



Mental health and domestic abuse:

A review of the literature

By Women's Aid

women's aid
until women & children are safe

Written by Jenny Birchall and Lizzie McCarthy, Women's Aid

December 2021

Thank you to all the survivors whose expertise and stories have informed the literature we have reviewed in this report. Thanks also to the staff at Women's Aid for their help in compiling this report.

Thank you to **Ravi K. Thiara and Christine Harrison** for their report which is published alongside this report and helps us ensure that our campaign is centred on the most marginalised survivor voices:

Reframing the Links: Black and minoritised women, domestic violence and abuse, and mental health - A Review of the Literature. (Published by Women's Aid, 2021)

We are extremely grateful to the Gamesys Foundation for its funding support for this report and the #DeserveToBeHeard campaign.

Please cite this report as:

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

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	6
Terminology	7
Gaps in the literature	9
Section One	11
The link between domestic abuse and mental ill health	11
(a) The impact of domestic abuse on mental wellbeing	11
The pathologisation of survivor responses to domestic abuse.....	11
Domestic abuse is a key cause of women’s mental ill health	13
The weaponisation of mental illness by perpetrators	14
(b) Intersecting forms of oppression and experiences of marginalised groups	15
Experiences of Black and minoritised survivors	15
Experiences of older and younger women.....	16
Pregnancy and maternity	17
Experiences of LGBTQ+ survivors	17
Experiences of disabled survivors.....	18
(c) The nature of mental health impacts	19
Impact on self-esteem	19
Mental illness diagnoses	20
The links between suicide and domestic abuse	21
Section two	23
The barriers to accessing mental health support	23
(a) Barriers to disclosure of survivors’ mental health support needs	23
Victim-blaming attitudes/unhelpful professional responses.....	23
The stigma and consequences of a mental health diagnosis.....	25
Disproportionate onus on survivor disclosure and help-seeking	25
Mental ill health is weaponised by perpetrators	26
Accessibility barriers	27
(b) Barriers to healthcare professional enquiry about domestic abuse	28
Gaps in healthcare knowledge	29
Lack of clarity about roles	30
Usefulness of routine enquiry	30
(c) Barriers to support availability	31
Long waiting lists and short-term therapy.....	31

Inappropriate interventions and lack of trauma-informed approaches in healthcare services.....	32
<i>Stretched mental health services and inconsistent service response across the country.</i>	33
Mental health services can create further trauma for survivors.....	34
<i>Under-funding of specialist domestic abuse services.....</i>	34
Section Three	36
Meeting the mental health recovery needs of survivors – the work of specialist domestic abuse services.....	36
a) The work of the women’s sector (including domestic abuse services)	37
Funding challenges.....	37
Mental health support within domestic abuse specialist services.....	38
Specific mental health support within refuges	40
Mental health support within ‘by and for’ specialist services	41
Mental health support offered by the broader women’s sector	43
b) Partnerships between health and domestic abuse services and professionals	43
PATH: Psychological Advocacy Towards Healing	43
IRIS: Identification and Referral to Improve Safety.....	44
Health Pathfinder	45
Conclusions and recommendations.....	47
References	53

Introduction

Domestic abuse can have a devastating and long-lasting impact on the mental health of survivors and their children. However, survivors face a range of barriers in accessing mental health support, and often find that the support that is available is not appropriate, does not recognise the links between domestic abuse and trauma, and can cause re-traumatisation. Meanwhile the mental health impacts of domestic abuse can be weaponised by perpetrators and misunderstood by the healthcare professionals that survivors come into contact with as they attempt to rebuild their lives.

This literature review was developed as part of Women's Aid's **Deserve To Be Heard** campaign.¹ The campaign is calling for recognition of the impact that domestic abuse has on the mental health of women and their children, and the importance of provision of support that meets their needs. This literature review presents an overview of available evidence around domestic abuse, mental health and trauma in the United Kingdom. It is accompanied by another review focusing specifically on the literature around Black and minoritised women, mental health and domestic abuse: **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***. This accompanying review was commissioned in recognition of the campaign's aim to centre the needs of survivors facing multiple forms of oppression, and the services that support them.

Methodology

This literature review was undertaken in 2021. It reviews a total of 64 publications, including peer-reviewed academic literature, grey literature², good practice guidance and case studies. Literature was identified using Google Scholar, with agreed search terms.³ Additional literature was recommended by experts working in the field of mental health and/or domestic abuse. Only English language literature from the year 2000 onwards, with a focus on the United Kingdom, was selected for inclusion. The research questions guiding the review were:

¹ See <https://www.womensaid.org.uk/deservetobeheard/>

² Literature that is not formally published in books or journals, for example third sector organisations' reports

³ The search terms were: "mental health" and/or "psychiatric health" and/or "mental wellbeing" + "domestic violence" and/or "domestic abuse" and/or "intimate partner violence" and/or "partner abuse"

1. What evidence is there of the link between domestic abuse and mental health trauma?
2. What are the barriers facing survivors in attempting to access and continuing to access mental health support?
3. How do specialist domestic abuse services (including 'by and for' services) meet the mental health recovery needs of survivors?

(See the **Terminology** section below for explanations of terms used.)

The limitation of the review is that while it includes evidence identified using the above methods, it cannot represent a complete and definitive overview of all literature in this area. However, it presents a structured and detailed overview of the literature identified on the topic of domestic abuse and mental health in the UK.

Terminology

This review focuses on women survivors, because women are disproportionately impacted by domestic abuse. Women are more likely to be victims of domestic abuse and are more likely to be subjected to coercive and controlling behaviours. Women experience higher rates of repeated victimisation, higher levels of fear and are much more likely to be seriously harmed or killed (Women's Aid, 2020; Women's Aid et al., 2021). The terms women, survivors and victims are used during the course of the review. Due to different terminology that exists to talk about this topic, the studies included in the review use the terms domestic abuse, domestic violence, intimate partner violence (IPV) and domestic violence and abuse (DVA).⁴ Some studies look more broadly at violence against women and girls (VAWG).

Mental health The literature discussed in this review uses a range of different terms when talking about mental health. These include mental ill health, mental illness, mental health problems or challenges, emotional or psychological distress, and mental disorders. When discussing particular studies this review includes the terminology used by those studies without, in all cases, validating such terms. Women's Aid's preference is for terminology that does not imply that there is something wrong with the survivor herself, but rather positions the abuse that the survivor is experiencing as the problem. However, we recognise that terms such as "disorder" can be useful in some circumstances, as a way of describing an impact of abuse that may otherwise be hidden and where diagnosis is an important route to support. However, it is important that the

⁴ The Domestic Abuse Act includes a statutory definition of domestic abuse, which can be found here: <https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted>

role of perpetrators of domestic abuse in causing or exacerbating mental ill health is not obscured.

Black and minoritised survivors The term 'Black and minoritised' is used to talk about survivors who have experienced marginalisation and exclusion because of structural racism. However, it is important to note that this is a broad term that can include women from a wide range of backgrounds and therefore can overlook differences within these groups (Thiara & Harrison, 2021).

'By and for' services When talking about 'by and for' services, we use Imkaan's (2018b) definition: "We define women only VAWG specialist organisations as the by and for expert sector (sometimes written as by and for expert services or organisations). This term refers to specialist services that are designed and delivered by and for the users and communities they aim to serve. This can include, for example, services led by and for Black and minoritised women, disabled women, LGBT women, etc. In the context of VAWG we refer to women only VAWG services as manifesting specific expertise designed and developed to address VAWG."

Trauma The literature we reviewed often discusses domestic abuse as causing trauma. "Trauma", however, is a term that is used in different ways by different authors and health/social care practitioners. The mental health charity Mind describes "trauma" in the following way:

"Going through very stressful, frightening or distressing events is sometimes called trauma. When we talk about emotional or psychological trauma, we might mean:

- situations or events we find traumatic
- how we're affected by our experiences.

Traumatic events can happen at any age and can cause long-lasting harm. Everyone has a different reaction to trauma, so you might notice any effects quickly, or a long time afterwards." From <https://www.mind.org.uk/information-support/types-of-mental-health-problems/trauma/about-trauma/> [Accessed November 2021]

Women's Aid uses a feminist understanding of trauma, which recognises that women as a group are disproportionately impacted by violence and abuse, takes into account the socio-political context of sexism, racism and other forms of structural oppression, and emphasises individual women's strengths and resilience.

Tseris (2013) summarises the feminist approach in the following way:

“Trauma theory, guided by feminist values, challenges the conventions of traditional mental health interventions with women by questioning the assertion that the assessment and diagnosis of clients are the cornerstones of effective work. As such, the focus of counseling is extended beyond the micro level of the “client in treatment,” instead emphasizing the sociopolitical context of women’s lives, especially high levels of trauma experienced by women, such as child abuse and sexual violence, and the impact of these experiences on women’s mental health.” (Tseris, 2013:153)

Trauma-informed This report includes literature that discusses the importance of a trauma-informed approach to supporting survivors of domestic abuse with their mental health. The term “trauma-informed” is often used but sometimes without a specific definition. Elliot et al. (2005) define trauma-informed services as “those in which service delivery is influenced by an understanding of the impact of interpersonal violence and victimization on an individual’s life and development.” The London VAWG Consortium, defines trauma-informed services as those that “work at the client, staff, agency and systems levels from the core principles of: trauma awareness; safety; trustworthiness, choice and collaboration; and building of strengths and skills”. These services “discuss the connections between trauma, gendered violence, multiple complex needs and offer support strategies that increase safety and support connection to services” (London VAWG Consortium, 2020:14).

Pathologisation We use the term pathologisation to mean reducing a survivor’s response to domestic abuse (or reducing a survivor herself) to a medical condition or disease, or defining her as abnormal or problematic, rather than recognising a survivor’s mental distress or ill health as the impact of abuse.

Gaps in the literature

The literature summarised in this report reflects available evidence identified using the strategy and search terms discussed above. Within the literature that this strategy yielded, some evidence gaps emerged.

Evidence gaps appeared around the mental health context for particular groups of women whose experiences of domestic abuse and mental health are impacted by multiple, intersecting forms of oppression. The searches conducted for this review did not yield many studies focusing specifically on the connections between domestic

abuse, trauma and mental health for women of different faiths, LGBTQ+ survivors, disabled women, or women facing different types of communication barriers. While the review of literature on Black and minoritised women, domestic abuse and mental health that accompanies this report (Thiara & Harrison, 2021) is very important in bringing existing literature on this topic together, the authors note that little is still known about some groups of minoritised women. These include 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 (Thiara & Harrison, 2021).

In addition, while the impact of domestic abuse and resulting mental health challenges on survivors in their roles as mothers or carers was included in several of the studies reviewed here, no studies were identified that looked specifically at this topic.

Finally, while the literature identified clearly demonstrates what is not working for survivors of domestic abuse in terms of access to mental health support and the type of support offered, the evidence base on the kinds of mental health support that meet survivors' needs is still emerging, and would benefit from being further developed. We hope to be able to add to this evidence base as the **#DeserveToBeHeard** campaign progresses.

The findings of the literature review are presented below, grouped under the three research questions outlined in the methodology section. These are followed by a final section pulling out some overall conclusions, which are discussed within the context of the current policy landscape for women's mental health.

