



Reframing the links: Black and
minoritised women, domestic
violence and abuse, and mental
health - **A review of the literature**

By Ravi K. Thiara and Christine Harrison,
University of Warwick



women's aid
until women & children are safe

Written by Professor Ravi K. Thiara and Professor Christine Harrison, University of Warwick

Published by Women's Aid, December 2021.

Women's Aid commissioned this report, which is independently researched and written by Ravi Thiara and Christine Harrison. We would like to thank them for this important contribution to the **Deserve To Be Heard** campaign.

Please cite this report as:

Thiara, R.K. and Harrison, C. (2021) *Reframing the Links: Black and minoritised women, domestic violence and abuse, and mental health - A Review of the Literature*. Bristol: Women's Aid.

This report should be read alongside **Mental health and domestic abuse: A review of the literature**, written and published by Women's Aid (2021).

Women's Aid

Women's Aid is the national charity working to end domestic abuse against women and children. Over the past 47 years, Women's Aid has been at the forefront of shaping and coordinating responses to domestic abuse through practice, research and policy. We empower survivors by keeping their voices at the heart of our work, working with and for women and children by listening to them and responding to their needs.

We are a federation of over 170 organisations which provide just under 300 local lifesaving services to women and children across the country. We provide expert training, qualifications and consultancy to a range of agencies and professionals working with survivors or commissioning domestic abuse services, and award a National Quality Mark for services which meet our quality standards. We hold the largest national data set on domestic abuse, and use research and evidence to inform all of our work. Our campaigns achieve change in policy, practice and awareness, encouraging healthy relationships and helping to build a future where domestic abuse is no longer tolerated.

Our support services, which include our Live Chat Helpline, the Survivors' Forum, the No Woman Turned Away Project, the Survivor's Handbook, Love Respect (our dedicated website for young people in their first relationships), the national Domestic Abuse Directory and our advocacy projects, help thousands of women and children every year.

www.womensaid.org.uk

www.loverespect.co.uk

Women's Aid's new campaign **Deserve To Be Heard** aims to ensure that the mental health needs of women, who are all too often not listened to and not believed, are heard and responded to effectively. For more information go to:

<https://www.womensaid.org.uk/deservetobeheard/>

Contents

Introduction	6
Methodology	8
Terminology	9
Section 1: Evidence of the linkage between DVA and mental health/wellbeing for Black and minoritised women	12
‘Race’/ethnicity, racism and mental health	12
Differing conceptualisations of mental ill-health	14
Violence against Black and minoritised women and intersectional context	16
Black and minoritised women, DVA and mental health/wellbeing	18
Black and minoritised women and mental health and wellbeing	20
Suicide and self-harm	22
COVID-19, DVA and the impact on mental health	24
Section 2: Barriers facing Black and minoritised survivors attempting to access support for mental health/wellbeing in the context of DVA	25
Structural and cultural barriers	25
Responses from mental health services	28
Barriers created by COVID-19	30
Section 3: Support valued by survivors in the recovery of their mental wellbeing from ‘by and for’ Black and minoritised organisations and specialist women’s services	32
Value of dedicated ‘by and for’ VAWG organisations for Black and minoritised women	32
An understanding of the social realities of the lives of Black and minoritised women	33
An intersectional understanding without essentialising the experiences of Black and minoritised women	34
Holistic, wraparound services, including intersectional advocacy	35
Access to help and support is a process based on reciprocity and trust	37
A range of alternatives to the use of medication	37
Information about services and what these involve	38
Language support	39

Understanding role of religion/faith in coping.....	39
Respecting women’s strengths and coping strategies.....	40
Group work and being part of a peer support group.....	40
Multi-agency collaboration and involving victim-survivors.....	41
Counselling that allows for choice.....	41
Specialist ‘by and for’ services for Black and minoritised survivors.....	42
Summary.....	44
Key considerations - in addressing the mental health and wellbeing of Black and minoritised survivors in contexts of abuse.....	47
References.....	51

Introduction

Violence against women and girls (VAWG)¹ remains a pervasive societal issue and constitutes a serious source of harm. It is a major human rights violation and a public health concern, with serious long-term consequences for the physical, emotional and mental wellbeing of survivors, who are predominantly women and girls (World Health Organisation, 2021). The COVID-19 pandemic has created a further 'conductive context' with increased levels of reported domestic abuse leading to greater concern about the consequences for survivors' mental wellbeing at a time when isolation is marked, abuse is expanded and access to support significantly constrained (AVA, 2021; Banga and Roy, 2020; Roesch *et al.*, 2020). So grave is this situation, that it has been referred to as a "pandemic within a pandemic" and a "dual pandemic" (Banga and Roy, 2021), which has impacted differentially on diverse groups of survivors.

The direct relationship between domestic violence and abuse (DVA), sexual violence and mental ill-health² has been widely documented in research (Aitken and Munro, 2018; Howard *et al.*, 2010a, 2010b; Humphreys and Thiara, 2003; Oram *et al.*, 2017; Rees *et al.*, 2011; Scott and McManus, 2016), though there is limited evidence for Black and minoritised women. Although an under-reported crime, available data suggests that women are more likely to be subjected to domestic and sexual violence (ONS, 2020³). Numerous studies have shown how DVA is rarely confined to a single incident or form of abuse, but rather involves multiple forms of abuse permeating all aspects of women's day to day lives, intended to maintain the perpetrator's coercive control over women and children (Department of Health, 2005; Myhill, 2015). Not only are women's mental health outcomes impacted by all forms of DVA (physical, sexual, emotional, psychological, economic and technological), but the pervasiveness and severity of abuse are known to escalate over time, exacerbating the impact on women and compromising their mental health (Ferrari *et al.*, 2014). Women are also less likely to report mental ill-health that results from this violence and abuse (Chandan *et al.*, 2019). Significantly, abuse often continues or intensifies in the post-separation period (Brownridge, 2006;

¹ While we know men also experience violence and abuse and mental ill-health, this literature review focuses on women who are disproportionately impacted by VAWG. Notably, the most common forms of VAWG encompassed in the research in this field are domestic and sexual violence.

² Mental ill-health refers to a spectrum of mild to severe, undiagnosed and diagnosed, emotional distress.

³ The Crime Survey for England and Wales (2020) showed that an estimated 2.3 million adults aged 16 to 74 years experienced domestic abuse in the last year, of which 1.6 million were women and 757,000 men.

Thiara, 2013). A range of factors limits women's access to safety and support for themselves and their children, and women often endure many years of serious abuse before separation occurs (Meyer, 2015). Critically, Black and minoritised women endure more than this in the length and breadth of abuse and they also face additional barriers to accessing services and securing safety and recovery for themselves and their children (Kanyeredzi, 2013; Rehman *et al.*, 2013; Siddiqui and Patel, 2010; Siddiqui, 2018; Thiara and Roy, 2020).

Literature has consistently shown that those affected by domestic and sexual violence are at increased risk of depression, anxiety, post-traumatic stress disorder (PTSD), self-harm, suicidal ideation and attempts (see Chandan *et al.*, 2019; Devries *et al.*, 2011; Rees *et al.*, 2011). These are particularly acute when violence is severe, of long duration, or where women cannot access support, factors that are all associated with Black and minoritised women's experiences of both abuse and help-seeking. The co-occurrence of DVA and mental ill-health in diverse health care settings has been well established: research on prevalence of DVA in psychiatric settings shows that up to 30% of female inpatients and almost 33% of female outpatients experienced lifetime DVA (Howard *et al.*, 2010b; Oram *et al.*, 2017); women accessing mental health support were three times more likely than women in the general population to have experienced DVA in the past year, and over two-thirds since the age of 16 (Khalifeh *et al.*, 2015). Female inpatients face a higher risk of sexual violence from patients, visitors and staff in NHS Mental Health Trust wards, highlighting ways that the mental health system itself can inflict institutional forms of harm (Care Quality Commission, 2018). As widely noted in the literature, the interconnection between DVA and mental ill-health is complex (Fox, 2018; Holly, 2017; Oram *et al.*, 2017). Women may experience mental health challenges prior to, during, and after DVA, and these may also be impacted by other negative life experiences and intersecting structural inequalities. These have a particular consequence for Black and minoritised women (Chantler *et al.*, 2003; Kanyeredzi, 2018; Rehman *et al.*, 2013; Thiara and Roy, 2020).

Whilst the research on DVA has both widened and deepened in theoretical and empirical terms, and recent research on the linkage between mental ill-health and domestic and sexual violence has provided valuable insight, much of this wider literature has little to say about the intersection of DVA and mental ill-health for Black and minoritised women (AVA, 2021; Femi-Ajoa, 2018; Siddiqui and Patel, 2010; Stockman *et al.*, 2015).

Methodology

Recognising the inadequate and/or fragmented nature of knowledge about Black and minoritised women, DVA and mental health/wellbeing, this literature review is focused on three significant areas:

- Evidence of the linkage between DVA and mental health/wellbeing for Black and minoritised women.
- Barriers facing Black and minoritised survivors attempting to access support for mental health/wellbeing in the context of DVA.
- Support valued by survivors in the recovery of their mental wellbeing from 'by and for'⁴ Black and minoritised organisations and specialist women's services.

The narrative literature review examined several sources of knowledge, which included published peer-reviewed research articles, unpublished research and other grey literature⁵. Given the limited amount of funded research in this area and the development of practice in responding to mental ill-health encountered by specialist services supporting Black and minoritised survivors, research and evaluation reports and good practice toolkits published by Black and minoritised organisations constitute an important source of insight and were included in the review. Not only does this bring visibility to the experiences and needs of Black and minoritised women from their own perspectives and those who work closely with them, but it also provides important direction and recommendations for service and practice development. Given the limited and dated nature of much of the existing research, the review included research from the 1980s across three broad fields of knowledge: 'race'/ethnicity and mental health, Black and minoritised women and VAWG, and Black and minoritised women and mental health and wellbeing.

Data from studies were analysed thematically as they related to each of the three focused areas covered by the review. It was not the intention of the review to generate new data, but to map the state of knowledge on the links between DVA and mental

⁴ 'By and for' provision is defined by Imkaan and End Violence Against Women coalition (2020) as specialist dedicated services that are delivered in consultation with or which directly involve Black and minoritised survivors. They are trusted by women because they recognise and understand the multiple forms of disadvantage and discrimination experienced by Black and minoritised women.

⁵ Literature that is not formally published in books or journals, for example third sector organisations' reports.

health and wellbeing for Black and minoritised women, the barriers they encounter, and what they find helpful in supporting their recovery.

This literature review was conducted to inform the campaign by Women's Aid Federation of England launched in September 2021 – **#DeserveToBeHeard**.

Terminology

We use the term 'Black and minoritised' to refer to women who have been subject to racist processes of marginalisation and exclusion; however, we also recognise that it is a broad term that encompasses women from a wide range of backgrounds and can overlook differences within these groups (AVA, 2021). Black and minoritised survivors may be migrants, refugees, asylum seekers, and women who have been trafficked and forced into sex work or domestic servitude. This collective term is used as indicative of common experiences of racism being as important as cultural or other differences. The research reviewed uses a range of terms, including ethnic minorities, BME, BAME, South Asian, West Indian, Afro-Caribbean and Pakistani, for instance; 'race' and ethnicity are also used within bodies of literature focused on Black and minoritised groups. Where citing specific pieces of work, therefore, the terms adopted within that research are used.

When referring to issues of mental health and wellbeing, again different terms are used in the literature reviewed. Most commonly used terms are mental health, psychiatric illness, mental ill-health, psychological distress, and mental distress, whilst some research has explored a specific issue such as depression, suicide or self-harm. In underlining mental ill-health as a normal response to violations, there is a growing body of work which critiques the role of pathologising⁶ labels for distress created by DVA and other forms of abuse. Our preferred terms are mental health/wellbeing and mental ill-health, used to capture the complex range of adverse effects generated by overlapping facets of DVA and other intersecting forms of oppression within a health inequalities framework (see, for example Bignall *et al.*, 2019).

⁶ To pathologise (and also to medicalise) assumes individual responsibility for health and refers to the attribution of physical and mental health issues to individual behaviours and traits, i.e. to pathologies effectively labels and blames the victim. This fails to take account of the political and social context of health (including racism, gender violence, poverty, disability, homophobia, transphobia) and the critical significance of health inequalities to the health and well-being of individuals and groups.

Similarly, terms such as interpersonal conflict, marital discord, and unhappy marriage are used in some of the surveyed literature when referring to DVA. It is now known that using such terms can hide DVA and fails to recognise its gendered nature. Again, for clarity and to focus discussion, the terms used by particular researchers will be used when findings are reported, while our preferred term is DVA and other forms of abuse.

Since the focus of the review is on women, who are disproportionately impacted by VAWG, when referring to those subjected to DVA and other forms of abuse, the terms women and survivors are used interchangeably.

Reviewing literature across several decades not only raises issues of terminology, but also that of conceptualisation. The review of the literature shows that there have been many shifts over time to accommodate developments in the way we think about the relationship between the individual, the cultural and the structural, and to offer more nuanced explanations about the intersecting nature and impact of oppression. It is evident that some earlier studies prioritised reductionist and static notions of culture, attributing responsibility and blame to internal cultural factors, as reflected in the notion of 'culture conflict', whilst overlooking issues of racism and other forms of discrimination. Intersectionality⁷ as an analytical concept and the nuanced insight it provides was little known at the time. Some literature contains pathologising content, using an individual deficit model⁸ to explain mental ill-health. Some studies also reflect an inadequate understanding of DVA, often subsuming it under a degendered notion of marital discord (viewing domestic abuse as arguments between couples, rather than power and control wielded by a man over a woman), and thus obscuring the extent and depth of its impact on mental health/wellbeing. However, noting this is not to dismiss the insight provided by such literature, which is of great value in developing an understanding of the specific issues encountered by Black and minoritised women in the UK.

While there are links and commonalities with white women's experiences and concerns, a recognition that Black and minoritised women are positioned in systemically unequal ways in terms of their access to and responses from services, as well as health

⁷ The concept of intersectionality was developed by Crenshaw in the US (Crenshaw, 1991), however, the idea of multiplicity existed within Black feminism in the US and UK. It refers to a way of analysing the interconnected nature of oppression and discrimination based on gender, 'race', class, age, disability, sexuality and other modes of oppression to understand the simultaneous oppression an individual or groups may experience. This intersection creates experiences which are specific, complex and contradictory.

⁸ An individual deficit model attributes mental ill-health to deficiencies within an individual person and puts the onus on the individual herself to overcome mental ill-health.

outcomes, is a key starting point for this review. Indeed, the specific experiences of Black and minoritised women are highlighted in the literature to enhance understanding of the specific issues they encounter, as well as to inform service development which takes account of their intersectional location. Further, to challenge the tenuous notion of an internal homogeneity, it is recognised that whilst Black and minoritised women face common experiences of marginalisation and racism they are also a heterogenous group with differentiated experiences.

The literature review is organised according to the three areas, which, in short, include: evidence of the linkage; barriers faced; and support valued by survivors. It concludes with a summary section that pulls together the key issues highlighted by the review.

Section 1: Evidence of the linkage between DVA and mental health/wellbeing for Black and minoritised women

Insight on Black and minoritised women, DVA, and mental health has to be derived from three broad fields of knowledge: 'race'/ethnicity and mental health, Black and minoritised women and VAWG, and Black and minoritised women and mental health and wellbeing. This section presents evidence of the linkage identified in the reviewed literature.

