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Investigación | Research

Barriers to care in people with mental disorders suffering from domestic violence

a scoping review

Barreras a la atención en personas con trastornos mentales que sufren violencia doméstica:una revisión del alcance.

Barreiras ao cuidado de pessoas com transtornos mentais vítimas de violência doméstica: uma revisão de escopo

Daniela **Rojas Loaiza**
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Resumen

Se ha descrito que los indicadores de violencia doméstica son mayores en personas con trastornos mentales y esto podría aumentar todavía más las barreras de acceso a la salud. El objetivo del presente estudio fue identificar estas barreras en personas con trastornos mentales que sufren violencia doméstica. La búsqueda se llevó en 2023, y usó como código las siguientes palabras clave ((Mental Disorders OR Persons with Mental Disabilities) AND (Sex Offenses OR Gender-Based Violence OR Domestic Violence)) AND (Barriers to Access of Health Services). De los 71 artículos incluidos de bases de datos y tres de literatura gris, 43 referenciaron barreras de Acceso a los Servicios de Salud en personas con trastornos mentales. Estas barreras son diversas y están influenciadas por factores individuales, sociales y del sistema de salud. El estigma, la falta de educación, la dependencia económica y emocional hacia el agresor, la pobreza y la actitud negativa del personal de salud son algunas de las principales barreras identificadas. Es evidente la necesidad de abordar estas barreras para garantizar que las personas con trastornos mentales que han sido víctimas de violencia reciban la atención médica adecuada.

Abstract

Purpose: The indicators of domestic violence are higher in people with mental disorders and could further increase the barriers to access to health. The aim of this study was to identify these barriers in people with mental disorders who experience domestic violence. Design/methodology/approach: The search was conducted in 2023 and used the following keywords as codes ((Mental Disorders OR Persons with Mental Disabilities) AND (Sex Offenses OR Gender-Based Violence OR Domestic Violence)) AND (Barriers to Access to Health Services). Findings: Of the 71 articles included from databases and three from gray literature, 43 referenced barriers to Access to Health Services in people with mental disorders. These barriers are diverse and are influenced by individual, social and health system factors. Stigma, lack of education, economic and emotional dependence on the aggressor, poverty, and the negative attitude of health personnel are some of the main barriers identified. Originality: The barriers people with mental disorders face to reach health services are pointed out. These barriers, although different from those of people without mental disorders, could improve care in the general population if addressed. There is a clear need to address these barriers to ensure that people with mental disorders who have been victims of violence receive appropriate medical care.

Resumo

Foi descrito que os indicadores de violência doméstica são mais elevados nas pessoas com perturbações mentais e que ambas as entidades em conjunto poderiam aumentar ainda mais as barreiras ao acesso à saúde. O objetivo do presente estudo foi identificar essas barreiras em pessoas com transtornos mentais que sofrem violência doméstica. Com base na abordagem metodológica de Arksey e O'Malley e do Instituto Joanna Briggs, todos os estudos de investigação (Pubmed, Scopus, Scielo, Embase e Redalyc) e literatura cinzenta que examinam estas barreiras. A busca foi realizada em 2023, e utilizou como código as seguintes palavras-chave ((Mental Disorders OR Persons with Mental Disabilities) AND (Sex Offenses OR Gender-Based Violence OR Domestic Violence)) AND (Barriers to Access of Health Services). Dos 71 artigos incluídos nas bases de dados e três na literatura cinzenta, 43 faziam referência a barreiras de acesso aos serviços de saúde em pessoas com transtornos mentais. Estas barreiras são diversas e influenciadas por fatores individuais, sociais e do sistema de saúde. O estigma, a falta de educação, a dependência económica e emocional do agressor, a pobreza e a atitude negativa do pessoal de saúde são algumas das principais barreiras identificadas. Há uma clara necessidade de abordar estas barreiras para garantir que as pessoas com perturbações mentais que foram vítimas de violência recebam cuidados medicos adequados.

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Introduction

Mental, neurological, and substance use disorders accounted for 10% of the global burden of disease (DALYs) and 25% of years lived with disability in 2019 (World Health Organization – WHO-, 2021). Furthermore, since COVID-19, the key role of home dynamics for mental health in countries like Colombia was ratified (Agudelo-Hernández et al., 2025).