Section One

The link between domestic abuse and mental ill health

There is a clear body of evidence from both the women's sector and academic research demonstrating how the trauma caused by domestic abuse can have devastating and long-term consequences for survivors' mental wellbeing. Howard et al. (2010) make clear this devastating impact in the following statement:

"The impact of domestic violence has been thought to have psychological parallels with the trauma of being taken hostage and subjected to torture (Dutton, 1992; Herman, 2001)" (Howard et al., 2010:527).

The Taskforce on the Health Aspects of Violence Against Women and Children (2010) points out the sheer scale of the health consequences (both mental and physical) caused by male violence and abuse against women and children:

"...we should start with an appreciation of the scale of the issue: more women suffer rape or attempted rape than have a stroke each year, and the level of domestic abuse in the population exceeds that of diabetes by many times. The same effort to ensure that a heart attack victim or a stroke patient gets rapid and appropriate care should be applied to the victims of violence and abuse" (Taskforce on the Health Aspects of Violence Against Women and Children, 2010:10).

This section explores the extent and nature of the impact of domestic abuse on women's mental wellbeing, the experiences of survivors from marginalised groups and the problematic pathologisation of survivors' mental ill health and mental distress. Our discussion is structured around three main areas:

- (a) the impact of domestic abuse on mental wellbeing;
- (b) intersecting forms of oppression and experiences of marginalised groups; and
- (c) the nature of mental health impacts.

(a) The impact of domestic abuse on mental wellbeing

The pathologisation of survivor responses to domestic abuse

Survivors experience mental ill health as a consequence of the trauma of being subjected to violence and abuse. The impact of this on survivors (including the coping strategies they employ, such as alcohol or drug use) is not generally well understood, including by some healthcare professionals. Furthermore, there is limited

understanding of the fact that abuse happens within a traumatising context of structural oppression (for example, racism and sexism) which also impacts survivors' responses. (See Bradbury-Jones et al., 2011; Mantovani and Allen, 2017; Oram et al., 2017; Sweeney et al., 2019; Trevillion et al., 2014, 2016; Women's Aid et al., 2021.) Analysis of in-depth survivor interviews about their experiences of justice and domestic abuse found that the language used to describe survivors' mental ill health (except sometimes by survivors in self-description) generally shows "very little and usually no understanding of mental illness as the result of trauma and a consequence of the perpetration of domestic abuse" (Women's Aid et al., 2021:48).

Emotional and mental distress are understandable reactions to being subjected to violence and abuse, or "symptoms of abuse" as Humphreys and Thiara describe it in the title of their 2003 article. As one survivor interviewed as part of the *Justice, Inequality and Gender-based violence Project*⁵ put it, what was labelled as depression was actually a sign of the impact oppression had had on her:

"Like what describes me is being bullied to death, you know ... and reacting to being bullied. What label is that, you know? So I've had mental health issues as regards to being depressed because of the situation ... oppression ... I call it oppression, not depression – I have a different description." (Survivor of domestic abuse cited in Women's Aid et al., 2021:56).

However, these reactions to domestic abuse are often pathologised, and the domestic abuse survivors are experiencing (or have experienced) is consequently side-lined or overlooked (Humphreys & Thiara, 2003; The National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019; Sweeney, et al., 2019; Yapp et al., 2018; Women's Aid et al., 2021). This leads to survivors being seen and labelled as problematic or disordered, rather than the perpetration of domestic abuse (and indeed, the perpetrator) being identified as the problem. The focus here is not on a survivor's strengths and needs, but rather on what she lacks, how she is "broken" or what is wrong with her (sometimes known as the "deficit model"). This can be reinforced by perpetrators themselves who tell the survivor and others that she is "crazy" and not to be believed (Stay Safe East, 2021a; Women's Aid et al., 2021; Yapp et al., 2018). As a consequence of this pathologising approach, the perpetrator of abuse is often left unchallenged and the survivor's safety is not addressed. In addition, the survivor may

⁵ <https://research-information.bris.ac.uk/en/projects/justice-inequality-and-gender-based-violence> ESRC-funded project, led by the University of Bristol with partners.

be re-traumatised by healthcare responses that do not show understanding of the dynamics of abuse and the importance of empowerment.

“The behaviours and thoughts that experts in some cultures label psychotic or schizophrenic are usually understandable reactions to our life events and circumstances. So rather than ask, ‘What is wrong with you?’ and ‘What shall we call it?’ It is more sensible, and useful, to ask, ‘What happened to you?’ and ‘What do you need?’ ” (Read, 2018, cited in Sweeney, et al., 2019:600).

Women’s Aid et al. (2021) discuss how being labelled as mentally unwell has long-lasting negative implications for survivors, characterising them as unstable and implausible, and over-shadowing professional responses to them. The authors also describe how these labels draw on wider sexist discourses that denote women as being supposedly unstable, over-emotional or hysterical⁶:

“Perpetrators often seemed to benefit from feeding into wider stereotypes of women as a group being markedly unstable or over-emotional (Glass, 1995). One survivor interviewed spoke of her father being convinced by the perpetrator that she was just one of these women ‘...that you know like I overreact.’ Others spoke of the rules (unspoken and sometimes spoken in advice given by others) to not appear emotional because of the negative stereotypes this would be reflecting.” (Women’s Aid et al., 2021:51)

Domestic abuse is a key cause of women’s mental ill health

The trauma caused by the perpetration of violence and abuse against women is a key driver of women’s mental ill health (Agenda, 2021; Barron, 2004; Jonas et al., 2016; Scott et al., 2015; Women’s Mental Health Taskforce, 2018) and therefore domestic abuse services need to be adequately resourced to meet women’s mental health support needs (Ferrari et al., 2016). Analysis of data from the Adult Psychiatric Morbidity Survey (a representative community-based sample)⁷ found that experiences of violence and abuse are strongly related to subsequent mental ill health (Scott et al., 2015).

⁶ The sexist origins of the word ‘hysteria’ are interesting to note. Oxford Learner’s Dictionaries describe the word’s origin as: “early 19th cent.: from Latin hystericus from Greek husterikos ‘of the womb’, from husterā ‘womb’ (hysteria was thought to be specific to women and associated with the womb).” From <https://www.oxfordlearnersdictionaries.com/definition/english/hysteria> [Accessed November 2021]

⁷ The study looked at six groups of people: those with relatively little experience of violence or abuse; those who had experienced physical violence from a partner; those who had experienced extensive physical violence from a partner; those who had experienced sexual violence as a child; those who had experienced sexual violence as an adult (and sometimes also in childhood); and those with experience of extensive physical and sexual violence as adult and child.

There is also evidence demonstrating the specific negative impacts of domestic abuse on the mental health of survivors. Ferrari et al. (2016) surveyed 260 women accessing specialist domestic abuse services in the UK. The study found that the proportion of women in the sample who presented symptoms of depression was twice as high as that of women in UK general practice, and for symptoms of anxiety, the proportion was three times higher. The study also found that increasing severity of intimate partner violence (IPV) was associated with worsening mental health, especially anxiety and a diagnosis of post-traumatic stress disorder (PTSD) (Ferrari et al., 2016). Jonas et al.'s (2016) analysis of the adult psychiatric morbidity survey also found that being a victim of IPV is strongly associated with a wide range of psychiatric diagnoses. This led the authors to argue that the:

“...high prevalence of experiences of partner violence, and the strength of the association with every disorder assessed, suggests enquiry about partner violence is important in identifying a potential risk and maintenance factor for psychiatric disorders, and to ascertain safety, particularly in women as they are at greatest risk of being victims of violence.” (Jonas et al., 2016:189)

The weaponisation of mental illness by perpetrators

Some perpetrators target women who are already experiencing mental health problems (problems that pre-exist the intimate relationship with the perpetrator). This means, because of abusers' actions in targeting women they perceive as vulnerable, women with pre-existing mental ill health are more likely to experience domestic abuse and sexual violence (Howard et al., 2010; Khalifeh et al., 2015; Pettitt et al., 2013; Stay Safe East, 2021a; Women's Mental Health Taskforce, 2018). Pettit et al. (2013) discuss this weaponisation of mental ill health by perpetrators of domestic abuse:

“Many participants felt that having a mental health problem was a factor in their victimisation. They gave examples of perpetrators picking up on visible signs of vulnerability and distress, and known perpetrators preying on them when they were unwell and less able to protect themselves. Some felt perpetrators targeted them because they understood that people with mental health problems are more easily discredited and commonly disbelieved when they report. A few said they felt perpetrators were motivated by hatred and hostility towards their mental health status.” (Pettit et al., 2013:7).

Khalifeh et al. (2015) state that, compared to the general population, their study found that patients with severe mental illness (SMI) “were at substantially increased risk of domestic and sexual violence [...] Comparing SMI patients with controls, adulthood

domestic violence was reported by 69% v. 33% of women” (2015:881).⁸ In their research into the experiences of people with mental health issues who had been victims of crime, Pettit et al. (2013) found that participants reported high rates of sexual and domestic violence. The authors found that 40% of women with mental health issues reported being a victim of rape or attempted rape in adulthood, and 10% had been a victim of sexual assault in the past year.⁹

(b) Intersecting forms of oppression and experiences of marginalised groups

Survivors of domestic abuse who are experiencing mental ill health (because of or exacerbated by the abuse) often feel stigmatised, marginalised or ignored (for example, see the survivors’ stories in McGarry & Hinliff-Smith, 2021, and in Pathfinder, 2021). Survivors fear that the label of ‘mentally unwell’ will cast doubt on their believability and these fears are often grounded in their life experiences of harmful responses to domestic abuse and sexism and misogyny (Women’s Aid et al., 2021). This process of marginalisation is compounded for groups of women who face additional forms of structural oppression. These forms of intersecting oppression include sexism, racism, ageism, discrimination against LGBTQ+ people, cultural and religious discrimination, and disability discrimination. We discuss the mental health experiences of marginalised groups of survivors below. For a discussion on barriers to support, also see **Section Two**.

Experiences of Black and minoritised survivors

The literature review published alongside this one (Thiara & Harrison, 2021) offers valuable insights on the experiences of Black and minoritised survivors in regards to mental health and experiences of mental health support.

Thiara & Harrison (2021) highlight that Black and minoritised women are often entrapped in contexts of extreme abuse for long periods of time and so are at increased risk of experiencing severe mental health problems. Their report shows that

⁸ The study randomly recruited 303 psychiatric patients who were interviewed using the British Crime Survey domestic/sexual violence questionnaire. Experiences of violence in this sample were then compared with those from general population controls.

⁹ “The survey used a modified version of the Crime Survey for England and Wales (CSEW) with a random sample of 361 people with severe mental illness (SMI) using community mental health services in London. The findings from this sample were compared with those from the general population who took part in the CSEW survey over the same time period in London.” (Pettit et al., 2013: 6)

structural racism contributes negatively to survivors' mental wellbeing, underlies barriers to accessing appropriate support and is weaponised by perpetrators in their abuse. The report also makes clear the importance of support related to mental health and domestic abuse that recognises and understands the intersection of multiple forms of oppression and discrimination:

"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" (Thiara & Harrison, 2021:44).