'Race'/ethnicity, racism and mental health

Exploring the complex relationship between 'race'/ethnicity, mental health and racism in the UK has a long history both in research and practice and highlights well documented concerns. Research from the early 1990s exposed health inequalities⁹ in access, treatment and outcomes for Black and minoritised groups within mental health services (Ahmad, 1992; Bhui *et al.*, 2003; Fernando, 1991). It draws attention to the significance of a range of interpersonal and structural social conditions and institutional factors, including racism, that contribute to the experience of mental ill-health, are relevant to the diagnosis and treatment of mental ill-health, and affect access to services and interventions (Synergi Collaborative Centre, 2018; Henderson *et al.*, 2018; Royal College of Psychiatrists, 2018). When the relationship between social inequalities and mental health is examined, the evidence about the interface between racism and mental health conditions (particularly depression) is compelling (Synergi Collaborative Centre, 2018; Khan, 2017; Moller *et al.*, 2016; Wallace *et al.*, 2016), and the role of racism in eroding mental health and wellbeing and reproducing intergenerational trauma is repeatedly underlined (AVA, 2021; Bignall *et al.*, 2019).

The ways in which racism perpetuates health inequalities is evident in how Black and minoritised groups access, or are deterred from accessing, forms of help and support, especially through statutory/mainstream mental health services (Synergi Collaborative Centre, 2018). It is known that access to mental health support is lowest amongst groups suffering the greatest disadvantage (NHS Digital, 2016; Royal College of Psychiatrists, 2018). Enduring inequality based on 'race'/ethnicity in access to mental health service provision has been repeatedly documented, despite government efforts to address this, and the absence of change attributed to systemic inequality,

⁹ A health inequalities approach rejects a deficit or individual pathology model, emphasising that such a model focuses on what an individual is lacking and holds them responsible for their health rather than examining how social inequalities shape the health outcomes of marginalised groups.

institutional discrimination and the culture of statutory services (see Bignall *et al.*, 2019; Kalathil *et al.*, 2011; Kapadia *et al.*, 2017; Moller *et al.*, 2016; Prajapati and Liebling, 2021). At primary care level, research has shown that GPs are less likely to recognise mental health issues among South Asian groups, for instance, and are less likely to make a referral to specialist mental health services than for other ethnic groups (Bhui *et al.*, 2003). Moreover, South Asian groups are more likely to receive psychiatric medication than a referral for talking therapies (Hussain and Cochrane, 2002).

In relation to African and African-Caribbean groups, a number of acute concerns have been identified about their treatment in mainstream services, including inappropriate and sometimes coercive care (NHS Digital, 2017). This relates not only to treatment by mental health services, for example through higher rates of diagnosis of schizophrenia and higher compulsory hospital admissions (Barnett *et al.*, 2019), but also in criminal justice systems (Kent, Surrey and Sussex Community Rehabilitation Company, 2020; Gangoli *et al.*, 2019; Walker, 2020; Khan *et al.*, 2017). Here, research evidence has established inappropriate criminalisation of what are mental health issues, and a lack of recognition when those on remand or convicted have a mental health challenge or may be suicidal (Sturge, 2018; Kalathil *et al.*, 2011). Further, the dominant influence of stereotypes about African-Caribbean service users as being 'mad, bad or dangerous' within mainstream services and in shaping 'racist social exclusion' has been highlighted (Adkison-Bradley *et al.*, 2009; McLean *et al.*, 2003: 662). This is asserted to affect the whole process in mainstream mental health provision: diagnosis, assessment, critical care, treatment, medication and aftercare. Lack of understanding and, related to this, misinterpretation of normal behaviour as pathological (that is, attributed to a mental illness or condition) is noted to lead to misdiagnosis (McLean *et al.*, 2003). Across other studies, institutional racism has been found to be embedded in services, and to act as a strong disincentive to approach services. However, when they do enter the mental health system, it is known that African-Caribbean service users are more likely treated with medication rather than non-drug treatment (Bignall *et al.*, 2019; McLean *et al.*, 2003).

Recent research has generated valuable insight into the abuse and trauma experienced by refugees and asylum seekers as part of their migration journeys and post-migration experiences, often inflicted by multiple perpetrators. The greater likelihood of poor mental health is explained through an examination of the inherent racism and discrimination in the UK, resulting in a lack of appropriate or accessible health services. For some migrants, the ever-present threat of deportation and lack of recourse to public funds increases mental distress and deters help-seeking (Mental Health Foundation, 2016; Turrini, 2017). Sexual violence has been identified as pervading the

asylum-seeking process and a common cause of PTSD amongst women (Girma *et al.*, 2014; Psarros, 2014; Refugee Council, 2009; WHEC *et al.*, 2016). Hence, it has been found that 'the pathway into mental health care for ethnic minority people is generally unremittingly aversive' (Synergi Collaborative Centre, 2018:7).

Differing conceptualisations of mental ill-health

Psychiatric diagnoses are known to oversimplify and obscure significant and complex sociocultural processes such as racial trauma and socioeconomic inequality, leading to reductionist and medicalised approaches to understanding emotional distress that cannot accurately represent the lived experiences of all groups (Prajapati and Liebling, 2021:2).

Debate about mental ill-health, symptoms, causes and in particular people's own descriptions of it in the 1980s-1990s raised some important issues about inter-cultural meanings of mental health. It highlighted that while there may be common ideas about mental health and illness, significant differences can also be found in the cultural expression of mental distress among different communities (Fenton and Sadiq-Sangster, 1996). Research with South Asian women into how people describe their 'illnesses', for instance, showed that they had a clear understanding of varying types of mental 'illness' and its links to physical health. However, they described mental distress in culturally and linguistically specific ways, which differed from English speakers, but shared features of 'depression' (Fenton and Sadiq-Sangster, 1996:66). Individual constructions of mental ill-health among some South Asian groups has been the focus of some research in the UK (see Curren, 1984 Fenton and Sadiq-Sangster, 1996), as well as amongst women of African and Caribbean heritage (Adkison-Bradley *et al.*, 2009; McLean *et al.*, 2003). Among the issues highlighted are differing conceptions of distress and its causes. Pathan women in Curren's (1984) study, for instance, viewed distress differently, where a sense of hopelessness, core to depression, was seen as being 'in God's hands' and not as being 'ill'; a somatisation¹⁰ of mental ill-health, where women use physiological descriptions and symbolism to express their distress, such as a 'sinking heart' (dil ghirda hai) used to describe social circumstances such as the absence of close family. The heart has been noted by some to be central to how South Asian women describe distress, as 'thinking too much in my heart' where 'thinking in my heart indicates thoughts inextricable from the emotions which accompany them' (Fenton and Sadiq-Sangster, 1996:75-76). Others have also found that Black and minoritised women

¹⁰ Somatisation refers to when emotional and psychological conditions or mental ill-health are either experienced as physical symptoms, or physical symptoms are used to express emotional feelings. In particular, when there is contact with medical practitioners, this can mean that there is misunderstanding and failure to fully understand an individual's mental distress.

attributed mental distress to social, political and economic pressures from within (family and community) and outside (racism, bullying), which created a sense of extreme isolation and silence. Consequently, South Asian and African-Caribbean women resorted to their own strategies and resources to deal with mental ill-health rather than speak out (Adkison-Bradley *et al.*, 2009; Chew-Graham *et al.*, 2002; McLean *et al.*, 2003). The under-reporting of mental ill-health as a result of conceptualising distress differently has been repeatedly highlighted in the literature (see Fenton and Sadiq-Sangster, 1996).

The link between culture¹¹ and expression of mental distress has raised the question in the literature of whether conceptualisation and expression of mental health and illness are culturally specific rather than universal categories. It is suggested that psychiatric categories such as depression, constructed in Western psychiatry and also, importantly, contested within the West, especially in relation to gender and mental health (see, for example, Watson, 2019), may have limited utility in other social and cultural contexts. More broadly, a critique has been made of the dominance of a Eurocentric model of mental health services, epitomised by the 'one-size fits all' approaches found in healthcare, which overlooks the norms and values of marginalised beliefs and cultures (Fernando and Keating, 2008). This model is regarded to assume that adopting a Western understanding of mental ill-health will improve service use and outcomes for all cultural groups (Prajapati and Liebling, 2021:17). The literature on different conceptualisations of mental health and illness provides interesting insight which can inform the ways in which interventions are framed and implemented for diverse groups of Black and minoritised survivors.

Further, there is long-standing critique of the concept of trauma, particularly amongst feminists and Black activists, which is critiqued for its lack of analytical clarity, its overuse, and the development of a 'trauma industry'. In particular, its application is often seen to minimise or ignore the significance of structural conditions and oppression, including in relation to 'race' and gender (see for example, Tseris, 2017). More recently, a challenge to the medicalisation and pathologisation of pain and distress through (unregulated) psychiatric diagnosis has been developed and provides a compelling argument for the reframing of responses to survivors through alternatives to the diagnostic approach (Watson, 2019). Within a context of DVA and in strengthening responses to survivors, great emphasis has been placed on developing

¹¹ Although the emphasis on cultural context guards against ethnocentric conceptions of mental illness, caution is also advised against regarding culture as static and fixed, especially where victim-blaming redirects attention from other structural factors in influencing mental health (Ahmad, 1993).

trauma-informed services which are underpinned by a clear understanding of what is meant by trauma and the wider social contexts that re/produce it beyond the individual. For instance, Women's Aid uses trauma to describe abusive actions done to women that cause harm as part of a wider context of sexism and misogyny and their intersection with other forms of inequality (see Women's Aid, 2021a). With regard to Black and minoritised survivors, the importance of considering intergenerational trauma, resulting from historic and contemporary racialised oppression and violence, has also been emphasized (see AVA, 2021).

Violence against Black and minoritised women and intersectional context

Literature on violence against Black and minoritised women offers some insight into how DVA and other forms of abuse impact on women's mental health and wellbeing, although this is often part of a wider exploration of their experiences of violence and abuse, help-seeking and the barriers encountered. In particular, this literature highlights how structural violence intersects with interpersonal/familial violence to amplify the impact on women's mental wellbeing. That intersectional location and situational context shape Black and minoritised women's experiences of violence and abuse, mental ill-health, and the responses received from services and professionals is repeatedly underlined. Indeed, Black and minoritised women's narratives across studies reveal the intersecting nature of violence and abuse with other structural inequalities, in what can be considered a web of (sometimes extreme) coercive control and a 'continuum of oppression' (see Anitha, 2010; Kanyeredzi, 2018; Rehman et al., 2013; Thiara and Roy, 2020). This both reflects broader findings about commonalities in women's experiences and the serious impact of intersecting abuse, but also extends this by providing nuanced insights into the lived experiences and wellbeing of Black and minoritised women.

There is evidence that Black and minoritised women have to contend with additional experiences that amplify the impact of DVA and other forms of abuse, with serious implications for their mental health and wellbeing (Karasz, 2005; Siddiqui, 2018), both within and outside of their specific cultural contexts and communities. There is strong evidence suggesting that Black and minoritised women take longer to seek help and suffer abuse for longer. The longer time spent in abusive contexts has been highlighted to result in more frequent and greater levels of more serious violence, for some at the hands of multiple family members, leading to 'social entrapment' resulting from the combination of sexism, racism and immigration status (Anitha, 2010; Kanyeredzi, 2018; Rehman *et. al.*, 2013; Thiara, 2013; Thiara and Roy, 2010). The resulting levels of extreme social isolation, also identified as a key factor in the mental health literature as marking the situations of those who are likely to report mental ill-health, is widely noted,

especially for those women migrating for marriage purposes without any family in the UK and who may also lack secure immigration status (Hague *et al.*, 2010). An absence of positive friendships and community networks has been identified as a key factor in enduring mental ill-health in the post-separation period (Chantler, 2003; Thiara, 2020). Amongst the issues highlighted in the literature are the coercion and intimidation endured from multiple people; abuse of insecure immigration status; specific forms of harm such as forced marriage, honour-related violence, and female genital mutilation; and the structural and cultural barriers to seeking help, all of which intersect to restrict women's 'space for action' (Chantler, 2012; Chantler and Gangoli, 2011; Gill, 2009; Gill and Anitha, 2011; Roach and Momoh, 2013; Sharp-Jeffs *et al.*, 2018; Thiara and Roy, 2020; Wilson, 2007). Stigma and shame and notions of izzat (a concept which refers to reputation, prestige and honour) and honour are widely highlighted in the literature to point to the ways in which these are culturally mediated and create specific impacts. While caution is needed in viewing shame as only and exclusively characteristic of the experiences of Black and minoritised women, the role of gendered shame and its associated concept of izzat in exacerbating women's mental ill-health through depression, anxiety and attempted suicide and self-harm is underlined, particularly in relation to South Asian women.

With regard to Black women, literature in the US, and increasingly in the UK, has also identified the role of the Strong Black Woman (SBW) stereotype and its association with strength, self-reliance and unconditional caregiving. Whilst this may enable Black women some protection against challenging life events resulting from racialised sexism and gendered racism, it also limits women's healthy coping (Graham and Clarke, 2021). The adoption and imposition of this stereotype can impact on women's wellbeing and result in greater negative mental health outcomes (Donovan and West, 2015; Graham and Clarke, 2021; Harrington *et al.*, 2010; Kanyeredzi, 2018; Thiara and Roy, 2020). The SBW, also more recently referred to as 'toxic Black femininity', is considered to be a survival response to exploitation during slavery and passed intergenerationally through socialisation (Beauboeuf-Lafontant, 2009). These concepts – of izzat, honour, SBW – have also been acknowledged to prevent women from seeking help for mental ill-health in contexts of DVA and other forms of abuse.

Alongside these contexts of abuse, as discussed later, many Black and minoritised women remain under-informed about support services or are reluctant to involve them; experience racism and discrimination from services-professionals; have few/no social networks; lack access to services due to insecure immigration status; fear being stigmatised and shamed within their communities; and lack the economic options to carve out independent lives (AVA 2021; Bignall *et al.*, 2019; Burman and Chantler, 2005;

Chantler and Gangoli, 2009; Kapadia, 2015; Thiara and Gill, 2010; Thiara and Roy, 2020). Clearly, the contexts in which violence is experienced and the barriers to positive interventions all have very specific implications for the mental health/wellbeing and recovery of Black and minoritised survivors.

Black and minoritised women, DVA and mental health/wellbeing

Whilst underlining the role of 'race'/racism, the early literature on 'race'/ethnicity and mental health was largely silent on the experiences of Black and minoritised women (Aitken, 1996; Burman *et al.*, 1998; Wilson, 2001). However, research from the late 1990s sought to address this gap (Bhugra *et al.*, 1999; Chantler *et al.*, 2001; Merrill and Owens, 1986; Soni-Raleigh, 1996; Yazdani, 1998), and emphasised the need to recognise how multiple forms of oppression and disadvantage contributed to mental ill-health, in addition to racism. This included gender (Abel and Newbigging, 2018), sexuality (Semlyen *et al.*, 2016), disability (Turner *et al.*, 2006), nationality, migration (Singh, 2012) and poverty (Boardman *et al.*, 2015; Mills, 2015). It remains the case that while the research base continues to grow, there are gaps in our knowledge base, and we know even less about some minoritised groups of women (Bignall *et al.*, 2019).

Much of the reviewed literature explores factors contributing to the experiences of mental ill-health amongst specific groups of Black and minoritised women, most commonly different groups of South Asian women, and does not directly address the links between mental ill-health and DVA. Information on this linkage has to be extrapolated from the wider research findings. It is evident from some of these studies, however, that DVA and other forms of violence are key factors in shaping mental ill-health for a significant number of women. Hicks and Bhugra (2003), for example, found a strong association between marital violence, depression and suicidal behaviour for South Asian women. Others indicate that as many as half of all Asian women living in the UK who have attempted suicide or self-harm have suffered DVA (Chantler *et al.*, 2001; Pande, 2017). Similarly, Karasz's (2005) review found that depression amongst Asian women strongly overlapped with what they describe as marital conflict. A recent review confirmed the significance of the relationship between DVA and mental health, more specifically depression, anxiety, PTSD, self-harm and disturbed sleep patterns (Kaur-Aujla *et al.*, 2019). In an evaluation of a specialist intervention with survivors, a majority of those interviewed attributed a direct causal link between their mental health problems and the violence and abuse they had endured and survived (Siddiqui and Patel, 2010:5). In this study, women reported high levels of mental health difficulties and mentioned a wide range of severe impacts on their emotional and mental wellbeing, described by one woman as resulting in being 'scarred for life' (Siddiqui and Patel, 2010:64).

