data or difficult to define were excluded, for example, 'instability within the perpetrator'.

Ethics

The study involves secondary analysis of publicly available DHRs, and ethical approval was not sought, consistent with other publications that have reviewed DHRs (Baker et al., 2026; Bracewell et al., 2021; Chantler et al., 2019; Gunby et al., 2025). The reports are also anonymised using pseudonyms before publication by local community safety partnerships. The data is available in a public repository and 'contains public sector information licensed under the Open Government Licence v3.0' (The National Archives, 2019). There is no access to details beyond these reports, and

the study objectives are consistent with the primary purpose of DHRs: to identify lessons learnt, improve agency responses, and better understand DVA to prevent future deaths (Home Office, 2016).

Working with DHRs raises a range of ethical issues that were proactively considered. In the absence of an ethical framework for the use of DHRs in research in England and Wales (Cook et al., 2023), the Women's Aid research integrity framework (2020) was applied to ensure the research was carried out responsibly. In line with these principles, the study approached DHRs as sensitive material, acknowledged their limitations as a data source, and remained attentive to avoid misrepresenting the findings.

Analysis

The data were extracted into Excel and analysed using SPSS version 26. Inter-rater reliability was assessed using percentage agreement and Cohen's Kappa (or intraclass correlation coefficient for continuous variables). The full table of agreement for the variables in this study is listed in Appendix E. Agreement across most variables was consistently high, ranging from strong to almost perfect agreement. Variables with zero variance did not yield a kappa value; therefore, percentage agreement was calculated instead. Cohen's Kappa values were interpreted according to McHugh's (2012) criteria: moderate (k = .60- .79), strong (k = .80- .90), and almost perfect (k> .90).

Descriptive analyses provided frequency counts for the variables. Ethnicity was grouped according to the 2021 UK Census (GOV.UK, 2021). An assessment was made based on the information provided in the DHR as to whether MH was linked to the homicide under the codes of 'Likely', 'Unlikely', or 'Not Explicit'. Cases were coded as 'likely linked' to mental health when the DHR provided explicit information indicating a deterioration in mental health prior to the homicide, or when aggravating factors were reported to have triggered such deterioration. Evidence of this included current or recent mental health service involvement, reporting's of the perpetrator being unfit to stand trial, plead guilty and sentencing outcomes such as hospital orders. Cases were coded as 'unlikely linked' where information reported indicated that other contextual factors appeared to feature more and were unrelated to mental health, or where references to mental health were historic or limited. A third category, 'not explicit,' was used to code cases where information was insufficient

to determine linkage to mental health. Coding decisions were piloted and cross-checked with the second rater, though interpretive judgement was also required.

The functional impact of alcohol and substance use was coded using a four-level rating (minimal, moderate, significant, not determinable), based on the descriptive information provided in each DHR. Chi-Square tests were conducted to examine the relationship between the 'likely' vs 'unlikely' groups and other categorical variables. Fisher's exact tests were used when assumptions were violated due to low cell counts. The phi coefficient was used to indicate the strength of any relationship. Effect sizes were interpreted according to Cohen's (1988) conventional thresholds, classifying phi values as small (φ=.10), medium (φ=.30), or large (φ=.50) (Kim, 2018). Recommendations were coded into overarching themes as defined in the coding framework, with similar ideas clustered and then counted to highlight the most common themes.

Results

Demographics

All perpetrators were male, and 114 victims were female (99.1%), with 1 victim being male (0.9%). The age of male perpetrators was reported in 91 DHRs, with a mean age of 46.54 (Range 17-87, *SD*=16.93). The age of victims was reported in 94 DHRs, with a mean age of 44.33 (Range 17-89, *SD*=17.48).

Data on ethnicity were missing for the perpetrator in 34 DHRs and for the victim in 31 DHRs. The majority were White British (70% of perpetrators and 69% of victims). Ethnicity groups are listed in Table 7. below.

Table 7.

Ethnicity of perpetrators and victims

	Perpetrator (*n*=81)		Victim (*n*=84)	
	Frequency	%	Frequency	%
White	64	79	68	81
Black, Black British, Caribbean or African	6	7.0	6	7.1
Mixed or Multiple Ethnic Groups	1	1.2	1	1.1
Asian or British Asian	7	8.6	6	7.1

Other	3	3.7	3	3.5

In 66.1% of the DHRs, the perpetrator and victim were current partners/spouses. 32.2% were ex-partners or spouses, and in 1.7% of cases, there was a 'suspected relationship'.

Circumstances of the death

Turning to the circumstances of the death, most cases (67%) were classified as a DH, whereby the perpetrator murdered the victim. 26.1% of cases were homicide-suicide, where the perpetrator murdered the victim and subsequently ended their life by suicide. 6.1% were a domestic abuse-related death by suicide. One case was classed as a 'natural death' in the DHR, yet the circumstances still involved significant perpetration of abuse towards the victim.

Sentencing

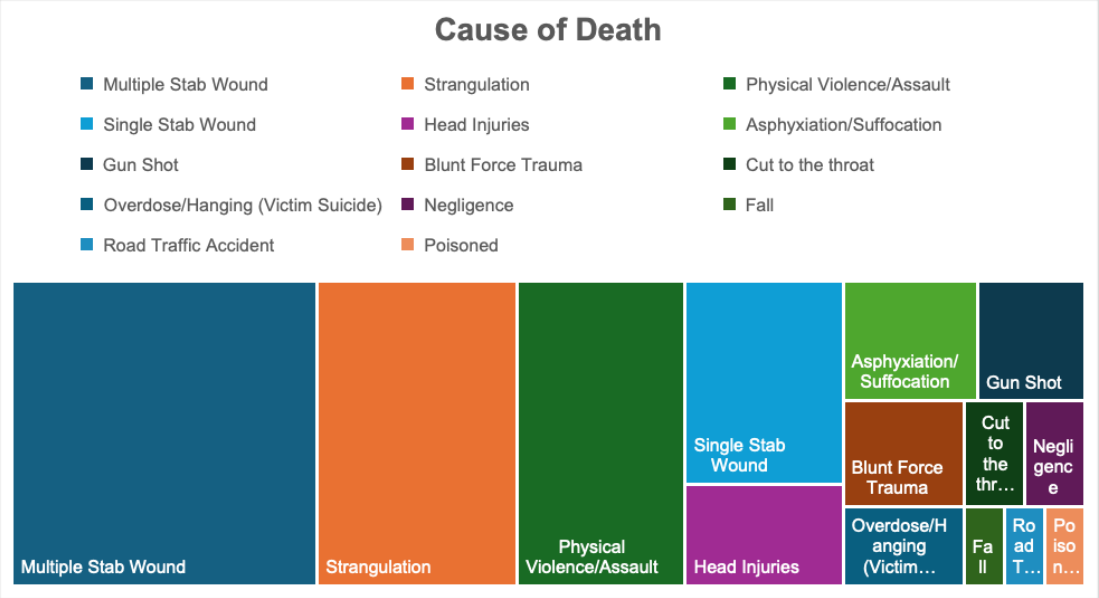
53% of the perpetrators were found guilty of murder (*n*=61) and 6.1% (*n*=7) were guilty of manslaughter. 8.7% (*n*=10) were found guilty of manslaughter by diminished responsibility, and (0.9%) (*n*=1) was found not guilty by reason of insanity. There was no verdict in 29.6% (*n*=34) of cases where the victim died by suicide or where the perpetrator had died by suicide following the homicide. One DHR (0.9%) did not specify the verdict, and in one case, the perpetrator was found not guilty (0.9%). Of those cases for which a verdict was given (*n*=74), the vast majority were given a prison sentence; 64.9% (*n*=48) a life sentence and 23% (*n*=17) a prison sentence of varying duration. Of the remainder, 10.8% received a hospital order (*n*=8) and 1.35% (*n*=1) received a hospital order with transfer back to prison after treatment.

Main cause of death

Figure 4 displays the cause of death of the victims reported in 102 cases; data were missing for 13 DHRs. At least 44.1% (*n*=45) of cases likely involved a weapon (e.g. stabbing, gunshot, or cut to the throat).

Figure 4.

Cause of Death of the Victims



Mental Health

Table 8 displays the reported MH conditions among perpetrators and victims, including co-morbidities. In 7.8% of cases (*n*=9), there was no mention of a specific perpetrator MH condition; however, they had documented in some cases evidence of historic self-harm or suicide attempts. In 65.2% of cases (*n*=75), perpetrator MH was 'mentioned'. In 27% of cases (*n*=31), the DHR explicitly reported that the perpetrator had a diagnosis of a MH condition.

In 45.2% of cases (*n*=52), there was no mention of victim MH. In 40% of cases (*n*=46), the victim's MH was mentioned. In 14.8% of cases (*n*=17), the victim had a diagnosis of a MH condition. 60 cases (52.2%) reported MH concerns within both the perpetrator and the victim. 49 cases (42.5%) reported MH within the perpetrator only. In 9 DHRs, both the perpetrator and victim had a reported diagnosis of a MH condition.

Table 8.

MH Conditions among Perpetrators and Victims (including co-morbidities)

	Perpetrator (*n*=106)		Victim (*n*=63)	
	Frequency	%	Frequency	%

Anxiety or fear related disorder				
Mentioned	36	33.9%	32	50.7%
Diagnosed	2	1.8%	4	6.3%
Depressive Disorder/Low Mood				
Mentioned	68	66.6%	43	68.3%
Diagnosed	16	15.1%	8	12.7%
Obsessive Compulsive or related disorders				
Mentioned	1	0.9%	3	4.7%
Diagnosed	0	0.0%	0	0.0%
Bipolar Related Disorders				
Mentioned	3	2.8%	5	7.9%
Diagnosed	1	0.9%	2	3.1%
Disorders Associated with stress (e.g. PTSD/Adjustment Disorder)				
Mentioned	5	4.7%	4	6.3%
Diagnosed	4	3.7%	0	0.0%
Dissociative Disorders				
Mentioned	0	0%	0	0.0%
Diagnosed	0	0%	1	1.6%
Schizophrenic/Psychotic Disorders				
Mentioned	4	3.7%	0	0.0%
Diagnosed	5	4.7%	1	1.6%
Substance Induced Disorders				
Mentioned	2	1.8%	1	1.6%
Diagnosed	2	1.8%	1	1.6%
Addictive Disorders				
Mentioned	1	0.9%	0	0.0%
Diagnosed	0	0%	0	0.0%
Neurocognitive Disorders				
Mentioned	4	3.7%	3	4.7%
Diagnosed	1	0.9%	3	4.7%
Neurodevelopmental Conditions				
Mentioned	5	4.7%	2	3.1%
Diagnosed	2	1.8%	2	3.1%
Personality Disorders				
Mentioned	9	8.4%	2	3.1%
Diagnosed	5	4.7%	2	3.1%
Eating Disorders				
Mentioned	0	0%	1	1.6%
Diagnosed	0	0%	1	1.6%

MH Service Contact

12.3% (*n*=14) had contact with services related to MH within one week of the homicide occurring, nine of which were with the GP. 11.3% (*n*=13) of perpetrators had contact within the past one to four weeks of the homicide date, eight of whom were the GP. 16.5% (*n*=19) had contact with

services within the last 1-6 months. 11.3% (*n*=13) had contact within the last 6-12 months, and 23.5% (*n*=27) had contact with services for MH more than 1 year ago. 20.9% (*n*=24) of perpetrators were not known to MHS, and in 4.3% (*n*=5) of DHRs, previous service contact was not determinable.

Perpetrator Characteristics

Suicidality and Self-Harm

Table 9 presents the frequency of recent, previous, and historic self-harm and suicidality among perpetrators reported in DHRs, based on the time frame in which the behaviour occurred prior to the homicide. Suicidality and self-harm indicators were coded independently; a single DHR could be coded in more than one category (e.g., both recent and historic self-harm). As a result, the frequencies reported below reflect all coded occurrences, not one code per DHR. A Fisher's Exact test indicated that previous suicidal ideation (within the past three to 12 months) was significant among perpetrators where MH was likely linked to the homicide, p=.011 (two-tailed). The cross-tabulation showed that 21.1% of perpetrators experienced suicidal ideation in the previous three to twelve months before the homicide, where mental health was likely linked. There were no significant differences among perpetrators regarding the presence of other self-harm and suicidality.

Table 9.

Presence of self-harm and suicidality among perpetrators prior to the homicide

	Self-Harm % (*n*)	Suicidal Ideation % (*n*)	Suicide Attempt % (*n*)
Recent (Past 3 months)	1.7% (2)	18.3% (21)	11.3% (13)
Previous (3 to 12 months prior)	6.1% (7)	13% (15)	4.3% (5)
Historic (More than 12+ months ago)	15.7% (18)	22.6% (26)	20.9% (24)

Alcohol and Substance Use

The frequencies of alcohol and substance use among perpetrators are summarised in Table 10. The table also outlines the assessed functional impact of alcohol and substance use on the perpetrator, based on the information provided within the DHRs.

Table 10.

Presence of the perpetrators' use of alcohol and substances

	N	%
Intoxicated at time of homicide	14	12.2%
Alcohol/ Substance Use (*n*=115)		
No use of either	47	40.9%
Alcohol use only	33	28.7%
Substance use only	4	3.5%
Both alcohol and substance use	31	27%
Evidence of Dependency (*n*=115)		
No dependency reported	88	76.5%
Dependent on alcohol only	17	14.8%
Dependent on substances only	4	3.5%
Dependent on both alcohol and substances	6	5.2%
Functional Impact of Alcohol Use (*n*=64)		
Minimal	34	53.1%
Moderate	21	32.8%
Significant	7	10.9%
Not determinable	2	3.1%
Functional Impact of substance use (*n*=35)		
Minimal	23	65.7%
Moderate	6	17.1%
Significant	4	11.4%
Not determinable	1	2.8%

Risk Factors, Potential Mechanisms, and Contextual Triggers Preceding Homicide Events

Perpetrators were assessed and categorised according to whether the homicide was likely linked to their MH. DHRs that were difficult to assess based on the information available were coded as 'not explicit' and excluded from the following analyses exploring possible mechanisms (Tables 11 & 12).

Psychiatric Features Associated with MH-Linked Homicides

Table 11. displays the chi-square analyses and frequency distributions of mental health conditions. Anxiety, Psychosis or Schizophrenic disorders and Neuro-cognitive disorders were significantly more common in homicide cases where MH likely played a role. Depression was highly prevalent among perpetrators in both groups but was not significantly different. There were no significant differences across other mental health conditions.

Table 11.

Chi-square analyses and frequency distributions of mental health conditions

Variable	Link to MH		Statistics			
	Likely (*n*=38)	Unlikely (*n*=43)	χ^2	*P*-Value	φ	φ Interpretation
	Frequencies % (*n*)					
Anxiety (Diagnosed or Mentioned)			**5.246**	***p*=.022**	**.254**	**Small to Moderate**
Present	44.7% (17)	20.9% (9)				
Not Present	55.3% (21)	79.1% (34)				
Depressive Disorder/Low Mood (Diagnosed or Mentioned)						
Present	76.3% (29)	69.8% (30)	.437	*p*=.508	.073	small
Not Present	23.7% (9)	30.2% (13)				
Schizophrenic/Psychotic Disorders			**Fishers Exact Test**	***p*=.047 (two-tailed)**	**.239**	**Small to Moderate**
Present	15.7% (6)	2.3% (1)				
Not Present	84.3% (32)	97.7% (42)				
Neuro-Cognitive Disorders			**Fishers Exact Test**	***p*=.044 (two-tailed)**	**.242**	**Small to Moderate**
Present	10.5% (4)	0.0% (0)				
Not Present	89.5% (34)	100% (43)				

Note:
χ^2 - Chi Squared
P-Value * - Indicates significant result
φ Phi – Effect size

Prior Abuse and Relational Dynamics

Physical, emotional and sexual abuse were significantly more common in cases where MH was unlikely linked to the homicide. Coercive controlling behaviours, stalking and harassment were also found to be significantly more frequent in this group. The effect sizes indicated small-to-moderate and moderate associations.

Arguments or conflicts, as well as separation or divorce, were also more prevalent when MH was not considered a contributing factor. In these cases, the victim was also more often described as fearing the perpetrator and feeling isolated. The effect sizes indicated small-to-moderate and moderate associations.

Caregiving Roles

The frequency of the perpetrator or victim being in a care-giving role appeared to be significantly more common in cases where MH was likely to be linked to the homicide. The effect sizes indicated a small-to-moderate association. Furthermore, couples described as 'devoted' were significantly more common in this group, with an effect size indicating a moderate association.

Table 12 presents the chi-square analyses examining whether variables differed between cases in which MH was likely or unlikely to be linked.

Table 12.