However, the report also notes that literature that explicitly focusses on the relationship between domestic abuse experienced by Black and minoritised women and their mental wellbeing is limited, and where there is evidence, this predominantly focuses on South Asian women.

Experiences of older and younger women

Older women¹⁰ have been historically marginalised from policy and practice discussions and research on domestic abuse, or misrepresented as unlikely victims of violent crime (Bows, 2016; McGarry et al., 2016). There are, however, significant links between older women's experiences of domestic abuse and mental ill health (McGarry, et al. 2016), and older women who have experienced abuse from a partner(s) for lengthy periods of time report a sense of loss and feelings of being "stripped of their identity" (McGarry, et al. 2016: 2188). For some older women, their experiences of abuse and violence have endured for most of their adult lives. McGarry et al. (2016) conclude that:

"While all abuse is detrimental to health and wellbeing, it was clear that the cost, in terms of mental health and wellbeing, for older women in our review was greatly felt" (McGarry et al., 2016: 2188).

Research by Agenda (2018) emphasises the specific experiences of young survivors. It notes that sexual exploitation, abuse and trauma are huge drivers of poor mental health in young women and estimates that more than a quarter of 16 to 24-year-old

¹⁰ The definition of "older" varies. McGarry et al. (2016: 2178) note that older women are "...defined variously within the literature globally as encompassing a broad age range of 45 years and over..." Hannah Bows, in her work on domestic homicides of older people (2019), defines "older" as aged sixty and over.

women have a common mental health diagnosis, one in seven have been diagnosed with PTSD and a quarter have self-harmed (Agenda, 2018).

Pregnancy and maternity

Evidence also shows that women who are pregnant or new mothers are impacted in particular ways. A review of 67 papers published before February 2013 aimed to estimate the prevalence and odds of experiencing domestic violence among women with antenatal and postnatal mental ill health. The authors concluded that high levels of symptoms associated with perinatal depression, anxiety and PTSD are significantly associated with having experienced domestic violence. They note the importance of high-quality evidence on how maternity and mental health services should address domestic violence and improve health outcomes for women and their infants in the perinatal period (Howard et al., 2013).

Experiences of LGBTQ+ survivors

There is a limited evidence base illustrating the specific experiences of LGBTQ+ survivors relating to the mental health impacts of domestic abuse. However, research from SafeLives (2019) indicated that within a sample of data collected by 50 domestic abuse services, a higher proportion of victims of domestic abuse identifying as LGBTQ+ reported having mental health needs. In addition, research from Stonewall and YouGov has highlighted the high numbers of LGBTQ+ people with mental health problems when compared to the general population, with 55% of LGBTQ+ women (in a survey of 5,000 LGBTQ+ people in England, Wales and Scotland) reporting having experienced depression in the last year (Bachmann & Gooch, 2018).

A report on transgender people's experiences of domestic abuse describes how transphobic emotional abuse from a partner combined with the harassment that transgender people often experience in their daily lives "...negatively impacts on their sense of self and emotional wellbeing" (Roch et al., 2010: 16). The report also highlights that:

"Mental health practitioners experienced in working with transgender people have found that transphobic reactions from partners and pressure on transgender people not to express their gender identity or transition have very negative impacts on their mental health..." (Roch et al., 2010: 16, citing Lev, 2004).

Experiences of disabled survivors

Stay Safe East¹¹ highlights the role that discrimination and exclusion play in perpetuating health inequalities for disabled women:

“Discrimination impacts on disabled women’s well-being, life expectancy and on their access to health services” (Stay Safe East, 2021c:8).

Their work shows how disabled women face intersecting inequalities through sexism and disability discrimination, and sometimes other forms of oppression as well (Stay Safe East, 2021a & 2021c).

Disabled women are more likely to experience domestic abuse than women who are not disabled. 14.7% of disabled women had experienced domestic abuse in England and Wales in the year ending March 2020, compared to 6.0% of women who are not disabled (ONS, 2020).¹²

One international study of the experiences of disabled survivors concluded that the impact of violence and abuse on mental health was “catastrophic”:

“Consequences of violence are very severe. The effects of violence on mental health were catastrophic, but violence was a major cause of other physical and cognitive impairments as well” (Ludwig Boltzmann Institute of Human Rights et al., 2014: 33-34, emphasis in original text).

McCarthy et al.’s study (2017) of the experiences of survivors with learning disabilities describes the “significant psychological impact” (p. 274) of domestic abuse.

“Many women described feeling humiliated by what was happening and how their self-esteem became very low.” (McCarthy et al., 2017:274)

Mental ill health can itself be described as a disability and (as discussed previously) women experiencing mental ill health and/or other disabilities may be targeted by perpetrators. Some disabled women face abuse by people who assume the role of their ‘carer’ (Hague et al., 2008; Ludwig Boltzmann Institute of Human Rights et al., 2014; Stay Safe East, 2021a; Stay Safe East, 2021c).

¹¹ Stay Safe East is “... the only user-led ‘by and for’ organisation in the UK providing long-term advocacy and support to disabled victims/survivors of multiple forms of abuse: domestic and sexual abuse and other forms of Violence against Women and Girls (VAWG), hate crime, harassment, cuckooing, abuse by care workers or personal assistants (which we consider to be domestic abuse), and abuse in residential and other institutions.” (Stay Safe East, 2021a:1).

¹² Based on data from the Crime Survey for England and Wales.

Disabled women face additional barriers in accessing domestic abuse support and as a result may be forced to experience the trauma of abuse for longer (Hague et al., 2008; Stay Safe East, 2021c). A survivor's disability or disabilities may over-shadow healthcare responses. Disabled women may present to healthcare professionals with mental ill health concerns or physical injuries caused by an abuser, but these are interpreted instead as consequences of her disability (Stay Safe East, 2021a & 2021c).

"Assumptions may be made about disabled women: that bruising and other physical marks, falls etc. are a result not of abuse but of the person's impairment; that women with fluctuating capacity due to cognitive impairments, mental health issues, learning disabilities or autism do not know their own minds and are 'imagining' abuse" (Stay Safe East, 2021a:20)

(c) The nature of mental health impacts

Impact on self-esteem

Studies have illustrated the negative impacts that the trauma caused by domestic abuse can have on survivors' self-esteem, and how it can erode their sense of identity (Barron, 2004; Bradbury-Jones et al., 2011; Hailes et al., 2018; Liverpool Mental Health Consortium's What Women Want group, 2014; McCarthy et al., 2017; National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019; Rivas et al., 2015). The report of the National Commission on Domestic and Sexual Violence and Multiple Disadvantage describes the long-lasting consequences of domestic abuse on identity and wellbeing in the following way:

"Women described how the consequences of abuse lead to years of depression, anxiety and uncertainty. The psychological consequences of abuse eroded their entire sense of self. At the same time, the social stigma they experienced from others, as women who were experiencing other challenges in their lives like addiction or mental ill health, compounded how they had been treated by their abusers" (National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019:8).

Humphreys and Thiara (2003) included the survivor's quote below in their research on the experiences of women and children using domestic abuse outreach services, which illustrates the devastating impact of abuse on mental wellbeing and self-esteem:

"I didn't see it as violence, being shouted at. I just thought I was too weak. You get worn down by it over the years; you think you are useless, you think you are worthless, you think you are hopeless." (Petra, from Cascardi et al. (1999), quoted in Humphreys & Thiara, 2003:214).

Mental illness diagnoses

There are several studies focusing on the type of mental health issues that can arise from domestic abuse and many use medical terms and descriptions, such as “post-traumatic stress disorder” (PTSD), “anxiety disorder”, “sleep disorder”. As noted previously, we are cautious of using such medical terms because of the risk of harmfully suggesting that there is something intrinsically wrong with the survivor, instead of the abuse she is experiencing/experienced and the actions of the perpetrator(s) being wrong. However, we also recognise that medical diagnoses and terms can be useful in helping survivors to access support and in describing the ill health that survivors are experiencing, as long as the impact of abuse is recognised and the survivors’ safety addressed as part of this support. Abrahams (2007) discusses the dilemma at the heart of using medical terms to describe the impact of domestic abuse in her discussion of the diagnosis of PTSD:

“The advantage of a diagnosis of PTSD is that it directly links domestic violence with its effects on mental health and emotional well-being and can enable a woman to access professional help, including appropriate medication, without feeling that she is, in some respect, personally deficient, inferior or inadequate, as might be the case with a diagnosis such as ‘borderline personality disorder’. However, it can be seen as continuing to pathologise women, focusing on ‘the woman’ and ‘her problem’ rather than taking account of the situation that has caused it, the controlling nature of the abuse and the circumstances in which she may have to continue to live.” (Abrahams, 2007:26)

Humphreys and Thiara (2003) noted that women themselves often describe how they are feeling as “emotional distress” resulting from the abuse. The emotional distress described by the women in their study often fitted patterns associated with diagnoses of PTSD, depression and/or self-harm. Several studies highlight the prevalence of PTSD among survivors of domestic abuse. Rivas et al. (2015) found that survivors are nearly four times more likely to experience PTSD than women who have not been abused by their partner. Howard et al. (2010) also found that PTSD was one of the two most prevalent mental health issues associated with domestic abuse (along with depression).

Oram et al. (2017) note that research to date has tended to focus on depression and PTSD when looking at the relationship between mental health and domestic abuse and/or sexual violence, but there is also evidence demonstrating the associations between domestic abuse and other mental health conditions such as self-harm and psychosis. This point is reinforced by a range of other studies. Rivas et al. (2015) state that women living in abusive relationships are two to three times more likely to be diagnosed with depression or psychosis. Howard et al. (2010) point out that after PTSD

and depression, domestic abuse is also associated with suicidal behaviour, sleep and eating-related health issues, social dysfunction, the exacerbation of psychotic symptoms and use of alcohol and drugs. The authors conclude that “any strategy to reduce the burden of women’s mental health problems should include efforts to identify, prevent or reduce violence against women” (Howard et al., 2010:527).

Work to analyse data from the 2007 adult psychiatric morbidity survey found that being a victim of IPV is strongly associated with a wide range of mental ill health diagnoses: PTSD; eating-related health issues; alcohol and drug misuse and psychosis. This was the case for both men and women, but the rates of IPV were significantly higher in women (18.7% of men had experienced some form of IPV compared with 27.8% of women). Physical abuse was associated with common mental disorders, eating disorders and PTSD in women, whereas there were significant associations for both women and men between physical abuse and substance and alcohol health problems and psychosis. Emotional abuse was significantly associated with common mental health diagnoses in both men and women (Jonas et al., 2014).

The links between suicide and domestic abuse

The links between domestic abuse and victim suicide/suicidal ideation have been highlighted in several recent pieces of research. In 2020-21, 45.6% of women in refuge services reported feeling depressed or having suicidal thoughts as a direct result of the domestic abuse they had experienced (Women’s Aid, 2021a and 2021e:9).¹³ Research based on a sample of 3500 of Refuge’s service users found that almost a quarter of these service users had felt suicidal at some point. 18% had made plans to end their life and 3.1% had made at least one suicide attempt. In addition, 86% of the sample scored above the cut off for clinical concern on the CORE-10 measure of psychological distress, and 83% reported feeling despairing and hopeless; a key determinant for suicidality (Aitken & Munroe, 2018).