A recent study identified how high levels of mental ill-health were experienced over long periods by women subjected to overlapping forms of abuse, including sexual violence. It also revealed the obstacles that were encountered when attempting to seek help. This reflected levels of disbelief on the part of agencies and their dis-engagement with Black and minoritised women's disclosures of abuse and mental ill-health (Thiara and Roy, 2020). More recent research on women with no recourse to public funds (NRPF), asylum-seeking and migrant women has noted high levels of mental distress, which results from abuse endured, intense social isolation, poverty and financial hardship (Dudhia, 2020; Thiara, 2020). Research on asylum-seeking women in the UK who had fled gender-based violence highlighted the serious negative impact on their mental health of rejected claims for asylum support and consequent poverty and homelessness, with 95% reporting feeling depressed and attempting to kill themselves (Dudhia, 2020). Similarly, another recent study showed that feeling/being insecure in relation to immigration and the discrimination that ensues entrenched mental distress without recourse to much needed support. It was found that uncertainty, primarily about their immigration status, even after they left the abusive context, caused high levels of depression and anxiety for women who were unable to rebuild their lives (Dudhia, 2020 Sharma and Marsh, 2017; Thiara, 2020). Many were on medication for depression and anxiety and talked about suicide ideation and/or actual suicide attempts. Helplessness and a lack of accessible therapeutic support, as a result of NRPF, entrenched women's trauma and sense of a lack of physical and psychological safety.

The need for an exploration of mental health difficulties to consider contextual factors, vulnerability factors and life events in triggering these has been widely underlined across the literature from the 2000s. In order to understand the complexity and nuanced nature of Black and minoritised women's mental health and wellbeing resulting from overlapping forms of abuse, a consideration of the impact of their intersectional location for mental health outcomes has been repeatedly emphasized. This underlines the importance of considering women's broader contexts (Chew-Graham *et al.*, 2002), both within communities (gender oppression) and externally (racism and discrimination). Literature notes a range of interconnected factors that contribute to mental ill-health, which include DVA and other forms of abuse, immigration uncertainty wrought by a racist immigration system, discriminatory responses from mainstream provision, racism, poverty, isolation and homelessness, further exploitation from within their own communities to women in vulnerable situations, and issues of loss (Chantler, 2003:37; Gask *et. al.*, 2011; Thiara and Roy, 2020). As noted by Chantler (2003) 'considerations and understandings of domestic violence and distress also need to be located within the context of national and local

housing policy, racial harassment, national and international policies on immigration, as well as cultural concepts such as honour and shame' (2003:37). Thus, the intersection of specific abuse contexts with structural inequality intensify and further nuance the experiences of mental health/wellbeing for Black and minoritised women.

It can be argued, as earlier suggested by Golding (1999) that for Black and minoritised women, the relationship between DVA and other forms of abuse and mental ill-health is strong – based on the extent of the association, and the ways in which this is demonstrated over time and in different contexts. As well as confirming this relationship between DVA and mental health and wellbeing for Black and minoritised women, the review also noted a significant linkage with systemic inequalities, racism, distress, and trauma (AVA, 2021; Bignall, *et al.*, 2019).

Black and minoritised women and mental health and wellbeing

Women from various BME communities have similar experiences of domestic violence and mental health problems, which include religious and cultural pressures, immigration and asylum issues, suicide and self-harm, racism and discrimination, low socio-economic status or financial hardship, and the role of the health service in medicalising them or ignoring their needs rather than providing counselling or social welfare support (Siddiqui and Patel, 2010:14).

In the range of impacts noted in the research, DVA and other forms of abuse are widely reported to have numerous negative effects on women's mental health/wellbeing. Among the adverse effects reported are depression, anxiety, and post-traumatic stress, and such consequences are recognised risks for suicide and suicidality (suicidal thoughts, plans and attempts). This is reported to be significantly higher for survivors of DVA and those subjected to chronic overlapping forms of abuse (Pico-Alfonso *et al.*, 2006). Alongside such shared issues, Black and minoritised women experience several additional difficulties as a result of their intersecting experiences of racism and sexism/misogyny, as already noted, which serve to entrap them in contexts of extreme abuse for prolonged periods and thus increase the risk of severe mental ill-health that may lead to serious self-harm and suicidal ideation (see the following discussion on 'Suicide and self-harm').

The abuse in their personal lives is reinforced by structural violence, through a hostile immigration and asylum system and discriminatory service responses, which further undermines women's wellbeing, (AVA, 2021; Gangoli *et al.*, 2019; Femi-Ajao *et al.*, 2020; Siddiqui and Patel, 2010).

The barriers encountered in securing affirming support shape the impacts of DVA and other forms of abuse such that the longer length of abuse endured, lack of social networks, stigma linked to mental ill-health amongst their families and communities, and high levels of social isolation all increase the possibility of women developing mental ill-health. Disproportionately high levels of Black and minoritised women have self-harmed, contemplated suicide, and attempted or committed suicide, with DVA found to be a causal or contributory factor rather than any pre-existing or diagnosed psychiatric illness (Siddiqui and Patel, 2010:9).

Key effects of DVA on Black and minoritised women’s mental health and wellbeing reported across the literature:

Anxiety	Confusion
Depression	Detachment
Erosion of sense of self	Extreme anger
Eating and sleeping problems (insomnia)	Stress
Low self-esteem	Inability to trust in others
Guilt and self-blame	Fear and shame
Anxiety and panic attacks	Memory loss
Feelings of shame and degradation	Murderous thoughts
Extreme fear	Feelings of helplessness
Inability to cope and make decisions	
Self-harm, suicidal thoughts and suicide attempts	

Suicide and self-harm

The link between DVA and suicidality began to be made in the mid-1990s, especially in the US, showing that those abused by a partner were more likely than non-abused women to make suicide attempts (see Stark and Flitcraft, 1995). Among Black and minoritised women, this link was found to be higher than for white women, with research in the US and later in the UK suggesting that the suicide risk is greater for abused Black and minoritised women, including migrants and refugees, as a result of structural and cultural factors (Chantler, 2003; Colucci and Montesinos, 2013; Devries *et al.*, 2011; Siddiqui and Patel, 2010). In their study of African-American women, Kaslow *et al.* (1998) found higher rates of physical and non-physical partner abuse among those who attempted suicide than amongst those who did not. Women who had attempted suicide also reported higher levels of distress, hopelessness and substance use, however, they were less likely to attempt suicide if they had access to social support (Kaslow *et al.*, 1998). They emphasised:

'...the importance of carefully assessing suicidal ideation and intent in women who are victims of partner abuse and for partner abuse in women who present with suicidal ideation, suicide attempts, or both... hopelessness and psychological symptoms should be evaluated thoroughly in women who are victims of intimate partner violence' (Kaslow *et al.*, 1998:538).

A number of UK studies in the 1990s, largely on South Asian women, explored the disproportionality in rates of self-harm and suicide where very few had any pre-existing history of psychiatric illness (Bhugra *et al.*, 1999; Chantler *et al.*, 2001; Merrill and Owens, 1986; Soni-Raleigh, 1996; Yazdani, 1998). Soni-Raleigh *et al.*'s (1992) study was among the first to highlight the high rate of suicide in young Asian women compared to other groups, with high levels of suicide by burning, comprising 20% compared to 2% in the general population (Soni-Raleigh and Balarajan, 1992). The suicide rate among Indian and East African (majority were Indian) women aged 15-24 was almost *three times* greater than the national rate (1992:366). Others have also reinforced these findings, showing that risks of self-harm, suicide attempts and deaths by suicide are *two-and-a-half* times higher for Asian women aged under 30 than for white women, with self-poisoning being the most common method of self-harm (Bhugra *et al.*, 1999; Merrill and Owens, 1986; Patel and Gaw, 1996). This rate in attempted suicide was found to be similar among those aged under 30 in the 'other' category which included refugees, Polish, Spanish and others from mainland Europe (Bhugra *et al.*, 1999:1129). In their earlier study of self-poisoning among Caribbean and white groups, Merrill and Owens (1987) also found that Caribbean patients in Birmingham were more likely to be young, female and single, who had not received previous psychiatric treatment or been

diagnosed with a personality disorder or alcoholism and had not self-poisoned previously. In explaining a similar finding for Asian groups, 'culture conflict' (the idea of culture conflict, while sometimes still persisting, has been widely critiqued) and marital problems (reported by over a half of women) were identified as key causative factors by Merrill and Owens (1986). These earlier studies attribute higher rates among the young to a range of internal cultural factors: 'interpersonal disputes particularly in relation to marriage and lifestyles, the pressures of economic competition with the loss of self-esteem associated with failure, and the anxiety attached to non-conformist behaviour', though there is some recognition also of racism as a factor in some studies (Soni-Raleigh and Balarajan, 1992:367). The need to provide appropriate support and counselling services to young women experiencing mental ill-health was also underlined by such research, especially through counselling services based within local communities rather than through mainstream external agencies.

Later research reinforced some of these earlier findings and also noted higher levels of vulnerability to suicide and self-harm amongst young Asian women (Bhardwaj, 2001; Chantler *et al.*, 2001; Patel, 2005). Bhardwaj (2001) highlighted the marginalisation of their voices and a perception of self-harm as a way of coping with stress and distress in circumstances in which they felt they had no control: 'The language of despair defeat and self-annihilation was pervasive' (Bhardwaj, 2001:57), something also noted by Gilbert *et al.* (2004). Young women who felt they had little power and control in their lives identified various contributory factors to self-harm and attempted suicide: competing expectations in the UK; gender inequalities; racism; male domination; and social, religious and intergenerational pressure. Young women were aware that their behaviour could jeopardise the whole family and result in the loss of family honour, and that violence and abuse were community-sanctioned control methods. Other research has also noted that levels of distress among those experiencing violence and abuse were such that some women viewed self-harm and suicide as a strategy to deal with this, and services were only accessed at a point of crisis (Chantler *et al.*, 2001; Chew-Graham *et al.*, 2002; Siddiqui and Patel, 2010). The absence of social support and someone to confide in were key factors for women attempting suicide and self-harm (Chew-Graham *et al.*, 2002:343).

The importance of viewing 'suicide attempts and self-harming ... [as] a 'rational' response to violence and brutality, rather than a mental "illness"', has been emphasised (Chantler, 2003:37). Others have also asserted that the mental ill-health experienced by those living in DVA situations should be regarded as the 'symptoms of abuse' (Humphreys and Thiara, 2003). Taking further note of the specificities of the intersectional experiences of Black and minoritised women enables support responses

to be better attuned to their needs. The body of research reviewed has emphasised the need for the provision of anti-discriminatory, intersectional and culturally sensitive service responses that have an insight into the wide-ranging abuse experienced by women. Indeed, available literature which highlights those service responses greatly valued by Black and minoritised survivors are located within arenas which take full account of their everyday lives and abuse contexts and provide holistic support, as discussed in section three.

COVID-19, DVA and the impact on mental health

It has been established that societal emergencies, including natural or man-made disasters, result in heightened prevalence of violence against women (see Gearhart *et al.*, 2018). Indeed, during the COVID-19 pandemic, increased rates of DVA and femicide have been widely documented across the globe, exacerbated by restrictions on movement, narrowed routes to help and safety as well as economic and social stressors created by the pandemic (Bradbury-Jones and Isham, 2020; Roesch *et al.*, 2020). Economic challenges wrought by unemployment and income insecurity have been disproportionately felt by marginalised communities alongside a greater burden of death and illness given their over-representation in sectors with reduced protection for workers. Disruption of social networks and greater social isolation, with limited routes to help, have especially impacted survivors in marginalised groups.

Women from Black and minoritised groups have been disproportionately impacted by the pandemic (Banga and Roy, 2020; Fawcett Society, 2020; Sheil, 2020). Heightened anxiety, fear, depression, suicide ideation and suicide attempts have been reported among women as existing trauma is aggravated during the pandemic (Thiara and Roy, 2021). Increased social isolation and lockdowns have created greater opportunities for abusers to impose coercive control, and to exploit and erode survivors' mental wellbeing (Ali *et al.*, 2021). What the fallout of this will be for survivors and the organisations supporting them remains to be evidenced, but there is likely to be high demand for domestic abuse support. This makes it all the more important that the wide-ranging effects of DVA and other forms of abuse are responded to through specialist support that recognises the complexity and nuance of differentiated experiences.

Section 2: Barriers facing Black and minoritised survivors attempting to access support for mental health/wellbeing in the context of DVA

Many anxieties are mobilised in highlighting issues of abuse, violence and distress in South Asian communities. These include how these aspects tend to be over-emphasised in many contexts (e.g. through the media), giving rise to racist interpretations of South Asian communities (Chantler, 2003:35).

There was for women a great amount of shame and embarrassment associated with psychological distress, which appeared to impact upon their disclosure of their suffering to others or seeking help (Graham and Clarke, 2021:143).

... we highlight the limitations of framing mental health policy and practice within a universalist approach that presumes equal entitlement is enabled by generic forms of service provision (Chantler, 2003:36).

A substantial focus of the surveyed literature is on survivors' experiences of accessing and receiving help from mainstream services. By centring the narratives of women and practitioners, repeatedly highlighted are the lack of understanding and discriminatory responses encountered by Black and minoritised survivors as well as a wide range of barriers and gaps in service provision (Chantler, 2003; Mclean *et al.*, 2003). It has been of concern for several decades that, despite the reported high rates of mental ill-health they experience, many survivors continue to underutilise support services, and often do not receive any positive support when they do so.

Structural and cultural barriers

The role of both 'internal' cultural factors and structural inequalities in reinforcing their exclusions and re/producing mental ill-health for survivors is extensively highlighted. For instance, immigration insecurity is identified to highlight how the intersection of state and familial oppression in a DVA context erodes mental health and wellbeing, given the high levels of immigration abuse by partners/families (for example, threatening a survivor with deportation if she reports DVA to the police) and discriminatory immigration policies (Chantler, 2003; Thiara, 2020). This illustrates how racist and patriarchal immigration laws align with patriarchy in Black and minoritised communities to oppress and silence women. Similar explanations – the cultural and/or the structural – are also provided for the underutilisation of services. It is likely that survivors encounter a range of cultural and structural barriers to accessibility and these

need to be addressed in a holistic response that takes account of both, without making assumptions that can result in inappropriate support being offered (Kalathil *et al.*, 2011).

Numerous intersecting factors are identified across the different literature to explain the inability and/or reluctance of those with eroded mental health to seek help for their difficulties. This is noted to include: a lack of information and knowledge about available mental healthcare and other helping services; scepticism about counselling support; mistrust of both white (ignorance and inability to relate to specific contexts and experiences) and Asian (concerns about confidentiality and gossip) professionals; fear of being misunderstood and/or invalidated given experiences of racism; lack of cultural sensitivity or negation of cultural identity; inadequate language support; and the stigma and shame of acknowledging and speaking out about issues of mental ill-health (Bhardwaj, 2001; Gilbert *et al.*, 2004; Meltzer *et al.*, 2000; Prajapati and Liebling, 2021). Further issues highlighted in the literature, mostly with regard to those experiencing mental ill-health, and which have been widely critiqued for locating barriers within communities, is an assumption that help-seeking is determined by 'culture' and religious beliefs; that there is inadequate understanding of mental health among Black and minoritised groups; that they somatise mental distress (see footnote 10, on p.14); that strong South Asian families offer protection against poor mental health; and that there is a failure to understand the link between physical illness and mental health (Fenton and Sadiq-Sangster, 1996:72). Whilst much of the literature focuses on South Asian groups, research also indicates that these barriers are profound for African and African-Caribbean women seeking help in relation to DVA, mental ill-health or both (Femi-Ajao, 2018; Femi-Ajao *et al.*, 2020; McLean *et al.*, 2003).