Chi-Square Analysis and Frequency Distributions of Homicide Mechanisms

Variable	Link to MH		χ^2	*P*-Value	φ	φ Interpretation
	Likely (*n*=38)	Unlikely (*n*=43)				
	Frequencies % (*N*)					
Criminal History			.407	*p*=.523	-.071	Small
Present	39.5% (15)	46.5% (20)				
Not Present	60.5% (23)	53.4% (23)				
History of DA/DV towards previous partners/family			.716	*p*=.397	-.094	Small
Present	39.5% (15)	48.8% (21)				
Not Present	60.5% (23)	51.2% (22)				
Previous abuse towards the Victim						
Physical Abuse			**7.498**	***p*=.006***	**-.304**	**Moderate**
Present	39.5% (15)	69.8% (30)				
Not Present	60.5% (23)	30.2% (13)				
Emotional Abuse			**8.748**	***p*=.003***	**-.329**	**Moderate**
Present	44.7% (17)	76.7% (33)				
Not Present	55.3% (21)	23.3% (10)				
Economical Abuse (including financial abuse)			.437	*p*=.508	-.073	Small
Present	23.7% (9)	30.2% (13)				
Not Present	76.3% (29)	69.8% (30)				
Sexual Abuse			**Fishers Exact Test**	***p*=.013* (two-tailed)**	**-.289**	**Small to Moderate**
Present	0% (0)	16.3% (7)				
Not Present	100% (38)	83.7% (36)				
Honor Based Abuse			Fishers Exact Test	*p*=.496 (two-tailed)	-.150	Small
Present	0% (0)	4.7% (2)				
Not Present	100% (38)	95.3% (41)				
Perpetrator Characteristics						
Jealousy			2.999	*p*=.83	-.192	Small
Present	23.7% (9)	41.9% (18)				
Not Present	76.3% (29)	58.1% (25)				
Coercive Controlling Behaviours			**6.359**	***p*=.012***	**-.280**	

Present	39.5% (15)	67.4% (29)				**Small to Moderate**
Not Present	60.5% (23)	32.6% (14)				
Anger/Aggression			1.851	*p*=.174	-.151	Small
Present	52.6% (20)	67.4% (29)				
Not Present	47.4% (18)	32.6% (14)				
Threats to Kill or Harm			.099	*p*=.753	-.035	Small
Present	31.6% (12)	34.9% (15)				
Not Present	68.4% (28)	65.1% (28)				
Paranoia/Suspicion			.230	*p*=.631	-.053	Small
Present	21% (8)	25.6% (11)				
Not Present	79% (30)	74.4% (32)				
Possessiveness			Fishers Exact Test	*p*=.162 (two-tailed)	-.175	Small
Present	5.3% (2)	16.3% (7)				
Not Present	94.7% (36)	83.7% (36)				
Planning the homicide			.000	*p*=.989	.001	Small
Present	21% (8)	20.9% (9)				
Not Present	79% (30)	79.1% (34)				
Stalking Behaviours			**7.400**	***p*=.007***	**-.302**	**Moderate**
Present	7.9% (3)	32.6% (14)				
Not Present	92.1% (35)	67.4% (29)				
Harassment Behaviours			**4.229**	***p*=.04***	**-.228**	**Small to Moderate**
Present	13.2% (5)	32.6% (14)				
Not Present	86.8% (33)	67.4% (29)				
Relational Characteristics						
Arguments or Conflict			**7.658**	***p*=.006***	**-.307**	**Moderate**
Present	52.6% (20)	81.4% (35)				
Not Present	47.4% (18)	18.5% (8)				
Separation/Divorce			**5.434**	***p*=.02***	**-.259**	**Small to Moderate**
Present	36.6% (14)	62.8% (27)				
Not Present	63.2% (24)	37.2% (16)				
Perpetrator caring for the victim			**Fishers Exact Test**	***p*=.023* (two-tailed)**	**.269**	**Small to Moderate**
Present	18.4% (7)	2.3% (1)				
Not Present	81.6% (31)	97.7% (42)				
Victim caring for the perpetrator			**Fishers Exact Test**	***p*=.02* (two-tailed)**	**.273**	**Small to Moderate**
Present	13.2% (5)	0% (0)				
Not Present	86.8% (33)	100% (43)				
Victim entered a new relationship			.065	*p*=.799	.028	Small
Present	18.4% (7)	16.3% (7)				
Not Present	81.6% (31)	83.7% (36)				
Devoted Couple			**Fishers Exact Test**	***p*<.001* (two-tailed)**	**.399**	**Moderate**
Present	26.3% (10)	0% (0)				
Not Present	73.7% (28)	100% (43)				
Victim feared or felt scared of the perpetrator			**4.678**	***p*=.031***	**-.240**	**Small to Moderate**
Present	15.8% (6)	37.2% (16)				
Not Present	84.2% (32)	62.8% (27)				
Victim felt isolated			**6.350**	***p*=.012***	**-.280**	

Present	7.9% (3)	30.2% (13)	**Small to Moderate**
Not Present	92.1% (35)	69.8% (30)	

Note:
X² - Chi Squared
P-Value * - Indicates significant result
Phi φ = Effect Size

Recommendations for MHS

Recommendations directed toward MHS were common across DHRs, with 35.7% reporting suggestions for improving services. The most frequent themes focused on enhancing the quality and consistency of clinical practice, strengthening assessments, updating organisational policies, and upskilling the workforce. Several reviews also suggested that improvements are needed in information sharing between agencies and within teams and providing clearer documentation on clinical systems. Further recommendations were focused on increasing awareness of DVA and professional curiosity within MHS. These themes are summarised in Table 13. The frequencies reported below reflect all coded occurrences, not one code per DHR. The chi-squared test indicated that sharing of information and improving systems/recording of information were significant in cases where MH was likely linked to the homicide vs unlikely linked ($\chi^2(1, n=81)=4.084$, $p=.043$,$\varphi=.225$ and $\chi^2(1, n=81)=5.106$, $p=.023$, $\varphi=.252$, respectively).

Table 13.

Frequency of recommendations for MHS

Variable	Frequency (*n*)	%
Recommendations made for MHS (*n*=115)		
Yes	41	35.7
No	75	64.3
Recommendations made to MHS (*n*=41)		
Assessments		
Present	24	58.5%
Policies/Procedures/Protocols		
Present	23	56%
Staff Training		
Present	21	51.2%
Sharing of Information		
Present	19	46.3%
Improving Systems/Recording of Information		
Present	17	41.5%

Increasing Awareness		
Present	15	36.6%
Increasing Communications		
Present	14	34.1%
Professional Curiosity		
Present	13	31.7%
Improve Referral Pathways		
Present	9	22%
Signposting/Onward Referrals		
Present	9	22%
Referral to MHS		
Present	3	7%

Discussion

The paper aimed to examine the mechanisms underlying the association between MH difficulties and men's perpetration of IPH and to identify recommendations for MHS. The study used QCA to discover patterns and trends to uncover potential mechanisms. This is the first study to examine more closely the role of MH in IPH, in a large subsample of DHRs in England and Wales, where MH concerns have been reported.

In considering the characteristics which show differences and directions in frequencies between DHRs where a MH link to the DH was demonstrated, it is important to note first that, in this sample of DHRs where 'mental health' had, by definition, been identified as important, this mostly related to depression and anxiety. Severe mental health conditions in the perpetrator, such as schizophrenia and neurocognitive disorders (e.g. dementia), were relatively rare. Certain patterns became more apparent when looking specifically at cases where MH was deemed likely to be linked to the homicide. In particular, anxiety, caregiving roles and descriptions of couples being 'devoted' were significantly more common in cases where MH was likely linked to the homicide. Schizophrenia or psychotic disorders and neurocognitive disorders, although low in frequency, were, when present, almost exclusively linked to MH-related homicides. It is important to acknowledge that the role of mental health varies case by case. In some cases, it may be an important factor, while equally in others it may not be.

On the other hand, factors more common when MH was unlikely to be linked to the homicide were patterns of prior abuse of the DH victim, including physical, emotional and sexual abuse, coercive control, stalking, and harassment. Other characteristics which featured more were difficult relationship dynamics, including arguments or conflict, separation, and victim fear or victim isolation. Across the study, effect sizes indicated small-to-moderate associations, suggesting meaningful but not large differences between groups. Depression was common regardless of whether MH was judged to be related to the DH, showing no significance between groups. In reviewing the different combinations of factors noted, it appears reasonable to suggest that there may be two pathways to IPH. One which appears to be characterised by prior abusive behaviours in cases where MH was less likely to feature, and a second pathway involving caring roles and relational closeness, heightening vulnerability to MH. These pathways should not be viewed as comprehensive and do not rule out that MH-related violence may arise through other mechanisms or contexts not entirely captured by this study. The findings are interpreted in relation to existing theory, their implications for clinical practice are considered, and the methodological limitations are outlined.

The Abuse-driven Pathway

Previous DA towards the victim, specifically physical, emotional, sexual, coercive, and controlling behaviours, was found to be associated in cases where the homicide was less likely linked to MH concerns. Furthermore, stalking and harassment behaviours from perpetrators were also associated with homicides that were unlikely to be associated with MH vulnerabilities. Together, these results indicate that in cases where MH appears to play less of a role, patterns of abuse towards the victim may precede the homicide, with mechanisms characterised by abuse, control, and surveillance. Previous DA predating IPH is consistent across the literature (Campbell et al., 2007; Matias et al., 2020; Monckton Smith, 2019). Stalking is also considered a significant risk factor for IPH (Chopra et al., 2022) and can be underreported (Baum et al., 2009) or occur online, which can be overlooked (Todd et al., 2020). The findings support Monckton Smith (2019), who also identified that previous abuse history, stalking, and coercive control preceded many IPH cases. The study also found that relationship tensions, such as arguments and separation, appeared to be associated in homicide

cases where MH was unlikely to be associated. Separation is a well-known, documented risk factor for victims of DA (Baker et al., 2026; Campbell et al., 2007; Garcia et al., 2007). Some have argued that perpetrators of intimate partner femicide possess an attitude of "if I cannot have you, then no one else can," and this type of thinking has led to the decision to kill (Monckton Smith, 2019). Changes in thinking have been known to precede homicides, for example, "last chance" thinking, where the perpetrator may feel like nothing is left for them (Monckton Smith, 2019).

The risk factors highlighted in this study (control, separation, and stalking) are also consistent with the Male Sexual Proprietariness Theory by Daly and Wilson (1988). The theory proposes that men may view their female partners as property over which they have exclusive rights, arguing that violence can occur when their sense of 'ownership' is challenged by events like separation, infidelity, or a loss of control. Some men may resort to violence, threats, or coercive behaviours to regain control of the relationship or their female partner (Serran and Firestone, 2004). The findings similarly align with Stark's (2009) coercive control theory, which explains that partner abuse is better understood as a pattern of domination instead of isolated incidents of violence. An increase in threats, abuse, and control is a mechanism a perpetrator uses to retain control. This theory can explain the act of homicide as the final act of control.

Together, the results support the idea that some cases of IPH may be better understood as an escalation within an abuse-driven pathway, rather than an outcome due to a vulnerability in the perpetrator's MH. Johnson (2008), as cited in Monckton Smith (2019), found two distinct typologies of abusers who are dangerous and controlling. Still, neither had significant links to mental illness, though there was a relationship to a personality disorder.

Caring Responsibilities as a Route to Mental Vulnerabilities

In cases where the perpetrator's MH was likely to have been linked to the homicide, caring roles were likely to feature. Baker et al., (2026) also found perpetrators of IPH-suicide were frequently carers for victims and struggling to cope. It is well documented that carers experience poorer MH and overwhelm (Carers UK, 2019). O'Dwyer et al. (2025) explored caregiver-perpetrated homicides, indicating some of the driving factors were to end suffering, carer burden or overwhelm.

Benbow et al. (2019) also found that caregiving can influence relational dynamics by altering the power relations or adding stress. The caregiver stress theory further suggests that a stressed or burdened carer is at greater risk of perpetuating abuse than a carer with less burden (Fundinho et al., 2021). Psychological pressures, such as carer burden or carer stress, may contribute to or exacerbate vulnerability to deteriorating MH. The stress from caring for a partner is known to be correlated with IPH-suicide cases (Baker et al., 2026), and caring for an ill partner is highly correlated with depression (Bourget et al., 2010).

Furthermore, a couple described in the DHR as 'devoted' was disproportionately associated in cases where MH was likely to be linked to homicide and yielded the strongest effect size in the analysis. This may reflect a level of dependency in the relationship and feeling unable to live without the victim, likely driving a percentage of the IPH or IPH-suicide cases. These findings are similar to Baker et al. (2026), who also found that some couples in their sample were described by services as 'loving' and 'devoted', which may mask the possibility that DA/DV is occurring within these relationships.

Together, these results indicate that there are plausible pathways suggested by the data, however other trajectories are likely to exist and merge through additional research. Interestingly, none of the theories discussed suggests a pathway centred on serious mental illness. This reflects the evidence, which doesn't appear to show a straightforward link between severe mental illness and domestic harm, or at least that it could be a rare pathway for it not to emerge in the DHRs sampled.

Anxiety and Depression in Perpetrators

Depression, followed by anxiety, was the most reported MH condition within both the perpetrators and victims of IPH in this study. Anxiety was associated with and more likely to feature in cases where MH was likely linked to homicide. Anxiety, therefore, might be a marker of MH vulnerability in perpetrators of IPH.

Depression or low mood was common among perpetrators but did not appear to be a distinguishing feature in cases where MH likely played a role. It is worth considering that DHRs do

not always explicitly state whether perpetrators had a diagnosis and could suggest that MH conditions may be undiagnosed or not fully recognised in perpetrators of IPH. Despite this, previous studies also found anxiety and depression to be common among perpetrators of IPH in DHRs in England and Wales (Chantler et al., 2019; MacInnes et al., 2023; Sharp-Jeffs & Kelly, 2016). Depression is also the most reported mental illness in homicide-suicide cases (Roma et al., 2012), with 27% to 32% of IPHs resulting in suicide (Campbell et al., 2007). This study found similar; 26.1% of cases were IPH-suicide.

Depression is also associated with physical IPV (Saunders et al., 2021). The "Big Build" model by Brownhill et al. (2005) suggests that men cope with emotional distress by acting inwards initially, through avoidance and numbing behaviours. As distress builds, they eventually act outwards with destructive behaviours as a release. Violence, aggression, risk taking, road rage, gambling and substance use have been deemed to be 'depressive equivalents' or 'masked depression' and are more common symptoms in men than social withdrawal or sleep problems, which are commonly found in women (Brownhill et al., 2005; Cavanagh et al., 2017; Martin et al., 2013; Winkler et al., 2005). These behaviours from men have been described as symptoms of 'hidden depression' as they are different to the traditional sad expressions seen in depression but not always labelled as symptoms of depressive illness (Brownhill et al., 2005). Male perpetrators of IPH might not be recognised as suffering from a depressive illness due to them exhibiting more anti-social or aggressive behaviours rather than the traditional symptoms outlined in the Diagnostic and Statistical Manual for Mental Disorders (American Psychiatric Association, 2013) OR ICD-11 (WHO, 2025). Furthermore, men can be more silent, struggle to report their symptoms (Brownhill et al., 2005) and are unlikely to seek help (Thompson et al., 2016) and could be missed by a professional or not diagnosed if they are not exhibiting the traditional symptoms of depression (Cheng & Jaffe, 2019).

Recommendations for MHS

Over one-third (35.7%) of DHRs made recommendations for MHS, indicating that MHS are likely to encounter both victims and perpetrators and may need to give separate consideration to the needs of both. The two possible pathways identified in this study also suggest that perpetrators and

victims can present with different profiles, levels of risk and need. Therefore, MHS must tailor assessment and intervention accordingly. However, organisational structures and practices might not sufficiently support MH professionals in identifying and responding to individuals at risk of DVA and DH (Hegarty et al., 2020). The most frequent themes were improving the quality of assessments, including risk assessments, updating policies and procedures, and upskilling the workforce through staff training. Previous research has also identified similar recommendations across mental health and other services, highlighting several areas for improvement (Chantler et al., 2024; Gunby et al, 2025; Chantler, n.d.; Jones et al., 2022; Home Office, 2016; Sharp-Jeffs & Kelly, 2016). Considering the strong association between coercive control, previous abuse, stalking and harassment, practitioners assessing risk should have awareness of these risk factors and routinely enquire about these experiences, particularly in women. Organisations can facilitate training to increase awareness among MH professionals; this is a widely recognised recommendation.

Nevertheless, for training to be effective, trust-wide DA policies should have established referral pathways (Sharp-Jeffs & Kelly, 2016). Without such structures, training can become a superficial intervention, which does not translate into substantial change. Although DHRs often produce detailed recommendations, translating these into meaningful change is challenging. MHS commonly face a gap between resources and need, alongside significant workforce pressures, which can hinder its ability to implement new practices. There has also been a significant delay in publishing DHRs, with many taking over two years to be published, which impacts the recommendations, as they are likely to be outdated by the time of publication (Bridger et al., 2017). Despite research examining service recommendations, there is little evidence that they are implemented (Jones et al., 2022). The lack of implementation raises doubts about whether opportunities for prevention are being missed.

Clinical Implications

Previous research has identified the need for health services to take an active role in prevention through working to identify victims at risk of DVA and perpetrators of DVA (MacInnes et al., 2023). MHS could be the first or one of the few services perpetrators of IPV engage with, and perpetrators with depression are more likely to access MH-related services than any other treatment

program (MacInnes et al., 2023). This positions MHS as a site for early detection and intervention. Anxiety was associated with cases where MH was likely linked to homicide. Anxiety may be a marker of a more extensive MH vulnerability and should be explored routinely in assessments. This aligns with the main recommendation from DHRs for MHS to strengthen and improve assessment quality. It is unlikely that perpetrators will disclose IPV or even recognise it; therefore, professionals need to be aware of risk factors and undertake thorough assessments that may surface otherwise hidden risks and identify the most appropriate support.

The high prevalence of depression and low mood among perpetrators in this study, together with previous evidence linking depression to DVA and domestic homicide-suicide (Saunders et al., 2021; Roma et al., 2012), highlights the importance of exploring depressive symptoms in clinical assessments and risk formulation. Assessments of depression in men should include the exploration of anger, aggression, risk-taking behaviours, and substance use as opposed to the traditional symptoms outlined in DMS-5/ICD-11. According to Rosenbaum and Bennett (1986, as cited in Cheng & Jaffe, 2019), structured interviews with direct questions related to suicidal and homicidal ideation are likely to increase disclosure rates. MacInnes et al. (2023) also note that IPH perpetrators are likely to access emergency services in crisis, and their contact with services tends to be episodic. The lack of formal diagnoses or subsequent monitoring creates challenges in assessing risk due to insufficient background information and discontinuity of care. Nevertheless, they recommend that MHS include information about partners, ex-partners, and family, even when follow-up is not required, as this could provide context for identifying risk.

It is important to ensure that where caregiving roles are identified, professionals signpost individuals for a carer's assessments, which has been a further critical finding in other DH research and consider the impact caring has on their mental health and wellbeing (Benbow et al., 2019; Chantler et al., 2024; Montique et al., 2019). Recognising and responding to this early may prevent deterioration and reduce risk.

Most of the perpetrators were found guilty of murder or manslaughter and received life or prison sentences. This evidence suggests that perpetrators of IPH are likely to enter the prison system

as opposed to secure psychiatric hospitals. Considering the high rate of anxiety plus depression among IPH perpetrators, this sheds light on how important it is for prison systems to be aware of MH. 56% of men in prisons report experiencing MH problems, with anxiety and depression being the most commonly reported (Prison Advice & Care Trust, [PACT] n.d.). However, there are gaps in MH provision in prisons and a lack of clinical staff due to a high number of vacancies and longstanding recruitment and retention issues. This leads to a large percentage of prisoners not receiving adequate support; 39% of male prisoners who need help said they received it (PACT, n.d.). This will continue to be a missed opportunity for prevention, in terms of preventing further harm within criminal justice systems and supporting the rehabilitation and risk management of offenders after release. There has been a request for an increase in government funding to be able to provide adequate resources for perpetrators in the prison system who continue to struggle with MH (PACT, n.d.).

Strengths and Limitations

This is the first study to examine the role of MH in cases of IPH in England and Wales more closely. The use of a second rater increases the reliability of the findings, reducing bias and enhancing the replicability of the coding framework in future research.

Although DHRs can be valuable sources of information (Bridger et al., 2017), they were not produced for research purposes (Bracewell et al., 2021; Chantler et al., 2019), and their quality can vary despite statutory guidance (Bracewell et al., 2021). DHRs rely on previously recorded information from various services, which may consist of brief or partial records, and there is always the potential for agencies to protect their reputations rather than participate in reflective learning (Chantler et al., 2019). DHRs may omit substantial information to preserve confidentiality, and the absence of a risk factor or variable does not necessarily indicate that it was absent (Chantler et al., 2019). Furthermore, reports may not include the perspectives of family and friends and may miss important information such as other risk or circumstantial factors and relational interactions. Comprehending the context and dynamics of relationships is also complex and nuanced. Information on MH and substance use can also be missing in these reports (MacInnes et al., 2023). Therefore, assessing the functional impact of such factors is particularly challenging. Many DHRs report

findings in a race-gender-neutral tone, which makes learning from DHRs challenging because the gender and racial nature of DVA and DH is left unstated (Chantler et al., 2024). When protected characteristics and structural inequalities are not explicitly examined, the factors that shape victims' vulnerability, service responses, and the escalation of risk remain unclear. This limits DHRs' ability to generate meaningful learning.