¹³ Data on number of women having reported feeling depressed or having suicidal thoughts are from On Track: The Women’s Aid case management and outcomes monitoring database. On Track is used by over 85 local service providers throughout England. Services contribute to a national dataset by recording information on women’s experiences of abuse, the support they are offered, and the outcomes achieved. Data here are from a sub-sample (3,194 refuge service-users) of this national dataset where information about service users was taken from cases closed during 1st April 2020 – 31st March 2021 and where a detailed abuse profile for service users was available.

Analysis of data from three commissioned domestic abuse service providers in Kent showed that 63% of clients were feeling depressed or having suicidal thoughts (Abbott et al., 2020). The team went on to analyse all publicly available Domestic Homicide Reviews (DHRs) in England since 2016 (93). 26% of these DHRs contained a suicide in either domestic abuse victim or perpetrator; 10 were victim suicides, and 13 were perpetrator suicides. This was considered an underestimation as many victims and perpetrators die by suicide without a DHR being conducted (Abbott et al., 2020).

Data from the Domestic Homicides Project, which examined deaths considered to be a domestic homicide or suspected victim suicide with a known history of domestic abuse since 23rd March 2020 and 31st March 2021, show that while the largest proportion of deaths in the sample (49%), were intimate partner homicides (IPH), 18% were attributed to suspected victim suicide. Female suspected suicide victims were even more likely than female IPH victims to be previously known as victims of high-risk domestic abuse involving coercive control. This previous domestic abuse was highly gendered; nearly all suspects were male (91%, where known) and 90% of victims were female. As with intimate partner homicide, attempted or actual separation was also a factor in a sizeable number of cases of victim suicide. The authors note that despite this new evidence of a sizeable number of suspected victim suicides with a known history of domestic abuse, these figures are likely to be an under-estimate, as they exclude those suicides where a prior history of domestic abuse was not known to police. They conclude that: “the persistent, high-risk, high-harm nature of the abuse which preceded these suspected suicides shows that domestic abuse has an extremely significant impact on victims’ mental health” (Bates et al., 2021:13).

In the next section we will present evidence on the barriers facing survivors in accessing support for the mental health concerns discussed above.

Section two

The barriers to accessing mental health support

This section explores the barriers to mental health support, wherever that support may be located. All of the barriers facing survivors that are discussed here are heightened for survivors from minoritised or marginalised groups, and for those who are experiencing multiple disadvantage (Agenda, 2021; Agenda, 2018; Bailey, 2017; Hailes et al., 2018; Thiara & Harrison, 2021). We will highlight evidence of these additional barriers (that we have found in the literature) throughout our discussion. See also the discussion on “Intersecting forms of oppression and experiences of marginalised groups” in **Section One**. A detailed discussion of the barriers facing Black and minoritised survivors can be found in Thiara and Harrison (2021), which is published alongside this report and highlights the connection between racism and health inequalities:

“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). (Thiara & Harrison, 2021:12).

The discussion below groups barriers under three main themes:

- (a) barriers to disclosure of survivors’ mental health support needs;
- (b) barriers to healthcare professional enquiry about domestic abuse; and
- (c) barriers to support availability.

(a) Barriers to disclosure of survivors’ mental health support needs

Our review of the literature revealed evidence of many barriers to disclosing mental health problems caused by domestic abuse and to seeking appropriate support.

Victim-blaming attitudes/unhelpful professional responses

Harmful victim-blaming attitudes and language are common, and inappropriate, discriminatory and unsympathetic responses from professionals pose a significant barrier to disclosing abuse and seeking related mental health support (Humphreys & Thiara, 2003; Liverpool Mental Health Consortium's What Women Want group, 2014; McGarry et al., 2021, National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019; Pettitt et al., 2013; Thiara & Harrison, 2021; Women’s Aid

et al., 2021). Some of the literature emphasises the importance of a trusting relationship between healthcare professionals and survivors for women to feel safe enough to be able to talk about domestic abuse and mental ill health (Bradbury-Jones et al., 2011; Hailes et al., 2018; Rose et al., 2011). Rose et al. (2011:189) note that both service users and professionals find that "...enquiry and disclosure were facilitated by a supportive and trusting relationship between the individual and professional."

Unhelpful professional responses include the separation of mental health concerns from experiences of abuse (see the discussion in **Section One** about the pathologisation of the impact of domestic abuse), focusing solely on mental health symptoms and physical injuries rather than the abuse that underlies them (Liverpool Mental Health Consortium's What Women Want group, 2014; Melendez-Torres et al., 2021; The National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019; Pettitt et al., 2013; Taskforce on the Health Aspects of Violence Against Women and Children, 2010; Yapp et al., 2018; Women's Aid et al., 2021). This means that individual domestic abuse survivors are seen as responsible for their mental health problems and related coping strategies (such as alcohol or drug use), rather than identifying the abusive actions of the perpetrator(s) as the root problem and recognising survivors' mental ill health as the consequence of trauma.

A report by The National Commission on Domestic and Sexual Violence and Multiple Disadvantage notes that:

"A failure to understand the impact of abuse could further compound women's negative experiences – pathologising their responses to violence, or blaming them for the problems they face, rather than acknowledging the root of the trauma they have experienced" (The National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019:2).

Thiara and Harrison's (2021) review, published alongside this report, includes a detailed analysis of the influence of racism on perpetuating health inequalities, including how racist stereotypes can exclude Black and minoritised women from accessing appropriate mental health support. The authors also highlight that, as a result: "There is strong evidence suggesting that Black and minoritised women take longer to seek help and suffer abuse for longer" (Thiara & Harrison, 2021:16-17).

The survivors' narratives included in McGarry and Hinscliff-Smith's (2021) research into experiences of women survivors within the healthcare system demonstrate how survivors' overriding feelings were of 'timewasting' and of guilt about not being able to comply with professional advice. Women blamed themselves for the circumstances in

which they found themselves; a sense of blame that was often reinforced by the perpetrator and sometimes by the healthcare professionals with whom they came into contact. Also, as previously discussed in **Section One**, disabled survivors may face “diagnostic overshadowing” in their interactions with healthcare services. This is where healthcare professionals do not recognise mental health concerns as being the result of abuse, but instead make assumptions that these are the consequences of disability (Stay Safe East, 2021a & 2021c).

The stigma and consequences of a mental health diagnosis

Survivors often fear that they will not be believed or taken seriously, or will be stigmatised and labelled as ‘mentally unwell’ if they speak about mental health challenges (these fears are sometimes informed by negative past experiences) (National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019; Women’s Aid et al., 2021). This prevents them from seeking support and disclosing mental health concerns and/or domestic abuse to healthcare professionals (Pettitt et al., 2013; Rose et al., 2011).

Women’s Aid’s recent research with the University of Bristol found that this label of “mentally unwell” has long-lasting negative implications for female survivors, undermining their credibility and overshadowing responses to domestic abuse (from family/friends and from professionals):

“The label of ‘mentally unwell’ cast doubt on their [female survivors] ‘wholeness’ as people, and relegated them to the position of “broken” or “psychologically so damaged”. This discourse designates female survivors as problematic (rather than the abuse and violence committed against them being the problem) and serves to minimise or obscure the perpetration of abuse” (Women’s Aid et al., 2021:48).

Survivors with children are also reluctant to disclose domestic abuse, and mental health challenges stemming from the abuse, for fear that social services may get involved and they will be judged as “failing to protect” their children from abuse (Rose et al., 2011). They also fear that mental health diagnoses will be used against them in any child contact or child protection legal proceedings (Humphreys & Thiara, 2003; Liverpool Mental Health Consortium’s What Women Want group, 2014; The National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019; Rose et al., 2011).

Disproportionate onus on survivor disclosure and help-seeking

An onus on the survivor herself disclosing abuse or seeking out support is in itself problematic. The emphasis should rather be on services reaching out to survivors and

healthcare professionals safely and sensitively asking the right questions (Hailes et al., 2018) (see the discussion later in this section on “routine enquiry”). The impact of domestic abuse is often lowered self-esteem (Bradbury-Jones et al., 2011; Evans et al., 2018a; Liverpool Mental Health Consortium's What Women Want group, 2014; Rivas et al., 2015) and feelings of shame (Barron, 2004; Rose et al., 2011), so survivors may not be in an emotional position to feel “strong enough” to ask for support (Pettitt et al., 2013). As noted in **Section One** of this report, McGarry et al. (2016) highlight that some older survivors have experienced domestic abuse for a long period of time (for some this has been the majority of their adult lives), and the impact on their self-esteem and confidence may be devastating, including feeling a “loss of personal identity” (p. 2188). Hailes et al. (2018) note:

“As well as mentioning specific services or interventions, some women were also clear that they were unable to engage with services as life felt too chaotic and complex to be able to do so. The expectation for women to be reaching out to services, rather than services proactively attempting to engage women where they are (either physically or emotionally), puts the onus on women to be responsible for their own protection and support. A few women said that being sectioned or given a prison sentence was the only thing that finally meant they had to engage with some form of service” (Hailes et al., 2018:14).

Mental ill health is weaponised by perpetrators

The stigma, shame and negative consequences associated with being diagnosed or seen as mentally ill are often weaponised by perpetrators of domestic abuse to mask their abuse and discredit survivors (Humphreys & Thiara, 2003; McGarry et al., 2021; Pettitt et al., 2013; Rose et al., 2011; Safelives, 2019; Women’s Aid et al., 2021), and undermine survivors’ roles as mothers in family court proceedings or contact with social services (Birchall and Choudhry, 2018; Coy et al., 2012; Katz, 2014; Safelives, 2019; Thiara & Harrison, 2016). As Women’s Aid et al. (2021) highlight:

“It was also clear in the survivors’ accounts that this label of being ‘crazy’ was an effective tool used by perpetrators to silence survivors, discredit stories of abuse and bolster their position as the person in control” (Women’s Aid et al., 2021:50).

A sense of contrast can be key in this weaponisation of mental ill health: the perpetrator presents himself as articulate, calm and reasonable and therefore to be believed; in contrast to the survivor’s mental and emotional distress (Barron, 2004; Women’s Aid et al., 2021). Perpetrators may also attend healthcare appointments with survivors and seem to be “over-protective” or talking on their behalves in order to control the situation and hide their abuse (Yapp et al., 2018). As discussed in **Section One**,

perpetrators can draw on sexist stereotypes that designate women as a group as markedly unstable or hysterical (Women's Aid et al., 2021).

As also noted in **Section One**, some survivors may be initially targeted by perpetrators because of the survivors' mental health problems (pre-existing the intimate relationship in question) (Howard et al., 2010; Pettitt et al., 2013; Stay Safe East, 2021a). Other tactics used by perpetrators include using a survivor's insecure immigration status (or lack of clarity about immigration status) as the basis of threats that prevent survivors talking to domestic abuse or healthcare services (Hailes et al., 2018; Thiara & Harrison, 2021).