However, warning against an essentialisation¹² of individuals, their cultures and communities, and in highlighting the severe forms of distress experienced by Black and minoritised women, others have argued that this is frequently a result of the failures of service provision offered to them (Chantler, 2003; Thiara and Roy, 2020), as a consequence of structural disadvantage and institutional discrimination (AVA 2021; Bignall *et al.*, 2019; Royal College of Psychiatrists, 2018). Survivors indicate that they interact with a wide range of agencies that they do not feel have heard or understood

¹² In the context of this literature review, 'essentialise' refers to the tendency to attribute to groups of Black and minoritised women defined characteristics (biological, cultural or behavioural) as though they are shared by all members of that group. Not only does this ignore diversity, but it also reinforces stereotyping and subordination and hence racism. The essentialising of Black and minoritised women is a key finding in a number of the studies that were reviewed.

them, or that respond in discriminatory ways. Repeatedly, literature identifies the poor responses from social and health care professionals, including GPs, mental health practitioners and therapists, housing and benefits agencies, police, immigration services, and even mainstream VAWG provision. For instance, it has been found that GPs are less likely to recognise mental distress among some Black and minoritised groups and less likely to make a referral to specialist mental health services than for other ethnic groups (Bhui *et al.*, 2003). Moreover, they are more likely to receive psychiatric medication than a referral for talking therapies (Abel and Newbigging, 2018; AVA, 2021; Hussain and Cochrane, 2002). Thus, it is not just that Black and minoritised survivors face severe barriers to seeking help, but that when they do (often in desperation) it takes them several attempts and years of help-seeking to get the support they need and value; for some this has been reported to take as long as seven years (Thiara and Roy, 2020).

It is widely acknowledged in research that mental ill-health compounds stigma and shame in some communities, leading to pressure to cover up issues of DVA and mental ill-health within their social networks (Anand and Cochrane, 2005; Moller *et al.*, 2016; Synergi Collaborative Centre, 2018). Arguably, such stigma exists in all majority and minoritised groups. For Black and minoritised women, the far-reaching ramifications of disclosing mental ill-health results in a silencing that creates a greater sense of helplessness, isolation and entrapment. This means that women are left to cope alone and draw on their personal resources through 'coerced choice' (Graham and Clarke, 2021; Kapadia *et al.*, 2017:1312). Indeed, confidentiality is recognised as a major concern for some in smaller communities, including in the use of interpreters. This closes down avenues for help-seeking and further complicates women's attempts to navigate a path to recovery (Anand and Cochrane, 2005; Bhardwaj, 2001; Hussain and Cochrane, 2003; Siddiqui and Patel, 2010). For instance, a lack of trust in mainstream agencies, alongside fear of community grapevine, prevented South Asian women living in smaller connected communities from accessing help for their problems and indicates this is an important area for attention in strengthening responses. That mainstream agencies were predominantly white, and the perception that they failed to understand their cultural contexts, and held racist stereotypical ideas about Asian women, all served to create reluctance to seek help and 'engender feelings of helplessness about service provision' (Chew-Graham *et al.*, 2002:345; Kapadia *et al.*, 2017). African-Caribbean and African women who were suffering from depression in McLean *et al.*'s (2003) study also reported the imposition by professionals of cultural stereotypes of them as strong and able to withstand any negative life events, as reflected in the notion of the SBW.

The collusion and/or the mirroring of responses between families and agencies, where women remain unheard, little understood and unsupported, and sometimes misdiagnosed as 'mentally ill', is a factor in their re-traumatisation and intensification of distress (Chantler, 2003; Thiara and Roy, 2020). Those who had attempted suicide and/or self-harmed related punitive and uncaring responses from their families and from mental health workers (Chantler, 2003:43). In the face of such responses, the importance of conducting full risk assessments in health settings, particularly A&E, to ascertain the level of care women are likely to receive from family is one of the recommendations made in the research. Women are further discouraged from seeking help because perpetrators frequently construct them as 'mad' in their interaction with professionals, make threats to take their children from them by using their mental ill-health, and child protection and other agencies, such as the courts, frequently consider the mental health and wellbeing of survivors in a negative manner when making decisions about children.

The identification of both structural and cultural factors in shaping the disclosure of mental ill-health and DVA and the multitude of barriers encountered in receiving positive responses from services suggests that both dimensions need to be addressed if Black and minoritised survivors are to be positively supported in their journeys of recovery.

Responses from mental health services

It is known that mental health services are underused by Black and minoritised women (Moller *et al.*, 2016; Bignall *et al.*, 2019). Where encounters with mental health services are reported, these are observed to raise a number of further issues. Inequities in access to primary and community care and treatment, the greater use of institutionalisation and coercive interventions such as sectioning and detention in place of therapeutic support and advocacy following a mental health crisis, and poorer rates of engagement with and recovery from generic IAPT¹³ interventions have been highlighted (Abel and Newbigging, 2018; Beck *et al.*, 2019; Bignall *et al.*, 2019; Independent Review of Mental Health Act, 2018; Sainsbury Centre for Mental Health, 2002; Synergi Collaborative Centre, 2018; Thomas, 2019). This wider context has a bearing on the ways in which Black and minoritised survivors experience their interactions with mental health support systems. Survivors of DVA and other forms of abuse being denied access to help as a result of a failure to meet the thresholds set by statutory mental health services has also been widely noted by VAWG practitioners.

¹³ Improving Access to Psychological Therapies programme began in 2008 in England as a treatment for adult anxiety disorders and depression.

Those who are able to gain access to such services report not being asked about the underlying causes of their symptoms or about the histories of abuse they have endured, sometimes since childhood (Karasz, 2005).

Further issues are highlighted by Black and minoritised survivors about their encounters with mental health practitioners, who are described as too busy, cold and lacking an insight into the ways in which abuse impacts their lives. Limited or no follow-up, a lack of continuity of care and an over-reliance on medication have also been identified. When responses were experienced as racist, where Black and minoritised survivors were judged not to be 'genuine victims' – 'she doesn't look like something happened to her' – this stopped women from accessing further help to avoid such discriminatory responses (Thiara and Roy, 2020:44). For instance, an African-Caribbean survivor reported that, instead of focusing on delivering appropriate support for her mental distress, '...the therapist I was engaging with was ... looking at my relationship with authority. Apparently, I am defiant, I have an issue with NHS and all of these organisations and I don't trust them! Well do you blame me?' (Thiara and Roy, 2020:44). Another reported being administered 11 different medications over several years before happening to encounter a GP who made the time to ask and listen to the underlying causes of her distress (Thiara and Roy, 2020). More recently, a critique has emerged about the over-use of psychiatric labels and a pathologisation of mental distress among survivors of abuse through the use of unreliable diagnostic frameworks, rather than recognising and working from their strengths (Kalathil *et al.*, 2011; for a further discussion see Watson, 2019).

...the accounts also highlight the need for working in ways which recognise and value people's strengths, that resist labelling, and that work with an understanding, rather than dealing solely with the symptoms, of distress (Chantler, 2003:43).

Whilst the need for mainstream mental health interventions for some survivors cannot be overlooked, it is evident that not only does the mental health system frequently lack an understanding of the complex and multiple effects of abuse on survivors but that it reproduces racist stereotypes of Black and minoritised women in its responses. Institutional racism experienced within mental health care systems is noted to reproduce racialised harms and inequalities and further exacerbate mental ill-health and trauma (Abel and Newbigging, 2018; McLean *et al.*, 2003; NHS England, 2020). Issues in relation to differences in the presentation of emotional distress have also been highlighted, with Black and minoritised groups noted to prefer a 'holistic conceptualisation of distress', one that takes account of 'cultural traditions, social

circumstances and faith' (Prajapati and Liebling, 2021:17). The dominant biomedical model¹⁴ of treatment based on Western concepts of mental illness is thus considered to be alienating to Black and minoritised women and impacts the quality of help and support received from mainstream mental health provision. Understanding the historical intersectional context of women's lives and the processes of racialisation that add to the trauma of violence is regarded as imperative to more effectively facilitating Black and minoritised survivors' healing (Washington, 2010).

Barriers created by COVID-19

The COVID-19 pandemic has not only exacerbated DVA but restricted access to support and spaces for healing (Mahase, 2020; UN Women, 2020; Women's Aid, 2020). This is noted to disproportionately impact Black and minoritised survivors in accessing the sorts of help they find valuable from Black and minoritised organisations, as discussed in Section 3. Whilst all VAWG services had to rapidly reshape their delivery, for example to include online provision, greater challenges were encountered by specialist Black and minoritised organisations, which are among the most under-funded (Cortis *et. al.*, 2021; Sheil, 2020). Survivors from these communities are also among the most impoverished in society which meant they often did not have the technology or IT skills to access remote support, something most acutely felt by migrant women with no recourse to public funds and those who were intensely socially isolated. Lockdown effectively removed the only sources of positive support and connection that many women had, and led to an intensification of mental ill-health, resulting especially in greater levels of reported anxiety, depression and suicide ideation (Thiara and Roy, 2021). In moving forward, whilst some women have valued the remote support made available to them, many Black and minoritised survivors who face intense social isolation are likely to want to recover the sense of connection offered through face-to-face and peer group support.

The box below is a summary of the barriers encountered by Black and minoritised survivors identified across the research literature.

¹⁴ The biomedical model views health purely in terms of biological factors and is focused on the individual, in contrast to the social model (of disability) for instance which locates barriers in society – both attitudinal and physical.

Structural/organisational

- Institutionalised racism - lack of understanding and awareness, stereotypical assumptions, and inappropriate and discriminatory responses on the part of agencies; negation of cultural identity and cultural pathologisation.
- Inappropriateness/Eurocentricity of assessment tools and lack of identification of needs.
- Structural factors such as poverty, disability, poor housing, unemployment.
- Imbalance of power and authority.
- Broader societal stigma and negative view of mental ill-health leading to fears about removal of children, negative labelling or compulsory hospitalisation.
- Professionals' lack of knowledge and understanding of mental health/wellbeing in the context of DVA.
- Immigration status – lack of access to statutory services due to lack of recourse to public funding; fear of detention and/or deportation.
- Language barriers and mistrust of interpreters.
- Concerns about (lack of) confidentiality.
- Inappropriate location of services and geographical distance from services.
- Difficulties in using public transport.
- Lack of childcare facilities.
- Long waiting lists for initial assessment.
- Lack of access to technology and online support.

Cultural/individual

- Negative perceptions and stigma associated with mental ill-health and mental health services.
- Family pressures and concerns about izzat and shame - reluctance to discuss and disclose both abuse and mental ill-health.
- Stereotypical assumptions about counselling and counsellors – e.g. white counsellors will be 'culturally ignorant' or even racist; counselling reinforces dysfunction and 'madness'.
- Stereotype of counselling as 'passive' and not proactive - direct advice and guidance valued over just listening.
- Counselling seen to be culturally incongruent - 'shameful' and stigmatising for the whole family.
- Concerns about confidentiality, leaking of information and gossip.
- Concerns about pathologising family and/or community and this resulting in greater racism.
- Women's understandings of their distress are different from those of mental health professionals.
- Survivors isolated/frightened by perpetrator.
- Fear of violence and being blamed.
- Lack of knowledge/awareness of different services.
- Lack of trust in professional interventions.
- Erosion of a strong sense of personal identity as a Black woman.

Section 3: Support valued by survivors in the recovery of their mental wellbeing from 'by and for' Black and minoritised organisations and specialist women's services

As noted above, the impact of DVA and other forms of abuse is deeply corrosive for survivors' mental health and wellbeing (Stockman *et al.*, 2015). There is as yet only a small body of research that explicitly explores the views of Black and minoritised women who have experienced DVA about how services have met their mental health/wellbeing recovery needs (Memon *et al.*, 2016). It is acknowledged that a consideration of gender and the distress and trauma created by intersecting forms of violence against women has yet to be mainstreamed within mental healthcare services (Abel and Newbigging, 2018; Spates, 2012), and that promotion of better services for Black and minoritised women relies on 'considering the intersection between gender, 'race', sexual orientation, age, disability and other factors when developing accessible and appropriate services' (p.4).

Against a background of recognised disparities in mental health provision for Black and minoritised survivors, this section consolidates findings from these different sources of knowledge, as well as drawing on the context already provided (including about barriers to access and use). It enables a more nuanced picture to be established in relation to those key themes that have emerged strongly from the review that can help inform future development and delivery of services (Anitha *et al.*, 2009; AVA, 2021; Department of Health, 2010; Royal College of Psychiatrists, 2018; Siddiqui and Patel, 2010; EACH, 2009). Consistent with earlier sections of this report, the diversity of survivors is recognised throughout this section (Anand and Cochrane, 2005) and acknowledges that there may be conflicting findings and multiplicity of needs (Kalathil *et al.*, 2011).

Value of dedicated 'by and for' VAWG organisations for Black and minoritised women

An overarching message from the literature is that dedicated 'by and for' VAWG organisations for Black and minoritised women experiencing DVA and mental ill-health are particularly valued by survivors (Siddiqui and Patel, 2010; Wright and Hutnik, n.d.; Yapp *et al.*, 2018; EACH, 2009). These dedicated services are described as crucial in enabling Black and minoritised survivors to leave abusive relationships and to rebuild their lives in an 'enduring' way (Anitha *et al.*, 2009:79). Studies report women who had used such 'by and for' integrated services for DVA and mental ill-health saying they were listened to, validated, and transformed (Anitha *et al.*, 2009; EACH, 2009; Siddiqui and Patel, 2010; Thiara and Roy, 2020).

More generally, positive responses were also described in relation to specialist community-based services for Black and minoritised groups experiencing mental ill-health than mainstream mental health services. While such community-based services are able to develop relationships of trust and promote awareness and access to mental health services, it is acknowledged that they may lack expertise in DVA and other forms of abuse that is particularly required in the provision of support to survivors (Bignall *et al.*, 2019). Therefore, whilst this section draws on all the research literature reviewed, the framework for thematic discussion derives from research about, and evaluations of, voluntary sector community based mental health services and dedicated 'by and for' VAWG services that are informed by the views of Black and minoritised survivors.

In meeting the recovery needs of Black and minoritised women who experience mental ill-health related to DVA and other forms of abuse, the following are particularly valued:

- An understanding of the social realities of the lives of Black and minoritised women.
- An intersectional understanding without essentialising the experiences of Black and minoritised women.
- Holistic, wrap-around services, including intersectional advocacy.
- Access to help and support is a process based on trust.
- A range of alternatives to the use of medication.
- Information about services and what these involve.
- Language support.
- Understanding role of religion/faith in coping.
- Respecting women's strengths and coping strategies.
- Group work and being part of a peer support group.
- Multi-agency collaboration and involving survivors.
- Counselling that allows for choice.
- Specialist 'by and for' services for Black and minoritised survivors.

An understanding of the social realities of the lives of Black and minoritised women

A key finding of the review was the relevance of discrimination and oppression as a context to mental ill-health related to DVA for Black and minoritised women. It is clear from their accounts that racism is woven into the lives of Black and minoritised survivors and contributes to the negative impacts on their mental wellbeing. The realities of their lives involve dealing with the impact, not just of DVA and racism, but also a wide range of inequalities (AVA, 2021; Royal College of Psychiatrists, 2018; Siddiqui and Patel, 2010). Women's narratives identify social, economic, cultural, familial and personal contexts as contributing to their mental health/wellbeing (Royal College of

Psychiatrists, 2018). An understanding of such intersecting structural factors that lead to social exclusion needs to be incorporated into and inform the responses of those providing support to survivors. Many women argued that structural and institutional racism was indivisible from their experience of gender violence: 'Black and minoritised survivors are being met with institutional racism at every junction, gravely obstructing the support they need. This demands a re-thinking and reforming of the systems and support currently available to survivors' (AVA, 2021:9).