Whilst QCA appeared to be the most appropriate method for the project, considering that the available data were written reports, DHRs can be complex; they are lengthy documents that include a range of contextual factors. There is a limitation to utilising QCA, as this method can be reductionist and lead to the trivialisation or oversimplification of the findings (Riffe et al., 2019) without considering the wider context. Rowlands (2022) calls for researchers to engage with DHRs critically and to consider their limitations as data sources, given their complexity. Despite the limitations, DHRs provide a comprehensive national repository for understanding the antecedents of DH in England and Wales. The breadth allows for identification of recurring patterns, even if the depth and nuance of cases are somewhat constrained.

Other limitations stem from the methodological decisions required in this study. Although the coding framework was developed and tested with a second rater, variables still required interpretive judgment based on the information provided in DHRs. Decisions to categorise into MH link ‘likely’, ‘unlikely’, or ‘not explicit’ involve some subjective decision-making, and the categories themselves are broad and somewhat crude. As DHRs vary in detail, some cases may have been placed differently had further information been available. Therefore, the mechanisms identified reflect patterns in the dataset, rather than definitive causal mechanisms and should be interpreted with caution.

Future Research

The current study was exploratory, focusing on perpetrators of IPH for whom MH concerns were reported in DHRs. The second aim of this study, examining the recommendations for MHS, was brief, and further work is needed to explore them in greater depth. Mixed-methods approaches would be valuable, as they enable quantitative patterns to be interpreted through qualitative perspectives, facilitating a more in-depth exploration of MH mechanisms and service responses. Furthermore,

future research could develop more nuanced classification systems. For example, instead of categorical judgements, researchers could rate the likelihood of MH function as a factor linked to homicide on a graded scale (0-10) or assess each case against a set of theoretically informed pathways, such as the ones found in this study. These approaches may reduce the reductiveness inherent in categorical coding.

Given that the most recent service contact for MH-related concerns was primarily with GPs, further research should also investigate the role of primary care in identifying DA, addressing MH concerns, and managing risk. This can provide important knowledge of missed opportunities for prevention. In addition, caring roles appeared to feature within the dataset and were most often reported in cases classified as 'likely linked MH-IPH'. This indicates that caring roles may be an important theme in IPH literature warranting further empirical investigation. Future research utilising mixed methods could explore how caring roles and caregiving dynamics, such as burden, stress, dependency and relational closeness intersect with mental health difficulties and risk of IPH. Such work could build on emerging evidence reported by O'dwyer et al., (2025).

Further analysis of sub-populations of perpetrators with diagnosed MH conditions could help identify other mechanisms or pathways that differ from those observed in the wider sample. Furthermore, research into Adult Family homicide is overlooked (Chantler et al., 2024) and previous research indicates perpetrators of AFH may suffer from more severe mental illness than perpetrators of IPV (Bracewell et al., 2021; MacInnes et al., 2023). Therefore, research exploring mental health more comprehensively in perpetrators of AFH warrants further study, as they may have distinct needs and require different intervention approaches.

Finally, previous research has emphasised the importance of an intersectional approach in DVA research to recognise how protected characteristics and structural inequalities shape victims' experiences and how these are reflected in DHRs (Chantler et al., 2024; Gunby et al., 2025; Women's Aid, 2020). Future research ought to therefore aim to explore DHRs through a more explicit intersectional lens, exploring how factors such as race, disability, and socio-economic disadvantage interact to influence risk, service response and homicide pathways.

Conclusion

This is the first study to explore more closely the role of MH in IPH, in a subsample of DHRs encompassing male perpetrators where MH concerns have been reported. Despite MH problems commonly reported in DHRs among perpetrators (Chantler et al., 2019; Bridger et al., 2017; Chopra et al., 2022; Benbow et al., 2019), this study's evidence suggests that MH was not consistently a significant feature or primary driver of IPH, and cases of severe mental illness were rare. The results suggest there are likely multiple pathways to homicide, with some involving prior abuse and conflict and others where MH vulnerability is present, alongside other relational and situational factors. The recommendations identify main themes that reflect areas where MHS may have missed opportunities and require improvement to better identify and respond to DA, including improving the quality of assessments, sharing information, and recording information.

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Chapter Five: General Discussion and Critical Evaluation

This final chapter presents a broad overview of the findings from both the systematic review and empirical study. Both studies are critically appraised, with their strengths and limitations discussed. Clinical and theoretical implications are explored, followed by considerations for future research. Lastly, the overall conclusions are presented.

Summary of Main Findings

The aim of the thesis was to contribute to the wider literature in the field of violence against women. Firstly, the systematic review and meta-analysis examined how IPV is defined across Europe and generated pooled estimates of its prevalence. This extends the earlier work of Hegarty and Roberts (1998) in Australia by exploring definitional variation of IPV within a European context.

Broader definitions which encompassed all types of IPV (physical, sexual, and emotional) yielded pooled prevalence estimates of 12.1%. Narrower definitions, comprising physical and/or sexual IPV, yielded lower estimates of 6.5%. The results further revealed that emotional IPV yielded higher estimates (22.1%), followed by physical IPV (7.4%), with sexual IPV being reported the least prevalent (3.1%).

Upon examining the specific definitions used for each IPV subtype, the way physical IPV was defined did not appear to meaningfully affect prevalence estimates. However, the way in which sexual and emotional IPV was defined did influence reported rates. Broader definitions of sexual abuse, including both force and coercion, yielded higher estimates of sexual IPV. Emotional IPV yielded higher estimates when defined through acts of intimidation, humiliation, and verbal abuse, whereas definitions emphasising acts of control or economic restriction produced lower estimates. One study, Costa et al. (2015), in particular, reported significantly higher estimates for emotional and sexual IPV than those reported in other literature. Removing this study through sensitivity analyses showed that sexual IPV prevalence dropped from 4.4% to 1.3% in the ‘Force and Coercion’ subgroup and reduced emotional IPV prevalence from 32.6% to 14.1% in the ‘Emotional Abuse Only’ subgroup. This demonstrates that a single study can meaningfully shift pooled estimates, particularly when the sample of eligible studies is small. Costa et al. (2015) used the CTS to measure IPV, which captures a range of behavioural acts related to violence. The CTS, a well-known and validated tool (Straus et al.

1996) and includes items on sexual coercion, which may have led to these higher figures. Furthermore, the CTS includes acts that might not be universally recognised as emotional abuse (e.g. stomping out of the room). This may inflate prevalence by counting behaviours that other measures exclude. Emotional abuse is often covert, difficult to 'see' or recognise; thus, an operationalised definition is essential to help with the identification (SafeLives, n.d.). Covert abuse can be more damaging than other forms of abuse (Parkinson et al., 2024). Without a clear definition, such behaviours may be overlooked or underestimated, leading to further variation in reported rates and adverse consequences for victims.

The review identified substantial heterogeneity in past-year IPV prevalence estimates. This level of variability across studies makes it problematic for researchers to make comparisons. Considering this, the pooled prevalence estimates should be interpreted with caution. At best, they represent an average across highly diverse contexts rather than a definitive figure for Europe. Variation in measurement tools and definitional differences leads to heterogeneity in IPV prevalence research. It further highlights that differences in prevalence estimates may reflect methodological differences across studies in how IPV is measured, not because IPV is actually more or less common in certain places.

The empirical study was an exploratory analysis into how mental health plays a role in the perpetration of IPH. Several other research studies using DHRs as data sources have reported the frequency of MH conditions; however, they have not yet examined potential mechanisms linking MH to IPH. A second aim was to explore the recommendations made to MHS. It was hoped that this would make a meaningful and valuable contribution to the existing literature on DH cases in England and Wales and would inform future research and clinical practice. Within both the victim and perpetrator, anxiety and depression were the most common reported mental health conditions. Serious mental illness, such as psychosis, schizophrenia and neuro-cognitive disorders, was less common, but when present, was assessed as likely being linked to the homicide. The data indicated there were different pathways to IPH. Where mental health was less likely to feature, patterns of previous domestic abuse, coercive control, stalking, harassment and relational tension, such as separation and conflict, appeared to feature more. In cases where mental health was assessed as likely to be linked to

the homicide, anxiety, schizophrenia and neuro-cognitive disorders featured more. Caring roles and relational closeness, where couples were more likely to be described as devoted, also featured more in IPH cases where MH was likely be linked to the homicide. The findings indicate that mental health can be present and likely interact with relational, situational and other contextual factors. Still, in some cases, relational dynamics may need attention, such as carer burden, dependency, conflict and control. The most frequent recommendations to MHS were improving the quality of assessments, updating policies and procedures and implementing staff training. Sharing of information and improving the recording of information were significantly more frequent in cases where MH was likely linked to the homicide. This indicates potential gaps in MHS provision, which need attention.

Together, the two studies explore how IPV prevalence is captured and conceptualised, and how risk can escalate to the most fatal outcomes. It further highlights that emotional abuse is highly prevalent, and aspects of emotional abuse and coercive control are precursors in many cases of IPH.

Theoretical and Clinical Implications

The systematic review revealed that definitions and measurement methods will shape how IPV is counted and, therefore, impact what is resourced. Narrower definitions (e.g., physical-only) may underestimate the problem. There is also further variation in how the concepts of violence are captured, depending on the questions included in the measurement tools. For example, emotional abuse can encompass aspects of humiliation and threats, but also acts of control. Thus, there is a risk that researchers might not be studying the same constructs. The high level of heterogeneity makes it challenging to make comparisons and also difficult to assess whether prevalence is changing over time. IPV appears widespread yet likely underestimated in women, due to different rates of disclosure and populations of women not included in surveys, e.g. institutionalised, homeless or disabled. Wide prediction intervals also indicate that pooled estimates are often an average across diverse contexts and should not be interpreted as a single figure. Policy makers may misinterpret pooled estimates, which may influence decisions around funding and resource allocation for those who need it, given the likely high level of need among both victims and perpetrators. Emotional IPV was more prevalent than physical and sexual IPV, yielding higher estimates, yet it is the least operationalised. Emotional abuse and control also often featured as a precursor to more serious, lethal violence, such as in IPH

cases (Spencer & Stith, 2018), indicating it is a serious risk factor. Thus, understanding and identifying coercive control is important in both the community and clinical settings.

The empirical study highlighted that there are likely multiple pathways to IPH, each requiring different theoretical models to understand the process and indicating distinct needs and interventions for perpetrators and victims. A history of previous abuse and coercive controlling behaviours was common in cases of IPH, which supports Monckton Smith's (2019) timeline to homicide. The findings further support Stark's (2009) coercive control theory and the male proprietariness theory (Daly & Wilson, 1988), which explain that patterns of domination, surveillance, and control often precede IPH. Identifying IPV is important in healthcare systems, including mental health services and there should be routine enquiry about IPV during assessments. A common recommendation was improving staff knowledge through training to support professionals in recognising IPV. Emotional abuse, including coercive control, should be taken seriously and not treated as 'lesser' forms of violence; it is more prevalent and often a precursor to IPH. Thus, training of healthcare professionals should also focus on increasing awareness of emotional abuse and coercive control. Furthermore, agencies should share information across services more effectively to continue monitoring and assessing risk, and to respond appropriately to any escalations in risk. Failure to do so will lead to abuse being minimised, overlooked and missed opportunities for early intervention.

Professionals assessing depression in men should consider going beyond the DSM-5/ICD criteria and consider how anger, risk-taking, aggression, and substance use can be 'hidden' symptoms of depression (Brownhill et al. 2005). Considering many DHRs did not report explicit diagnoses of a mental health condition, but often mentioned low mood and or anxiety and other characteristics, this points to the importance of considering not only diagnosis but also the mechanisms that may drive violence, for example, anger, jealousy, or even fragile self-esteem and separation insecurity. Some of these characteristics are documented in the literature on personality (Krueger et al., 2012; Krueger et al., 2013) yet can be difficult to capture in DHRs. The alternative model to personality disorder (AMPD) may be more clinically useful to understand what combinations of personality functioning

can intersect and influence how a person acts and may drive risk behaviours in IPV and IPH cases (Krueger & Hobbs, 2020). This can improve risk formulation and early intervention.

Carer burden must also be recognised as a potential risk factor for abuse, and carer assessments should be undertaken to identify the needs of carers to mitigate the risk of future abuse. The needs of victims or perpetrators with carer stress are likely to be different to those who experience dynamics explained more by power, control and abuse.

Finally, the majority of perpetrators received prison sentences, indicating perpetrators are more likely to be in the criminal justice system. MHS in prisons require urgent investment to rehabilitate offenders with mental health concerns and reduce recidivism.

While the systematic review highlights the challenges of accurately measuring the scale of IPV, the empirical study also indicates factors that require more attention and where organisational systems may fail to recognise IPV on the frontline. The consequences are devastating when IPV and abuse are minimised, unrecognised or inconsistently measured, allowing risk to escalate and missing opportunities for prevention and early intervention.

Critical Appraisal

The portfolio as a whole contributes to a growing evidence base in IPV towards women and IPH perpetrated by males. The portfolio combines population-level data with individual cases, offering insights and understanding at different levels.

The similarities among papers are that IPV exists and is widespread. It was also a frequent theme across the sampled DHRs. One of the differences noticed was that in certain cases, IPH can occur in the context of mild cognitive impairment and/or carer burden, without a history of previous violence. This suggests that victims and perpetrators in these contexts likely have different needs and require different intervention strategies. Whilst the systematic review examined data from a European context, the empirical paper zoomed in on the most extreme form of IPV occurring in England and Wales.

Strengths of the systematic review included a comprehensive search strategy that followed PRISMA guidelines, with rigorous screening and data extraction. The analysis consisted of several meta-analyses and additional subgroup and sensitivity analyses to assess the stability of the findings. Prediction intervals were reported and interpreted, a practice rarely used in meta-analyses of IPV prevalence. The high level of heterogeneity among studies was taken into consideration and interpreted alongside the results, which indicated that the results should be interpreted with caution. Furthermore, acknowledging the limitations are important as they will shape how confidently the findings can be interpreted. The review relied on published studies, and grey literature searches were not conducted, introducing publication bias. Some countries and regions of Europe were underrepresented, and all studies used self-report surveys to capture data, which can lead to underreporting of figures. Data in some surveys was arguably outdated, and studies not published in the English language were excluded, potentially leaving out relevant European data. There was also a risk of underrepresentation of older women and marginalised groups. It was also difficult to assess the severity levels of violence, as studies often did not report them. The absence of severity data and under-representation of certain groups of women may limit the evidence base and understanding the true magnitude of the problem. However, it is unlikely that these factors would suggest the study has led to the over-estimation of IPV, the results are reasonable to be seen as minima, with true prevalence likely to be higher.

A coding framework was developed for the empirical study, grounded in theory and refined with a second rater. This can be utilised to replicate similar studies, which is a strength and a starting point for future research. Subsequently, reading and coding rigorously a large sample of 115 DHR reports focusing on mental health and IPH requires a high level of resilience and patience. Data was engaged with sensitivity, knowing the limitations of DHRs as a data source. Firstly, DHRs are to be critically engaged with, as they vary in quality and depth. Causality cannot be inferred in the chosen research design, and quantitative content analysis is necessarily reductionist, leading to the loss of contextual meanings when complex experiences are reduced to numerical indicators. Information can often be missing or inconsistently reported. The interpretation of mental health and its linkage to homicide introduces subjectivity; however, the coding framework is there to mitigate this. Variables

were assessed based on their presence of explicit information in the DHR. This approach was taken to strengthen the findings and reduce subjectivity, researcher bias, and overinterpretation of ambiguous information. However, this increases the risk of under-reporting certain variables and underestimating the presence of certain risk factors. Some patterns and associations may appear less weak or less frequent than they truly are.

Furthermore, the findings and pathways implied reflect what DHRs capture, rather than the full complexity of cases. Where previous abuse, coercive control or mental health were present, this methodology does not capture how it manifested. The methodology also did not capture the severity of control or violence when this occurred in DHRs, which could be incorporated into future research and revisions of the coding framework.

Together, both papers relied on secondary data on victims of IPV. There were no survivor or practitioner voices to support the findings. The focus on European studies and IPH within England and Wales limits global generalisability.

Future Research

Utilising mixed methods and introducing interviews with practitioners or survivors could help identify additional findings and challenges in this field that research could focus on, similar to a previous study, which combined DHR data with interviews (Munro et al, 2024). Furthermore, many contextual factors could not be accounted for or quantified using solely quantitative methods. Approaches utilising machine learning could be useful when analysing DHRs considering the depth and breadth of quantitative and qualitative data included within these, to add data driven findings.

The study also did not examine same-sex relationships or men as victims of IPV. Emerging evidence has suggested that those in same-sex relationships are reported to experience the same if not higher rates of IPV (Aguiar, 2025) and public health systems need to recognise male victimisation and provide gender sensitive responses (Isangha et al., 2026; Rehman et al., 2023). These fields warrant their own evidence base and targeted prevention and intervention strategies.

Developing standardised IPV definitions across Europe could improve the measurement of IPV and its subtypes. Furthermore, enhancing the reporting of mental health within DHRs could provide additional information on the pathway to homicide where mental health is a contextual

feature. Continuing to explore perpetrator pathways can identify particular intervention points. Examining IPV and IPH from an intersectional lens is central to understanding IPV and IPH, considering there are often multiple overlapping factors that shape risk, help-seeking and service responses. Emerging evidence suggests that further cross-cultural studies are also needed to develop culturally appropriate IPV interventions with sociocultural norms integrated (Güler et al., 2023).

The impact of substance or alcohol use was reported but not focused on in the main empirical paper. There was a small subset of perpetrators who used substances, which were assessed as having a significant functional impact on them. Future research could examine subsets of perpetrators with alcohol or substance misuse to identify other pathways to homicide involving substance use.

Overall conclusions

The thesis both supports existing literature and contributes to the growing evidence base of research on violence against women. IPV remains widespread across Europe, but measurement inconsistencies obscure its true scale. Mental health plays a role in some IPHs; coercive control and prior abuse appear more often. By examining both the prevalence of IPV and the most fatal consequences, this thesis portfolio illuminates the urgent need for consistent measurement of IPV, early detection and intervention of IPV and coordinated responses to prevent the escalation of abuse into homicide.