Accessibility barriers

Survivors also experience barriers when information and services on mental health and trauma are not accessible to all. This can include communication barriers affecting survivors from a range of marginalised groups, including those who are: Deaf and hard of hearing; speakers of languages other than English; blind or visually impaired; have communication impairments (such as being non-verbal); are neurodiverse; have learning difficulties; and have basic or no access to literacy (VAWG sector working group, 2021). It can also include physical barriers for disabled survivors, who even in urban areas may struggle to travel to services, or if they are wheelchair users, may experience difficulties accessing services' physical locations (Stay Safe East, 2021a). In addition, Stay Safe East argues that "the physical environment of most mental health wards presents considerable access barriers for disabled patients [...] inadequate physical access to toilets, showers, bedrooms and shared facilities; intense lighting which may trigger sensory overload in neuro-diverse people, high levels of noise" (Stay Safe East, 2021b:7).

Survivors with insecure immigration statuses may fear deportation if they reach out to services (LAWRS, accessed 2021; Liverpool Mental Health Consortium's What Women Want group, 2014; Thiara & Harrison, 2021), and may not have access to accurate information about their rights and the availability of free healthcare services (Hailes et al., 2018; Liverpool Mental Health Consortium's What Women Want group, 2014; The National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019). Survivors who are denied recourse to public funds because of their immigration status do not have access to many publicly funded services (Liverpool Mental Health Consortium's What Women Want group, 2014; Women's Aid, 2021b, 2021c). In addition, some migrant survivors have fears about data sharing between health and immigration agencies, which prevent them from attempting to access services (HMICFRS et al., 2020).

Where 'by and for' specialist services set up for particular communities of survivors are not available, women from marginalised groups may find their only option is to attempt

to access more generic mental health and/or domestic abuse services. However, this is difficult if staff members do not have the required cultural awareness of how mental distress and illness are expressed (Thiara & Harrison, 2021), and if services are not provided in survivors' first languages and do not have access to appropriately trained interpreters (Hailes et al., 2018; Liverpool Mental Health Consortium's What Women Want group, 2014; The National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019; Thiara & Harrison, 2021). Hailes et al. (2018) warn that:

“Misinformation about their rights, including threats of what would happen if they were to disclose this abuse, along with the fact that many of these women do not speak English as their first language, contributes to their inability and lack of awareness when it comes to accessing vital support” (Hailes et al., 2018:9).

(b) Barriers to healthcare professional enquiry about domestic abuse

The issue of survivors not being asked about possible domestic abuse by healthcare professionals (including GPs and mental healthcare specialists) is a key theme in the literature (Barron, 2004; Howard et al., 2010; Liverpool Mental Health Consortium's What Women Want group, 2014; Melendez-Torres, 2021; Rose et al., 2011; Trevillion et al., 2016; Yapp et al., 2018). On the occasions when enquiry about domestic abuse is made, it can tend to focus on physical injuries (Humphreys & Thiara, 2003). This lack of enquiry potentially leads to missed opportunities to support survivors, help them be safe and address the abuse being perpetrated. One study that engaged with 42 female survivors of domestic abuse found “...few examples of health professionals asking women if they had experienced domestic abuse...”, and only two of the 42 women in the study had been given information about or directly referred to a specialist domestic abuse support service by healthcare professionals (Liverpool Mental Health Consortium's What Women Want Group, 2014).

Healthcare professionals may also lack clarity on how and when to share information about domestic abuse and how to record information about abuse (Dheensa, 2020; Trevillion et al., 2016). There are discrepancies between and some gaps within guidance documents that have been produced on these issues (Dheensa, 2020).

The main reasons suggested by the literature behind this lack of enquiry seem to be gaps in healthcare professionals' knowledge about potential signs of domestic abuse, lack of knowledge about the link between mental ill health and trauma, and a lack of clarity about whose role it is to enquire about potential domestic abuse. We explore these issues below.

Gaps in healthcare knowledge

One research report argues that “presentation of symptoms of mental illness in generalist or psychiatric practice should be considered a potential indicator of past or current IPV, or possibly non-partner domestic violence” (Ferrari et al., 2016:8). However, the evidence strongly shows that many healthcare professionals are not making the links between domestic abuse, trauma and mental ill health (Liverpool Mental Health Consortium's What Women Want group, 2014; Melendez-Torres, 2021; Pettitt et al., 2013; Taskforce on the Health Aspects of Violence Against Women and Children, 2010; The National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019; Yapp et al., 2018).

A number of studies agree that gaps in healthcare professionals’ knowledge about domestic abuse (and the consequential negative impact on professionals’ confidence in addressing abuse) present a major barrier for survivors seeking support (Bradbury-Jones et al., 2011; Mantovani & Allen, 2017; Oram et al., 2017; Rivas et al., 2015; Rose et al., 2011; Sweeney et al., 2019; Trevillion et al., 2014 & 2016). Barron (2004) also notes that a lack of expertise and confidence in discussing domestic abuse may lead healthcare professionals to fear opening a “can of worms” when enquiring about possible abuse. In addition, time constraints can mean healthcare professionals feel they do not have opportunity to ask about domestic abuse or adequately respond to disclosures (Rivas et al., 2015). In one national online survey, only 23% of survivor respondents¹⁴ were confident that mental health professionals are aware of and/or able to identify signs of violence and abuse (Pathfinder, 2021). While some of the literature identified for this review included qualitative data demonstrating health professionals’ feelings around enquiring about domestic abuse (for example, Mantovani & Allen, 2017; Rose et al., 2011), we did not find quantitative data measuring professionals’ levels of confidence.

Knowledge gaps can be addressed through specialist training, as demonstrated by the success of the Identification and Referral to Improve Safety (IRIS) programme in identifying patients who are experiencing domestic abuse and referring them to specialist domestic abuse support (see **Section Three** of this report for further details) (Barbosa, et al., 2020; Feder et al., 2011 & 2016). IRIS provides ongoing training and education for the clinical teams and ancillary staff, clinical enquiry and care pathways for primary health care practitioners and an enhanced referral pathway to specialist

¹⁴ 143 survivors took part in the Pathfinder survivor consultations, but it is not clear how many of these 143 completed the national online survey stage of the consultations.

domestic abuse services for patients with experience of domestic abuse (Barbosa, et al., 2020).

Lack of clarity about roles

There seems to be a lack of clarity about whose role it is to enquire about domestic abuse, with some healthcare professionals believing this does not fall under their remit (Oram et al., 2017; Rose et al., 2011). Rose et al. (2011) include this quote from a mental health professional in their research:

“It’s not in my list of things that I now have to cover... I suppose my first response to that is, should we be addressing this? Because I think so many things are coming under the role of psychiatry to sort out when actually they are not mental health problems... suppose I struggle a bit with us taking on things that aren’t mental health problems... perhaps we should be directing people elsewhere.” (P20, female, psychiatrist cited in Rose et al., 2011:191)

Usefulness of routine enquiry

Some of the literature discusses routine enquiry about domestic abuse by healthcare professionals. While Howard et al., writing in 2010, described "...a limited evidence base on the effectiveness of routine enquiry in improving health outcomes..." (2010:531), subsequent studies have strengthened the evidence base in favour of routine enquiry (Feder et al., 2016; Jonas et al., 2014; Melendez-Torres et al., 2021). Howard et al. (2010) go on to state that:

“...studies suggest that routine enquiry will be optimally effective if mental health care professionals are trained in how to ask about domestic violence safely, understand the nature of domestic violence and are able to support victims, including by appropriate referral to domestic violence services.” (Howard et al., 2010:531)

Where discussed in the literature, routine enquiry is generally seen as desirable, providing that the healthcare professionals have received specialist training, are able to enquire in a sensitive and safe way, and know what action to take when abuse is disclosed (Agenda, 2019; Barron, 2004; Feder et al., 2016; Ferrari et al., 2016; Howard et al., 2010; Liverpool Mental Health Consortium's What Women Want group, 2014; Mantovani & Allen, 2017; McManus et al., 2016; Melendez-Torres et al., 2021; Stay Safe East, 2021a; The Women's Mental Health Taskforce, 2018). Stay Safe East (2021a) notes that disabled people usually have contact with a wide range of health and social care professionals and could be routinely asked **“Do you feel safe? Are you scared of anyone? Is anyone hurting you?”** (Stay Safe East, 2021a: 20, emphasis in original). Evaluation of the Pathfinder intervention, which had as one of its aims to increase

professionals' ability to routinely and sensitively enquire about domestic violence and abuse, found that in most of the intervention sites, selective, targeted enquiry was adopted, rather than routine enquiry. At the same time, however, it was clear that "top-down, trust-wide policies in relation to enquiry were considered important contextual factors supporting consistent, safe enquiry" (Melendez-Torres et al., 2021:64). In addition, the evaluation notes that enquiry on its own is not effective if not accompanied by meaningful follow up and referral processes (Melendez-Torres et al., 2021:81).

(c) Barriers to support availability

When mental ill health stemming from experiences of domestic abuse is correctly identified by professionals, or survivors feel able to disclose, further barriers exist to women (and their children) accessing appropriate and effective support. These barriers are discussed below.

Long waiting lists and short-term therapy

A decade of austerity measures has led to funding cuts and a significant reduction in support for mental health services (SafeLives, 2019). As a result, when survivors do disclose mental health problems and are taken seriously, there are long waiting lists for mental health support for adult survivors and for their children (Crenna Jennings & Hutchinson, 2020; Hailes et al., 2018; The National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019; Pathfinder, 2021; SafeLives, 2019). Lengthy waiting times can add to the trauma survivors are experiencing (Hailes et al., 2019).

Crenna Jennings and Hutchinson (2020) found that (prior to the onset of the Covid-19 pandemic) national waiting times for children and adolescents referred to and accepted for mental health treatment were double the government's proposed four-week standard. Demand for child and adolescent mental health support has risen still since the onset of the pandemic with "...a record number of under 18s seeking mental health support through the NHS" (Mind, 2021).

Figures published by the Royal College of Psychiatrists in 2020 also revealed "hidden waiting lists", where patients are waiting between the initial assessment appointment and the start of treatment. They found that from a poll of 513 British adults diagnosed with a mental illness, "...nearly two thirds (64%) wait more than four weeks between their initial assessment and second appointment. One in four (23%) wait more than three months and one-in-nine (11%) wait longer than six months" (RCP, 2020). The Covid-19 pandemic has further exacerbated waiting time lengths. A recent Royal College

of Psychiatrists press release (September 2021) raised concerns about the backlog of patients waiting for mental health support after a surge in demand during the pandemic. The Royal College cites an estimated figure of 1.6 million people waiting for treatment from mental health services (and the actual number is likely to be greater) (RCP, 2021, citing NHS England estimates).

Some of the literature also highlights that when survivors are eventually able to access mental health support, this support can be short-term in nature (Hailes et al., 2018; Pettitt et al., 2013; The National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019). The National Commission on Domestic and Sexual Violence and Multiple Disadvantage (2019) highlights women's frustrations "...at having a timeframe imposed on them in relation to the length or type of support they could receive, for example, only being offered a certain amount [number] of sessions of counselling when they needed something much longer to address the impact of their trauma" (2019:20). Hailes et al. (2018) also highlight the harm caused to survivors by having to wait for support and then having only short-term therapy available, and navigating different services for different specific issues:

"Combined with long waiting lists, short-term therapy and a lack of consistent practitioners, this service fragmentation compounded women's experiences of frustration and trauma" (Hailes et al., 2018:18).