Survivors also recognise that multiple structural issues were integral to the barriers they faced, such as unemployment, poor housing, poverty, immigration insecurity, and lack of knowledge about services (AVA, 2021). The importance of addressing systemic intersectional inequality in immigration, housing and poverty for survivors of DVA and other forms of abuse is repeatedly underlined across much of the literature and cautions against mistaking 'the structural for the cultural' (Chantler, 2003:45). The critical and valuable role of dedicated Black and minoritised VAWG organisations in offering survivors a safe and healing space is also consistently highlighted in the literature.

Structural oppression amplifies the impact of trauma and constrains recovery. Taking account of such structural exclusions in the framing of service provision on the part of statutory and voluntary mental health agencies may require fundamental restructuring of services. Repeatedly underlined is the need for women to feel confident that they will not be pathologised and blamed for their circumstances in order to take up services. The centrality of gender to understanding DVA and mental ill-health and trauma is also critical. It may be particularly difficult for Black and minoritised women to trust male service providers to understand their experiences, and their experiences may mean that they just do not feel safe.

An intersectional understanding without essentialising the experiences of Black and minoritised women

An understanding of diverse intersectional and cultural contexts is seen as integral to an approach which challenges the intersectional discrimination encountered by Black and minoritised survivors (Anand and Cochrane, 2005; Bignall *et al.*, 2019; Kalathil *et al.*, 2011; Wright and Hutnik, n.d.). A number of studies showed that Black and minoritised women felt pressures from within, as well as outside of, their cultural contexts that inhibited their access to support services for mental ill-health (Kalathil *et al.*, 2011; Moller *et al.*, 2016; Siddiqui and Patel, 2010). It is important that this is recognised, but not in a way that essentialises communities and displaces intersecting structural considerations (Anand and Cochrane, 2005).

Instead of relying solely on dominant biomedical models and interventions, services need to incorporate an understanding of different cultural meanings and beliefs accorded to mental ill-health (Anand and Cochrane, 2005; Fenton and Sadiq-Sangster, 1996; Moller *et al.*, 2016), together with an acknowledgement of the impact of social exclusion and racism (McLean *et al.*, 2003). Without pathologising communities or cultures or falling back on a 'cultural conflict' explanation (Patel, 2005), this involves understanding the importance of somatised descriptions, where mental distress may be explained in terms of physical symptoms, and the significance of culturally mediated feelings of stigma and shame. It also involves recognising the impact of stereotypical assumptions that are often applied by professionals and services (of the Strong Black Woman, for example) (AVA, 2021). Black and minoritised women have a deep fear of contributing to essentialist attitudes towards their communities through disclosing DVA and/or mental ill-health and, alongside language barriers, is a commonly cited barrier to accessing services (Anitha *et al.*, 2009; Thiara and Roy, 2020).

Where there is misinterpretation of normal responses as pathological, misdiagnosis can easily occur (McLean *et al.*, 2003). Understanding distress also relies on recognising the impact of intergenerational racial trauma (Adkison-Bradley *et al.*, 2009; AVA, 2021; McLean *et al.*, 2003) and the conceptualisation of toxic black femininity (AVA, 2021) and how this shapes the strategies Black and minoritised women adopt to survive gendered racism. These understandings are intrinsic to the positive promotion of Black identity (AVA 2021; Kalathil *et al.*, 2011; McLean *et al.*, 2003); they need to be seen in culturally appropriate spaces and support services (McLean *et al.*, 2003). If these are not provided this can re-traumatise survivors (AVA, 2021).

*Holistic, wraparound services, including intersectional advocacy*¹⁵

What emerges strongly from work with Black and minoritised survivors, and this is not surprising given the pervasive nature and impact of DVA and other aspects of oppression and discrimination, is the wide range of services that have been found helpful and healing (Anitha *et al.*, 2009; Kalathil *et al.*, 2011; McLean *et al.*, 2003; Siddiqui and Patel, 2010). This resonates with the kind of services Black and minoritised women value in relation to mental ill-health (Kalathil *et al.*, 2011; McLean *et al.*, 2003). This range of services encompasses all aspects of women's lives, as they seek not only to recover

¹⁵ Intersectional advocacy recognises that Black and minoritised survivors rarely require help with a single issue and instead have multi-dimensional needs; thus 'by and for' organisations have to address the complex ways that gender, 'race', class and other social systems re/produce their marginalisation. This frequently results in discriminatory responses to survivors from mainstream service providers, which 'by and for' organisations challenge through their everyday advocacy work.

from the impact of DVA on their mental health/wellbeing, but also to re-establish their lives and reclaim their futures, for themselves and their children. In tune with awareness of the broader context of structural exclusion and inequalities, this is exemplified by the Southall Black Sisters (SBS) model (see Siddiqui and Patel, 2010). The SBS model combines a number of practical and therapeutic services in a flexible way. Safety is crucial for survivors (Siddiqui and Patel, 2010) and other therapeutic services are likely to be ineffective if women do not feel safe. In addition, women may be dealing with homelessness, poverty, and insecure immigration and displacement issues. Holistic wraparound services, including intersectional advocacy, are particularly valued when lives feel overwhelming, and approaching a multiplicity of formal services is daunting and even feared.

Individual trauma-informed counselling is valued by survivors, but this does not always address the complex realities of women's lives. It has been repeatedly found that Black and minoritised survivors value both practical and emotional support from interventions (Anitha *et al.*, 2009; Thiara and Roy, 2020; Wright and Hutnik, n.d.). Practical help is vital, and also helps build the trust that may enable women to take up other forms of support from agencies. Timeliness is also an issue, and on initial contact with agencies, survivors may not be ready to take up therapeutic support. Complementary therapies (yoga, massage, acupuncture, for example) are also appreciated in themselves and as a bridge to other interventions. A strength of dedicated 'by and for' Black and minoritised VAWG services especially, and some specialist women's services who have thought through the issues for different groups of women, is the integrated and flexible nature of services (Anitha *et al.*, 2009):

Their long experience in working on this issue, their tendency to listen to the women, avoid colluding with the dominant attitudes to the abuse, their validation of women's experiences, the combination of practical assistance as well as emotional support, as well as long term support makes them the ideal services in enabling women to restore their sense of self and sustain independent living (Anitha *et al.*, 2009:82).

Other services mentioned included drop-in facilities, women's groups, peer support, outreach, and support to transition from refuge to other accommodation. Some women do not want to leave the abusive relationship and their community but need support to deal with the abuse. Women who do eventually leave may do so as a last resort and need support to enable them to take that step (Thiara and Hussain 2005:7).

Access to help and support is a process based on reciprocity and trust

A number of studies have highlighted how women need time and space to talk freely and in depth about what has happened to them, and to feel safer and more confident in their help seeking (AVA, 2021; Kalathil et al., 2011). Moller *et al.*'s (2016) study, for example, found that initially women made partial disclosures when they approached GPs as they searched for responses to their mental ill-health. This is not unusual in relation to other forms of trauma, or indeed DVA, but likely to be pronounced given the evidence about women's fears about shame, stigma and confidentiality (Anand and Cochrane, 2005; Chew-Graham *et al.*, 2002; Patel, 2005). This constrains help seeking and indicates that time may be needed. When feeling safe and validated, women are more likely to talk fully about their experiences of DVA and how they think this has affected their mental health/wellbeing. This is most likely to be provided by dedicated Black and minoritised VAWG organisations. Following this support, they may feel more confident to approach a range of formal and informal sources of support, and able to engage with different interventions (Anitha *et al.*, 2009; Siddiqui and Patel, 2010).

Kalathil *et al.* (2011) in their research with African-Caribbean and South Asian women about DVA and mental health, found that time and space were necessary so that women could make sense of what had happened to them, and the causes of their ill-health. Attesting to the complexity and multifaceted nature of need, they also identify opportunities and interventions which are valued, but which are not solely or directly trauma related. Women relate not just to a narrow view of recovery but also to overall empowerment. Importantly: 'A friendly, long-term relationship with the health care provider may be an important factor in creating the interpersonal context for such a relationship' (Karasz, 2005:179).

A range of alternatives to the use of medication

Acute concerns remain about the (over) medication with psychotropic drugs of women (particularly young women) in relation to their mental health/wellbeing in contexts of abuse (Abel and Newbigging, 2018; Siddiqui and Patel, 2010). As already noted, a number of studies have highlighted that when Black and minoritised women are able to access formal mental health services, they are more likely than white women to be offered medication and less likely to be offered talking therapies or other non-drug treatments. Medication does not address the underlying problem of mental ill-health and trauma created by DVA and other forms of abuse, the side effects are often debilitating and can threaten safety planning: 'The doctor gave me tablets for depression, but after using it I used to feel so drowsy that I got scared and I decided not to use them again' (Anitha *et al.*, 2009:70).

This has been noted in relation to South Asian, African and African-Caribbean women, including those who have experienced DVA (Kaur-Aujla *et al.*, 2019; McLean *et al.*, 2003). It reinforces structural exclusion and reproduces health inequalities, not least because women are likely to find the financial and privatised nature of non-drug therapies to be prohibitive (Ahmad *et al.*, 2005). Medicalisation, and the pathologisation of distress this entails, can also be used by perpetrators, families and professionals against women, in issues involving children for instance. The views of Black and minoritised women, and the dedicated 'by and for' organisations that support them, indicate that this is inequitable, unacceptable, and does not respond adequately to the complex social realities of their lives (Kalathil *et al.*, 2011). The issue of medicalisation and its ramifications reinforces support for the approach of dedicated 'by and for' Black and minoritised organisations and specialist women's services that offer a range of more bespoke support and interventions.

Information about services and what these involve

Many Black and minoritised women affected by DVA are socially isolated within their families and communities and their opportunities to gain information may be extensively compromised by the tactics of abuse inflicted by a perpetrator and worsened by the COVID-19 pandemic (Roesch *et al.*, 2020). Women's activities may be monitored and they may be accompanied when visiting health professionals, such as GPs and ante-natal care professionals, who could be important sources of information, particularly when DVA screening has been integrated within their practices. A number of the studies included the promotion of information-giving strategies to overcome barriers to access faced by Black and minoritised women (Anand and Cochrane, 2005; Anitha *et al.*, 2009). Moller *et al.* (2016) noted the lack of publicity about DVA services in key locations and stressed the importance of providing such information; this was seen not merely as information giving, but also as awareness raising. Participants in Anitha *et al.*'s (2009) study felt that information should be placed in GPs surgeries, community centres, libraries and schools.

This was extended to include publicity campaigns, media events and community-based initiatives, although the political will from service providers to do so was doubted (McLean *et al.*, 2003). Kalathil *et al.* (2011) also suggest that 'developing a sense of social justice through community participation, campaigns for equality, campaigns against violence, involvement in user/survivor movements' (p.76) was affirming. Beyond this, the importance of greater awareness material on mental health, trauma and forms of therapeutic support, including counselling, has been emphasised.

Language support

A strong finding across a number of studies was the barriers presented by language (Anitha *et al.*, 2009; Moller *et al.*, 2016), identified as one of the most significant factors to accessing services. This point goes further than just English language support and, as McLean *et al.* (2003) found, the language used to describe symptomology was not always understood. This was closely related to the degree of cultural awareness within the agency and amongst the staff offering services (Fenton and Sadiq-Sangster, 1996). A common fear noted among women is that if their meanings and expressions of distress are not understood, then misdiagnosis can occur. This fear deterred women from approaching mental health services or reduced confidence in using the service. Research indicates that the availability of sensitive and sympathetic support in appropriate languages with 'unspoken' understanding is crucial to enable women to rebuild their lives (Parmar *et al.*, 2005; Rai and Thiara, 1997; Thiara and Hussain, 2005):

I can express my emotions in my own language. If they know our culture, its better. I was with [BME worker] and I told her, if it was some other people I wouldn't start. Sometimes our emotions, we can't express in another language. I feel better, lighter after I meet her... someone who helps you emotionally, sits and listens to you, it's like an angel has been sent to you... (Thiara and Roy, 2020: 51).

Importantly, this is not just a consideration when English is a second language: 'A voluntary worker mentioned that, while the need of other ethnic groups for interpreters or language support was recognised, an African-Caribbean vernacular is not perceived to require special interpretation' (McLean, *et al.*, 2003:663)

The value of the use of interpreters in relation to counselling for trauma is highly debated and regarded as problematic. Research has noted difficulties with this (Siddiqui and Patel, 2010) and women are also distrustful (Moller *et al.*, 2016). Given the difficulties of providing therapeutic support through interpreters, the importance of counselling in the first language has been emphasised by several researchers and organisations when reporting what survivors value (Anitha *et al.*, 2009; EACH, 2009; Kalathil *et al.*, 2011; Siddiqui and Patel, 2010).

Understanding role of religion/faith in coping

Faith and religious belief emerged strongly as a mode of coping with mental ill-health and DVA for a range of Black and minoritised women (Anand and Cochrane, 2005; Hussain and Cochrane, 2003; McLean *et al.*, 2003; Wright and Hutnik, n.d.). This was important not just as a source of strength, but as a significant aspect of personal

identity. As part of the process of recovery and healing, 'faith and/or personal spiritual grounding' (Kalathil et al., 2011:9) may be intertwined with cultural identity and recognition of this positively supports a woman's sense of self (Wright and Hutnik, n.d.): 'I have received a lot of help. They understand my culture and religion and can see where I am coming from. It was easy for me to talk to them' (Woman referring to dedicated support, Anitha et al., 2009:6).

It is also the case that some Black and minoritised women who have experienced mental ill-health as a result of DVA may have lost their faith, compounding other losses and trauma, and this should also be recognised.

Respecting women's strengths and coping strategies

It is evident from the review that Black and minoritised women experiencing mental ill-health, including from DVA, relied mostly on themselves and developed their own coping strategies. This included prayer and crying (Hussain and Cochrane, 2003; Wright and Hutnik, n.d.), self-harm and attempted suicide (Chantler, 2003), and disordered eating (Thiara and Roy, 2020). In contexts of DVA, high levels of social isolation, fears instilled by the perpetrator that they might be made the subject of punitive mental health intervention or lose their children because they are 'mad', and stigma and shame associated with speaking out all led women to develop their own coping strategies (Anitha et al., 2009; Humphreys and Thiara, 2003).

A significant contribution made by dedicated Black and minoritised VAWG organisations and some specialist women's services was to help women reframe their experiences and to view their coping as a source of strength (Thiara and Roy, 2020). When supporting agencies and professionals can recognise and harness women's strengths, resilience and agency, this is valued by women and can contribute to recovery and empowerment (Kalathil et al., 2011). This includes involvement in peer group support and self-help groups, which provide a source of support and connection with other survivors, confidence building and recovery (Chantler, 2003; Thiara and Roy, 2020). This helped women to explore commonalities in experiences within and across different minoritised communities and facilitated a sense of solidarity and support in the face of racism and sexism, further helping to feel connected and to heal (Thiara and Roy, 2020).

Group work and being part of a peer support group

Although women often talked about shame and the negative reactions of their family and community members, the role of group work within dedicated services was positively evaluated as reflecting the valued support of new-found friends (Francis-Spence, 1997; Kalathil et al., 2011). Meeting women in similar circumstances, even in a

group counselling context, had the benefit of reducing the impact of pathologising and stereotyped responses that held women back in their recovery (Anitha *et al.*, 2009; Kalathil *et al.*, 2011; Siddiqui and Patel, 2010; Thiara and Roy, 2020). In the context of a peer support group, as well as individually, the validity of women's agency can be reinforced (Adkison-Bradley, 2009; McLean *et al.*, 2003).

Sharing experiences is also an important step in moving away from individual medicalised approaches, and a number of studies highlighted that Black and minoritised women experiencing mental ill-health did not have access to this form of help and support. As noted by Kalathil *et al.* (2011) in relation to women's recovery: 'Another key factor in moving towards recovery included addressing these conflicts within a collective setting in the context of shared understandings with other women in similar situations' (p.39).