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Appendices

Appendix A: Guidelines for the Journal of Family Violence

Instructions for Authors
General
The *Journal of Family Violence* (JOFV) is a peer-reviewed publication committed to the dissemination of rigorous research on preventing, ending, and ameliorating all forms of family violence. JOFV welcomes scholarly articles related to the broad categories of child abuse and maltreatment, child to parent abuse, sibling abuse, dating violence, domestic and intimate partner violence, and elder abuse. Within these categories, JOFV emphasizes research on physical, psychological, and sexual violence as well as homicides that occur in families. Studies on families in all their various forms and diversities are welcome.

All submitted manuscripts submitted to JOFV should reflect research and scholarship that has been conducted in an ethical manner. Please see "Springer's Guide: Publishing Ethics for Journals" for detailed guidance: http://www.springer.com/gp/partners/society-zone-issues/springer-s-guide-publishing-ethics-for-journals/15064.

Manuscripts, in American English, should be submitted to the Editor's Office via the journal's web-based online manuscript submission and peer-review system: https://www.editorialmanager.com/jofv/

When submitting a manuscript, authors are encouraged to include a cover letter including the following information as relevant. Note the type of manuscript being submitted, i.e., a Full-length Article, a Brief Report, a Systematic Review and/or Meta-Analysis, a Letter to the Editor, or a Special Article. Note if the findings presented in the study have been presented elsewhere previously, e.g., at a conference, in a dissertation, in a pre-print. Note if the study presented in the manuscript comes from a parent study, as well as how the present study is distinct from other research previously published from the parent study. Note when manuscript is being submitted in response to an invitation for a special issue. Authors are also encouraged to note any other information concerning the manuscript and study that may be important for editorial and peer review.

Editorial procedure

Double-blind peer review

This journal follows a double-blind reviewing procedure. This means that the author will remain anonymous to the reviewers throughout peer review. It is the responsibility of the author to anonymize the manuscript and any associated materials.

- Author names, affiliations and any other potentially identifying information should be removed from the manuscript text and any accompanying files (such as figures of supplementary material);
- A separate Title Page should be submitted, containing title, author names, affiliations, and the contact information of the corresponding author. Any acknowledgements, disclosures, or funding information should also be included on this page;
- Authors should avoid citing their own work in a way that could reveal their identity.

This journal also publishes special/guest-edited issues. The peer review process for these articles is the same as the peer review process of the journal in general.

Additionally, if a guest editor authors an article in their issue/collection, they will not handle the peer review process.

Article Types

JOFV publishes full-length articles that describe studies using rigorous quantitative, qualitative, and/or mixed methods involving the collection and analysis of primary data and/or the analysis of secondary data. Additionally, rigorous systematic reviews, meta-analyses, and theoretical analyses are welcome, as well as letters to the editor and brief reports. To help advance scientific understandings of family violence, JOFV is especially interested in research using transdisciplinary perspectives and innovative research methods. Because family violence is a global problem requiring solutions from diverse disciplinary perspectives, JOFV strongly encourages submissions from scholars worldwide from all disciplines and backgrounds.

Full-length Articles: Full-length articles reporting on the collection and analysis of primary data and/or the analysis of secondary data should not exceed 35 double-spaced pages, inclusive of title page, abstract, text, references, tables, figures, and footnotes.

Brief Reports: Authors may wish to share limited, though nonetheless important, findings and lessons-learned from the field, from practice, and from research, even when such results do not warrant a full-length article. Accordingly, JOFV welcomes the presentation of such results in the form of brief reports. Brief reports should not exceed 20 double-spaced pages, inclusive of title page, abstract, text, references, tables, figures, and footnotes. At submission, authors should indicate that their manuscript is a brief report in their cover letter to the editor. Also, authors are encouraged to indicate that their manuscript is a brief report in key places in the manuscript, such as the title, abstract, introduction, and discussion.

Systematic Reviews, Meta-Analyses, and Scoping Reviews: JOFV welcomes rigorous systematic reviews, meta-analyses, and scoping reviews. These manuscripts should not exceed 40 double-spaced pages, inclusive of title page, abstract, text, references, tables, figures, and footnotes. All reviewed articles should be cited in the reference list with an asterisk preceding the first author's name (e.g., *Watson, K. K, & Ellison, E.,…). PRISMA should be used for reporting in systematic reviews and meta-analyses. PRISMA-ScR should be used for reporting in scoping reviews.

Letters to the Editor: Letters to the Editor are brief articles that respond to content published in JOFV. These pieces should promote beneficial and thoughtful discussions of JOFV content, as well as of important issues in the family violence field broadly. Such letters are typically brief (i.e., no more than 10 pages in length and often less). When commenting on a published JOFV article, such letters should be submitted in a timely manner (i.e., soon after the article appears in online first or in print). See Johnson and Green's (2006) article on writing Letters to the Editor for guidance: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2647072/

Research Rigor

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Once and if the paper is accepted for publication, the production department will put the respective statements in a distinctly identified section clearly visible for readers.

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Examples of statements to be used when funding has been received:

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- This study was funded by […]
- This work was supported by […] (Grant numbers […] and […]

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- No funding was received for conducting this study.
- No funds, grants, or other support was received.

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- The authors have no competing interests to declare that are relevant to the content of this article.
- All authors certify that they have no affiliations with or involvement in any organization or entity with any financial interest or non-financial interest in the subject matter or materials discussed in this manuscript.
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When reporting a study that involved human participants, their data or biological material, authors should include a statement that confirms that the study was approved (or granted exemption) by the appropriate institutional and/or national research ethics committee (including the name of the ethics committee) and certify that the study was performed in accordance with the ethical standards as laid down in the 1964 Declaration of

Helsinki and its later amendments or comparable ethical standards. If doubt exists whether the research was conducted in accordance with the 1964 Helsinki Declaration or comparable standards, the authors must explain the reasons for their approach, and demonstrate that an independent ethics committee or institutional review board explicitly approved the doubtful aspects of the study. If a study was granted exemption from requiring ethics approval, this should also be detailed in the manuscript (including the reasons for the exemption).

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If a study has not been granted ethics committee approval prior to commencing, retrospective ethics approval usually cannot be obtained and it may not be possible to consider the manuscript for peer review. The decision on whether to proceed to peer review in such cases is at the Editor's discretion.

Ethics approval for retrospective studies

Although retrospective studies are conducted on already available data or biological material (for which formal consent may not be needed or is difficult to obtain) ethics approval may be required dependent on the law and the national ethical guidelines of a country. Authors should check with their institution to make sure they are complying with the specific requirements of their country.

Ethics approval for case studies

Case reports require ethics approval. Most institutions will have specific policies on this subject. Authors should check with their institution to make sure they are complying with the specific requirements of their institution and seek ethics approval where needed. Authors should be aware to secure informed consent from the individual (or parent or guardian if the participant is a minor or incapable) See also section on **Informed Consent**.

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If human cells are used, authors must declare in the manuscript: what cell lines were used by describing the source of the cell line, including when and from where it was obtained, whether the cell line has recently been authenticated and by what method. If cells were bought from a life science company the following need to be given in the manuscript: name of company (that provided the cells), cell type, number of cell line, and batch of cells.

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Further information is available from the International Cell Line Authentication Committee (ICLAC).

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Research Resource Identifiers (RRID) are persistent unique identifiers (effectively similar to a DOI) for research resources. This journal encourages authors to adopt RRIDs when reporting key biological resources (antibodies, cell lines, model organisms and tools) in their manuscripts.

Examples:
Organism: *Filip1*$^{tm1a(KOMP)Wtsi}$ **RRID:MMRRC_055641-UCD**
Cell Line: RST307 cell line **RRID:CVCL_C321**
Antibody: Luciferase antibody DSHB Cat# LUC-3, **RRID:AB_2722109**
Plasmid: mRuby3 plasmid **RRID:Addgene_104005**
Software: ImageJ Version 1.2.4 **RRID:SCR_003070**

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The World Health Organization (WHO) definition of a clinical trial is "any research study that prospectively assigns human participants or groups of humans to one or more health-related interventions to evaluate the effects on health outcomes". The WHO defines health interventions as “A health intervention is an act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions” and a health-related outcome is generally defined as a change in the health of a person or population as a result of an intervention.

To ensure the integrity of the reporting of patient-centered trials, authors must register prospective clinical trials (phase II to IV trials) in suitable publicly available repositories. For example www.clinicaltrials.gov or any of the primary registries that participate in the WHO International Clinical Trials Registry Platform.

The trial registration number (TRN) and date of registration should be included as the last line of the manuscript abstract.

For clinical trials that have not been registered prospectively, authors are encouraged to register retrospectively to ensure the complete publication of all results. The trial registration number (TRN), date of registration and the words 'retrospectively registered’ should be included as the last line of the manuscript abstract.

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Observational studies (STROBE)
Systematic reviews and meta-analyses (PRISMA) and protocols (Prisma-P)
Diagnostic/prognostic studies (STARD) and (TRIPOD)
Case reports (CARE)
Clinical practice guidelines (AGREE) and (RIGHT)
Qualitative research (SRQR) and (COREQ)
Animal pre-clinical studies (ARRIVE)
Quality improvement studies (SQUIRE)
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Summary of requirements

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• All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The study was approved by the Bioethics Committee of the Medical University of A (No. ...).

• This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of University B (Date.../No. ...).

• Approval was obtained from the ethics committee of University C. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

• The questionnaire and methodology for this study was approved by the Human Research Ethics committee of the University of D (Ethics approval number: ...).

Examples of statements to be used for a retrospective study:

• Ethical approval was waived by the local Ethics Committee of University A in view of the retrospective nature of the study and all the procedures being performed were part of the routine care.

• This research study was conducted retrospectively from data obtained for clinical purposes. We consulted extensively with the IRB of XYZ who determined that our study did not need ethical approval. An IRB official waiver of ethical approval was granted from the IRB of XYZ.

• This retrospective chart review study involving human participants was in accordance with the ethical standards of the institutional and national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. The Human Investigation Committee (IRB) of University B approved this study.

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• The data reproduced from Article X utilized human tissue that was procured via our Biobank AB, which provides de-identified samples. This study was reviewed and deemed exempt by our XYZ Institutional Review

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Authors are responsible for correctness of the statements provided in the manuscript. See also Authorship Principles. The Editor-in-Chief reserves the right to reject submissions that do not meet the guidelines described in this section.

Informed consent

All individuals have individual rights that are not to be infringed. Individual participants in studies have, for example, the right to decide what happens to the (identifiable) personal data gathered, to what they have said during a study or an interview, as well as to any photograph that was taken. This is especially true concerning images of vulnerable people (e.g. minors, patients, refugees, etc) or the use of images in sensitive contexts. In many instances authors will need to secure written consent before including images.

Identifying details (names, dates of birth, identity numbers, biometrical characteristics (such as facial features, fingerprint, writing style, voice pattern, DNA or other distinguishing characteristic) and other information) of the participants that were studied should not be published in written descriptions, photographs, and genetic profiles unless the information is essential for scholarly purposes and the participant (or parent/guardian if the participant is a minor or incapable or legal representative) gave written informed consent for publication. Complete anonymity is difficult to achieve in some cases. Detailed descriptions of individual participants, whether of their whole bodies or of body sections, may lead to disclosure of their identity. Under certain circumstances consent is not required as long as information is anonymized and the submission does not include images that may identify the person.

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Regardless of whether material is collected from living or dead patients, they (family or guardian if the deceased has not made a pre-mortem decision) must have given prior written consent. The aspect of confidentiality as well as any wishes from the deceased should be respected.

Data protection, confidentiality and privacy

When biological material is donated for or data is generated as part of a research project authors should ensure, as part of the informed consent procedure, that the participants are made aware what kind of (personal) data will

be processed, how it will be used and for what purpose. In case of data acquired via a biobank/biorepository, it is possible they apply a broad consent which allows research participants to consent to a broad range of uses of their data and samples which is regarded by research ethics committees as specific enough to be considered "informed". However, authors should always check the specific biobank/biorepository policies or any other type of data provider policies (in case of non-bio research) to be sure that this is the case.

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For all research involving human subjects, freely-given, informed consent to participate in the study must be obtained from participants (or their parent or legal guardian in the case of children under 16) and a statement to this effect should appear in the manuscript. In the case of articles describing human transplantation studies, authors must include a statement declaring that no organs/tissues were obtained from prisoners and must also name the institution(s)/clinic(s)/department(s) via which organs/tissues were obtained. For manuscripts reporting studies involving vulnerable groups where there is the potential for coercion or where consent may not have been fully informed, extra care will be taken by the editor and may be referred to the Springer Nature Research Integrity Group.

Consent to Publish

Individuals may consent to participate in a study, but object to having their data published in a journal article. Authors should make sure to also seek consent from individuals to publish their data prior to submitting their paper to a journal. This is in particular applicable to case studies. A consent to publish form can be found

here. (Download docx, 36 kB)

Summary of requirements

The above should be summarized in a statement and placed in a 'Declarations' section under a heading of 'Consent to participate' and/or 'Consent to publish'. The Declarations section should be placed on a title page that is separate from the manuscript. Please use the title page as outlined in the Title Page section of these Instructions for Authors for providing the statements. Other declarations include Funding, Competing interests, Ethics approval, Consent, Data and/or Code availability and Authors' contribution statements.

Please see the various examples of wording below and revise/customize the sample statements according to your own needs.

Sample statements for **"Consent to participate"**:
Informed consent was obtained from all individual participants included in the study.
Informed consent was obtained from legal guardians.
Written informed consent was obtained from the parents.
Verbal informed consent was obtained prior to the interview.
Sample statements for **"Consent to publish"**:
The authors affirm that human research participants provided informed consent for publication of the images in Figure(s) 1a, 1b and 1c.
The participant has consented to the submission of the case report to the journal.
Patients signed informed consent regarding publishing their data and photographs.
Sample statements if identifying information about participants is available in the article:
Additional informed consent was obtained from all individual participants for whom identifying information is included in this article.

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Appendix B: Database Search Strategy

PUBMED (600 results)

Filter: English Only, Adult 19+.

((("Spouse Abuse"[Mesh] OR "Domestic violence" OR "intimate partner violence" OR "IPV" OR "domestic abuse" OR "partner abuse" OR "relationship violence" OR "spousal violence" OR "Intimate partner abuse")) AND (("Prevalence"[Mesh] OR "epidemiology" [Subheading] OR "Rate*" OR "incidenc*" OR "frequenc*" OR "estimate*" OR "occurance"))) AND ((Europe[Title/Abstract] OR EU[Title/Abstract] OR European[Title/Abstract] OR "Albania"[Title/Abstract] OR "Andorra"[Title/Abstract] OR "Armenia"[Title/Abstract] OR "Austria"[Title/Abstract] OR "Azerbaijan"[Title/Abstract] OR "Belgium"[Title/Abstract] OR "Bosnia and Herzegovina"[Title/Abstract] OR "Bulgaria"[Title/Abstract] OR "Croatia"[Title/Abstract] OR "Cyprus"[Title/Abstract] OR "Czechia"[Title/Abstract] OR "Denmark"[Title/Abstract] OR "Estonia"[Title/Abstract] OR "Finland"[Title/Abstract] OR "France"[Title/Abstract] OR "Georgia"[Title/Abstract] OR "Germany"[Title/Abstract] OR "Greece"[Title/Abstract] OR "Hungary"[Title/Abstract] OR "Iceland"[Title/Abstract] OR "Ireland"[Title/Abstract] OR "Italy"[Title/Abstract] OR "Latvia"[Title/Abstract] OR "Liechtenstein"[Title/Abstract] OR "Lithuania"[Title/Abstract] OR "Luxembourg"[Title/Abstract] OR "Malta"[Title/Abstract] OR "Republic of Moldova"[Title/Abstract] OR "Monaco"[Title/Abstract] OR "Montenegro"[Title/Abstract] OR "Netherlands"[Title/Abstract] OR "North Macedonia"[Title/Abstract] OR "Norway"[Title/Abstract] OR "Poland"[Title/Abstract] OR "Portugal"[Title/Abstract] OR "Romania"[Title/Abstract] OR "San Marino"[Title/Abstract] OR "Serbia"[Title/Abstract] OR "Slovak Republic"[Title/Abstract] OR "Slovenia"[Title/Abstract] OR "Spain"[Title/Abstract] OR "Sweden"[Title/Abstract] OR "Switzerland"[Title/Abstract] OR "Turkiye"[Title/Abstract] OR "Ukraine"[Title/Abstract] OR "United Kingdom"[Title/Abstract] OR "Scotland"[Title/Abstract] OR "England"[Title/Abstract] OR "Wales"[Title/Abstract]))

ASSIA [All Abstract and Summary]

summary("Domestic violence" OR "intimate partner violence" OR "IPV" OR "domestic abuse" OR "spousal abuse" OR "partner abuse" OR "relationship violence" OR "spousal violence" OR "Intimate partner abuse") AND summary("Prevalence" OR "Rate*" OR "incidenc*" OR "frequenc*" OR "estimate*" OR "occurance" OR "epidemiology") AND summary(Europe OR EU OR European OR "Albania" OR "Andorra" OR "Armenia" OR "Austria" OR "Azerbaijan" OR "Belgium" OR "Bosnia and Herzegovina" OR "Bulgaria" OR "Croatia" OR "Cyprus" OR "Czechia" OR "Denmark" OR "Estonia" OR "Finland" OR "France" OR "Georgia" OR "Germany" OR "Greece" OR "Hungary" OR "Iceland" OR "Ireland" OR "Italy" OR "Latvia" OR "Liechtenstein" OR "Lithuania" OR "Luxembourg" OR "Malta" OR "Republic of Moldova" OR "Monaco" OR "Montenegro" OR "Netherlands" OR "North Macedonia" OR "Norway" OR "Poland" OR "Portugal" OR "Romania" OR "San Marino" OR "Serbia" OR "Slovak Republic" OR "Slovenia" OR "Spain" OR "Sweden" OR "Switzerland" OR "Türkiye" OR "Ukraine" OR "United Kingdom" OR "Scotland" OR "England" OR "Wales")

Search Strategy for SCOPUS

(TITLE("Domestic violence" OR "intimate partner violence" OR "IPV" OR "domestic abuse" OR "spousal abuse" OR "partner abuse" OR "relationship violence" OR "spousal violence" OR "Intimate partner abuse") AND TITLE("Prevalence" OR "Rate*" OR "incidenc*" OR "frequenc*" OR "estimate*" OR "occurance" OR "epidemiology") AND TITLE-ABS-KEY(Europe OR EU OR European OR "Albania" OR "Andorra" OR "Armenia" OR "Austria" OR "Azerbaijan" OR "Belgium" OR "Bosnia and Herzegovina" OR "Bulgaria" OR "Croatia" OR "Cyprus" OR "Czechia" OR "Denmark" OR "Estonia" OR "Finland" OR "France" OR "Georgia" OR "Germany" OR "Greece" OR "Hungary" OR "Iceland" OR "Ireland" OR "Italy" OR "Latvia" OR "Liechtenstein" OR "Lithuania" OR "Luxembourg" OR "Malta" OR "Republic of Moldova" OR "Monaco" OR "Montenegro" OR "Netherlands" OR "North Macedonia" OR "Norway" OR "Poland" OR "Portugal" OR "Romania" OR "San Marino" OR "Serbia" OR "Slovak Republic" OR "Slovenia" OR "Spain" OR "Sweden" OR "Switzerland" OR "Türkiye" OR "Ukraine" OR "United Kingdom" OR "Scotland" OR "England" OR "Wales"))