Inappropriate interventions and lack of trauma-informed approaches in healthcare services

There is evidence to show missed opportunities and mistakes being made by health professionals when survivors are referred directly to mental health services or medicated without any referral or signposting to specialist domestic abuse support services (McGarry & Hinsliff-Smith, 2021; Pathfinder, 2021). This serves to reinforce victim-blaming narratives and fails to address the underlying issue of the trauma caused by domestic abuse (Melendez-Torres et al., 2021). (See discussions above and in **Section One** about the problematic separation of mental health issues from the underlying trauma of domestic abuse). Survivor consultation around the Pathfinder programme highlighted that a number of survivors had felt "palmed off" with medication and had not been referred to mental health support or other services to address the trauma of domestic abuse (Pathfinder, 2021). Thiara and Harrison (2021) note that "...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." (2021:37-38).

A number of studies highlight the barriers created by the lack of effective, trauma-informed services (Agenda, 2018; Humphreys & Thiara, 2003; Pathfinder, 2021; SafeLives, 2019; Women's Mental Health Taskforce, 2018). Without services that understand and support survivors, prioritise the building of trusting relationships, and recognise survivors' strengths (rather than pathologising their responses to domestic abuse), survivors cannot access appropriate mental health support (Hailes, et al., 2018; Sweeney, et al., 2019). Ferrari et al. (2016) note:

"The high mental health morbidity among women seeking support from DVA services highlights the need for effective, trauma-informed support services for this population. Equipping non-specialist support workers in advocacy agencies with psychological skills to support survivors of IPV may represent an important avenue for improving survivors' well-being" (Ferrari et al., 2016:8).

Stretched mental health services and inconsistent service response across the country

The barriers faced by survivors are impacted to some degree by where they live, with an inconsistent mental health service provision across the country (Bailey, 2017; The National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019). Within a context of workforce shortages, funding pressures and reconfiguration of services in the NHS, along with staff 'burnout' and stress (House of Commons Health and Social Care Committee, 2021), mental health services are over-stretched (Pettitt et al., 2013). This situation has only been exacerbated by the Covid-19 pandemic (RCP, 2021).

There is a lack of effective joined-up working between healthcare services, and these services are usually structured around one primary issue (Hailes et al., 2018; The National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019; Pettitt et al., 2013). This leads to survivors having to cope with the stress of managing different services for different issues (for example, mental ill health and substance abuse) and having to retell their story multiple times (with clear traumatic impact on them on each repetition) (Pathfinder, 2021; Pettitt, 2013). Pettitt et al. (2013) state:

"Participants also faced problems in accessing help because of the barriers in the services themselves. They described services as simply not existing or being so overstretched that they were unable to offer them the support when they needed it, as well as services having strict limitations on the type or amount of support they were able to offer. This left some participants managing relationships with multiple services, something which caused them stress during a time when they felt very vulnerable." (Pettitt et al., 2013:10)

Mental health services can create further trauma for survivors

Attempting to engage with some mental health services can worsen survivors' mental health issues and create further trauma. For example, survivors may be discouraged from continuing to seek help if they experience a mental health service that is not trauma-informed, does not address the links between domestic abuse and mental health, and does not provide safe opportunities and spaces for survivors to tell their own stories (Barron, 2004; Pathfinder, 2021; Women's Mental Health Taskforce, 2018). There is also evidence of mental health professionals putting domestic abuse victims at greater risk as a result of their knowledge gaps and their service's overall lack of domestic abuse awareness; for example, by suggesting marital therapy or discussing domestic abuse in front of the perpetrator (Trevillion et al., 2014; 2016). Barron (2004) notes the dangerous and traumatic situations that survivors had been placed in while getting mental health support:

"A few of the women I talked to had spent some time within psychiatric in-patient facilities. This was consistently described as a very negative experience. All the wards had been mixed sex, making them "really scary places", to quote a woman who had experienced this. One woman said that many of the male patients had alcohol or drug problems, and because of her experience with her alcoholic partner, 'men who drink frighten the life out of me.'" (Barron, 2004:50)

The Women's Mental Health Taskforce (2018) also highlights how survivors can be re-traumatised in mental health facilities by the use of physical restraint and one-to-one observation by male staff members. In addition, the Taskforce notes that:

"Some women described feeling unsafe in in-patient services, specifically in relation to the risk of sexual assault or harassment, from both members of staff and patients." (The Women's Mental Health Taskforce (2018:24)

Thiara and Harrison (2021), in their report published alongside this review, discuss in detail the harms experienced by Black and minoritised survivors that are caused by institutional racism present within mental health care systems.

Under-funding of specialist domestic abuse services

Specialist domestic abuse services are well placed to meet many of the mental health needs of survivors due to their gendered and intersectional understanding of survivors' experiences, their ability to build trusting and empowering relationships, and progress in trauma-informed support within the sector. However, these important services are not adequately funded and are usually not included in health budgeting (Bailey, 2017; Women's Aid, 2021b). Just 10.2% of community-based services in 2019-20 were funded

by clinical commissioning groups (CCG) (Women's Aid, 2021b). Despite the clear need for support, services are struggling to meet survivors' needs; only 14.5% of all refuge services have a specialist mental health support worker(s) and only 9.3% have specialist drug use workers and specialist alcohol use workers. Only 36.1% of refuge services are able to provide a formal counselling service (Women's Aid, 2021e). The funding challenges faced by domestic abuse services is further explored in **Section Three**. Research looking at funding shortages for 'by and for' specialist services demonstrated how acutely these services are impacted by a lack of funding for their work (Imkaan, 2018a). A mapping study published in 2021 found that "...LGBT+ specialist domestic abuse services are largely unavailable within many local authority areas in England and Wales but particularly in the South West and North East of England and in Wales" (Donovan et al., 2021: 21).

The under-funding of specialist, trauma-informed services creates barriers to meeting the mental health needs of survivors. Data from Women's Aid's No Woman Turned Away project, which provides support to survivors of domestic abuse who face structural inequalities and barriers to accessing a refuge space, show that just over half of the 166 women supported in 2020 had mental health support needs. Just over 21% of women supported since the start of the Covid-19 pandemic said they felt triggered by the pandemic or experienced PTSD symptoms as a result of it, and just under 11% of participants said they were unable to access mental health support, counselling or support groups as a result of the pandemic (Women's Aid, 2021d).

The next section looks at examples of specialist domestic abuse services' work in meeting the mental health support needs of survivors, including work in partnership with healthcare professionals. We also look at some of the funding challenges that are restricting domestic abuse services' work in this area.

Section Three

Meeting the mental health recovery needs of survivors – the work of specialist domestic abuse services

Specialist domestic abuse services, as well as services within the broader women's sector, work in a number of ways to support survivors' mental health needs. Key to this work is an understanding of each woman's situation and experiences, and how this has impacted on her mental health. As Bailey (2017) points out in her review of the policy landscape around women's mental health:

“Every day specialist women's organisations work with women who are displaying a myriad of mental health symptoms ranging from depression, anxiety to complex post-traumatic stress and psychosis. Women have described that group activities, peer support and specialist one to one counselling, offered over the long term by professionals who understand the correlation with interpersonal trauma, HIV, discrimination and mental health, are crucial to their recovery.” (Bailey, 2017:2).

An understanding of trauma and how trauma impacts survivors of domestic abuse is central to the work of specialist domestic abuse services. Survivors struggling with mental health issues report “that they want gender-specific support, meaning care that takes into account and responds to their specific needs as women, and which works holistically to help them address the root causes of the issues they face” (Agenda, 2018:4). Specialist services ‘by and for’ for Black and minoritised women experiencing domestic abuse, other forms of VAWG and mental distress are particularly valued for addressing women's specific, intersectional needs (Thiara & Harrison, 2021).

There is a need for more evidence to assess the impacts of trauma-informed mental health support and the impact of the work of women's organisations. We hope to add to this evidence base as the **#DeserveToBeHeard** campaign progresses. Evidence gaps in this area are linked to the limited resources available to the women's sector for data gathering and evaluation.¹⁵ A research review that collated academic literature focusing

¹⁵ Women's Aid does offer support for local services in monitoring the impact of their work. On Track is Women's Aid case management and outcomes monitoring system. On Track's outcome monitoring can help services to monitor mental health outcomes, it includes the Personal Outcomes and Wellbeing Record (POWeR) that can be used to record changes in mental wellbeing. On Track also documents other health outcomes, such as, a survivor receiving support for their mental health or if they are better able to manage their mental health at the end of the service. For more information: <https://www.womensaid.org.uk/what-we-do/ontrack/>

on the impacts of advocacy interventions (within or outside healthcare settings for women who have experienced intimate partner violence) found that the evidence is inconsistent, and not of good quality. Overall, the authors conclude that: “brief or intensive advocacy administered to abused women may improve a wide range of outcomes, but the magnitude and consistency of these benefits are still uncertain” (Rivas et al., 2015:66).

However, there are relevant studies and good practice examples (the majority published after Rivas et al.’s review). These provide evidence of the value placed by domestic abuse survivors on the work of specialist domestic abuse services and professionals to address their mental health needs, using an approach that understands mental ill health as result of trauma caused by the perpetration of abuse (Bailey, 2017; Evans et al., 2018a; Holly, 2017). These examples can be divided into:

- a) the work of the women’s sector, including domestic abuse services;
- b) partnerships between health and domestic abuse services and professionals.

These are discussed in the sections below.

a) The work of the women’s sector (including domestic abuse services)

Funding challenges

As mentioned in **Section Two**, the domestic abuse sector is facing high demand and many funding challenges (Women’s Aid, 2021b). As such, services are not always adequately resourced to provide the mental health support that they would like to make available for survivors. 54.5% of respondents to the Women’s Aid Annual Survey 2020 were running an area of their domestic abuse service without any dedicated funding in 2019-20. 14.3% of services with no dedicated funding were unable to support women with more complex needs due to the level of support available (Women’s Aid, 2021b).¹⁶ Respondents also reported staff shortages and burnout, and said they were increasingly relying on volunteers in order to keep services running (Women’s Aid, 2021b). One organisation responding to our annual survey wrote:

“Our community-based services are under constant pressure due to inadequate funding from local authorities and as a result of the lack of funding from continued year on year serious erosion of service budgets, services are now cut to the bone.” (Domestic abuse organisation cited in Women’s Aid, 2021b:52)

¹⁶ 77 organisations running domestic abuse services responded to the annual survey in 2020.

This funding crisis is acutely felt in 'by and for' services (Donovan et al., 2021; Imkaan, 2018a; Women's Aid, 2021c). Illustrative of the funding challenges facing 'by and for' services is the fact that at November 2020, a much higher percentage (57.5% or 146 out of 254) of refuge spaces in 'by and for' services were provided by non-commissioned services, compared to the overall 18.5% (Women's Aid, 2021c).

Women's Aid estimates that at least £409 million is needed to run the specialist domestic abuse services across England, including ring-fenced funding for specialist 'by and for' services (Women's Aid, 2021f).