The gap between individuals in need of mental health care and those who have access to it remains considerable. For example, only 29% of individuals with psychosis and only one-third of individuals with depression receive formal mental health care (WHO, 2021).

These identified gaps between individuals with mental disorders and timely comprehensive care are affected by few trained mental health professionals, lack of specialized centers, lack of awareness about mental health rights, and the stigma associated with mental illnesses, which exacerbates other barriers (Rojas-Bernal et al., 2018). Negative experiences with mental health professionals perceived as discriminatory, as well as discrimination experienced by others due to having a mental illness, can discourage individuals from seeking treatment (Henderson et al., 2013). At the level of healthcare services, we encounter barriers such as lack of time for healthcare professionals, dehumanization in healthcare services, stigma and discrimination from healthcare personnel, as well as inadequate spaces for care (Brenisin et al., 2021; Panamerican Health Organization – PAHO-, 2023).

Domestic violence is a serious violation of human rights and has been defined as any act of violence that results in physical, sexual, or psychological harm or suffering, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether it occurs in public or private life (Silva et al., 2022). Domestic violence generates or exacerbates mental illnesses and affects the healthy development and well-being of children and families. It also hinders women from fully participating in various areas of their lives, such as family, community, and society (Campbell, 2002; DeCou et al., 2023).

Among the barriers to seeking help for victims of domestic violence in the general population, there is a lack of knowledge about available health services, a lack of appropriate language to describe the abusive situation, insufficient knowledge to identify abusive situations, lower educational levels, and some form of disability (Scriver et al., 2013). Other reviews have identified barriers such as fear, the inability to verbalize what has happened, knowledge about sexuality, lack of resources, and myths and misconceptions about sexuality and rights as additional barriers (Ghasemi et al., 2021).

Moreover, people with disabilities are at a higher risk of experiencing targeted violence, harassment, and abuse (Scriver et al., 2013; Sin et al., 2010). It is reported that individuals with disabilities are four times more likely to experience sexual abuse and nearly twice as likely to experience robbery, threats, or the use of violence. In women with schizophrenia or bipolar disorder, it has also been found that they are at a higher risk of experiencing rape compared to the general population (Sin et al., 2010).

Factors such as a lack of knowledge about respectful relationships, a limited support network of friends and family, and a low capacity of the environment to share experiences and receive information appear to contribute to this vulnerability (Olsen & Carter, 2016). Some studies mention that between 25% and 50% of adults with psychosocial disabilities have experienced sexual exploitation, with almost 1,400 new cases occurring in the United Kingdom each year. In Australia, sexual violence is reported to be 10.7 times higher among individuals with learning disabilities compared to the general population (Dawson et al., 2019; Ghafournia & Healey, 2022).

The services available for individuals with disabilities who have experienced abuse are few and widely scattered (Olsen & Carter, 2016). Similarly, healthcare personnel may be inadequately prepared to address the needs of individuals with violence and mental disorders. Some studies indicate that women noted a sense of lack of acceptance related to various factors, including socioeconomic status, gender, and disability. This led to a reluctance to seek help when experiencing recurring violent situations (Mantler et al., 2022; McGilloway et al., 2020).

In addition to stigma and factors associated with the healthcare system, an intersectional approach has been proposed to understanding these barriers (Ghasemi et al., 2021). Regarding trauma associated with conflict, barriers to recovery have been identified, such as geographic inaccessibility, lack of services, insufficient availability of psychotropic medications, and shortage of human resources (Østergaard et al., 2023). There are also barriers within the family and community, such as lack of knowledge, uncertainty, or unwillingness to assist family members in accessing treatment (Kisa et al., 2016). Some studies even pointed out factors such as political repression (Østergaard et al., 2023).

Although domestic violence is a significant public health issue (Campbell, 2002) and is more prevalent among individuals with disabilities (McGilloway et al., 2020), few studies have specified the particular barriers faced by individuals with mental disorders in accessing care pathways when they have been victims of violence in the family environment (Olsen & Carter, 2016). Based on the aforementioned, the objective of this review is to identify the barriers faced by individuals with mental disorders who are victims of domestic violence in accessing mental health services. It is expected that by identifying these barriers, the capacities of the healthcare system will be strengthened, public and healthcare personnel stigma will be reduced, and social, cultural, and political factors will be better considered to address the intersection between these two factors.