Multi-agency collaboration and involving victim-survivors

The need for greater cooperation/communication between statutory and voluntary sectors in order to strengthen responses to survivors with eroded mental health and wellbeing has been identified across the literature. The lack of understanding among practitioners in the different sectors poses great challenges given the increased divisions between services (silos) (Holly, 2017), the withdrawal of funding from voluntary sector services (Women's Aid, 2021b), and service level agreements that fund gender-neutral services (Hirst and Rinne, 2012).

A positive development over recent years that has received support is the greater inclusion of Black and minoritised women survivors in the design, delivery and evaluation of services (Goodman, *et al.*, 2016), which has led to some changes in primary and acute services. Recognising survivors' expertise, promoting their greater involvement in the development of services and making a commitment to addressing the intersectional disadvantage faced by the most marginalised groups in the design and delivery of services has been emphasised in recent research (Thiara and Roy, 2020).

Counselling that allows for choice

I did not feel comfortable with the counsellor...I just was not able to connect to her and felt very uncomfortable after ten minutes with her...I just wanted to leave the room. The whole atmosphere was very formal. I don't know, I felt very uncomfortable...I suppose I would have benefited from an Asian counsellor... someone who could understand how it is in Asian families. The shame of these issues makes it very difficult to talk about it (Anitha *et al.*, 2009:75).

Many of the studies included in the review examined aspects of counselling (Kapadia, 2015; Kapadia *et al.*, 2017; Moller *et al.*, 2016). The issues that this revealed ranged from women's lack of knowledge about counselling, their fears and anxieties about counselling, and their lack of confidence in the process of counselling. There were disparate views amongst Black and minoritised women about the cultural 'matching' of service user and counsellor, with some feeling they would benefit from this and others very definitely wanting to avoid it (Moller *et al.*, 2016). For example, some respondents in Moller *et al.*'s (2016) study with South Asian women felt that cultural matching would promote cultural understanding whilst others did not. Some respondents thought that white counsellors would be 'culturally ignorant' (p.205), whilst others felt that a white counsellor would be preferable and more likely to be non-judgemental.

At the heart of these considerations is the need for experiences and emotions to be understood within both a cultural and a structural context, including an understanding of the deep shame and stigma many women feel. Further, women have been noted to value 'supportive and social or problem focused counselling approaches' (Karasz, 2005:179). Many survivors continue to be sceptical about sitting and 'talking' with a counsellor they cannot relate to in a formal therapeutic relationship, though they may value speaking informally with someone they feel understands them (Thiara and Roy, 2020). For some women, religion is a key consideration in their choice of counsellor.

It is evident from the review that alongside trauma-informed counselling provided within a 'by and for' context, a sufficiently diverse range of counsellors and/or other professionals within mainstream services are required to enable women to have some level of choice and control in who they choose to form trusting relationships with. For survivors, having someone from a similar background to them, who understands the issues of trauma and mental wellbeing within a context of violence and abuse, to work with is shown to be of the greatest value.

Specialist 'by and for' services for Black and minoritised survivors

The weight of research reported in this review underlines the vital role of dedicated 'by and for' Black and minoritised VAWG organisations and specialist women's services with an intersectional understanding in supporting survivors' mental wellbeing and recovery in contexts of DVA and other forms of abuse. Women's narratives repeatedly highlight the importance of such services in helping them to view their future more positively, to feel hopeful and to have greater self-esteem. While some women experiencing mental ill-health may value greater choice, dedicated 'by and for' VAWG organisations are particularly regarded, and documented, as the most helpful in assisting Black and minoritised survivors to address and recover from the mental ill-health created by DVA

and other forms of abuse (Thiara and Roy, 2020). Being understood, feeling heard, made to feel safe physically and emotionally, and having those who 'look like them' support them 'from the heart' has been highlighted in the literature as qualities valued by survivors (AVA, 2021; Chantler, 2003:42; Kalathil *et al.*, 2011; Thiara and Roy, 2020). This encompasses many of the points made above about the kind of services that are needed and the ways in which these are provided (Anitha *et al.*, 2009; Kalathil, *et al.*, 2011; Siddiqui and Patel, 2010; Thiara and Roy, 2020). It also echoes several evaluations of DVA provision more generally (Hague and Mullender, 2006; Robbins and Cook, 2018). The importance of a broader 'understanding' and empathy is underlined in addition to the value of similarity of 'race' and gender (as well as experience of mental ill-health) as a basis for understanding:

The importance of an attitude of care and a non-judgmental approach was often underlined; this not only enabled women to 'speak' and recover voice, but the depth of conversations, needed for healing and recovery, they were able to have with those they trusted were markedly different from any others... When this happened, women regarded it as a form of liberation (Thiara and Roy, 2020:50).

Summary

We should not underestimate the complexity involved in providing an appropriate and informed response to Black and minoritised women who experience mental ill-health as a result of DVA and other forms of abuse. Although challenging, understanding this complexity is vital in bringing their needs into view and ensuring better responses to their mental health and wellbeing. In this summary, we want to highlight some salient points that have emerged from this critical review of the literature and those most relevant to informing future developments in services.

- DVA is a criminal offence and erodes the mental health and wellbeing of survivors, alongside other negative impacts. This is the responsibility of perpetrators and not survivors. Many of the factors identified below will have been used by perpetrators to reinforce their abuse and to make sure that survivors are isolated and will not be believed, even when they manage to look for help.
- Living in a racist society and experiencing racism is indivisible from understanding the impact of DVA on Black and minoritised women. Racism intersects with gender and other forms of structural oppression that shape the realities of women's everyday lives, and reflect entrenched inequalities with which they have to contend.
- Black and minoritised women do not constitute a homogenous group, even when they have common experiences of racism. The intersection of specific abuse contexts with structural inequality intensify and further nuance the experiences of mental health/wellbeing for Black and minoritised survivors. In mainstream provision, a 'one size fits all' approach has predominated, which takes inadequate account of the full range of differentiation and diversity among groups of women.
- There is now greater recognition of inter-generational trauma which is experienced and carried by Black and minoritised women who sit at the intersection of multiple forms of oppression and discrimination. The experience of DVA and other forms of abuse intersects with both historical and contemporary experiences of racism and creates specific impacts on women's mental health and wellbeing. When we think of distress and trauma in relation to Black and minoritised survivors, and develop trauma-informed services, practice

development needs to be informed by an understanding of this complexity and intensity, both historical and contemporary.

- There are differing conceptualisations of mental ill-health amongst Black and minoritised groups which can inform the ways in which interventions are framed and implemented for diverse groups of Black and minoritised survivors. However, these are often displaced by dominant ideas and approaches to its diagnosis and medicalised treatment. This acts as a strong deterrent to seeking formal help and pushes women back into reliance on their individual resources and coping strategies.
- Considerable tension is created by the contrast in Black and minoritised survivors' perceptions about the causation of their mental ill-health, and the role of structural factors in compounding this, and the individualising and pathologising approach of mainstream mental health services.
- Cultural explanations on their own are insufficient in understanding mental ill-health. Culture is dynamic and evolving, rather than static and homogeneous. The need to avoid the pathologisation of individuals and communities, whilst understanding the mediating, rather than the determining, role of cultural factors has been an important insight emphasised in the literature.
- Women's recognition of their families' and communities' views about the stigma and shame of mental ill-health reinforces their silence. Gender violence also results in stigma and shame and may similarly render women's accounts inadmissible. There is, then, an amplifier effect in relation to mental ill-health in contexts of DVA and other forms of abuse. An understanding of these dynamics is crucial in enabling survivors to break their silence and support their healing.
- Acknowledging the presence of shame within all communities (as culturally mediated) helps dismantle the influence of stereotypes that only associate shame with particular communities and serve to constrain women's help-seeking.
- The more serious the mental ill-health, the greater the likelihood that DVA and other forms of abuse will remain or become invisible. When the mental health and wellbeing of Black and minoritised women is under focus, the underlying contributory factors of violence and abuse are left unexplored by mainstream

professionals and agencies. Again, this may reflect on a mental health system which is individualising and pathologising. It is also indicative of the imposition of racist stereotypes which contribute to misdiagnosis and overuse of medical treatment by professionals. The impact of structural factors and social processes, which are evident in women's accounts, are often disregarded, particularly in mainstream services.

- Literature emphasises the implications of social and community isolation and the lack of support networks for Black and minoritised women experiencing DVA and other forms of abuse. Isolation from friends and family is often a primary objective of a perpetrator. In the process of recovery, it has been noted that women highly value time, space and opportunities to (re)connect with friends, peers and other survivors. An important aspect of this is the need for women to feel that a sufficient level of understanding exists and that they will be believed without judgement. The reinforcement of the coping strategies that women are known to value can reduce their mental distress.
- Black and minoritised women are not served well by mainstream primary health care and mental health services. This relates not just to their patterns of help-seeking, but also the kinds of responses received when mainstream services are contacted and accessed. It is well recognised that mental ill-health and trauma resulting from DVA and other forms of abuse is under-recognised and over-pathologised within mental health services. Issues raised include: inappropriate assessment frameworks; lack of recognition of the strengths of Black and minoritised women; cultural relativism; over medication; high levels of compulsory hospital admissions; criminalisation/diversion into criminal justice systems; and lack of access to talking or alternative therapies.
- For Black and minoritised women, there are profound fears about the consequences of accessing mainstream mental health services and the implications, for example, in relation to arrangements for child contact and residence and the intervention of child protection agencies.
- The lack of recourse to public funding for those with insecure immigration status is considered to be both inhumane and a denial of human rights, preventing access to services, even though women may be suffering high levels of mental distress as a result of DVA and other harm related to migration.

- Issues of mental health and wellbeing are produced, harnessed and deployed within strategies of abuse by perpetrators, including in post-separation violence. This can and does include making threats about detention or deportation or the removal of children by the state. The precarity for women in these circumstances cannot be overstated in relation to their psychological and physical wellbeing, and sometimes it is fatal through murder or suicide.
- There are some Black and minoritised women about whom far too little is known, and, therefore, their invisibility remains pronounced. This includes women who are: from traveller or Roma groups; disabled; in prison populations; sex workers; women who have been trafficked; and those who are in the process of or who have transitioned in relation to their gender identity as women.
- The literature that explicitly explores the relationship between DVA and other forms of abuse, Black and minoritised women and mental health is limited. There are similarities, but also differences, between the histories and experiences of Black and minoritised women. In order to develop greater understanding and to strengthen responses, further research is required on these linkages amongst diverse groups of Black and minoritised women as well as what support and interventions are found to be most effective to facilitate healing and recovery.
- Dedicated 'by and for' Black and minoritised VAWG services, where they exist, are highly valued and positively evaluated for understanding their abuse and intersectional contexts by Black and minoritised survivors. They are considered able to provide timely, community-based holistic wraparound support, including intersectional advocacy and therapeutic services, with a value base that is anti-discriminatory. They embody flexibility, work to women's strengths and affirm their experiences, and are shaped by what women find helpful and empowering for their recovery.

Key considerations - in addressing the mental health and wellbeing of Black and minoritised survivors in contexts of abuse

This review of available literature constitutes a body of evidence that emphatically points to the links between mental ill-health and DVA/other forms of abuse, a failure of

existing mental healthcare responses, and a generalised lack of understanding among mainstream provision about the complex ways in which trauma is experienced and re/produced for Black and minoritised survivors. The literature also highlights what survivors find helpful in their journeys to recovery and there is some evidence of promising practice in responding to their intersectional needs. Overwhelmingly, the evidence points to the importance of supporting the mental health and wellbeing of Black and minoritised survivors through dedicated services underpinned by an intersectional understanding which take account of their multiple abuse contexts and locate mental ill-health within broader processes of structural marginalisation. Some key considerations for future policy and practice development from the review are as follows:

- All available evidence suggests a need to ensure that dedicated 'by and for' Black and minoritised VAWG services are sustainably funded and widely available, including to provide mental health support. When adequately resourced, such services play an invaluable role in helping survivors to recover and heal. These services recognise the wider intersectional context of survivors' experiences and use a strengths-based trauma-informed approach to support women's mental health and wellbeing through integrated community-based, holistic services that are highly valued by survivors. Further, consideration is required of survivors who are deemed to have no recourse to public funds. Providing such services is cost effective and a form of early intervention and prevention.
- Survivors of DVA and intersecting abuse are highly likely to be misdiagnosed and offered medicalisation by statutory services, due to inadequate recognition and understanding about the impacts of abuse as well as the existence of discriminatory stereotypes about Black and minoritised survivors. Recognising the barriers these dual pathologising processes create for access to support and how practice can be strengthened is a necessary underpin to improving the responses of a range of practitioners, including acute and mental health services. This is required at both healthcare policy (greater emphasis on the health consequences of intersecting forms of abuse) and operational levels (training for enhancing confidence and practice development).
- Improving the understanding of all practitioners and service providers about the role of DVA and intersecting abuse in creating trauma for survivors is required as well as the ways in which perpetrators 'weaponise' women's mental health in their dealings with professionals and agencies. The impacts of DVA and

intersecting abuse on Black and minoritised survivors' mental health and wellbeing should be made a focus in professional learning, continuing development and inter-agency training programmes. Building knowledge and confidence through training should not be underestimated as it provides a context for practitioners to learn, including how perpetrators can manipulate women's mental health, and develop non-pathologising and creative strategies for better addressing the needs of those who are currently poorly served by services.

- Healthcare professionals are powerfully placed to respond to survivors and are widely accessed, especially in acute services. Building knowledge about the linkage between mental ill-health and intersecting forms of abuse and the specific issues this creates can help to counteract the medicalised and discriminatory responses to Black and minoritised survivors. Further, routine enquiry and referral to specialist support, including dedicated 'by and for' VAWG services where they exist, should be made and access to non-medical non-pathologising therapies explored.
- Co-ordinated responses between statutory, voluntary and dedicated VAWG services and local pathways to access and support can be improved through strengthening inter-agency partnership working and a sharing of knowledge and expertise. Learning lessons from dedicated 'by and for' services about what is valued by survivors can feed into reframing mainstream provision. This may serve to prevent more expensive, pathologising and retraumatising routes of support and treatment.
- Given the dominance of medicalised responses that often side line the views and conceptualisations of Black and minoritised groups, ensuring assessment frameworks within mental healthcare and other key statutory services are adequate and informed by the lived experiences of Black and minoritised survivors is absolutely key to positively addressing their needs. Again, learning gained about what works by dedicated 'by and for' services in supporting survivors is a necessary dimension of this reframing.
- The reviewed literature provides some insight into the issues and challenges encountered by Black and minoritised survivors with regard to their mental health and wellbeing in contexts of intersecting abuse. Further national and local research is required on these issues which centres the lived experiences of

diverse groups of Black and minoritised women and which is directed towards improvements in service responses. Further, there is a need to identify and evaluate interventions that already exist to generate and disseminate further evidence of promising practice in meeting the needs of Black and minoritised survivors.