Mental health support within domestic abuse specialist services

One study that followed 100 women and children survivors of domestic abuse over a three-year period (2011-2014) highlighted the importance of the mental health support provided by specialist domestic abuse services. The study's authors point out, however, that counselling and other types of mental health support do not tend to be considered a core part of domestic abuse services, which are increasingly (through funding arrangements) forced to focus on short-term risk reduction (Kelly, et al., 2014; see also Women's Aid 2021b for a discussion of funding challenges). The authors point out that counselling integrated into specialist domestic abuse support "...not only saved their lives but also costs to the NHS, where delays and inappropriate interventions led to dependence on medication, in some cases worsening mental health" (Kelly, et al., 2014:87).

Women who had received counselling while accessing domestic abuse services rated it very highly because the counsellors understood the dynamics of domestic abuse and its impacts. One of the research participants described how the counselling made her feel:

"They made me feel – because I was beating myself up so much about what I should've done and didn't do and the all the rest of it – they made me feel... gave me my dignity that yes, all this had happened but it wasn't a reflection on me." (13, W1, in Kelly et al., 2014:84)

Other participants spoke about their desire for longer term support:

"I would have liked to have continued that for a bit longer. I mean I know it's only limited but... I would have liked to have been able to go to some of the drop in sessions cos every now and again it all comes back." (85, W4, in Kelly et al., 2014:84)

Research by Humphreys and Thiara (2003) into the experiences of women and children using domestic abuse outreach services identified that survivors valued the “non-stigmatizing” approach that these services offered. The authors note that:

“While many of the women in our study had been users of mental health services, it was the advocacy, counselling, group work, and support from services outside the mental health sector that were consistently mentioned as helpful in their recovery from abusive experiences. To some extent this can be understood as a function of the sample drawn from domestic violence outreach services. However, it was clear that a non-stigmatizing service that responds with sensitivity to women’s abuse experiences was the key to working successfully in this area.” (Humphreys & Thiara, 2003:222)

Services that helped lift blame from survivors and helped them to name the abuse they had experienced were particularly valued. The quote below from Gurdip illustrates this:

“For the first time in my life, I thought that someone knows what exactly I feel. Somebody knows I am right... in the past, my customs and culture tell me that I am the guilty person... for the first time someone says, ‘No, you are right, that was wrong’. That’s how I knew that” (Gurdip, in Humphreys & Thiara, 2003:220)

Survivors emphasised the importance of holistic support services that helped them to recover from abusive experiences. They valued “an attitude of belief, a non-judgemental approach, and time for support, listening, and understanding” (Humphreys & Thiara, 2003:222). Survivors also valued support that included an emphasis on their safety. As Humphreys and Thiara (2003:221) note “little progress can be made on alleviating the distress of post-traumatic reactions while people continue to live with violence or the threat of violence.”

Peer support plays an important role in survivors’ emotional recovery from domestic abuse and domestic abuse services are often best-placed to offer and facilitate such support (Abrahams, 2007; Humphreys & Thiara, 2003; Sweeney et al., 2019). Sweeney et al. (2019) note that when women have experienced pathologisation and further harm through engagement with services that are not trauma-informed, they choose to connect through mutual peer support instead. Abrahams (2007:111) found that women living in domestic abuse refuges “...consistently talked of the importance of this support in helping them to recover from domestic violence and the way in which both the giving and the receiving of support provided opportunities for personal understanding and development and the growth of self-esteem.” This is also illustrated by the following survivor quote:

“It [support group] offers a lot because you’ve got other women there... that have been in the same... but different situations... You can relate back to things that you’re experiencing and things that have happened in the past... the support group is better than I thought it would be... it’s fantastic” (Myra, in Humphreys & Thiara, 2003:222).

As the literature review on Black and minoritised women, domestic abuse and mental health (Thiara & Harrison, 2021) that accompanies this review shows, peer support can also offer solidarity around experiences of multiple forms of oppression:

“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)” (Thiara & Harrison, 2021:41).

Specific mental health support within refuges

As discussed earlier, evidence shows that survivors of domestic abuse in refuges have particularly high levels of need around trauma and mental health support (see ‘The links between suicide and domestic abuse’ in **Section Two**). However, refuge services are struggling to meet high demand and are facing funding challenges that limit the support they can offer (Women’s Aid, 2021b). As discussed in **Section Two**, few refuge services (14.5%) have a specialist mental health support worker(s) and fewer still have specialist drug use workers and specialist alcohol use workers (9.3%). Only just over a third of refuge services (36.1%) are able to provide a formal counselling service (Women’s Aid, 2021e).

Refuges have developed innovative ways of working with survivors and their children to address trauma and support mental health. An evaluation of the *Refuge Access for All* project, which aimed to create a psychologically-informed environment across one organisation’s refuges, identified several positive results arising from the work. Refuge staff reported a significant measurable increase in the understanding and confidence of staff in dealing with issues around mental ill health and substance use. Refuge residents reported measurable improvements on a trauma-informed practice scale over a period of six months, and play therapy was found to make a difference in the behaviour and emotional wellbeing of children and their mothers during their stay in the refuge (AVA & SWA, 2017).

Hilary Abrahams’ research (2007) into women’s experiences of refuge services found that the holistic approach taken by refuges is important in addressing a range of practical and emotional needs. This approach is complex, however, and requires

adequate funding, but could ultimately be saving health and social care services money. She notes that:

“If women are to be successfully supported to recover from the effects of domestic violence, they need to be able to access practical support, advocacy and information. The research shows, however, that important though this is, it is not sufficient on its own. They also need the personal support and acceptance which will enable them to rebuild their self-respect and gain the confidence to live independently. The value of this complex and demanding work needs to be fully appreciated and properly funded, taking into account its one-to-one nature and the requirement for extended support within the community. Combining practical and emotional assistance in this way enhances the prospect of a successful transition to a new life for the woman and may also lessen future demands on health and social care provision and possible expensive crisis interventions” (Abrahams, 2007:128).

Abrahams also discusses how opportunities to talk and be listened to (both formal and informal opportunities) in refuges are helpful in survivors’ recovery:

“Because of the isolation imposed on them by their abuser, time to talk and be heard was considered very important by women. It appeared to be needed on three levels – everyday conversation, which helped to restore social skills eroded by domestic violence, talk which was emotionally or practically supportive and the type of ‘healing’ talk provided by counselling or group work. Women valued the gift of time and understanding and actively sought to communicate on a variety of levels” (Abrahams, 2007:118).

Mental health support within ‘by and for’ specialist services

As noted previously, women’s sector organisations are facing funding challenges and are often very limited in their ability to gather evidence on the impact of their services due to under-funding. For ‘by and for’ services, which are providing specialist support for Black and minoritised, Deaf and disabled, and LGBTQ+ survivors, these funding challenges are acutely felt (for more information on funding challenges see Donovan et al., 2021; Imkaan, 2018a; Women’s Aid, 2021b & c). There is evidence that survivors highly value the specialist support of ‘by and for’ services (see Magić & Kelley, 2019; Thiara and Harrison, 2021; Thiara & Roy, 2020; Stay Safe East, 2021a), but for this review we have struggled to find published evaluations of the work of ‘by and for’ specialist services in specific relation to mental health. However, we include examples of their work and evidence of impact below.

Stay Safe East describes their work in supporting disabled survivors as informed by “an intersectional approach to the social model of disability” that recognises the barriers

that disabled survivors face are caused by structural oppression. They describe their work in addressing mental health needs in the following way:

“In the past 11 years, we have supported clients in dealing with mental health professionals, been with them when they have gone to A&E after suicide attempts or a severe mental health crisis, and advocated for them when they were detained in hospital; since the Covid pandemic we have provided life-saving support to isolated clients with severe mental health issues, filling the gap left by mental health services during lockdown.” (Stay Safe East, 2021b:2)

Magić & Kelley (2019) discuss how specialist LGBTQ+ domestic abuse services address a variety of survivor support needs, including mental health needs. Their report includes the case study of *LGBT Jigsaw* which is a partnership project led by Stonewall Housing, which includes “...addressing underlying problems such as mental health and emotional issues, offer access to counselling and group support...” (p. 48). The report also includes this quote from an LGBTQ+ Domestic Abuse Service Manager about the range of support needs specialist services meet, including mental health support needs:

“The skills and the specialism that is required makes LGBTQ+ specialist workers so hard to recruit. They need to have a good knowledge of complexities around domestic abuse, the LGBTQ+ communities, local and regional services, national mental health system and criminal justice system. Basically you are looking for a mini professional in everything” (Magić & Kelley, 2019: 51).

Evidence on specialist ‘by and for’ services for Black and minoritised women shows that survivors particularly value specialist support services that help with complex emotional, immigration, and cultural issues (Humphreys & Thiara, 2003; Thiara & Harrison, 2021). However, there is as yet only a small body of research that explicitly explores the views of Black and minoritised women who have experienced domestic abuse about how services have met their mental wellbeing and recovery needs (Thiara & Harrison, 2021). The evidence that Thiara and Harrison include in their 2021 review demonstrates a range of values and practices that Black and minoritised women particularly value within the services they use.

“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.” (Thiara & Harrison, 2021:47)

Thiara and Harrison (2021) note that the studies included in their review demonstrate the significant contribution made by dedicated Black and minoritised VAWG organisations, and some specialist women’s services “to help women reframe their experiences and to view their coping as a source of strength” (Thiara & Harrison, 2021:40).

Mental health support offered by the broader women’s sector

Evidence is also available about the services provided by the broader women’s sector to support survivors’ mental health needs. A mapping exercise looking at the provision of specialist services for women experiencing multiple disadvantage¹⁷ in England and Wales (Holly, 2017), found that the voluntary sector was delivering 42.9% of all the women’s mental health services identified. The support they offer was created specifically for women on the basis of women-only spaces being a safe, more comfortable environment that women are more willing to access.

b) Partnerships between health and domestic abuse services and professionals

Among the literature included in this review are several reports and evaluations of initiatives developed in partnership between health and domestic abuse services/professionals. These cover the Psychological Advocacy Towards Healing (PATH) intervention, the Identification and Referral to Improve Safety (IRIS) programme, and the Health Pathfinder intervention. These are discussed below.

PATH: Psychological Advocacy Towards Healing

Two recent papers report on the findings of evaluation of the Psychological Advocacy Towards Healing (PATH) intervention, which is delivered by domestic abuse advocates under the supervision of a psychologist (Evans et al., 2018a; Ferrari et al., 2018). The evaluation compared the experiences of women receiving a psychological intervention with women receiving “usual” domestic abuse support. It found that there was a clinically relevant improvement in mental health outcomes for women receiving the intervention compared to “usual” advocacy. Women valued the educational, psychological and emotional elements of the intervention, they felt safe to explore repressed emotions for the first time and experienced a reduction in self-blame,

¹⁷ Holly (2017) describes multiple disadvantage in the following way:

“Women’s and men’s experiences of multiple disadvantage are significantly different. Women facing homelessness, substance misuse and contact with the criminal justice system are more likely to have experiences of abuse, violence and trauma and particularly poor mental health.” (p. 3)

improved sense of identity and greater self-esteem. Women also learnt new skills and self-help techniques, developed new coping strategies and reported feeling more in control of their life and future. The evaluation revealed that “the transformative power of the PATH intervention led many women on a powerful healing journey” (Evans et al., 2018a:8).