Search Strategy for Web of Science (All Databases)

"Domestic violence" OR "intimate partner violence" OR “IPV” OR "domestic abuse" OR "spousal abuse” OR “partner abuse” OR "relationship violence" OR "spousal violence" OR "Intimate partner abuse" (Title) and “Prevalence” OR “Rate*” OR “incidenc*” OR “frequenc*” OR “estimate*" OR "occurance" OR "epidemiology" (Title) and Europe OR EU OR European OR "Albania" OR "Andorra" OR "Armenia" OR "Austria" OR "Azerbaijan" OR "Belgium" OR "Bosnia and Herzegovina" OR "Bulgaria" OR "Croatia" OR "Cyprus" OR "Czechia" OR "Denmark" OR "Estonia" OR "Finland" OR "France" OR "Georgia" OR "Germany" OR "Greece" OR "Hungary" OR "Iceland" OR "Ireland" OR "Italy" OR "Latvia" OR "Liechtenstein" OR "Lithuania" OR "Luxembourg" OR "Malta" OR "Republic of Moldova" OR "Monaco" OR "Montenegro" OR "Netherlands" OR "North Macedonia" OR "Norway" OR "Poland" OR "Portugal" OR "Romania" OR "San Marino" OR "Serbia" OR "Slovak Republic" OR "Slovenia" OR "Spain" OR "Sweden" OR "Switzerland" OR "Türkiye" OR "Ukraine" OR "United Kingdom" OR "Scotland" OR "England" OR "Wales" (Abstract)

Search Strategy for EBSCO (All Databases)

TI ("Domestic violence" OR "intimate partner violence" OR “IPV” OR "domestic abuse" OR "spousal abuse” OR “partner abuse” OR "relationship violence" OR "spousal violence" OR "Intimate partner abuse") AND TI (“Prevalence” OR “Rate” OR “incidenc” OR “frequenc” OR “estimate" OR "occurance" OR "epidemiology") AND AB (Europe OR EU OR European OR "Albania" OR "Andorra" OR "Armenia" OR "Austria" OR "Azerbaijan" OR "Belgium" OR "Bosnia and Herzegovina" OR "Bulgaria" OR "Croatia" OR "Cyprus" OR "Czechia" OR "Denmark" OR "Estonia" OR "Finland" OR "France" OR "Georgia" OR "Germany" OR "Greece" OR "Hungary" OR "Iceland" OR "Ireland" OR "Italy" OR "Latvia" OR "Liechtenstein" OR "Lithuania" OR "Luxembourg" OR "Malta" OR "Republic of Moldova" OR "Monaco" OR "Montenegro" OR "Netherlands" OR "North Macedonia" OR "Norway" OR "Poland" OR "Portugal" OR "Romania" OR "San Marino" OR "Serbia" OR "Slovak Republic" OR "Slovenia" OR "Spain" OR "Sweden" OR "Switzerland" OR "Türkiye" OR "Ukraine" OR "United Kingdom" OR "Scotland" OR "England" OR "Wales")

Appendix C: Table of Expanded IPV Definitions and Measure Items from Included Studies

Author / Year	Measure or definition used to capture IPV/IPV sub-types
Alkan and Demïr, (2025)	Questions adapted from the **WHO study titled 'multi-country study** on women's health and domestic violence against women' **Emotional Violence** "Did your spouse or one of your partners upset you by insulting or swearing at you?", "Did your spouse or one of your partners insult or humiliate you in front of others?", "Did your spouse or one of your partners frighten or threaten you? (fr example, by staring, shouting, or breaking something)" "Did your spouse or one of your partners threaten to harm you or your relatives?"
Burazeri et al. (2005)	**Physical Violence** Definition: 'hit, slapped, kicked or physically hurt by husband' at least once in the past year. No validated measure
Costa et al., (2015)	**Revised Conflict Tactics Scales (CTS2)** – standardised across languages. **Physical Assault (12 items)** "Kicked, bit or punched partner, slapped partner, beat up partner, hit partner with something, choked partner, slammed partner against wall, grabbed partner, threw something at partner that could hurt, used knife or gun on partner, pushed or shoved partner, twisted partners arm or hair, burned or scalded partner on purpose" **Psychological Aggression (8 items)** "Insulted or swore at partner, shouted at partner, stomped out of room, threatened to hit or throw something at partner, destroyed something of partners, did something to spite partner, called partner fat or ugly, accused partner of being a lousy lover" **Sexual Coercion (7 items)** "used force to make partner have sex, used threats to make partner have anal sex, used force to make partner have anal sex, insisted on anal sex (no force), used threats to make partner have sex, insisted on sex (no force), insisted on sex without a condom (no force)"
Dude, 2007	**Physical Violence** Definition: 'kicked, hit, slapped, pushed or attacked with a weapon by a current or former sexual partner' *No validated measure
Garcia-Moreno et al. (2006)	**Questions used in the WHO study** **Physical violence** by an intimate partner 1. Was slapped or had something thrown at her that could hurt her 2. Was pushed or shoved Severe violence: 3. Was hit with fist or something else that could hurt 4. Was kicked, dragged, or beaten up 5. Was choked or burnt on purpose 6. Perpetrator threatened to use or actually used a gun, knife, or other weapon against her **Sexual violence** by an intimate partner 1. Was physically forced to have sexual intercourse when she did not want to 2. Had sexual intercourse when she did not want to because she was afraid of what partner might do 3. Was forced to do something sexual that she found degrading or humiliating

Gracia et al. (2023)	*Not a validated measure however the study examined the psychometric properties of the measure for IPV – found to be psychometrically sound. **Physical Violence (7 items)** 1.He slapped you or threw something that could hurt you. 2. He pushed, grabbed, or pulled your hair. 3.He hit you with his fist or something else that could hurt you. 4.He kicked, dragged, or beat you. 5.He purposely tried to suffocate or burn you. 6. He threatened to use or used a gun, knife, or other dangerous weapon or substance against you. 7. He used force against you, in any other of the ways listed above, in a way that harmed you or could have harmed you. **Sexual Violence (8 items)** 1. He forced you to have sexual intercourse by threatening you, holding you down, or harming you in any way. By sexual intercourse we mean vaginal or anal penetration with a penis or objects, or oral sex. 2.He made you have sex when you were unable to refuse because you were under the influence of alcohol or drugs. 3. You had unwanted sex because you were afraid of what he might do to you if you refused. 4. He forced you to have sex when you did not want to have sex. 5. He tried to force you to have sex against your will, but did not succeed. 6. He touched your genitals or breasts, or engaged in any other type of sexual touching, when you did not want him to. 7. He made you touch his genitals or forced you to perform another type of sexual touching when you did not want to. 8. He forced you to engage in any other sexual practices not already mentioned. **Psychological Violence (17 items).** 1. He tried to prevent you from seeing your friends. 2. He tried to prevent you from interacting with your immediate family or relatives. 3. He insisted on knowing where you were at any time. 4. He ignored you or treated you with indifference. 5. He would get angry if you talked to another man or woman. 6. He suspected, without reason, that you were unfaithful. 7. He expected you to ask for permission before going to certain places on your own, such as a hospital or health centre, a cultural or sports centre, etc. 8. He refused to give you money for household expenses when the couple had money for other things. 9. He prevented you from making decisions related to family finances and/or making purchases independently. 10. He would not allow you to work or study outside the home. 11. He used your money or credit card, or took out loans in your name, without your consent. 12. He insulted you or made you feel bad about yourself. 13. He belittled or humiliated you in front of other people. 14. He verbally threatened to harm you. 15. He verbally threatened to harm your children or someone else who is or was important to you 16. He threatened to harm himself if you left him. 17. He threatened to take your children away from you.
Hashemi et al. (2025)	**Adult Psychiatric Morbidity Survey:** Questions adapted from the **British Crime Survey and originally based on the CTS** Unable to obtain questionnaire for specific wording or definition

Ismayilova, (2015)	**Physical Violence (7 items):** 1. Push you, shake you, or throw something at you? 2. Slap you? 3. Twist your arm or pull your hair? 4. Punch you with his fist or with something that could hurt you? 5. Kick you, drag you, or beat you up? 6. Try to choke you or burn you on purpose? 7. Threaten or attack you with a knife, gun, or any other weapon? **Emotional Violence (3 items):** 1. Say or do something to humiliate you in front of others? 2. Threaten to hurt or harm you or someone close to you? 3. Insult you or make you feel bad about yourself? **Sexual Violence (2 items):** 1. Physically force you to have sexual intercourse even when you did not want to? 2. Force you to perform any sexual acts you did not want to?
Khalifeh et al. (2013)	**British Crime Survey - Domestic Violence, Sexual Victimisation and Stalking module administered.** **Physical IPV (7 items)** 1. Choked or tried to strangle you 2. Threatened to kill you 3. Pushed you, held you down, or slapped you 4. Used some other kind of force against you 5. Threatened you with a weapon—for example, a stick or a knife 6. Used a weapon against you—for example, a stick or a knife 7. Kicked, bit, or hit you with a fist or something else, or threw something at you **Sexual IPV (2 items)** 1. Penetrative (attempted or actual penetrative sexual assault) 2. Nonpenetrative (indecent exposure, unwanted sexual touching, sexual threats) **Emotional IPV (4 items)** 1. Frightened you by threatening to hurt you or someone close to you 2. Repeatedly belittled you to the extent that you felt worthless 3. Prevented you from having your fair share of the household money 4. Stopped you from seeing friends and relatives
Laanpere et al. (2012)	**Physical Violence:** "had been exposed to threats of physical violence, pushed, shaken, something thrown at her, hit with something that caused/could have caused physical injury, threatened with a knife/gun/violent object" **Sexual violence:** "forced to have intercourse, threatened or frightened into having intercourse or forced to participate in other sexual acts"

Lövestad and Krantz (2012)	A questionnaire based on the **revised CTS.** **Physical Assault** Threw something Twisted arm or hair Pushed or shoved Used knife or tool Hit with something that could hurt Choked Slammed against a wall Beat up Grabbed Slapped Burned or scaled Kicked **Sexual Coercion** Made partner have sex without condom Used force to have sex Insisted on having sex Used threats to have sex
Nerøien & Schei (2008)	Questionnaire used from previous national studies in Nordic countries. Unclear if it is validated. **Physical Violence (Mild/Moderate/Severe)** ‘‘Have your current or previous partner ever threatened to use violence or used violence against you such as ... Threats of violence Prevented from moving, grabbed Slapped Had a hard object thrown at Beating with fists or a hard object/kicked Other violence Strangling Threats of or use of knife or other weapons Beating head against something “ **Sexual Violence** “Tried to force you to have sex”
Nybergh et al. (2013)	The WHO’s **Violence Against Women Instrument (VAWI)** **Physical Violence (6 items)** 1. Pushed or shoved me 2. Thrown something that could have hurt me 3. Hit me with his/her fist or with some other object 4. Kicked and dragged me and beaten me up 5. Choked me or burnt me on purpose 6. Hurt me with a knife, a gun or some other weapon. **Sexual Violence (3 items)** 1. Demanded to have sex with me even though I did not want to 2. Forced me to have sex against my will by using his/her physical strength 3. Forced me to perform sexual acts that I experienced as degrading and/or humiliating **Psychological Violence (4 items)** 1. Insulted me in a way that made me feel bad 2. Belittled and humiliated me in front of others 3. Tried to scare and terrorize me on purpose 4. Threatened to hurt me or someone I care about
O’Leary et al. (2008)	**Partner Aggression** defined as “Pushed, grabbed or shoved; threw something; slapped or hit”
Ruiz-Perez et al. (2018)	Questions adapted from a scale proposed by the **World Health Organization Multi-Country Study** on Women's Health and Life Events

	Intimate partner violence measured with a set of three items asking whether or not the participants were abused **physically** (hit, slapped, pushed, etc.), **psychologically** (threatened, insulted, humiliated, etc.), or **sexually** (forced them into sexual activities) during the last 12 months.
Ruiz-Perez et al. (2017)	Measure: **Index of Spouse Abuse (30 item).** Adapted and validated in Spain. Measures physical and psychological violence. Sexual violence is included under the physical subscale. **Physical Violence (11 Items)** 1. My partner becomes surly and angry if I tell him he is drinking too much. 2. My partner makes me perform sex acts that I do not enjoy or like. 3. My partner punches me with his fists. 4. My partner threatens me with a weapon. 5. My partner beats me so badly that I must seek medical help. 6. My partner screams and yells at me. 7. My partner slaps me around my face and head. 8. My partner becomes abusive when he drinks. 9. My partner acts like a bully towards me. 10. My partner frightens me. 11. My partner acts like he would like to kill me. **Psychological Violence (19 Items)** 1. My partner belittles me. 2. My partner demands obedience to his whims. 3. My partner becomes very upset if dinner, housework or laundry is not done when he thinks it should be. 4. My partner is jealous and suspicious of my friends. 5. My partner tells me I am ugly and unattractive. 6. My partner tells me I really couldn't manage or take care of myself without him. 7. My partner treats me like his personal servant. 8. My partner insults or shames me in front of others. 9. My partner becomes very angry if I disagree with his point of view. 10. My partner is stingy with the money I need to run our home. 11. My partner belittles me intellectually. 12. My partner demands that I stay home to take care of the children. 13. My partner feels that I should not work or go to school. 14. My partner is not a kind person. 15. My partner does not want me to socialise with my female friends. 16. My partner demands sex whether I want it or not. 17. My partner orders me around. 18. My partner has no respect for my feelings. 19. My partner treats me like a dunce.
Sanz-Barbero et al. (2018)	Measured via standardized **FRA-VAW questionnaire** items. **"Physical aggressions** include to be pushed, slapped, grab- bed, burned, thrown a hard object, beaten with a fist, tried to strangle, cut or stabbed, beaten her head against something. **Sexual aggressions** include to be forced or attempted to force her into sexual intercourse, made woman take part in any form of sexual activity when she did not want or when woman consented to sexual activity because she was afraid"

Sanz-Barbero et al. (2019)	Following the "guidelines for the production of **statistics on violence against women: statistical surveys** published by the **United Nations**." "Severe **physical violence** - When she reported that her partner had "tried to smother or burn her intentionally" or had "threatened her with a gun, knife or other weapon". Moderate physical violence - Aggressions such as being punched, hit, kick, dragged, etc. **Sexual violence** includes aggressions such as the obligation or intent to have sex against her will, the acceptance of sex due to fear, as well as receiving humiliating treatment against her will. **Psychological violence** includes: psychological control and attitudes related to jealousy, monitoring of women's agendas and activities and the imposition of limitations on who women can relate to among friends and family members. **Emotional violence** includes attitudes related to humiliation, insult, devaluing, and verbal threats and intimidation. **Economic violence** refers to control of domestic finances and the decrease in women's economic independence through prohibition of a woman's pursuit of work or studies outside of the house".
Stöckl and Penhale (2015)	Physical and sexual IPV measured using a **modified CTS-2.** **Physical or sexual violence**, **or both** "Partner pushed, lightly slapped, bit or scratched her, twisted her arm, kicked, shoved, hardly slapped or threw something at her, hit her with an object, seriously threatened to assault or kill her, hit her with a fist, beat her up, strangled, scalded or burned, threatened or injured her with a weapon, physically assault her in another way and tried to or actually forced her to sexual intercourse" Measurements for emotional IPV, controlling behaviours and economic IPV derived from 33 questions, not standardised and assumed to be in the past year therefore they have not been reported in this table or included in the meta-analysis.
Vives-Cases et al. (2011)	"**Current IPV**: this was measured using two questions. First, women were asked if they had suffered any kind of violence during the previous 12 months. If they answered 'yes' they were asked who the aggressor was. The options were: (1) An unknown man, (2) an unknown woman, (3) their male intimate partner, (4) a known woman or (5) a known man. Women who answered affirmatively to the first question and said that their male intimate partner was the aggressor were considered victims of IPV"
Waltermaurer et al. (2013)	"The experience of IPV was measured using the **modified eight-item CTS**, which includes acts of physical, psychological (e.g., insults and threats of harm) and sexual abuse of ever-married women during her lifetime and within the past year. This study focused on "prior to past year" and "past year" reports of physical violence only, which included being pushed, shoved, slapped, kicked, hit with the fist or an object, beaten up, and threatened with a knife or other weapon."