Methods

This scoping review is based on the methodological framework presented by Arksey and O'Malley (Tricco et al., 2018) and the methodology manual published by the Joanna Briggs Institute for scoping reviews (Peters et al., 2015). The objective of a scoping review is to "quickly map the key concepts that underpin an area of research and the main sources and types of evidence available, especially when an area is complex or has not been comprehensively reviewed before." (Mays et al.,2001, p. 194).

For this review, a barrier was defined as any factor that limits or restricts the transition in care from emergency services, hospitalization, and community-based support in long-term care. This scoping review was conducted following the checklist for reporting systematic reviews and meta-analyses extensions for scoping reviews (PRISMA-ScR) (Tricco et al., 2018).

Sample and inclusion/exclusion criteria

To conduct the scoping review, the following databases were utilized: Emerald, PubMed, Google Scholar, Scielo, and Redalyc. Additionally, searches in gray literature (using similar search terms targeted at providers, agencies, and support services) were conducted. The Boolean code was generated using MESH descriptors and widely accepted definitions in the literature, specifically for terms related to mental disorders, gender/sexual violence, and barriers to accessing health services. The research was conducted using the following keywords (MESH and DESC): ((Mental Disorders OR Persons with Mental Disabilities) AND (Sex Offenses OR Gender Violence OR Domestic Violence)) AND (Barriers to Accessing Health Services) in the aforementioned databases. Additionally, manual searches were conducted in the reference lists of relevant articles to identify any articles or documents that were not generated in the database search.

The search was conducted between April and May 2023, including studies from 2001 to 2023. This timeframe and the year of inception were considered based on the recent Declaration of Caracas at that time. The selected studies were required to meet the following inclusion criteria: experimental studies, quasi-experimental studies, observational studies, guidelines, narrative reviews, and policy or program documents that examined individuals with mental disorders who were victims of violence and barriers to accessing health services.

Articles that did not address at least two variables of the aforementioned criteria were excluded from the review. Studies that did not include individuals with mental disorders or barriers to accessing health services were also excluded from the review. In the Scielo and Redalyc databases, no studies were found that matched the proposed Boolean code.

Study protocol

The recommended steps outlined by the Joanna Briggs Institute (Tricco et al., 2018) were followed, in addition to those proposed by Arksey and O'Malley (Peters et al., 2015). The Population, Concept, and Context (PCC) strategy was used to formulate the research question, where P: People with mental disorders, C: People with mental disorders who are victims of abuse, and C: Barriers to accessing health services. The research question was "What are the barriers faced by individuals with mental disorders who are victims of abuse in accessing health services?".

After conducting the search, the bibliographic citations were identified in the EndNote X9/2018 software, and duplicate studies were removed. For the selection of studies, the titles and abstracts were initially reviewed by four researchers: an epidemiologist, a psychiatrist, a psychologist with a master's degree in community psychology, and a psychiatrist with a PhD in social sciences.

The selection was based on the inclusion criteria. The researchers conducted the verification of eligibility criteria using a random sample of 25 articles. The inter-rater agreement, determined using Cohen's Kappa coefficient, was 0.86 (95% CI: 0.66-1.00), which indicates a good level of agreement between the observers. The selection of studies was done through consensus among the panel of reviewers, in accordance with critical appraisal tools. Those studies that passed the quality assessment were included in the review.