References

- Abel, K.M. and Newbigging, K. (2018) *Addressing Unmet Needs in Women's Mental Health*, London: British Medical Association
- Adkison-Bradley, C., Maynard, D., Johnson, P. and Carter, S. (2009) 'British African Caribbean women and depression', *British Journal of Guidance and Counselling*, 37 (1), 65-72.
- Ahmad, W. (1992) *'Race' and Health in Contemporary Britain*, Buckingham: Open University Press.
- Ahmad, W. (1993) 'Making black people sick: 'race', ideology and health research'. In Ahmad, W. (ed) *'Race' and Health in Contemporary Britain*, Buckingham: Open University Press.
- Ahmad, F., Shik, A., Vanza, R., Cheung, A. George, U. and Stewart, D. (2005) 'Voices of South Asian women, immigration and mental health', *Mental Health Women and Health*, 40(4), 113-130.
- Aitken, G. (1996) 'The present absence/pathologised presence of black women in mental health services'. In Aitken, G., Burman, E., Aldred, P., Allwood, R., Billington, T., Goldberg, B., Gordo Lpoez, A.J., Heenan, C., Marks, D. and Warner, S. (eds) (1996) *Psychology Discourse Practice: From regulation to resistance*, London: Taylor and Francis.
- Aitken, R. and Munro, V. (2018), *Domestic Abuse and Suicide: Exploring the links with Refuge's client base and work force*, London: Refuge and University of Warwick.
- Ali, P., Rogers, M. and Heward-Belle, S. (2021) 'COVID-19 and domestic violence: impact on mental health', *Journal of Criminal Psychology*, 11(3), 188-202.
- Anand, A.S. and Cochrane, R. (2005) 'The mental health status of South Asian women in Britain: A review of the literature', *Psychology and Developing Societies*, 17(2), 195-214.
- Anitha, S., Chopra, P., Farouk, W., Haq, Q., Khan, S., Mahmood, A. and Mansoor, A. (2009) *Domestic Violence and Mental Health: Experiences of South Asian Women in Manchester. Report of the community-led research project on the mental health needs of South Asian women who are survivors of domestic violence*, Saheli and Centre for Ethnicity and Health, UCLAN.
- Anitha, S. (2010) 'No recourse, no support: State policy and practice towards South Asian women facing domestic violence in the UK', *British Journal of Social Work*, 40(2), 462-79.

AVA. (2021) *Race, Trauma, and Violence Against Women and Girls*, Ascent and AVA, London. <https://www.wrc.org.uk/race-trauma-and-violence-against-women-and-girls-ava>

Banga, B. and Roy, S. (2020) *The Impact of the Two Pandemics: VAWG and COVID-19 on Black and Minoritised Women and Girls*, London: Imkaan.

Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., Ariyo, k., Bhui, K., Halvorsrud, K., Pilling, S. and Smith, S. (2019) 'Ethnic variations in compulsory detention under the Mental Health Act: A systematic review and meta-analysis of international data', *The Lancet Psychiatry*, 6 (4), 305-317.

Beauboeuf-Lafontant, T. (2009) *Behind the Mask of the Strong Black Woman*, Philadelphia, PA: Temple University Press.

Beck, A. (2019) 'Understanding Black and Minority Ethnic service user's experience of racism as part of the assessment, formulation and treatment of mental health problems in cognitive behaviour therapy', *The Cognitive Behaviour Therapist*, Volume 12. Available at: <https://doi.org/10.1017/S1754470X18000223> [Accessed 22 September 2021].

Bhardwaj, A. (2001) 'Growing up young, Asian and female in Britain: A report on self-harm and suicide', *Feminist Review*, 68, 52-67.

Bhugra, D., Desai, M., Baldwin, D. (1999) 'Attempted Suicide in West London, Rates Across Ethnic Communities', *Psychological Medicine*, 29, 1125-1130.

Bhui, K., Bhugra, D., Goldberg, D., Dunn, G. and Desai, M. (2001) 'Cultural influences on the prevalence of common mental disorder, general practitioners' assessments and help-seeking among Punjabi and English people visiting their general practitioner', *PsycholMed*, 31 (5), 815-825.

Bhui, K., Stansfield, S., Hull, S., Priebe, S., Mole, and Feder, G. (2003) 'Ethnic variations in pathways to and use of specialist mental health services in the UK: Systematic review', *British Journal of Psychiatry*, 182 (2), 105-116.

Bignall, T., Jeraj, E., Helsby, E. and Butt, J. (2019) *Racial Disparities in Mental Health: Literature and Evidence Review*, London: VCSE and Race Equality Foundation.

Boardman J., Dogra, N. and Hindley, P. (2015) 'Mental health and poverty in the UK: time for change', *British Journal of Psychiatry International*, 12 (2), 27-28.

Bradbury-Jones, C. and Isham, L. (2020) 'The pandemic paradox: The consequences of COVID-19 on domestic violence', *Journal of Clinical Nursing*, 29 (13-14), 2047-2049.

Brownridge, D.A. (2006) 'Violence against women post-separation', *Aggression and Violent Behaviour*, 11 (5), 14-530.

Burman, E. and Chantler, K. (2005) 'Domestic violence and minoritisation: Legal and policy barriers facing minoritised women leaving violent relationships', *International Journal of Law and Psychiatry*, 28 (1), 59-74.

Burman, E., Gowrisunkur, J. and Sangha, K. (1998) 'Conceptualising cultural and gendered identities in psychological therapies', *European Journal of Psychotherapy and Counselling*, 1 (2), 231-255.

Care Quality Commission. (2018) *Sexual Safety on Mental Health Wards*, Newcastle upon Tyne: Care Quality Commission.

Chandan, J., Thomas, T., Bradbury-Jones, C., Russell, R., Bandyopadhyay, S., Nirantharakumar, K. and Taylor, J. (2019) 'Female survivors of intimate partner violence and risk of depression, anxiety and serious mental illness', *The British Journal of Psychiatry*, 1-6. Available from: doi: 10.1192/bjp.2019.124

Chantler, K. (2003) 'South Asian women: Exploring systemic service inequalities around attempted suicide and self-harm', *European Journal of Social Work*, 6 (1), 33-48.

Chantler, K. (2012) 'Recognition of and Intervention in Forced Marriage as a form of Violence and Abuse', *Trauma, Violence and Abuse*, 13 (3), 176-183.

Chantler, K., Burman, E., Batsleer, J. and Bashir, C. (2001) *Attempted suicide and self-harm: South Asian women*, Manchester: Women's Studies Research Centre, Manchester Metropolitan University.

Chantler, K., Burman, E. and Batsleer, J. (2003) 'South Asian women: exploring systemic service ties around attempted suicide and self-harm', *European Journal of Social Work*, 6 (1), 33-48.

Chantler, K. and Gangoli, G. (2009) 'Forced marriage in the UK: Religious, cultural, economic or state violence', *Critical Social Policy*, 29 (4), 587-612.

Chantler, K. and Gangoli, G. (2011) 'Violence against women in minoritised communities: cultural norm or cultural anomaly'. In Thiara, R.K., Condon, S. and Schrottle, M. *Violence Against Women and Ethnicity: Commonalities and Differences Across Europe – A Reader*, Berlin: Barbara Budrich.

Chaudhry N., Husain N., Tomenson B. and Creed F. (2012) 'A prospective study of social difficulties, acculturation and persistent depression in Pakistani women living in the UK', *Psychological Medicine*, 42 (6), 1217-1226.

Centre for Women's Justice, End Violence Against Women coalition, Imkaan and Rape Crisis England and Wales. (2020) *The Decriminalisation of Rape: Why the justice system is failing rape survivors and what needs to change*, London: End Violence Against Women.

Chew-Graham, C., Bashir, C., Chantler, K. and Burman, E. (2002) 'South Asian women, psychological distress and self-harm: lessons for primary care trusts', *Health and Social Care*, 10 (5), 339-347.

Colucci, E. and Montesinos, A. (2013) 'Violence against women and suicide in the context of migration: A review of the literature and a call for action', *Suicidology Online*, 4, 81-91.

Cortis, N., Smyth, C., Valentine, K., Breckenridge, J. and Cullen, P. (2021) 'Adapting Service Delivery during COVID-19: Experiences of Domestic Violence Practitioners', *The British Journal of Social Work*, 51 (5), 1779-1798.

Crenshaw, K. (1991) 'Mapping the Margins: Intersectionality, Identity Politics and Violence Against Women of Color', *Stanford Law Review*, 43 (6), 1241-1299.

Currer, C. (1984) 'Pathan women in Bradford - Factors affecting mental health with particular reference to the effects of racism', *International Journal of Social Psychiatry*, 30 (1-2), 72-76.

Devries, K., Kiss, L., Watts, C., Yoshihama, M. and Deyessa, N. (2011) 'Violence against women is strongly associated with suicide attempts: Evidence from the WHO multi-country study on women's health and domestic violence against women', *Social Science and Medicine*, 73, 79-86.

Department of Health. (2005) *Responding to Domestic Abuse: A resource for health professionals*, London: Department of Health.

Donovan, R.A. and West, L. M. (2015) 'Stress and mental health: Moderating role of the Strong Black Woman stereotype', *Journal of Black Psychology*, 41 (4), 384-396.

Dudhia, P. (2020) *Will I Ever Be Safe? Asylum-seeking women made destitute in the UK*, London: Women for Refugee Women.

EACH (2009) *Asian Women, Domestic Violence and Mental Health Toolkit*, EACH, London. Available at: <https://equation.org.uk/wp-content/uploads/2012/12/Asian-women-Domestic-Violence-and-Mental-Health.pdf> [Accessed 12 September 2021].

Fawcett Society. (2020), "Coronavirus: impact on BAME women" Available at: www.fawcettsociety.org.uk/coronavirus-impact-on-bame-women

Femi-Ajao, O. (2018) 'Intimate partner violence and abuse against Nigerian women resident in England, UK: a cross-sectional qualitative study', *BMC Women's Health*, 18 (1), 123.

Femi, Ajao, O., Kendal, S. and Lovell, K. (2020) 'A qualitative systematic review of published work on disclosure and help seeking for domestic violence and abuse amongst women from ethnic minority populations in the UK', *Ethnicity and Health*, 25 (5), 732-746.

Fenton, S. and Sadiq-Sangster, A. (1996) 'Culture, relativism and the expression of mental distress: South Asian women in Britain', *Sociology of Health & Illness*, 18 (1), 66-85.

Fernando, S. (1991) *Mental Health, Race and Culture*, London: Macmillan in association with MIND Publications.

Fernando, S. and Keating, F. (2008) *Mental Health in a Multi-Ethnic Society: A multidisciplinary handbook*, London: Routledge.

Ferrari, G., Agnew-Davies, R., Bailey, J., Howard, L., Howarth, E., Peters, T. and Feder, G. (2014) 'Domestic violence and mental health: a cross-sectional survey of women seeking help from domestic violence support services', *Global Health Action*, 7.

Fox, S. (2018) *It's sort of a chicken and egg scenario: Women's experiences of substance use, domestic abuse and support*, Unpublished Thesis, Manchester Metropolitan University.

Francis-Spence, M. (1997) 'Groupwork and Black women viewing networks as groups: Black women meeting together for affirmation and empowerment'. In Mistry, T. and Brown, A. (eds.) *Race and Group Work*, London: Whiting and Birch.

Gangoli, G., Bates, L., and Hester, M. (2019) 'What does justice mean to black and minority ethnic (BME) victims/survivors of gender-based violence?' *Journal of Ethnic and Migration Studies*. Available at: <https://doi.org/10.1080/1369183X.2019.1650010>

Gask, L., Aseem, S., Waquas, A. and Waheed, W. (2011) 'Isolation, feeling "stuck" and loss of control: Understanding persistence of depression in British Pakistani women'. *Journal of Affective Disorders*, 128 (1-2), 49-55.

Gearhart, S., Perez-Patron, M., Hammond, T.A., Goldberg, D.W., Klein, A. and Horney, J.A. (2018) 'The impact of natural disasters on domestic violence: an analysis of reports of simple assault in Florida (1999-2007)', *Violence and Gender*, 5 (2), 87-92.

Gilbert, P., Gilbert, J. and Sanghera, J. (2004) 'A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby', *Mental Health, Religion & Culture*, 7 (2), 109-130.

Gill, A. (2009) 'Honour killings and the quest for justice in Black and minority ethnic communities in the United Kingdom', *Criminal Justice and Policy Review*, 20 (4), 475-494.

Gill, A. and Anitha, S. (eds.) (2011) *Forced Marriage: Introducing a social justice and human rights perspective*, London: Zed Books.

Girma, M., Radice, S., Tsangarides, N. & Walter, N. (2014) *Detained: Women asylum seekers locked up in the UK*, London: Women for Refugee Women. Available at: <http://refugeewomen.com/wpcontent/uploads/2014/01/WRWDetained.pdf> [Accessed on 12 November 2021].

Golding, J. (1999) 'Intimate partner violence as a risk factor for mental disorders: a meta-analysis', *Journal of Family Violence*, 14, 99-132.

Goodman, L. A., Fauci, J. E., Sullivan, C. M., DiGiovanni, C. D., & Wilson, J. M. (2016). Domestic violence survivors' empowerment and mental health: Exploring the role of the alliance with advocates. *American Journal of Orthopsychiatry*, 86 (3), 286-296.

Graham, R. and Clarke, V. (2021) 'Staying strong: exploring experiences of managing emotional distress for African Caribbean women living in the UK', *Feminism and Psychology*, 31 (1), 140-159.

Hague, G. and Mullender, A. (2006) 'Who listens? The voices of domestic violence survivors in service provision in the UK', *Violence Against Women*, 12 (6), 568-587.

Hague, G., Gangoli, G., Joseph, H. and Alphonse, M. (2010) 'Raising silenced voices: South Asian women immigrating after marriage', *Ethnicity and Inequalities in Health and Social Care*, 3 (1), 25-35.

Harrington, E. F., Crowther, J. H. and Shipherd, J. C. (2010) 'Trauma, binge eating, and the "Strong Black Woman"', *Journal of Consulting and Clinical Psychology*, 78, 469-479.

Henderson, C. Evans-Lacko, S. and Thornicroft, G. (2013) 'Mental illness stigma, help seeking, and public health programs', *American Journal of Public Health*, 103, 777-780.

Hicks, M.H. and Bhugra, D. (2003) 'Perceived causes of suicide attempts by UK South Asian women', *American Journal of Orthopsychiatry*, 73 (4), 455-462.

Hirst, A. and Rinne, S. (2012) *The Impact of Changes in Commissioning and Funding on Women Only Services*, Manchester, Equality and Human Rights Commission.

Holly, J. (2017) *Mapping the Maze: Services for women experiencing multiple disadvantage in England and Wales*. London: Agenda and AVA.

Howard, L. M., Trevillion, K. and Agnew-Davies, R. (2010a) 'Domestic violence and mental health', *International Review of Psychiatry*, 22 (5), 525-34.

Howard, L. M., Trevillion, K., Khalifeh, H., Woodall, A., Agnew-Davies, R. and Feder, G. (2010b) 'Domestic violence and severe psychiatric disorders: prevalence and interventions', *Psychological Medicine*, 40 (6), 881-93.

Humphreys, C. and Thiara, R. (2003) 'Mental Health and Domestic Violence: 'I Call is Symptoms of Abuse'', *The British Journal of Social Work*, 33 (2), 209-226.

Hussain F.A. and Cochrane R. (2002) 'Depression in South Asian women: Asian women's beliefs on causes and cures', *Mental Health Religion Culture*, 5 (3), 285-311.

Hussain F.A. and Cochrane, R. (2003) 'Living with depression: coping strategies used by South Asian women, living in the UK, suffering from depression', *Mental Health Religion Culture*, 6 (1), 21-44.

Independent Review of Mental Health Act (2018) *Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion*. Available at: <https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review>

Kalathil, J. with Collier, C., Bhakta, R., Daniel, O., Joseph, D. and Trivedi, P. (2011) *Recovery and Resilience: African, African Caribbean and South Asian Women's Narratives of Recovering from Mental Distress*, London: Mental Health Foundation.

Kanyeredzi, A. (2013) 'Finding a Voice: African and Caribbean Heritage Women Help Seeking', in Y. Rehman, L. Kelly and H. Siddiqui *Moving in the Shadows: Violence in the Lives of Minority Women and Children*, Farnham, Surrey: Ashgate, 205-224.

Kanyeredzi, A. (2018) *Race, Culture, and Gender: Black Female Experiences of Violence and Abuse*, London: Palgrave Macmillan.

Kapadia, D. (2015) *How Are Social Networks Associated with Mental Health Service Use? A comparison between Pakistani women, and women of other ethnic groups in the UK*, PhD thesis, University of Manchester.

Kapadia, D., Brooks, H. L., Nazroo, J. and Tranmer, M. (2017) 'Pakistani women's use of mental health services and the role of social networks: a systematic review of quantitative and qualitative research', *Health Soc Care Community*, 25, 304-1317.