Zorrilla et al. (2009)	**Physical Violence measured based on the CTS** **Physical Violence** "In the last 12 months how many times has he… Thrown something at you (some object) Pushed, grabbed or shoved you Slapped you Kicked, bit or hit you with a fist Hit or tried to hit you with some object Beat you up Choked you Threatened you with a knife or a gun Used a knife or fired a gun" **Psychological or Sexual Violence was measured using the module in the France National Survey of Violence Against Women** **Sexual Violence** "Did he physically force you to have sexual intercourse when you did not want to Did your partner force you to do something sexual that you rejected' **Psychological Violence** "Kept you from seeing or talking to your friends or your family Prevents you from speaking with other men (he is jealous) Criticized or belittled what you do Has made unpleasant comments about your appearance Imposed on you a way of dressing up or behaving in public Has despised or scorned your opinions Tells you what you should think Insists on knowing with who and where you are at all times Refuses completely to talk or discuss an issue with you Prevents you from having access to money for daily living needs Threatens to take away your children Threatens to commit suicide Threatens to hurt you or someone of your family Insulted or was offensive to you Turned you homeless or prevented you from entering the home'

Appendix D: Condensed Version of the Coding Framework

Variable	Code	Definition
Relationship between Perpetrator and Victim		
Current partner/spouse/boyfriend	0	Perpetrator and victim are reported to have been in an intimate relationship together or married at the time of the homicide.
Ex-partner/spouse	1	Perpetrator is referred to as ex-husband, ex-partner or ex-boyfriend, where they were previously in an intimate relationship but had since separated/divorced or the relationship is described as 'on/off'. Code ex-partner if they are going through a divorce or living separate lives. Code ex-partner if it is unclear what the status of the relationship is, but there was a separation.
Suspected Relationship	2	Code if it is unclear whether there was an intimate relationship taking place or not during the review period, but the circumstances indicate there was some form of relationship between the perpetrator and victim which was more than platonic (and they are not family/related to one another)
Circumstances of death		
Domestic Homicide	1	Code if the review states the perpetrator murdered the victim
Victim completed suicide	2	Code if the review states the victim took their own life **This could be linked to peer pressure or because of experiencing domestic abuse from the perpetrator*
Homicide – Suicide	3	Code if the review states the perpetrator murdered the victim then took their own life shortly after. Also code if perpetrator took own life sometime after homicide, e.g. in jail.
Natural Death	4	Code if the death was described as a natural death (can occur in circumstances where abuse is taking place, and the victim passes away due to other reasons)
Did perpetrator attempt to or take their life after the homicide?		
NA/No	0	No or not applicable – because the circumstance was a domestic homicide or victim suicide.
Yes Attempt	1	Yes they attempted suicide, but the attempt was not fatal or resulted in death of the perpetrator
Yes Suicide	2	Yes, the perpetrator took their own life after the homicide, including sometime after homicide such as in prison
How did the perpetrator take or attempt to take their life?		
Not Applicable	0	Not applicable as perpetrator did not attempt or take their life
Gun Shot	1	Code if this was the method stated in the DHR
Overdose	2	Code if this was the method stated in the DHR
Train Jump	3	Code if this was the method stated in the DHR
Hanging	4	Code if this was the method stated in the DHR

Fire	5	Code if this was the method stated in the DHR
Ligature	6	Code if this was the method stated in the DHR
Drowning	7	Code if this was the method stated in the DHR
Ingesting Poison	8	Code if this was the method stated in the DHR
Stab Wound	9	Code if this was the method stated in the DHR
Missing	10	Code if this was the method stated in the DHR
Exhaust Fumes	11	Code if this was the method stated in the DHR
Fall	12	Code if this was the method stated in the DHR
Main Method of killing - This refers to the main or primary cause of death for the victim		
Strangulation	0	Review mentions victim died because of strangulation or neck compression.
Blunt Instrument	1	Review mentions the killing occurred with a blunt instrument.
Stab wound/multiple stab wound	2	Review mentions victim died due to stab wound
Multiple Stab Wound	3	Review mentions victim died due to multiple stab wound
Gun Shot	4	Review mentions victim died due to a gun shot.
Physical violence /Assault (Hitting/Kicking/beating)	5	Review mentions victim died due to experiencing physical violence or assault from perpetrator. Also, code for violence if victim found with 'injuries'
Arson	6	Review mentions victim died due to fire/arson set by the perpetrator.
Burning/Scalding	7	Review mentions victim died due to being burnt or scalded.
Drowning	8	Review mentions victim died due to being drowned
Fall against hard surface	9	Review mentions victim died due to falling against a hard surface.
Suffocation	10	Review mentions victim died due to suffocation
Asphyxiation	11	Review mentions victim died due to asphyxiation
Pressure between heart and head	12	Review mentions victim died due to pressure
Negligence	13	Review mentions victim died due to negligence
Overdose	14	Review mentions victim died due to overdose
Ischaemia	15	Review mentions victim died due to ischaemia

Hanging	16	Review mentions victim died due to hanging
Cut to throat	17	Review mentions victim died due to cut to their throat
Head Injury	18	Review mentions victim died due to a head injury
Poisoned	19	Review mentions victim died due to being poisoned
Missing	20	Record missing if cause of death missing or not determinable.
Not Applicable	21	Record N/A in circumstances where it was a natural death and there was no cause' of death reported.
Court Verdict		
No court verdict/Not applicable	0	No court verdict was made or agreed / Not applicable (e.g. because the perpetrator took their own life before sentencing took place).
Guilty - Murder	1	Court verdict was murder
Guilty - Manslaughter	2	Court verdict was manslaughter
Not Guilty- Diminished Responsibility	3	Court verdict was diminished responsibility
Guilty manslaughter – diminished responsibility	4	Court verdict was the perpetrator was guilty by manslaughter due to diminished responsibility.
Does not mention	5	Code if the court verdict was not reported or mentioned in the DHR
Not Guilty – Reason of insanity	6	Court verdict was reason of insanity
Not Guilty	7	Code if the court verdict was that the perpetrator was found not guilty
Charge		
Not applicable	0	Perpetrator not alive to receive sentence
Life Imprisonment/sentence with a minimum Term	1	The perpetrator received a life sentence or sentence with a minimum term to serve in prison.
Hospital Order	2	The perpetrator received a hospital order
Prison sentence not life	3	Perpetrator receives a prison sentence which is not indicated as 'life'
Hospital and Prison	4	Perpetrator receives hospital order then transfer back to prison after treatment.
Missing	5	This information is missing from the review
Detained Under the Mental Health Act	6	The review states the perpetrator was detained under the mental health act.
Sentence and Rehabilitation order	7	Code if perpetrator received a prison sentence and rehabilitation order.
Evidence the homicide linked to mental health? To determine if there is a link to mental health, look for **explicit** evidence that the homicide was linked to the perpetrator's mental health. If it feels ambiguous, or there is not enough information, code 'not explicit'.		

Unlikely	0	Review states homicide was linked to other trigger or aggravating factor which was likely to not have had an impact on mental health, or mental health was not deemed to be a factor within the homicide. Mental health may not be mentioned or discussed in great detail; information could be lacking on how mental health featured. Other factors such as anger, jealousy coercive control may be playing more of a role than mental health is. Mental health not seen as primary driver due to insufficient information or limited information of mental health. Limited/no evidence of receiving treatment or care for their mental health, mental health not seen to be a current factor in the homicide. Assessments indicate no evidence of a mental health disorder.
Likely	1	Review states **explicitly** homicide was linked to mental health, or there was a deterioration or an aggravating factor likely to have influenced their mental health or cognitive decline, causing delusions, unable to cope, loss of control, depression/low mood (e.g. Stress, Carer Stress, Illness, side effects from other medications, grief or loss). There could be an increase in personal risk – self harm/suicidal ideation or attempts, struggling to cope, in conjunction with reported mental health difficulties prior to the homicide. Known to mental health services and receiving support or treatment is also an indicator that mental health could be featuring in their life and may be linked to the homicide or stopping taking prescribed medication with the onset of deterioration prior to homicide. Other evidence might suggest the perpetrator was unable to stand trial/be fit to plead due to their mental health and or received a hospital order – therefore the homicide is likely linked to their mental health.
Unclear/Not Explicit	2	It is not clear from the review whether the homicide was linked to mental health. This might be due to lack of information to make a decision. There might be a combination of factors at play – e.g. Current relationship issues, historic mental health mentioned, current substance use, jealousy but no further information to conclude if mental health was linked to homicide or a primary driver. Mental health may be mentioned however it might appear historic or insufficient evidence of how it currently features in the perpetrator's life and lead up to the homicide.
HOW? Attempt to code for the reasons why the perpetrator committed the homicide and how it was linked to mental health.		Code qualitatively and copy/paste from the review the sentence or context – e.g. 'perpetrator experienced delusions and thought victim was the devil'. *Impact of alcohol/substance use is also coded for separately.*
Perpetrator Demographics		
Age		Code age as number e.g. 27 years old, code as '27'
	999	Code 999 if the age is missing or not reported in the DHR
Ethnicity		
Code Qualitatively	'White British' 'Black British'	Code Qualitatively initially, then cluster into groups at the end
Missing	999	Code 999 if ethnicity is missing or not reported in the DHR for the perpetrator

Criminal History		
Not Present	0	Review documents the perpetrator had no previous convictions prior to the homicide.
Present	1	Evidence there are previous convictions, offences, cautions, charges, fixed penalty notices documented for the perpetrator (as an adult only)
Evidence of <u>previous</u> domestic abuse/violence towards <u>previous</u> <u>partners/family.</u>		
Not present	0	No evidence in the review to suggest perpetrator was previously violent or abusive towards **<u>past</u>** partners and/or family members.
Present	1	Review refers to perpetrator being violent or abusive to **<u>past</u>** partners and or family members. Abuse can be physical, sexual, emotional, economic or psychological actions or threats of actions that influence another person. This includes any behaviours that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, or wound someone.
Evidence of <u>previous</u> <u>physical</u> <u>violence</u> towards <u>victim</u> prior to homicide. (Monkton Smith - Stage 1 of Domestic Homicide) Physical abuse can take many forms from a push or shove to a punch, use of weapons, choking or strangulation, grabbing, hitting, slapping, kicking.		
Not Present	0	No evidence in the review to suggest the perpetrator was previously physically violent towards the **victim**.
Present	1	Evidence in the review of previous physical violence towards the **victim**.
Evidence of <u>previous non-violent abuse towards victim</u>? (Monkton Smith - Stage 1 of Domestic Homicide)		
Not Present	0	No evidence in the review to suggest the perpetrator was previously abusive towards the victim.
Present	1	Previous abuse towards victim (This could include emotional, psychological, economic, financial, sexual or other forms of abuse such as honour-based abuse)
Evidence of the types of non-violent abuse towards current victim Code 0 for 'not present' if no evidence is in the review to suggest the perpetrator perpetrated the type of abuse listed Code 1 - present if there is evidence in the review to suggest the perpetrator perpetrated the type of abuse listed		
Emotional/psychological abuse towards victim	0 = Not Present 1 = Present	Code Present if there is evidence of any of the following in the review, indicating the perpetrator perpetrated emotional abuse towards the victim. Verbal abuse and threats are to be coded for as 'emotional/psychological' abuse. *Threats are also coded as a separate variable.* *Coercive control is also coded as a separate variable.* Definition from: https://www.womenslaw.org/about-abuse/forms-abuse/emotional-and-psychological-abuse • humiliating you in front of others;

		• calling you insulting names, such as “stupid,” “disgusting,” or “worthless”; • getting angry in a way that is frightening to you; • threatening to hurt you, people you care about, or pets; • the abuser threatening to harm him/herself when upset with you; • saying things like, “If I can’t have you, then no one can;” • deciding things for you that you should decide, like what you wear or eat; • acting jealous, including constantly accusing you of cheating; • continually pretending to not to understand what you are saying, making you feel stupid, or refusing to listen to your thoughts and opinions; • questioning your memory of events or denying that an event happened the way you said it did, even when the abuser knows that you are right; • changing the subject whenever you try to start conversations with the abuser and others and questioning your thoughts in a way that makes you feel unworthy; and • making your needs or feelings seem unimportant or less important than those of the abuser.
Financial abuse towards victim	0 = Not Present 1 = Present	Code Present if there is evidence of any of the following in the review, indicating the perpetrator perpetrated financial abuse towards the victim. Financial abuse indicated or stated in the review towards victim. Taking their money or stealing from the victim.
Economic Abuse towards victim *Example of an item from DASH risk assessment	0 = Not Present 1 = Present	Code Present if there is evidence of any of the following in the review, indicating the perpetrator perpetrated economical abuse towards the victim. Economic abuse might be explicitly stated in the review, this can also include financial abuse, damage to property (which impacts the victim). *‘Economic abuse can include exerting control over income, spending, bank accounts, bills and borrowing. It can also include controlling access to and use of things like transport and technology, which allow us to work and stay connected, as well as property and daily essentials like food and clothing. It can include destroying items and refusing to contribute to household costs’* Definition retrieved from https://survivingeconomicabuse.org/what-is-economic-abuse/#:~:text=It%20can%20include%20destroying%20items,of%20coercive%20and%20controlling%20behaviour.
Sexual Abuse/Assault towards the victim	0 = Not Present 1 = Present	Code Present if there is evidence of any of the following in the review, indicating the perpetrator perpetrated sexual abuse or assault towards the victim. Sexual abuse might be explicitly stated in the review. Sexual abuse can include the use of threats, force or intimidation to obtain sex, deliberately inflicting pain during sex, or combining sex and violence and using weapons. There is lack of consent from the victim for inappropriate touching or sexual acts. unwanted kissing, touching genitals, or pressing against someone for sexual pleasure without permission. Definition obtained from https://rapecrisis.org.uk/get-informed/types-of-sexual-violence/what-is-sexual-assault/#:~:text=The%20Sexual%20Offences%20Act%202003,that%20the%20other%20person%20consents.

Honor based abuse towards victim	0 = Not Present 1 = Present	Honor based violence or abuse is stated in the review This can include victims being policed in their home and being extremely isolated.
Mental Health		
No Mention	0	Code 0 if there is no mention of mental health within the perpetrator at any point during the review.
Mentioned	1	Code 1 if the review mentions mental health but does not indicate the perpetrator has a diagnosis
Diagnosed	2	Code 2 if the perpetrator has a diagnosis of a mental health condition or a retrospective diagnosis was given (e.g. Recognised afterwards and recorded in the DHR there should have been a diagnosis). Do not 'assume' the perpetrator has a diagnosis even if they are taking prescribed medication e.g. anti-depressants.
Mental Health Conditions Code 0 if the review does not mention the mental health condition within the perpetrator Code 1 if the review mentions there was a mental health condition within the perpetrator but doesn't explicitly state this was a diagnosis. Code 2 if the review mentions the mental health condition was diagnosed within the perpetrator or a retrospective diagnosis was given (e.g. Recognised afterwards there should have been a diagnosis). **Do not assume there is a diagnosis** if it doesn't explicitly state it, even if they were being treated by the GP for a condition or accessing services. Disorders are clustered according to the ICD-11. See for details: https://icd.who.int/browse/2025-01/mms/en		
Anxiety or fear related disorders	0 = No mention 1 = Mention 2 = Diagnosis	*Anxiety or Fear-Related Disorders* include the following: • 6B00 Generalized Anxiety Disorder • 6B01 panic disorder • 6B02 Agoraphobia • 6B03 Specific Phobia • 6B04 Social Anxiety Disorder • 6B05 Separation Anxiety Disorder • 6B06 Selective Mutism • 6B0Y Other Specified Anxiety or Fear-Related Disorders *Code 'anxiety and depression' individually*
Depressive disorders **Code for a depressive disorder if the review mentions 'low mood' in perpetrator**	0 = No mention 1 = Mention 2 = Diagnosis	**6A70** Single episode depressive disorder ▷**6A71** Recurrent depressive disorder **6A72** Dysthymic disorder **6A73** Mixed depressive and anxiety disorder **GA34.41** Premenstrual dysphoric disorder **6A7Y** Other specified depressive disorders **6A7Z** Depressive disorders, unspecified
Obsessive-Compulsive or Related Disorders	0 = No mention 1 = Mention 2 = Diagnosis	*Obsessive-Compulsive or Related Disorders* include the following: • 6B20 obsessive-compulsive disorder • 6B21 Body Dysmorphic Disorder • 6B22 Olfactory Reference Disorder

		• 6B23 Hypochondriasis (Health Anxiety Disorder) • 6B24 Hoarding Disorder • 6B25 Body-Focused Repetitive Behaviour Disorders • 6B25.0 Trichotillomania (Hair Pulling Disorder) • 6B25.1 Excoriation (Skin Picking) Disorder • 6B2Y Other Specified Obsessive-Compulsive or Related Disorders
Bipolar Related Disorder	0 = No mention 1 = Mention 2 = Diagnosis	**6A60** Bipolar type I disorder ▷**6A61** Bipolar type II disorder **6A62** Cyclothymic disorder **6A6Y** Other specified bipolar or related disorders **6A6Z** Bipolar or related disorders, unspecified
Dissociative Disorders	0 = No mention 1 = Mention 2 = Diagnosis	*Dissociative Disorders* include the following: • 6B60 Dissociative Neurological Symptom Disorder • 6B61 Dissociative Amnesia • 6B62 Trance Disorder • 6B63 Possession Trance Disorder • 6B64 dissociative identity disorder • 6B65 Partial Dissociative Identity Disorder • 6B66 Depersonalization-Derealization Disorder • 6B6Y Other Specified Dissociative Disorders
PTSD / CPSTD **Disorders associated with stress**	0 = No mention 1 = Mention 2 = Diagnosis	*Disorders Specifically Associated with Stress* include the following: • 6B40 Post-Traumatic Stress Disorder • 6B41 Complex Post-Traumatic Stress Disorder • 6B42 Prolonged Grief Disorder • 6B43 adjustment disorder • 6B44 Reactive Attachment Disorder • 6B45 Disinhibited Social Engagement Disorder • 6B4Y Other Specified Disorders Specifically Associated with Stress
Schizophrenia or psychotic disorders	0 = No mention 1 = Mention 2 = Diagnosis	*Schizophrenia or Other Primary Psychotic Disorders* include the following: • 6A20 Schizophrenia • 6A21 schizoaffective disorder • 6A22 schizotypal disorder • 6A23 Acute and Transient Psychotic Disorder

		• 6A24 Delusional Disorder • 6A2Y Other Specified Schizophrenia or Primary Psychotic Disorders (Psychosis not otherwise specified)
Substance induced Disorders	0 = No mention 1 = Mention 2 = Diagnosis	e.g. mental/behavioural disorder due to substances or drug induced psychosis. Substance use disorders include the following • 6C40 Disorders Due to Use of Alcohol • 6C41 Disorders Due to Use of Cannabis • 6C42 Disorders Due to Use of Synthetic Cannabinoids • 6C43 Disorders Due to Use of Opioids • 6C44 Disorders Due to Use of Sedatives, Hypnotics or Anxiolytics • 6C45 Disorders Due to Use of Cocaine • 6C46 Disorders Due to Use of Stimulants including Amphetamines, Methamphetamine or Methcathinone • 6C47 Disorders Due to Use of Synthetic Cathinones • 6C48 Disorders Due to Use of Caffeine • 6C49 Disorders Due to Use of Hallucinogens • 6C4A Disorders Due to Use of Nicotine • 6C4B Disorders Due to Use of Volatile Inhalants • 6C4C Disorders Due to Use of MDMA or Related drugs, including MDA • 6C4D Disorders Due to Use of Dissociative Drugs including Ketamine and Phencyclidine (PCP) • 6C4E Disorders Due to Use of Other Specified Psychoactive Substances, including Medications • 6C4F Disorders Due to Use of Multiple Specified Psychoactive Substances, including Medications • 6C4G Disorders Due to Use of Unknown or Unspecified Psychoactive Substances • 6C4H Disorders Due to Use of Non-Psychoactive Substances
Addictive disorders	0 = No mention 1 = Mention 2 = Diagnosis	Gambling disorders, gaming disorders video gaming disorder
Neurocognitive Disorders **(Keep a note of what neurocognitive disorder is stated)**	0 = No mention 1 = Mention 2 = Diagnosis	Delerium Alzheimer's or Dementia related diagnoses including substance induced delirium or alcohol related dementia. Mild cognitive impairment can be coded under neurocognitive disorders. See link for extensive list from ICD-11 https://icd.who.int/browse/2024-01/mms/en#213458094
Neuro-developmental Disorder **(Keep a note of what neurodevelopmental disorder is stated)**	0 = No mention 1 = Mention 2 = Diagnosis	*Neurodevelopmental Disorders* include the following: • 6A00 Disorders of Intellectual Development • 6A01 Developmental Speech or Language Disorders • 6A01.0 Developmental Speech Sound Disorder