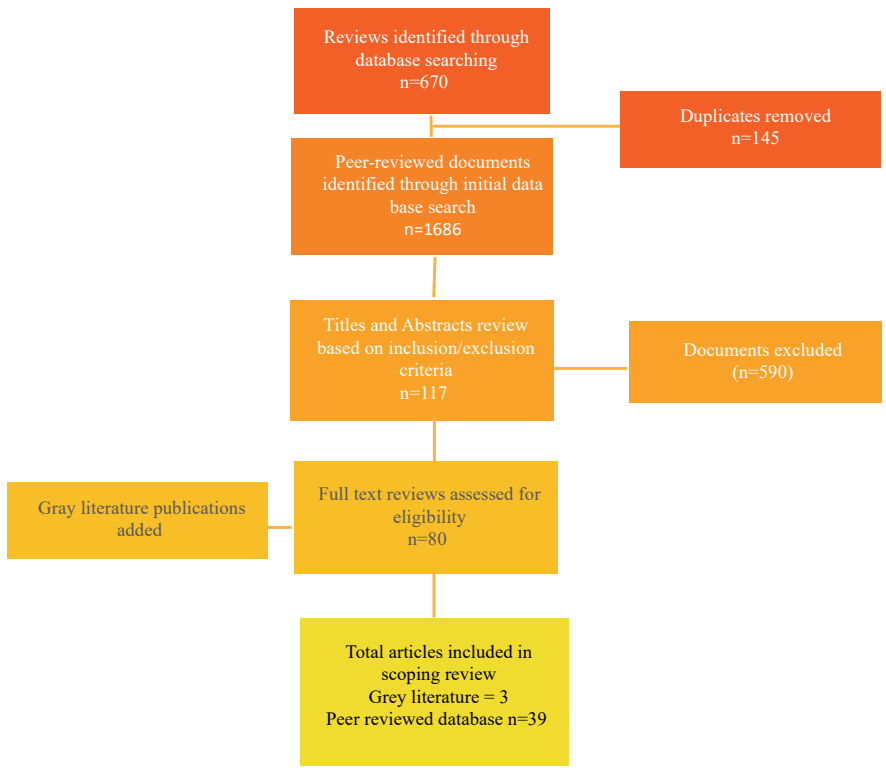
Studies were considered to have acceptable quality when all four evaluators reached a consensus on at least 70% of the elements in the evaluation instruments as positive. The four reviewers evaluated the titles and abstracts according to the inclusion and exclusion criteria. Subsequently, the reviewers independently examined each retrieved title and abstract to determine eligibility using the inclusion criteria. After this, the full text of the articles was reviewed to further determine their eligibility.

All eligible articles were entered into Microsoft Excel, and the following information was extracted: year of publication, background, study objectives, applied methodology, study sample, mental health diagnoses, age ranges covered in the article, results, barriers to seeking help for violence in individuals with mental health problems, notable aspects of the results, and conclusions. The data were organized and analyzed using a conventional content analysis approach (Hsieh & Shannon, 2005), with the research questions serving as a guide (Levac et al., 2010). Duplicate components or functions were eliminated. If some search results fell into multiple categories, agreement was sought with the researchers to determine the appropriate classification.

Results

Out of the 71 articles included from databases and three from gray literature, 39 referenced barriers to accessing health services in individuals with mental disorders (Figure 1). The majority of the studies that were thoroughly reviewed were excluded because they did not specify the barriers faced by individuals with mental disorders.

Figure 1
Flowchart of search results.



Note. Flowchart of search results. Prepared by the authors.

Below, the selected studies are presented according to mental health diagnoses, life course, study country, methodology used, type of barrier, kind of violence, and year. Based on the findings, categories were also created to relate the studies on barriers in health services, individual barriers, cultural barriers, and other types of barriers. These categories are presented in Table 2.

Table 1
Description of the findings

Diagnosis	Number of articles	Age	Country	Methodology	Type of barrier	Type of violence	Year
Learning disorders	5	>18 years old >8 years old >55 years old	United Kingdom, Ireland	Quantitative descriptive analysis as qualitative	Cultural, personal, health services, institutional barriers	Gender, sexual, psychological domestic and community violence	2008, 2010, 2013, 2018, 2016
Post-traumatic stress disorder	8	>18 years old	USA	Descriptive quantitative, descriptive qualitative, narrative review	Personal, cultural and health services barriers	Gender, sexual and domestic violence, armed conflict	1994, 2009, 2011, 2018, 2021, 2022, 2023
Anxiety and depression disorder	8	>18 years old	USA (3) United Kingdom	Qualitative and quantitative, descriptive, narrative review	Cultural, Personal and health servicies barriers	Community, gender, domestic and sexual violence, armed conflict	1994, 2009, 2011, 2018, 2021, 2022, 2023
Suicide attempt	2			Narrative review	Health services, cultural and personal violence	Armed conflict, gender and domestic violence	1994, 2023.