Karasz, A. (2005) 'Marriage, depression and illness: Sociosomatic models in a South Asian immigrant community', *Psychology and Developing Societies*, 17 (2), 161-180.

Kaslow, N. J., Thompson, M. P., Meadows, L. A., Jacobs, D., Gibb, B., and Bornstein, H. (1998) 'Factors that mediate and moderate the link between partner abuse and suicidal behaviour in African American women', *Journal of Consulting and Clinical Psychology*, 66, 533-540.

Kaur-Aujla, H., Shain, F. and Lillie, A. (2019) 'A Gap Exposed: What is Known About Sikh Victims of Domestic Violence Abuse (DVA) and Their Mental Health?' *European Journal of Mental Health*, 14 (1), 179-189.

Khalifeh, H., Moran, P., Borschmann, R., Dean, K., Hart, C., Hogg, J. et al. (2015) 'Domestic and sexual violence against patients with severe mental illness', *Psychological Medicine*. 45 (4), 875-86.

Khan, U. (2017) *Muslim South Asian Women's Experience of Medication for Mental Health Problems*, Dissertation, MSc Counselling Psychology, Keele University.

Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC). (2020) Domestic Abuse in Black, Asian and Minority Ethnic Groups. [Online]. Available at: <https://www.ksscrc.co.uk/2020/10/29/domestic-abuse-in-black-asian-and-minority-ethnic-groups>. [Accessed on 22 September 2021].

Mahase, E. (2020) 'Covid-19: EU states report 60% rise in emergency calls about domestic violence', *British Medical Journal (Online)*, 369:1872.

McLean, C., Campbell, C. and Cornish, F. (2003) 'African-Caribbean interactions with mental health services in the UK: experiences and expectations of exclusion as (re)productive of health inequalities', *Social Science and Medicine*, 56, 657-69.

Meltzer, H., Bebbington, P.E., Brugha, T.S., Farrell, M., Jenkins, R. and Lewis, G. (2000) 'The reluctance to seek care for neurotic disorders', *Journal of Mental Health*, 9, 319-327.

Memon, A., Taylor, K., Mohebbati, L., Sundin, J., Cooper, M., Scanlon, T. and de Visser, R. (2016) 'Perceived barriers to accessing mental health services among Black and minority ethnic (BME) communities', *BMJ Open* 6 (11) e012337.

Mental Health Foundation. (2016) *Fundamental Facts about Mental Health*, London: Mental Health Foundation.

Merrill, J. and Owens, J. (1986) 'Ethnic differences in self-poisoning: a comparison of Asian and White groups', *British Journal of Psychiatry*, 148, 708-712.

- Meyer, S. (2015) 'Still blaming the victim of intimate partner violence? Women's narratives of victim desistance and redemption when seeking support', *Theoretical Criminology*, 20 (1), 75-90.
- Mills, C. (2015) 'The psychiatrisation of poverty: rethinking the mental health-poverty nexus', *Social and Personality Psychology Compass*, 9 (5), 213-222.
- Moller, N., Burgess, V. and Jogiyat, Z. (2016) 'Barriers to counselling experienced by British South Asian women: a thematic analysis exploration', *Counselling and Psychotherapy Research*, 16 (3), 201-10.
- Myhill, A. (2015) 'Measuring coercive control: what can we learn from national population surveys?' *Violence Against Women*, 21 (3), 355-375.
- NHS Digital. (2016) *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England 2014*. Available at: <https://digital.nhs.uk/catalogue/PUB21748>
- NHS Digital. (2017) Mental Health Act Statistics Annual figures 2016/2017 NHS England (2020) *Advancing Mental Health Equalities Strategy*, Available at: <https://www.england.nhs.uk/publication/advancing-mental-health-equalities-strategy/>
- Office for National Statistics (ONS). (2020) *Domestic abuse in England and Wales overview: November 2020 Figures on domestic abuse from the Crime Survey for England and Wales, police recorded crime and a number of different organisations*, November.
- Oram, S., Khalifeh, H. and Howard, L.M. (2017) 'Violence against women and mental health', *The Lancet Psychiatry*, 4 (2), 159-170.
- Pande, A. (2017) 'Women in Indian diaspora: redefining self between dislocation and Relocation'. In Pande, A. (ed.) (2017) *Women in the Indian Diaspora: Historical Narratives and Contemporary Challenges*, Singapore: Springer.
- Parmar, A., Sampson, A. and Diamond, A. (2005) *Tackling domestic violence: Providing advocacy and support to survivors from Black and other minority ethnic communities*, Home Office Development and Practice Report 35, London: Home Office.
- Patel, S. (2005) *Suicidality in Young Asian Women: The Role Of Shame*, London: Thesis University College London
- Patel, S.P. and Gaw, A.C. (1996) 'Suicide amongst immigrants from the Indian subcontinent: a review', *Psychiatric Services*, 47 (5), 517-521.

Pico-Alfonso, M. A., Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburua, E. and Martinez, M. (2006) 'The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: Depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide', *Journal of Women's Health*, 15, 599-611.

Prajapati, R. and Liebling, H. (2021) 'Accessing Mental Health Services: a Systematic Review and Meta-ethnography of the Experiences of South Asian Service Users in the UK', *Journal of Racial and Ethnic Health Disparities*, 1-2.

Psarros, A. (2014) Women's Voices on Health – addressing barriers to accessing primary care, Maternity Action. Available at: <https://www.maternityaction.org.uk/wpcontent/uploads/2014/05/AccessstoPrimaryCarerreportFINAL.pdf>

Rai, D. and Thiara, R.K. (1997) *Redefining Spaces: The needs of Black women and children and black workers in Women's Aid*, Bristol: Women's Aid Federation of England.

Raleigh, V. and Balarajan, R. (1992) 'Suicide and Self-burning among Indians and West Indians in England and Wales', *British Journal of Psychiatry*, 161 (3), 365-368.

Rees, S., Silove, D., Chey, T., Ivancic, L., Steel, Z., Creamer, M., et al. (2011) 'Lifetime prevalence of gender-based violence in women and the relationship with mental disorders and psychosocial function', *Journal of American Medical Association*, 306 (5), 513-521.

Refugee Council. (2009) *The Vulnerable Women's Project Refugee and Asylum Seeking Women Affected by Rape or Sexual Violence Literature Review*, London: Refugee Council

Rehman, Y., Kelly, L. and Siddiqui, H. (2013) *Moving in the Shadows: Violence in the Lives of Minority Women and Children*, Farnham, Surrey: Ashgate.

Roach, M. and Momoh, C. (2013) Two Steps Forward, One Step Back: The Fight against Female Genital Mutilation in the UK. In Rehman, Y., Kelly, L. and Siddiqui, L. (eds.) *Moving in the Shadows: Violence in the Lives of Minority Women and Children*. Farnham, Surrey: Ashgate.

Robbins, R. and Cook, K. (2018) "'Don't even get us started on social workers'": Domestic violence, social work and trust- an anecdote from research', *British Journal of Social Work*, 48 (6), 1664-1681.

Roesch, E., Amin, A. and Gupta, J. (2020) 'Violence against women during the covid-19 pandemic restrictions', *British Medical Journal*, 369:m1712

Royal College of Psychiatrists. (2018) *Racism and Mental Health: Position statement*, London: Royal College and Psychiatrists.

Sainsbury Centre for Mental Health. (2002) *Breaking the Circles of Fear A review of the relationship between mental health services and African and Caribbean communities*.

Available at:

https://www.centreformentalhealth.org.uk/sites/default/files/breaking_the_circles_of_fear.pdf

Scott, S. and McManus, S. (2016) *Hidden Hurt: Violence, abuse and disadvantage in the lives of women*. London: Agenda. Available at: <https://weareagenda.org/wp-content/uploads/2015/11/Hidden-Hurt-executive-summary1.pdf>

Semlyen, J., King, M., Varney, J., and Hagger-Johnson, G. (2016) 'Sexual orientation and symptoms of common mental disorder or low wellbeing: combined meta-analysis of 12 UK population health surveys', *BMC Psychiatry*, 16: Article 67.

Sharma, S. and Marsh, V. (2017) 'Group work: a powerful site of resistance for migrant women experiencing gender-based violence', *Families, Relationships and Societies*, 6(2):307-315.

Sharp-Jeffs, N., Kelly, L., and Klein, R. (2018) 'Long Journeys toward freedom: The relationship between coercive control and space for action - measurement and emerging evidence' *Violence Against Women*, 24(2):163-185.

Sheil, F. (2020) *'Women Cannot Speak Right Now': Calculating the costs of domestic abuse and Covid-19 on specialist services for Black and minoritised women and girls in England, Scotland, Wales*, London: Imkaan.

Siddiqui, H. (2018) 'Counting the cost: BME women and gender-based violence in the UK', *Progressive Review*, 24(4):361-368.

Siddiqui, H. and Patel, M. (2010) *Safe and Sane: A Model of Intervention on Domestic Violence and Mental Health, Suicide and Self-Harm Amongst Black and Minority Ethnic Women*, Middlesex: Southall Black Sisters.

Singh, S.P. (2012) 'Migration and mental health', *British Journal of Psychiatry* 200 (2), 155.

Soni-Raleigh, V. (1996) 'Suicide patterns and trends in people of Indian subcontinent and Caribbean origin in England and Wales', *Ethnicity and Health*, 1(1):55-63.

Soni-Raleigh, V. and Balarajan, R. (1992) 'Suicide and self-burning among Indians and West Indians in England and Wales', *British Journal of Psychiatry*, 161, 365-368.

Spates, K. (2012) "The Missing Link": The Exclusion of Black Women in Psychological Research and the Implications for Black Women's Mental Health', *SAGE Open*, July-September: 1-8. DOI:10.1177/2158244012455179

Stark, E. and Flitcraft, A. (1996) 'Killing the beast within: Women battering and female suicidality', *International Journal of Health Services*, 25, 43-64.

Stockman, J., Hayashi, H. and Campbell, J. (2015) 'Intimate partner violence and its health impact on disproportionately affected populations, including minorities and impoverished groups', *Journal of Women's Health*, 24 (1), 62-79.

Sturge, G. (2018) UK Prison population statistics, Briefing paper, number CBP04334, London: House of Commons Library.

Synergi Collaborative Centre (2018) *The Impact of Racism on Mental Health*, The Synergi Collaborative Centre. Available at: <https://synergicollaborativecentre.co.uk/wp-content/uploads/2017/11/The-impact-of-racism-on-mental-health-briefing-paper-1.pdf>. [Accessed 5 November 2021].

Thiara, R.K. (2013) "It's all about stopping you from getting on with your life": Post-separation violence in the Lives of Asian and African-Caribbean Women', in Y. Rehman, L. Kelly and H. Siddiqui *Moving in the Shadows: Violence in the Lives of Minority Women and Children*, Farnham, Surrey: Ashgate, 113-126.

Thiara, R.K. (2020) *Safe and Secure: The No Recourse Fund*, London: Southall Black Sisters and University of Warwick.

Thiara, R.K. and Gill, A.K (eds.) (2010) *Violence Against Women in South Asian Communities: Issues for Policy and Practice*, Jessica Kingsley Publishers, London.

Thiara, R.K. and Gill, A. (2012) *Domestic Violence, Child Contact and Post-Separation Violence: Issues for South Asian and African-Caribbean Women and Children*, London: NSPCC.

Thiara, R. K. and Hussain, S. (2005) *Supporting some people: Supporting People and services for Asian women and children affected by domestic violence*. London: Imkaan

Thiara, R.K. and Roy, S. (2010) *Vital Statistics 2: Key findings report on Black, Minority Ethnic and Refugee Women's and Children's Experiences of Gender-Based Violence*, London: Imkaan.

Thiara, R.K. and Roy, S. (2020) *Reclaiming Voice: Minoritised Women and Sexual Violence*, London: Imkaan and University of Warwick.

Thiara, R.K. and Roy, S. (2021) *Providing Support to Black and Minoritised Survivors during COVID-19*, London: Imkaan.

Thiara, R.K. and Roy, S. (forthcoming 2021) *New Challenges: Impact of Covid-19 on BME Women and BME VAWG Services*, London: Imkaan.

Thomas, A. (2019) 'Resistance, rebellion, resilience and recovery', in J. Watson (ed.) *Drop the Disorder: Challenging the Culture of Psychiatric Diagnosis*, Monmouth: PCCS Books Ltd., 110-119.

Tseris, E. (2017) 'A feminist critique of trauma therapy' in B. Cohen, (2017) *Routledge International Handbook of Critical Mental Health*, London: Routledge.

Turner, R.J., Lloyd D.A. and Taylor, J. (2006) 'Physical disability and mental health: an epidemiology of psychiatric and substance disorders', *Rehabilitation Psychology*, 51 (3), 214-223.

Turrini, G., Purgato, M., Ballette, F., Nose, M., Ostuzzi, G., and Barbui, C., (2017) 'Common mental health disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies', *International Journal of Mental Health Systems*, 11 (52), 51.

UN Women. (2020) *COVID-19 and ending violence against women and girls: ERAW COVID-19 briefs*. Available at:
<https://www.unwomen.org/en/digital-library/publications/2020/04/issue-brief-covid-19-and-ending-violence-against-women-and-girls>

Walker, S. (2020) 'Systemic racism: big, Black, mad and dangerous in the criminal justice system', in Majors, R., Carberry, K. and Ranshaw, T. (2020) *The International Handbook of Black Community Health*, England: Emerald Publishing Limited.

Wallace, S., Yzet Nazroo, J., and Becares, L. (2016) 'Cumulative effect of racial discrimination on the mental health of ethnic minorities in the UK', *American Journal of Public Health*, 106 (7), 1294-300.

Washington, P.A. (2010) 'Disclosure patterns of black female sexual assault survivors', *Violence Against Women*, 7 (11): 1254-1283. Watson, J. (ed.) (2019) *Drop the Disorder: Challenging the Culture of Psychiatric Diagnosis*, Monmouth: PCCS Books Ltd.

Watson, J. (ed.) *Drop the Disorder: Challenging the Culture of Psychiatric Diagnosis*, Monmouth: PCCS Books Ltd.

WHEC, Imkaan, Positively UK and Rape Crisis England & Wales. (2016) *Women's Mental Health and Wellbeing: access to and quality of mental health services*, London: Imkaan.

Wilson, A. (2007) 'The forced marriage debate and the British State', *Race and Class*, 49 (1), 25-38.

Wilson, M. (2001) Black women and mental health: working towards inclusive mental health Services. *Feminist Review*, 68, 34-51.

Women's Aid. (2020) *A Perfect Storm: The Impact of the Covid-19 Pandemic on Domestic Abuse Survivors and the Services Supporting Them*, Bristol: Women's Aid.

Women's Aid. (2021a) *Mental health and domestic abuse: A review of the literature*. Bristol: Women's Aid

Women's Aid. (2021b) *Fragile Funding Landscape: The extent of local authority commissioning in the domestic violence sector in England 2020*, Bristol: Women's Aid.

World Health Organisation (WHO). (2021) *Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women*, Geneva: World Health Organization.

Wright, S and Hutnik, N. (n.d.) *Black Spaces Project South Asian Women Study: Strategies for Living*, London: Black Spaces and Mental Health Foundation.

Yapp, E.J., Oram, S., Lempp, H.K., Agnew-Davies, R., Feder, G., Trevillion, K. and Howard, L.M. (2018) *LARA-VP: A Resource to Help Mental Health Professionals Identify and Respond to Domestic Violence and Abuse (DVA)*, London: King's College London.

Yazdani, A. (1998) *Young Asian women and self-harm: Mental health needs assessment of young Asian women in Newham*, London: Newham Innercity Multifund and Newham Asian Women's Project.

All survivors **#DeserveToBeHeard**

We will not be silenced until all women and children have access to the mental health support they deserve.

© Women's Aid 2021

Women's Aid Federation of England is a registered charity in England & Wales (1054154) and is a company limited by guarantee in England & Wales (3171880)