		• 6A01.1 Developmental Speech Fluency Disorder • 6A01.2 Developmental Language Disorder • 6A02 autism spectrum disorder • 6A03 Developmental Learning Disorder • 6A04 Developmental Motor Coordination Disorder • 6A05 attention deficit hyperactivity disorder • 6A06 Stereotyped Movement Disorder • 6A0Y Other Specified Neurodevelopmental Disorders Dyslexia can also be coded under neuro-developmental disorders.
Personality Disorder **(Keep a note of what personality disorder is stated)**	0 = No mention 1 = Mention 2 = Diagnosis	Code if the review mentions whether the perpetrator likely has a personality disorder or if a diagnosis has been given.
Evidence that the perpetrator made threats to kill or harm themselves? This can be stated anywhere within the review and threats could have been heard or reported by the victim, family, friends or services.		
Not Present	0	No evidence the perpetrator made threats to kill themselves
Present	1	There is evidence the perpetrator made threats to kill themselves
Evidence of Recent self-harm in the perpetrator's history Intentional self-injury within the past 3 months but not with the intention of taking their life. Do not code for self-inflicted injury which occurred *after* the homicide.		
Not Present	0	
Present	1	
Evidence of Previous self-harm in the perpetrator's history Intentional self-injury within the past 3 months to 12 months but not with the intention of taking their life.		
Not Present	0	
Present	1	
Evidence of Historic self-harm in the perpetrator's history Intentional self-injury which occurred over 12 months ago but not with the intention of taking their life.		
Not Present	0	
Present	1	
Evidence of recent suicidal ideation within past 3 months of homicide occurring in the perpetrator's history Thoughts/communication of taking their life. Perpetrator threatens to take own life? Do not code for suicidal ideation which occurred *after* the homicide.		
Not present	0	

Present	1	
Evidence of previous suicidal ideation between 3 months – 12 months prior to homicide in the perpetrator's history		
Not Present	0	
Present	1	
Evidence of historic suicidal ideation over 12 months ago from date of homicide occurring in the perpetrator's history		
Not present	0	
Present	1	
Evidence of Recent suicide attempt within past 3 months of homicide occurring in the perpetrator's history A suicide attempt could occur without prior suicidal ideation being communicated. Do not automatically code for suicidal ideation if it was not present, but an attempt occurred. Do not code for a suicide or suicidal attempt which occurred *after* the homicide.		
Not present	0	
Present	1	
Evidence of previous suicide attempt between 3 months – 12 months prior to homicide in the perpetrator's history		
Not Present	0	
Present	1	
Evidence of historic suicide attempt over 12 months ago from date of homicide occurring in the perpetrator's history		
Not Present	0	
Present	1	
Last/Most Recent contact with what service for mental health? Where possible, try to record the last known contact recorded in the DHRs, that the perpetrator had with any mental health service.		
None	0	No contact with services for Mental health related issues mentioned at all within the review
GP	1	Last contact was with the GP for mental health related issues.
Secondary Care/CMHT	2	Last contact was with the GP for mental health related issues.
Crisis/Home Treatment Team	3	Last contact was with crisis or home treatment team
Inpatient Services	4	Inpatient MH services were the last contact
Substance Use Services	5	Drug or alcohol related services were the last contact
Private services	6	Private services / private psychiatrist

Other	7	Other services not coded for For example, ASD assessment service, A&E, custody, support services/carers.
How recent was the Mental Health related contact This includes contact with the GP for mental health related issues. Try to record as best as possible or calculate from information within the DHR when the most recent contact with mental health services was, or with services for mental health related concerns.		
No contact as not known to any services for mental health	0	Not known to services for mental health related issues.
Not determinable	1	Unable to determine how recent the contact was for mental health related issues.
Current (within 1 week) of the homicide	2	Review indicates contact with services for mental health occurred anywhere between the day of the homicide to the week before the homicide
Between 1 week to 1 month before the homicide	3	Contact with services for mental health occurred at some point between 1 week before the homicide to 1 month before the homicide
Between 1- 6 months before the homicide	4	Most recent contact related to mental health occurred within the past 1 - 6 months before the homicide
Not current time of homicide but within the past 6-12 month	5	Most recent contact related to mental health occurred 6 – 12 months before the homicide
More than 1 year ago	6	Most recent contact with services related to mental health was more than 1 year ago
Evidence of Alcohol Use / Substance Use (anywhere in the review)		
No Use	0	No alcohol or substance use
Alcohol Use Only	1	Review mentions alcohol use by perpetrator but no mention of substance use. This can be anywhere in the review, from recreational drinking to problematic.
Substance use only	2	Review mentions substance use by perpetrator (of both prescription and nonprescription drugs) but no mention of alcohol. This can be anywhere in the review, from recreational to problematic usage.
Both alcohol and substance use	3	Review mentions use of both alcohol and substances by perpetrator. This can be anywhere in the review, from recreational to problematic.
Evidence of Dependency on alcohol or substances from the perpetrator		
No Dependency stated	0	Review mentions no dependency on alcohol or substances.
Alcohol Dependent only	1	Review mentions or alludes to dependency on alcohol or e.g. ‘long term use’ ‘or ‘problem with alcohol’
Substance Dependent only	2	Review mentions or alludes to dependency on substances or e.g. ‘long term use’ ‘or ‘problem with substances’ Key search for ‘substances’ ‘drugs’ ‘use’ ‘problem’
Dependent on both	3	Review clearly mentions perpetrator was dependent on both alcohol and substances or indicates problematic usage or long-term usage of both. Substances can include illicit or non-illicit (prescription drugs).
Evidence the perpetrator was intoxicated at time of homicide? *Difficult to determine as investigation or discovery likely occurred hours after the homicide, thus perpetrator could have detoxified by then?		
Not Present/Not stated	0	Review does not state the perpetrator was intoxicated at the time of the homicide

Present	1	Review states clearly the perpetrator was intoxicated at the time of the homicide
Overall impact of alcohol use on the perpetrator		
No Alcohol Use	0	No use of alcohol by the perpetrator
Evidence of alcohol use with minimal functional impact	1	Alcohol use present but no concerns reported within the review in context of alcohol use. No evidence of a dependency or limited or no evidence of impact on functioning or mental health and behaviour. E.g. They were not brought to attention of police. Alcohol not reported or seen to be a risk factor in the review.
Evidence of alcohol use with moderate functional impact	2	Alcohol use present, along with likely dependency where drinking behaviours could be described as 'excessive' or 'heavy consumption' AND There are also Evidence of concerns from others about alcohol use and possibly police involvement. Reporting's of behaviours occurring when under the influence such as aggression, drink driving, arguments. Victim reporting concerns about perpetrator drinking and links to behaviour e.g. aggression/violence. May impact some aspects of mental health such as mood / sleep etc. Could be seen or documented as a risk factor.
Evidence of alcohol use with significant impact	3	Alcohol use present, along with dependency and/or evidence of strong concerns from others about alcohol use Reporting's of concerning behaviours occurring when under the influence (such as violent acts/aggression/arguments) which adversely impact others *and or* People feeling scared/fearful of the perpetrator when they are intoxicated *and or* Reporting's of mental health becoming adversely affected with alcohol use (loss of control, behavioural and or emotional instability) Alcohol use linked to increased risks in crime/abuse of others (theft to fund alcohol addiction). Drunk and disorderly offences/police involvement. Alcohol treatment may be required Impact of alcohol might be described as a major/significant risk factor in homicide, and/or both present and/or previous history.
Impact of substance use overall on the perpetrator and their life		
No substance use	0	No substance use
Evidence of substance use with minimal functional impact	1	Substance use present but no concerns reported within the review in context of Substance use.
Evidence of substance use with moderate functional impact	2	Substance use present, along with likely dependency. Evidence of concerns from others about Substance use. Reporting's of substances impacting the behaviour of the perpetrator, for example behaviours occurring when under the influence such as aggression, arguments, disordered thoughts/perceptions. May impact some aspects of mental health such as mood / sleep etc. May impact relationships with others
Evidence of substance use with significant functional impact	3	Substance use present, along with dependency and evidence of strong concerns from others about substance use Reporting's of concerning behaviours occurring when under the influence (such as violent acts/aggression/arguments/disordered thoughts or perceptions) which adversely impact others and increase the risk of inappropriate behaviours

		and or People feeling scared/fearful of the perpetrator when they are intoxicated *and or* Reporting's of mental health becoming adversely affected with Substance use (loss of control, behavioural and or emotional instability, disordered thoughts or perceptions) disordered thoughts or perceptions use linked to increased risks in crime/abuse of others (theft to fund addiction). Offences/police involvement due to drug use. Involved in supplying drugs, linked to drug debt. Impacts physical health. Impact of substance use might be described as a major risk factor in both present and/or previous history.
Evidence Perpetrator is a carer for the victim		
Not present	0	No evidence to suggest the perpetrator was not a carer for the victim
Present	1	The perpetrator was described to be a carer/caring for the victim at the time of the homicide or at some point prior to the homicide. This can be formal or informal. E.g. Victim may have moved into a care home, but perpetrator regularly visited and continued to support the victim. Circumstances indicate the victim had a condition which the perpetrator provided them care and support with.
Evidence perpetrator was receiving care from the victim		
Not Present	0	No evidence to suggest the perpetrator was in receipt of care from the victim or the victim was a carer for the perpetrator.
Present	1	Evidence to suggest the victim was a carer/caring for the perpetrator. The victim was described to be a carer/caring for the perpetrator at the time of the homicide or at some point prior to the homicide. This can be formal or informal. Circumstances indicate the perpetrator had a condition which the victim provided them care and support with.
Motives / Risk Factors / Aggravating Factors		
Evidence of arguments/conflict within the relationship		
Not Present	0	No evidence in the review of the couple/ex couple arguing.
Present	1	Evidence in the review the couple would argue (including past and present). Code if arguing appeared to occur frequently. Code if arguments/conflict led to police being called/police involvement. *Do not count historic reports of 'one argument' or 'argument on the odd occasion' as this is to be expected in a relationship.*
Evidence of jealousy within perpetrator		
Not Present	0	Review does not mention jealousy/resentment in relation to the perpetrators character.
Present	1	The review mentions jealousy/resentment as characteristics of the perpetrator which could be historic or recent.
Evidence of coercive control from perpetrator (Monkton Smith Stage 3)		
Not Present	0	Review does not mention coercive control or The DHR analysis section does not conclude there were acts of coercive control from perpetrator towards victim or previous partners

Present	1	Review does mention or concludes that there were acts of coercive control from perpetrator towards victim or previous partners. (This information can often be found in the 'analysis' section of the DHR or searched for using CTRL +F).
Evidence of perpetrator described as or displaying anger/aggression/quick to temper anywhere within the review or perpetrators history.		
Not Present	0	Review does not refer to the perpetrators character as being aggressive, angry, quick to temper.
Present	1	Review does refer to the perpetrator being aggressive/angry/quick to temper/rage or any other word which is associated with 'anger/rage/aggression'.
Report includes perpetrator making threats to kill or harm victim/others *Include where perpetrator makes any statement about victim being dead as well as threats to kill them or inflict violence*		
Not Present	0	No evidence of the perpetrator making threats to kill the victim or others
Present	1	Evidence anywhere within the review (including historic), which indicates the perpetrator made threats to kill either the victim or others.
Evidence of Paranoia / Suspicion / Accusations This could include perpetrator being suspicious of victim or mistrustful, checking their phone or emails? Accusing the victim of cheating. This can be recent or historic.		
Not Present	0	No evidence in the review
Present	1	Evidence in the review to suggest the perpetrator was paranoid or experiencing paranoia, appearing mistrusting or suspicious of the victim. this could be recent or historic.
Evidence of possessiveness Evidence in the review which states the perpetrator was possessive or demanding of attention from the victim.		
Not Present	0	No evidence in the review
Present	1	Evidence in the review which states the perpetrator was possessive or demanding of attention from the victim.
Evidence the perpetrator presented with stalking behaviour (Monkton Smith - Stage 1 of Domestic Homicide) - Current or Historic Stalking may include: • following the victim • going uninvited to the victim's home • hanging around somewhere they know the victim often visits • watching or spying on the victim • identity theft (signing-up to services, buying things in the victim's name) • writing or posting online about the victim, which is unwanted or the victim did not know Definition obtained from https://www.police.uk/advice/advice-and-information/beta-stalking-and-harassment/what-is-stalking-harassment/		
Not Present	0	No evidence of stalking behaviour noted within the review
Present	1	See above for definition of stalking and what it would include, code if the review states any of the above points regarding stalking behaviour including historic (for example towards previous partners or others)
Evidence of the perpetrator presenting with harassment behaviours - Current or Historic Harassment may include: • sending unwanted, obsessive or abusive text messages or images or emails		

• posting abusive messages on social media • neighbour disputes that involve abusive behaviour or damage to property • repeated antisocial behaviour • making unwanted, obsessive or offensive phone calls • Not leaving the victim alone Definition obtained from https://www.police.uk/advice/advice-and-information/beta-stalking-and-harassment/what-is-stalking-harassment/		
Not Present	0	No evidence
Present	1	See above for definition of harassment and what it would include, code if the review states any of the above points regarding harassment, including historic (for example towards previous partners or others)
Evidence of divorce or separation		
Not Present	0	No evidence to suggest the perpetrator and victim had divorce or separated and were still in a relationship at the time of the homicide.
Present	1	The review states the perpetrator and victim at the time of the homicide • had separated • Were in the process of separating • Had chosen to separate/divorce • Had discussed separating or divorcing prior to the homicide (up to 3 months before) • Were in the process of divorce • Had been divorced
If separation is coded present, when was the separation in relation to the homicide date? this will likely need to be calculated from the information available in the DHR on timeframes/dates which indicate the separation occurred. If it is unclear because the couple were on and off, code for the most recent time the review states they had separated or divorced.		
Not Applicable	0	Code N/A if no signs of separation were indicated.
Within the past month	1	The couple or victim had suggested or chosen to separate at some point within the past month before the homicide.
Within past 1-3 months	2	The couple had divorced/separated within the 1-3 months before the homicide.
Within past 3-6 months	3	The couple had divorced/separated within the past 3-6 months before the homicide.
6-12 months ago	4	The couple had divorced/separated within the 6-12 months before the homicide.
Over 12 months ago	5	The couple had divorced/separated over 12 months ago before the homicide.
Unclear	6	Code if it is unclear when the separation was, but there is reference to separation or divorce proceedings.
Evidence the victim entered a new relationship or was involved with someone else		
Not present/Not Mentioned	0	No evidence to suggest the victim had entered into a new relationship which was not the perpetrator

Present	1	The review documents the victim had intentions to move on with someone else, moved on with someone new or entered another relationship which was not with the perpetrator. Code present if the victim had become involved with someone else such as seeing someone else behind the perpetrators back. Code if victim tried to move on/got into a new relationship which then came to an end linked/likely linked to the external influence of the perpetrator.
Evidence the relationship was 'devoted' Family/friends accounts refer to the couple being devoted to one another or being 'loving' Do not code if there are doubts within the review as to whether the couple were really devoted. Do not code if the review suspects the 'devotion' could have been a form of 'control' on the perpetrator's behalf, instead code for coercive control if there is sufficient evidence also within the review which suggests there was 'control' from the perpetrator. Only code present if the review suggests the couple were genuinely devoted to one another, where there are no signs of abuse or risk factors.		
Not Present	0	
Present	1	
Evidence of escalation of perpetrators emotions, behaviours (including stalking), abuse/violence prior to homicide (Stage 5) Someone who chronically abused the victim continually overtime may not have appeared to 'escalate' their abuse, thus the information might not be obvious or explicit in the review. Only code if there is clear evidence of escalation of abuse.		
Not Present	0	There is no evidence within the review that there was an escalation in risk or violence towards the victim.
Present	1	There is evidence within the review that there was an escalation in risk or violence towards the victim. Information in the review could indicate that there were more frequent abusive acts or events, increased stalking or harassment, increased conflict in the lead up to the homicide.
Evidence of perpetrator planning (Stage 7) Clear evidence in the review that the perpetrator was planning the homicide. E.g. Buying weapons, seeking to get victim alone		
Not Present	0	No information in the review to indicate that the perpetrator was planning the homicide.
Present	1	Information is contained within the review to indicate the perpetrator was planning the homicide.
Victim Demographics		
Gender of victim		
Male	0	Victim was male
Female	1	Victim was female
Age of victim	Enter age	Reported Age of victim within the report. Report '999' if the age of the victim is missing.
Ethnicity of victim (code qualitatively)		

White British	'White British'	Code ethnicity qualitatively.
Missing	999	Code 999 if ethnicity is missing
Evidence of Physical Health problems/disability within victim Code if the victim had physical health issues which impacted their well-being/quality of life, vulnerability. Do not code if their physical health does not appear to be a factor in the victim's vulnerability or well-being.		
Not Present	0	Review does not document victim *suffered* with physical health problems. Visits to the GP for physical health are to be expected, however if the physical health issues are not reported to be chronic/disabling or having an adverse impact on the victim, code 'not present'
Present	1	Review indicates victim experienced and suffered with physical health issues. Code 1 for if physical health issues are reported to be chronic, disabling or have an adverse impact on the victim.
Mental Health		
No Mention	0	Code 0 if there is no mention of mental health within the victim at any point during the review.
Mentioned	1	Code 1 if the review mentions mental health but does not indicate the victim has a diagnosis
Diagnosed	2	Code 2 if the victim has a diagnosis of a mental health condition or a retrospective diagnosis was given (e.g. Recognised afterwards in the DHR that there should have been a diagnosis). Do not 'assume' the perpetrator has a diagnosis even if they are taking prescribed medication e.g. anti-depressants.
Mental Health Conditions Code 0 if the review does not mention the mental health condition within the victim. Code 1 if the review mentions there was a mental health condition within the victim but doesn't explicitly state this was a diagnosis. Code 2 if the review mentions the mental health condition was diagnosed within the victim or a retrospective diagnosis was given (e.g. Recognised afterwards there should have been a diagnosis). **Do not assume there is a diagnosis** if it doesn't explicitly state it, even if they were being treated by the GP for a condition or accessing services. Disorders are clustered according to the ICD-11. Categorise the mental health condition(s) reported in the review using the following categories listed below. See for details: https://icd.who.int/browse/2025-01/mms/en		
Anxiety or fear related disorders	0 = No mention 1 = Mention 2 = Diagnosis	*Anxiety or Fear-Related Disorders* include the following: • 6B00 Generalized Anxiety Disorder • 6B01 panic disorder • 6B02 Agoraphobia • 6B03 Specific Phobia • 6B04 Social Anxiety Disorder • 6B05 Separation Anxiety Disorder • 6B06 Selective Mutism • 6B0Y Other Specified Anxiety or Fear-Related Disorders *Code 'anxiety and depression' individually*
Depressive disorders **Code for a depressive disorder if the review mentions 'low mood' in perpetrator**	0 = No mention 1 = Mention 2 = Diagnosis	**6A70** Single episode depressive disorder ▷**6A71** Recurrent depressive disorder **6A72** Dysthymic disorder **6A73** Mixed depressive and anxiety disorder **GA34.41** Premenstrual dysphoric disorder