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Diagnosis	Number of articles	Age	Country	Methodology	Type of barrier	Type of violence	Year
Substance abuse	4		USA	Qualitative study, narrative review.	Health services, cultural and personal violence	Community, domestic violence	1994, 2009, 2018, 2021,
Panic disorder	1			Narrative review	Personal, cultural and health services barriers	Gender and domestic violence	1994
Bipolar affective disorder	1	>8 years old	United Kingdom	Narrative review	Cultural, Personal and health services barriers	Community, gender and sexual violence,	2010
Schizophrenia	2	>8 years old	United Kingdom	Narrative review	Cultural, personal and health services barriers	Community, gender violence	2010, 1994
Personality disorders	1			Narrative review	Personal and health services barriers	Gender and sexual violence	2011
Sleep disorders	1			Narrative review	Health services barriers	Gender and domestic violence	2022, 2018
Compulsive sexual behavior disorders	1			Narrative review	Health services barriers	Gender,	2022
Eating disorders	1			Narrative review	Personal and health services barriers	Community, domestic violence	2018

Note. Table prepared by the authors

Table 2.
Types of barriers to accessing mental health services in individuals with mental disorders and domestic violence.

Type of barrier	Research where referenced
Barriers to health services	
Lack of trust in the healthcare service	Anderson, S. (2011); Østergaard et al., (2023); Freedberg P. (2006); Silva et al. (2022); Anderson & Overby, (2020); Henderson et al., (2013)
Lack of privacy or confidentiality in the healthcare service	Robinson & Spilsbury. (2008); Silva et al. (2022); Overstreet & Quinn (2013)
Lack of access to appropriate services	Mantler et al., (2022); Monteiro S & Brigeiro M. (2019); Agudelo SF, et al. (2007); Rojas LA, Castaño GA & Restrepo DP (2018); Rozo N, et al. (2022); Nichols EM, et al. (2018); Kisa et al., (2016); Hickson et al. (2013)
Lack of medication, human resources, or infrastructure	Østergaard et al., (2023); Monteiro S & Brigeiro M. (2019); McGilloway et al., (2020); Alhusen, et al. (2020); Kisa, et al. (2016)
Misbeliefs and victim-blaming by healthcare personnel	Loring & Smith (1994); McGilloway et al., (2020); Overstreet & Quinn, (2013)
Discrimination, denial, or prejudices from healthcare personnel.	Loring & Smith (1994); McGilloway et al., (2020); Herz (1999); Henderson et al., (2013)
Lack of identification of intellectual disabilities	McGilloway et al., (2020); Herz (1999)
Lack of identification of abuse or violence	Anderson, S. (2011); Olsen & Carter (2016); Loring & Smith (1994); Robinson & Spilsbury, (2008); Silva et al. (2022); Herz (1999); Alhusen et al. (2020)
Limited time for patient care	Anderson, (2011); Robinson & Spilsburk, (2008); Silva, et al. (2022); Rodríguez, et al. (2009)
Limited appointment availability	Anderson, (2011); Monteiro & Brigeiro, (2019); Rozo, et al. (2022); Nichols et al. (2018)
Presence of the abusive partner during the consultation	Rodríguez, et al. (2009)
Lack of training and knowledge among healthcare personnel	Rodríguez, et al. (2009); Loring & Smith (1994); Freedberg (2006); Herz, (1999); White Hughto et al. (2018); Mantler et al., (2022); Robinson & Spilsbury, (2008); Silva et al., (2022); Alhusen et al., (2020)
Lack of support from healthcare personnel	Brenisin et al. (2021); Loring & Smith (1994); Alhusen et al. (2020)
Previous institutionalization in mental health units.	O'Hara, (2008)
Lack of comprehensive management in healthcare services	Anderson, (2011); McGilloway et al., (2020); Agudelo et al., (2007); Alhusen et al., (2020)
Lack of female-only staff in healthcare services	Anderson, (2011)
Poor attitude from healthcare personnel	Anderson, (2011); Alvarez & Fedock, (2018); Loring & Smith, (1994); Robinson & Spilsbury, (2008); Silva et al., (2022); Herz, (1999); Overstreet & Quinn, (2013); Kisa et al. (2016)
Lack of humanization in healthcare services	Anderson, (2011); Loring & Smith (1994); Monteiro & Brigeiro, (2019); Freedberg, (2006); Robinson & Spilsbury, (2008)
Inappropriate gender identification by the healthcare service	White Hughto et al., (2018); Freedberg, (2006)
Previous negative experiences with the healthcare system	Nichols et al., (2018); Overstreet & Quinn, (2013)

Type of barrier	Research where referenced
Homophobic attitudes from healthcare personnel	Zibin et al., (2022); Freedberg, (2006)
Not being enrolled in a health insurance plan	Rozo N, et al. (2022)
Poor coordination in care, follow-up, and discharge planning	Anderson, (2011); Loring & Smith (1994); Sin et al. (2010); Kisa et al. (2016)
Intellectual disability	Anderson, S. (2011); Østergaard et al., (2023); Freedberg P. (2006); Silva et al. (2022); Anderson & Overby, (2020); ; Henderson et al., (2013)
Personal barriers	
Financial barriers or poverty	O'Hara, (2008); Mantler et al., (2020); Loring & Smith (1994); Freedberg, (2006); Anderson & Overby (2020); Lucea et al. (2013); Kisa et al. (2016)
Psychological trauma (state of shock)	Gilmore et al. (2021); Loring & Smith (1994); Anderson & Overby (2020)
Alcoholism	Gilmore, et al. (2021)
Symptoms of post-traumatic stress disorder	Gilmore, et al. (2021)
Ethnic minorities / Immigrants	O'Hara, (2008); Rodríguez et al. (2009); Alvarez & Fedock (2018); Robinson & Spilsbury (2008)
Delay in disclosing violence	Anderson & Overby (2020); Nichols et al., (2018); Kisa et al., (2016)
Economic and emotional dependence on the abuser (learned helplessness)	O'Hara, (2008); Sin et al. (2010); Loring & Smith (1994) Silva et al., (2022); Petersen et al., (2004); Herz, (1999); Alhusen et al., (2020); Lucea et al., (2013)
Lack of education in general; mental health, rights, and sexuality	O'Hara, (2008); Scriver et al., (2013); Rodríguez et al. (2009); Østergaard et al. (2023); Sin et al. (2010); McGilloway et al., (2020); Henderson et al., (2013).
High prevalence of mental illnesses.	O'Hara, (2008)
Lack of support	Scriver et al., (2013); Østergaard et al., (2023); Kisa et al., (2016)
Non-recognition of abuse	Scriver et al., (2013)); Sin et al., (2010); Loring & Smith (1994); Silva et al. (2022); Anderson & Overby, (2020); Petersen et al.,(2004); Kim E & Hogge I (2015).
Gender	O'Hara, (2008); Zibin et al. (2022); Freedberg P. (2006); Hickson et al. (2013)
Language or communication barriers	Scriver et al., (2013)); Olsen & Carter (2016); Rodríguez et al., (2009); Alvarez & Fedock, (2018); Robinson & Spilsbury, (2008); McGilloway et al., (2020)
Lack of knowledge about care pathways	Scriver et al., (2013)); Olsen & Carter (2016); Alvarez & Fedock, (2018); Silva et al. (2022); ; Henderson et al., (2013)
Geographical barriers (rurality) / transportation limitations	Mantler et al., (2022); Mantler et al., (2022); Østergaard et al., (2023); Anderson & Overby, (2020); Rozo N, et al. (2022); Logan TK, Evans L, ; Kisa et al., (2016)
Fear	Mantler et al., (2022); Loring & Smith (1994); Robinson & Spilsbury, (2008); Anderson & Overby, (2020); McGilloway et al., (2020); Petersen et al.,(2004); Alhusen et al., (2020); Logan TK, Evans L, ; ; Overstreet & Quinn (2013)
Feelings of shame	Alvarez & Fedock, (2018); Loring & Smith (1994); Robinson & Spilsbury, (2008); Anderson & Overby, (2020); Petersen et al.,(2004); Alhusen et al., (2020); ; Overstreet & Quinn (2013); Hickson et al. (2013)
Self-stigma	Rodríguez et al., (2009); Østergaard et al., (2023); Loring & Smith (1994); Silva et al. (2022); Petersen et al.,(2004); Nichols EM, et al. (2018); Overstreet & Quinn (2013)
Social isolation	Alvarez & Fedock, (2018); Silva et al. (2022); Anderson & Overby, (2020)
Intellectual disability	O'Hara, (2008); Scriver et al., (2013); McGilloway et al., (2020); Herz (1999)
Cultural barriers	
Unequal power relationships.	O'Hara, (2008); Sin et al., (2010)
Masculine norms	Zibin et al. (2022)
Normalization of abuse	Overstreet & Quinn (2013)
Non-recognition of disability	Kisa et al., (2016)
Insensitive environment for victims of violence	Mantler et al., (2022)
Lack of policies that increase attention to ethnicities or immigrants	Rodríguez et al., (2009)
Cultural values	Alvarez & Fedock, (2018)
Political represión	Østergaard et al., (2023)
Lack of shelters for abused individuals with disabilities	Herz, (1999); Foster (2010).
Social stigma	White Hughto et al. (2018); Zibin et al. (2022); Olsen & Carter (2016); Silva et al. (2022); Kisa et al., (2016)
Other types of barriers	
Deprivation of liberty (criminal justice system).	O'Hara, (2008)