		6A7Y Other specified depressive disorders **6A7Z** Depressive disorders, unspecified
Obsessive-Compulsive or Related Disorders	0 = No mention 1 = Mention 2 = Diagnosis	*Obsessive-Compulsive or Related Disorders* include the following: • 6B20 obsessive-compulsive disorder • 6B21 Body Dysmorphic Disorder • 6B22 Olfactory Reference Disorder • 6B23 Hypochondriasis (Health Anxiety Disorder) • 6B24 Hoarding Disorder • 6B25 Body-Focused Repetitive Behaviour Disorders • 6B25.0 Trichotillomania (Hair Pulling Disorder) • 6B25.1 Excoriation (Skin Picking) Disorder • 6B2Y Other Specified Obsessive-Compulsive or Related Disorders
Bipolar Related Disorder	0 = No mention 1 = Mention 2 = Diagnosis	**6A60** Bipolar type I disorder ▷**6A61** Bipolar type II disorder **6A62** Cyclothymic disorder **6A6Y** Other specified bipolar or related disorders **6A6Z** Bipolar or related disorders, unspecified
Dissociative Disorders	0 = No mention 1 = Mention 2 = Diagnosis	*Dissociative Disorders* include the following: • 6B60 Dissociative Neurological Symptom Disorder • 6B61 Dissociative Amnesia • 6B62 Trance Disorder • 6B63 Possession Trance Disorder • 6B64 dissociative identity disorder • 6B65 Partial Dissociative Identity Disorder • 6B66 Depersonalization-Derealization Disorder • 6B6Y Other Specified Dissociative Disorders
PTSD / CPSTD **Disorders associated with stress**	0 = No mention 1 = Mention 2 = Diagnosis	*Disorders Specifically Associated with Stress* include the following: • 6B40 Post-Traumatic Stress Disorder • 6B41 Complex Post-Traumatic Stress Disorder • 6B42 Prolonged Grief Disorder • 6B43 adjustment disorder • 6B44 Reactive Attachment Disorder • 6B45 Disinhibited Social Engagement Disorder • 6B4Y Other Specified Disorders Specifically Associated with Stress

Schizophrenia or psychotic disorders.	0 = No mention 1 = Mention 2 = Diagnosis	*Schizophrenia or Other Primary Psychotic Disorders* include the following: • 6A20 Schizophrenia • 6A21 schizoaffective disorder • 6A22 schizotypal disorder • 6A23 Acute and Transient Psychotic Disorder • 6A24 Delusional Disorder • 6A2Y Other Specified Schizophrenia or Primary Psychotic Disorders (Psychosis not otherwise specified)
Substance induced Disorders	0 = No mention 1 = Mention 2 = Diagnosis	e.g. mental/behavioural disorder due to substances or drug induced psychosis. • 6C40 Disorders Due to Use of Alcohol • 6C41 Disorders Due to Use of Cannabis • 6C42 Disorders Due to Use of Synthetic Cannabinoids • 6C43 Disorders Due to Use of Opioids • 6C44 Disorders Due to Use of Sedatives, Hypnotics or Anxiolytics • 6C45 Disorders Due to Use of Cocaine • 6C46 Disorders Due to Use of Stimulants including Amphetamines, Methamphetamine or Methcathinone • 6C47 Disorders Due to Use of Synthetic Cathinones • 6C48 Disorders Due to Use of Caffeine • 6C49 Disorders Due to Use of Hallucinogens • 6C4A Disorders Due to Use of Nicotine • 6C4B Disorders Due to Use of Volatile Inhalants • 6C4C Disorders Due to Use of MDMA or Related drugs, including MDA • 6C4D Disorders Due to Use of Dissociative Drugs including Ketamine and Phencyclidine (PCP) • 6C4E Disorders Due to Use of Other Specified Psychoactive Substances, including Medications • 6C4F Disorders Due to Use of Multiple Specified Psychoactive Substances, including Medications • 6C4G Disorders Due to Use of Unknown or Unspecified Psychoactive Substances • 6C4H Disorders Due to Use of Non-Psychoactive Substances
Addictive disorders	0 = No mention 1 = Mention 2 = Diagnosis	Gambling disorders, gaming disorders video gaming disorder
Neurocognitive Disorders **(Keep a note of what neurocognitive disorder is stated)**	0 = No mention 1 = Mention 2 = Diagnosis	Delerium Alzheimer's or Dementia related diagnoses including substance induced delirium or alcohol related dementia. Mild cognitive impairment can be coded under neurocognitive disorders.

		See link for extensive list from ICD-11 https://icd.who.int/browse/2024-01/mms/en#213458094
Neuro-developmental Disorder **(Keep a note of what neurodevelopmental disorder is stated)**	0 = No mention 1 = Mention 2 = Diagnosis	*Neurodevelopmental Disorders* include the following: • 6A00 Disorders of Intellectual Development • 6A01 Developmental Speech or Language Disorders • 6A01.0 Developmental Speech Sound Disorder • 6A01.1 Developmental Speech Fluency Disorder • 6A01.2 Developmental Language Disorder • 6A02 autism spectrum disorder • 6A03 Developmental Learning Disorder • 6A04 Developmental Motor Coordination Disorder • 6A05 attention deficit hyperactivity disorder • 6A06 Stereotyped Movement Disorder • 6A0Y Other Specified Neurodevelopmental Disorders Dyslexia can also be coded under neuro-developmental disorders.
Personality Disorder **(Keep a note of what personality disorder is stated)**	0 = No mention 1 = Mention 2 = Diagnosis	Code if the review mentions whether the perpetrator likely has a personality disorder or if a diagnosis has been given.
Eating Disorders	0 = No mention 1 = Mention 2 = Diagnosis	Feeding or eating disorders ▷**6B80** Anorexia Nervosa **6B81** Bulimia Nervosa **6B82** Binge eating disorder **6B83** Avoidant-restrictive food intake disorder **6B84** Pica **6B85** Rumination-regurgitation disorder **6B8Y** Other specified feeding or eating disorders **6B8Z** Feeding or eating disorders, unspecified
Difficulties with sleep mentioned?		
Not Present	0	Code not present if no sleep/insomnia issues are mentioned throughout the review in relation to the victim
Present	1	Code if issues with sleep is mentioned anywhere within the review in relation to the victim E.g. 'insomnia' or reporting to the GP about problems with sleep.
Evidence of 'Stress' or 'not coping' implied or mentioned?		
No	0	Code not present if 'stress' or not coping is not mentioned or implied throughout the review in relation to the victim.
Yes	1	Code if 'stress' is mentioned anywhere within the review in relation to the victim. Code if victim unable to cope or information implies victim struggling or undergoing current or historic stressful circumstances.

Victim: Evidence of Alcohol Use / Substance Use		
No alcohol or substance use	0	Review does not mention the victim used alcohol or substances
Alcohol use, no substance use	1	The review states the victim drank alcohol. This can be anywhere in the review, from recreational drinking to problematic.
Substance use, no alcohol use	2	The review states the victim took substances, this can be anywhere in the review, from recreational to problematic usage.
Both alcohol and substance use	3	The review states the victim used both alcohol and substance use. This can be anywhere in the review, from recreational to problematic.
Evidence the victim was isolated?		
Not Present	0	The review does not contain evidence the victim was / felt isolated or trapped.
Present	1	The review does contain evidence the victim was / felt isolated or trapped. Isolation can include isolated from family friends or the community, or the victim felt trapped in the relationship with the perpetrator.
Evidence victim was scared/fearful of perpetrator Evidence the review mentions the victim feared the perpetrator at any point, even if fear only appears in certain contexts such as substance or alcohol use, still code as 'present'. Code 0 if there is no evidence to suggest the victim feared the perpetrator.		
Not Present	0	No evidence
Present	1	Evidence in the review the victim felt scared or feared the perpetrator.
Are there recommendations for Mental Health Services?	0 = No 1 = Yes	Does the DHR make SPECIFIC recommendations for mental health services? The review will likely contain a 'single agency recommendation' section, where this information is likely to be. Sometimes DHR's will cluster recommendations and refer to 'all services', if Mental health services were involved in the review, also code for the recommendations where it states, 'all services/all professionals....'. If 'YES' Code for the following variables / recommendations as listed below.
Assessments	0 Not Present 1 Present	Are there recommendations in relation to improving assessments? (this could be risk assessments, holistic assessments, assessment of mental health, identfying and referring carers for assessments etc).
Professional curiosity	0 Not Present 1 Present	Are there recommendations in relation to 'professional curiosity'/ 'Routine enquiry' Eg – staff to be asking more questions or gathering additional information to inform their assessments, being open minded, to enquire about DV/DA/ or enquire further about someone's coping, background or mental health. This could be within conducting assessments or to inform assessments.
Training of staff to improve skills/competence	0 Not Present 1 Present	Are there recommendations in relation to training of staff to improve skills or competence? For example – recommendations to improve responses to da/dv disclosure with training how to ask questions sensitively?
Improve policy/procedure/protocols/processors.	0 Not Present 1 Present	Recommendations which suggest Mental Health services should review and/or update their policies, procedures, processors or protocols.
Awareness	0 Not Present 1 Present	Are there any recommendations which suggest mental health services/staff should improve their awareness (likely in relation to domestic abuse/violence, coercive control, or becoming more 'carer aware') For example, of hidden harm, older people/carers, non-disclosures, victim engagement/complex needs.

Sharing of information between agencies	0 Not Present 1 Present	Code is there are any recommendations suggesting or related to the sharing of information within or across mental health services, for example sharing known information with other agencies.
Increasing Communication	0 Not Present 1 Present	Code is there are any recommendations suggesting or related to increasing communications (more regular meetings or discussions) with other services or within services (for example more regular discussions in supervision or MDTs)
Recording of information/systems	0 Not Present 1 Present	Are there any recommendations which suggest improvements must be made to systems that record information (e.g. adding a 'flagging' marker) or improvements in the recording of information or clinical notes by staff in mental health services?
Referral to MH services	0 Not Present 1 Present	Were recommendations that a referral should have been made to mental health services?
Referral	0 Not Present 1 Present	Are there any recommendations which suggest there must be improvements in referral pathways to mental health services or that a referral should have been made?
Sign posting/onward referral for other needs	0 Not Present 1 Present	Are there recommendations for mental health services to signpost to relevant services, provide information about other services or to have completed an onward referral? Eg referring for a carers assessment?
Other	Code qualitatively	Keep a log of qualitative notes of other recommendations which are made, which may/may not fall under the listed categories, but provide additional context or information.
Victim family/friend involvement Code if any family, friends, colleagues, people who knew the victim (not services) who contributed to the review. This information can usually be found under the section headed 'family/friend involvement' or similar.		
Not Present	0	No evidence of family or friend involvement who knew the victim
Present	1	Evidence in the review that friends and family of the victim contributed to the review
Perpetrator family/friend involvement? Code if any family, friends, colleagues, people who knew the perpetrator (not services) contributed to the review. This information can usually be found under the section headed 'perpetrator involvement' or similar.		
Not Present	0	No evidence of family or friend involvement who knew the perpetrator.
Present	1	Evidence in the review that friends and family of the perpetrator contributed to the review.
Evidence of Perpetrator involvement Code if the perpetrator themselves contributed to the review. This information can usually be found under the section headed 'family/friend involvement' or similar.		
Not present	0	No, the perpetrator did not contribute or declined to do so.
Present	1	The perpetrator did contribute to the review (likely via interview from prison).
How many services contributed information?	Input the number as a continuous variable	This information can often be found under the section called 'contributions' / 'methodology' and the services are often listed as 'agencies which contributed to the review' Count the services in the list and input this as a number. Eg if 5 services contributed write '5'

Appendix E: Inter-rater Agreement Table

Inter-rater agreement table for variables included in the analysis Where Cohen's Kappa could not be calculated due to no variation in the ratings, the percentage agreement was reported.			
Variables included in the analysis	Percentage Agreement	Cohens Kappa	Cohens Kappa Interpretation
Gender of Perpetrator	100%	1.00	Almost Perfect
Gender of Victim	100%	1.00	Almost Perfect
Age of Perpetrator	100%	1.00 (Interclass Correlation)	Almost Perfect
Age of Victim	100%	1.00 (Interclass Correlation)	Almost Perfect
Perpetrator - Ethnicity	100%	1.00	Almost Perfect
Victim - Ethnicity		.944	Almost Perfect
Relationship between perpetrator and victim	100%	1.00	Almost Perfect
Circumstances of the death	100%	1.00	Almost Perfect
Offence	100%	1.00	Almost Perfect
Sentencing	100%	1.00	Almost Perfect
Main cause of death	100%	1.00	Almost Perfect
Was there a link between the homicide and the MH of the perpetrator?	96.7%	.939	Almost Perfect
Perpetrator - Criminal History	100%	1.00	Almost Perfect
Previous DA/DV towards previous partners/family	96.7%	.932	Almost Perfect
Physical abuse towards victim	100%	1.00	Almost Perfect
Emotional abuse towards the victim	93.33%	.857	Strong
Financial abuse towards the victim	93.33%	.712	Moderate
Economic abuse towards the victim	93.33%	.841	Strong
Sexual abuse towards the victim	100%	1.00	Almost Perfect
MH in perpetrator (Diagnosed/Mentioned)	100%	1.00	Almost Perfect
Perpetrator – Anxiety related disorder	96.7%	.933	Almost Perfect
Perpetrator – Depressive Disorder/Low Mood	100%	1.00	Almost Perfect
Perpetrator – Obsessive Compulsive Disorder	100%	N/A	
Perpetrator – Bipolar Related Disorder	100%	1.00	Almost Perfect
Perpetrator – Disorders Associated with Stress	100%	1.00	Almost Perfect
Perpetrator – Dissociative Disorders	100%	1.00	Almost Perfect
Perpetrator – Schizophrenic/Psychotic Disorders	100%	1.00	Almost Perfect
Perpetrator – Substance Induced Disorders	100%	1.00	Almost Perfect
Perpetrator – Neurocognitive Disorders	100%	1.00	Almost Perfect
Perpetrator – Neurodevelopmental Conditions	100%	N/A	
Perpetrator – Personality Disorders	100%	1.00	Almost Perfect
Perpetrator – Addictive Disorders	100%	N/A	
Perpetrator – Eating Disorders	100%	N/A	
Perpetrator – Threats to harm/kill themselves	100%	1.00	Almost Perfect
Perpetrator – Recent Self-Harm (Last 3 months)	100%	1.00	Almost Perfect
Perpetrator – Previous Self Harm (Last 3-12 months)	96.7%	.651	Moderate

Perpetrator – Historic Self Harm (Over 12 months ago)	100%	1.00	Almost Perfect
Perpetrator – Recent Suicidal Ideation (Last 3 months)	96.7%	.911	Almost Perfect
Perpetrator – Previous Suicidal Ideation (Last 3-12 months)	96.7%	.889	Strong
Perpetrator – Historic Suicidal Ideation (Over 12 months ago)	93.3%	.792	Moderate
Perpetrator – Recent Suicide Attempt (Last 3 months)	96.7%	.839	Strong
Perpetrator – Previous Suicide Attempt (Last 3-12 months)	96.7%	.651	Moderate
Perpetrator – Historic Suicide Attempt (Over 12 months ago)	100%	1.00	Almost Perfect
Perpetrator – Timeframe of last MH Service Contact	80%	7.21	Moderate
Perpetrator – Evidence of Alcohol/Substance Use	93.3%	.904	Almost Perfect
Perpetrator – Dependency on Alcohol/Substance Use	93.3%	.867	Strong
Perpetrator Intoxicated at time of homicide?	93.3%	.760	Moderate
Perpetrator – Functional Impact of Alcohol Use	93.3%	.905	Almost Perfect
Perpetrator – Functional Impact of Substance Use	93.3%	.891	Strong
Perpetrator – Coercive Controlling Behaviours	100%	1.00	Almost Perfect
Perpetrator - Jealousy	100%	1.00	Almost Perfect
Perpetrator – Anger/Aggression	93.3%	.867	Strong
Perpetrator – Threats to kill or harm	100%	1.00	Almost Perfect
Perpetrator – Paranoia/Suspicion	93.3%	.814	Strong
Perpetrator - Possessiveness	90%	.710	Moderate
Perpetrator – Evidence of planning the homicide	93.3%	.793	Moderate
Perpetrator – Stalking Behaviours	96.7%	.870	Strong
Perpetrator – Harassment Behaviours	90%	.757	Moderate
Arguments or Conflict	93.3%	.862	Strong
Separation or Divorce	96.7%	.933	Almost Perfect
Perpetrator caring for victim	100%	1.00	Almost Perfect
Victim caring for Perpetrator	93.3%	.630	Moderate
Victim enter a new relationship	100%	1.00	Almost Perfect
Devoted Couple	96.7%	.889	Strong
Victim feared / scared of perpetrator	93.3%	.842	Strong
Victim felt isolated	90%	.757	Moderate
MH in Victim (Diagnosed/Mentioned)	100%	1.00	Perfect
Victim – Anxiety related disorder	100%	1.00	Almost Perfect
Victim – Depressive Disorder/Low Mood	100%	1.00	Almost Perfect
Victim – obsessive compulsive disorder	100%	1.00	Almost Perfect
Victim – Bipolar Related Disorder	100%	1.00	Almost Perfect
Victim – Disorders Associated with Stress	100%	1.00	Almost Perfect
Victim – Dissociative Disorders	100%	1.00	Almost Perfect
Victim – Schizophrenic/Psychotic Disorders	100%	1.00	Almost Perfect
Victim – Substance Induced Disorders	100%	1.00	Almost Perfect
Victim – Neurocognitive Disorders	100%	1.00	Almost Perfect
Victim – Neurodevelopmental Conditions	100%	N/A	N/A

Victim – Personality Disorders	100%	1.00	Almost Perfect
Victim – Addictive Disorders	100%	N/A	
Victim – Eating Disorders	100%	1.00	Almost Perfect
Recommendations made for MHS	100%	1.00	Almost Perfect
Assessments	93.3%	.831	Strong
Policies/Procedures	96.7%	.911	Almost Perfect
Staff Training	100%	1.00	Almost Perfect
Sharing of Information	96.7%	.911	Almost Perfect
Improving systems/Recording of information	100%	1.00	Almost Perfect
Increasing Awareness	96.%	.609	Moderate
Increasing Communications	96.7%	.870	Strong
Professional Curiosity	93.3%	.714	Moderate
Improve Referral Pathways	93.3%	.712	Moderate
Signposting/Onward Referral	100%	1.00	Almost Perfect
Referral to MHS	100%	1.00	Almost Perfect