Note. Table prepared by the authors

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Discussion

This scoping review aimed to identify the barriers faced by individuals with mental disorders who are victims of domestic violence in accessing health services. It was found that these barriers are multifaceted and depend on cultural context, the healthcare system, families, and the limitations experienced by the victims themselves. The majority of barriers described in previous studies regarding individuals with mental disorders who are victims of violence significantly increase when both circumstances are present.

As evidenced in the present study, the population with mental health diagnoses most frequently mentioned in the literature are those with depressive disorders, anxiety disorders, post-traumatic stress disorder, and intellectual disabilities. Among the most frequently mentioned barriers in the various studies, the following were identified: stigma associated with mental disorders, lack of education on sexual and health rights, economic and/or emotional dependence on the aggressor, poverty, negative attitude of healthcare personnel, lack of access to appropriate health services, and distrust towards these services.

The identified barriers have been grouped into different categories based on the areas in which they generate limitations in access. Regarding the barriers related to health services, the following were mentioned: lack of trust in healthcare personnel, lack of training and knowledge in violence-related issues, inadequate identification of violence in victims, difficulty in accessing medical appointments, lack of time among healthcare professionals, stigma, discrimination, and misconceptions about patients who have experienced violence.

Regarding the barriers related to the individual, notable factors include fear, shame, poverty leading to economic dependence on the abuser, lack of education, gender, living in rural areas with limited transportation access, and non-recognition of abuse as significant barriers. In the sociocultural domain, barriers identified include social stigma, lack of cultural sensitivity towards victims of violence, and insufficient policies in shelters for victims of violence.

One of the populations with a higher number of studies is individuals with intellectual disabilities, who face additional barriers such as lack of language to communicate what has happened, lack of recognition of the abuse, lack of education about their rights and where to seek help, as well as physical and economic dependence on the abuser (Alhusen et al., 2020; Herz, 1999; Keilty & Connelly, 2001; Wacker et al., 2009). Furthermore, healthcare professionals have a knowledge gap in identifying signs of violence in individuals with intellectual disabilities, which hinders their categorization and appropriate approach in healthcare services.

Regarding the types of violence that were most identified, it was found that gender violence was present in the majority of the articles found, followed by domestic violence and sexual violence.

Domestic violence accounts for a quarter of all violent crimes, and women who experience domestic violence are twice as likely as other women who use health services to have mental illness diagnoses such as depression and post-traumatic stress disorder (PTSD). O'Hara J., 2008).

With respect to gender violence, among the barriers to access health services most frequently found in people who are victims of said violence, cultural barriers were found such as social stigma and health services; In a study that focused on people with mental disorders who were victims of gender violence towards men, it was found that the homophobic thinking of health personnel interferes with the correct care of patients who are victims of this type of violence (Zibin et al., 2022).

Another of the types of violence mentioned is armed conflict, which was only found in one of the selected articles, where cultural, personal and health service access barriers were identified; This is a type of large-scale violence that is prevalent in our country, and it would be worth delving into the barriers to access to health services in people with mental disorders in future studies.

In Colombia, there are routes aimed at comprehensive violence care, such as in cases of sexual violence, where there is active participation from the health, justice and protection sectors, sectors that play an important role in prevention, identification, care, protection and reparation for crimes of sexual violence; The health route is mandatory for both the public and private sectors (Alcaldía de Medellín., 2018). In this area, the aim is to carry out an adequate identification of cases of asexual violence, carrying out a physical and mental approach that maintains the integrity of the victim;

Incorporating the perspective of the types of barriers that people with mental health disorders present in health care can be essential for the planning and implementation of health care programs. types of violence and types of barriers must be equally recognized and addressed in policy development, research, implementation and organization of services.

It is worth noting that among the analysis of the 46 different types of articles, only four directly mentioned in their objectives the identification of barriers to accessing health services in victims of violence with mental disorders (Gilmore et al., 2021; Herz, 1999; Nichols et al., 2018; Østergaard et al., 2023). The other studies mainly focused on identifying barriers in individuals who are victims of violence in general, although some cases of individuals with undiagnosed symptoms of mental disorders were found. This highlights the need to specifically focus on the population with mental disorders who are also victims of violence (DeCou et al., 2023; Herz, 1999).

Other studies have found a higher prevalence of depression, anxiety, and post-traumatic stress disorder in cases of violence (Østergaard et al., 2023), highlighting the lack of education among healthcare professionals as a barrier to the identification, treatment, and follow-up of patients with mental illnesses who have experienced violence. (Herz, 1999; Nichols et al., 2018).

One of the limitations found was that the ages included in the studies were mostly above 18 years old, with very few studies including extreme ages of life such as childhood or adolescence. Only studies with participants over 55 years old were found, and very few studies

included individuals over 8 and 16 years old. This highlights the need for studies that encompass all stages of life.

The main types of studies included in this scoping review were narrative reviews and quantitative and qualitative descriptive studies. No systematic review studies were included because they did not meet the proposed inclusion criteria, nor were public policy reports or country reports on violence, due to the design and methods that were not included in this scoping review, which highlights the need for studies with greater scientific rigor that address the proposed research question, and future studies that can delve deeper into the country reports, specifying the approach to mental health.

The inclusion of articles in Spanish and English represents a limitation in this review, and it is recommended for future work to consider other languages that can expand the knowledge base. There were also geographical limitations in the studies, as the majority were conducted in the United Kingdom and the United States, which implies a lack of diversity in the sample.

The aforementioned limitations highlight the need to exercise caution in interpreting the significance of the findings. However, despite the methodological limitations of this review, it is important not to disregard the emerging findings regarding the various barriers faced by individuals with mental disorders who are victims of violence when seeking help in healthcare services.

The approach to domestic violence should consider other factors, even beyond mental illness. Among these factors are economic status, geographical dispersion, community violence, political violence, and more. This should be integrated into the analysis of health situations to improve their approach and management (Ghasemi et al., 2021).

As ethical considerations, although the studies were not specifically categorized for the analysis of the results, it was taken into account that all included studies had approval from a bioethics committee. In addition, it was verified that these studies had a care mechanism in case any type of specific violence was detected. This ensures that ethical standards were respected and the necessary protection was provided to participants.

In conclusion, this scoping review highlights the barriers faced by individuals with mental disorders who are victims of violence in accessing healthcare services. These barriers are diverse and influenced by individual, social, and healthcare system factors. Stigma, lack of education, economic and emotional dependence on the perpetrator, poverty, and negative attitudes of healthcare providers are some of the main barriers identified.

It is evident that addressing these barriers is necessary to ensure that individuals with mental disorders who have experienced violence receive appropriate medical care. Greater awareness and training of healthcare personnel are required to recognize and address violence in this population. Additionally, policies and programs that promote a supportive environment and equitable access to healthcare services need to be implemented.

It is crucial that future studies focus specifically on the population of individuals with mental disorders who are victims of violence, in order to gain a better understanding of the barriers they face and develop effective interventions. The comprehensive care of these individuals requires an interdisciplinary approach that involves collaboration among mental health professionals, social service providers, and support organizations.

Ultimately, improving access to healthcare services for individuals with mental disorders who are victims of violence is essential to ensure their physical and psychological well-being, promote their recovery, and break the cycle of violence. This review highlights the need to continue researching and advocating for concrete policies and actions to address these barriers and achieve inclusive and equitable healthcare for this vulnerable population.

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