Participants highlighted the importance of delivery by domestic abuse specialists rather than mental health specialists. The authors of one of the papers point out that:

“The most highly valued feature for women receiving PATH was the working alliance with their SPA, a DVA specialist, embedded in an agency providing support and advocacy for DVA. Continuity of provision from a single advocate should be the gold standard, and any unavoidable transitions should be sensitively handled” (Evans et al. 2018a:9).

This is echoed in quotes from the trial participants, such as the one below:

“A (SPA/advocate) is brilliant, she’s absolutely brilliant, I can talk about stuff and it’s okay to talk about stuff. I used to feel incredibly guilty that I brought all this stress and trauma onto my children, my parents, my friends, my family.... I used to feel so guilty ... you feel like you’ve done something wrong, that’s why he hurt me because I did something really bad, so therefore I must be a bad person in some way. The realisation of actually you’re not bad, it wasn’t your fault it happened. It’s like to just come to that point ... we’ve had quite a lot of intense sessions and stuff, um, but to get to that point where you feel good about yourself is just amazing” (PATH trial participant, in Evans et al., 2018b:1).

Issues relevant to the success of the PATH intervention were women’s ‘psychological readiness’ to engage, the competing demands of practical issues such as housing insecurity, legal proceedings or the availability of childcare, and breaks in the continuity of professional care (Evans et al. 2018a).

IRIS: Identification and Referral to Improve Safety

Evaluation has also been conducted on the impact of the IRIS (Identification and Referral to Improve Safety) intervention, which involves collaboration between primary care and domestic abuse specialist organisations (Feder et al., 2016). IRIS is a training and support programme for general practice that aims to improve the response to women experiencing domestic abuse. Domestic abuse specialists (or advocate educators) are linked to general practices and work with a clinical lead to deliver IRIS training to the whole of the practice team. Staff learn to safely use a pop-up prompt which appears on medical records when particular diagnoses are entered, and there is

also an enhanced referral pathway to domestic abuse services. Evaluation of IRIS' progress from initial trial to commissioned programme found that it is a cost-effective intervention with benefits to both women and NHS staff. A cluster randomised controlled trial found that three times more women experiencing domestic violence were identified in IRIS intervention practices than in the control practices (Feder et al., 2011). IRIS training and support intervention "had a substantial effect on recorded referrals to specialist domestic violence agencies and on recorded identification of women experiencing domestic violence, albeit from a low baseline" (Feder et al., 2011: 1793). Referrals to specialist services increased and clinicians were exhibiting a safer, more appropriate response to domestic abuse disclosures and women reported positive interactions with their GP (Feder et al., 2016). The authors note that:

"Women were often relieved at being able to disclose to their GP, felt hopeful and felt their disclosure enabled them to ask for further help. They also described being able to let go of some of their shame and self-blame. In terms of their AE [advocate educator], they felt accepted and understood. The empathetic encounter helped them to realise they had choices and that a future without DVA was possible" (Feder et al., 2016:7).

Health Pathfinder

Evaluation of the Health Pathfinder intervention, another example of health (including mental health) professionals working together with domestic abuse specialists, also reported positive results (Melendez-Torres, et al., 2021). The evaluation focused on Health Pathfinder sites, included acute trusts, mental health trusts and primary care, between 2017 and 2019. It found that the intervention had generated meaningful system-level changes in both the identification and referral of cases, and had identified and supported survivors of domestic abuse at an earlier stage in the process (Melendez-Torres et al., 2021).

There was flexibility around allocation of funds and the role of specialist domestic abuse services and professionals. For example, some intervention sites included co-located Independent Domestic Violence Advisers (IDVA), advocate educators, or a domestic abuse coordinator. Evaluation of the intervention noted the importance of domestic abuse 'cultures' within the intervention sites; the organisational culture of each site would determine readiness for and receptiveness to the intervention. The inclusion of a domestic abuse specialist as a visible part of the health team was found to be very important for generating (and maintaining) awareness of domestic abuse within this culture (Melendez-Torres et al., 2021). The evaluation authors note that:

“The presence and visibility of the IDVA or advocate educator not only generated basic awareness, but also provided health professionals with the security to identify domestic violence and abuse in their everyday practice, leading to an increase in referrals. Their visibility acted as a constant reminder of domestic violence and abuse to health professionals and was seen as a mechanism to increase referrals” (Melendez-Torres et al., 2021:48).

The evaluation also demonstrated other benefits arising from the co-location of health and domestic abuse professionals. Some IDVAs and advocate educators were involved in formal training of health professionals, while others provided informal coaching. The authors point out that: “the informal learning that takes place as a result of informal conversations, combined with raised awareness as a result of the IDVA’s everyday visibility, was regarded as incredibly valuable in upskilling health professionals. IDVAs and advocate educators were coaching health professionals step-by-step through cases” (Melendez-Torres et al., 2021:52). In addition, IDVAs and advocate educators reported benefitting from co-location in terms of their own knowledge and practice, particularly in relation to survivors’ journeys through mental health settings and services (Melendez-Torres et al., 2021).

Conclusions and recommendations

There is a strong body of evidence highlighting the inadequacy of many of the current mental health models and practices when it comes to supporting survivors of domestic abuse who have experienced trauma and psychological distress. There is some evidence on what survivors want and need from mental health services, and emerging evidence on good practice in addressing these needs. This emerging evidence suggests the benefits of trauma-informed approaches which contextualise mental health within broader socio-political systems and experiences. More research is needed to build the evidence base for this. There is also evidence of the benefits of co-operation between healthcare professionals and domestic abuse support practitioners in meeting survivors' mental health support needs.

This section sets out some emerging recommendations based on the literature reviewed for this report, discussing these recommendations within the current policy landscape for women's mental health.

1. **Key finding:** Domestic abuse is a major driver of women’s mental ill health

Recommendation: Tackling domestic abuse must be explicitly recognised as a public health priority, with greater emphasis on the mental health impacts of domestic abuse in healthcare policy and funding. The reforms proposed in the Health and Care Bill and the forthcoming Women’s Health Strategy are key opportunities to recognise the mental health consequences of domestic abuse.

Domestic abuse can have devastating and long-term negative consequences for survivors’ mental ill health. The trauma caused by the perpetration of violence and abuse against women is a key driver of women’s mental ill health. Research using data from the Adult Psychiatric Morbidity Survey is illustrative of this; the analysis found that experiences of violence and abuse are strongly related to subsequent mental ill health (Scott et al., 2015). The Taskforce on the Health Aspects of Violence Against Women and Children highlighted the sheer scale of the health consequences (both mental and physical) caused by male violence and abuse against women and children. It recommended that the health consequences of male violence against women and children be regarded as an NHS priority and noted that “...more women suffer rape or attempted rape than have a stroke each year, and the level of domestic abuse in the population exceeds that of diabetes by many times...” (Taskforce on the Health Aspects of Violence Against Women and Children, 2010:10).

We welcome the commitments the government has made to increase NHS investment in mental health services; via the Five Year Forward View for Mental Health and the NHS long term plan (Mental Health Taskforce to the NHS, 2016; NHS, 2019). The government also recently announced £150 million in the Autumn Budget “...to invest in NHS mental health facilities linked to A&E and to enhance patient safety in mental health units.”¹⁸

Looking ahead (at the time of writing), the reforms proposed in the Health and Care Bill¹⁹ are also intended to build on the commitments in the NHS long term plan, whilst the forthcoming Women’s Health Strategy aims to consider women’s health over the life course, from adolescence through to older age.²⁰ These developments offer key opportunities to ensure that the mental health needs of survivors are explicitly

¹⁸ Autumn Budget and Spending Review 2021 (p.94)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1029973/Budget_AB2021_Print.pdf

¹⁹ Health and Care Bill: <https://bills.parliament.uk/bills/3022> [Accessed October 2021]

²⁰ Women’s Health Strategy: Call for Evidence:

<https://www.gov.uk/government/consultations/womens-health-strategy-call-for-evidence/womens-health-strategy-call-for-evidence> [Accessed October 2021]

recognised and practically addressed. However, if these opportunities are to be taken, it will be essential to better recognise domestic abuse as a critical public health issue and that specialist support is needed. The evidence discussed in **Section Three** demonstrates the value of partnerships between health and domestic abuse professionals and services. Reforms should capitalise on this potential, ensuring the voices of survivors and specialist services are represented in decision-making structures (such as within Integrated care systems, ICSs), including duties to monitor and report back on key outcomes for survivors.

- 2. Key finding:** While there is clear evidence that the trauma of being subjected to domestic abuse has negative consequences on survivors' mental health, this is often poorly understood by health practitioners. Problematically, the focus becomes on what is 'wrong' with the survivor and the cause (domestic abuse) is side-lined or overlooked.

Recommendation: Services and professionals responding to survivors' mental health must work in a trauma-informed way that avoids pathologising survivors' reactions to domestic abuse. Greater partnership work between health services and specialist domestic abuse services and specialist training of healthcare professionals are key ways of achieving this aim.

The evidence clearly emphasises the importance of developing an approach for working with survivors of domestic abuse that understands the traumatic impact of abuse and avoids pathologising women's responses and emphasises women's strengths. Investment in partnership work that combines health and domestic abuse expertise is a key way of working towards safe, effective and accessible healthcare responses to survivors. This could be achieved, for example, by co-locating domestic abuse professionals in health settings, adopting the 'whole health' model endorsed by the Pathfinder project as part of the new ICSs, and establishing specialist Domestic Abuse Coordinators in every NHS trust to ensure strong referral pathways from health services to specialist domestic abuse support.²¹

Healthcare professionals need specialist training in order to appropriately respond to survivors of domestic abuse; to ask the right questions and recognise the warning signs, and consistently refer or signpost to specialist domestic abuse support. There needs to be greater levels of safe, sensitive enquiry about domestic abuse from health

²¹ See *INCADVA Briefing on the Domestic Abuse Bill House of Lords Second Reading Debate A whole-health response model to Domestic Abuse*:
<https://safelives.org.uk/sites/default/files/resources/INCADVA%20DA%20Bill%20Briefing%20Lords.pdf>

professionals – particularly GPs, A&E professionals and those working in mental health services. Furthermore, professionals need greater knowledge and training about what the barriers to disclosure are for survivors (including the additional barriers faced by minoritised groups), and what action to take if a woman does disclose. As part of this, there needs to be much stronger links between health services and professionals and local specialist domestic abuse support services (see the examples given in **Section Three**).

- 3. Key finding: Survivors experience domestic abuse and health responses to domestic abuse within a wider context of structural oppression. Sexism, racism and other intersecting forms of structural inequality and discrimination perpetuate health inequalities and create barriers to survivors accessing mental health support.**

Recommendation: The intersecting forms of structural oppression that survivors face must be considered in any policy or strategy relating to women’s health, with sustainable funding for ‘by and for’ specialist domestic abuse services

Domestic abuse survivors’ experiences of trauma and mental ill health need to be understood in the context of intersecting forms of structural oppression, including sexism, racism, ageism, LGBTQ discrimination and disability discrimination. Thiara and Harrison (2021) highlight that access to mental health support is lowest amongst the most marginalised groups and racism perpetuates health inequalities. Unless health policies and healthcare reforms also include a focus on reducing health inequalities and breaking down barriers to accessing mental health support, marginalised groups of survivors will continue to be disadvantaged healthcare structures. It is therefore important that the Women’s Health Strategy includes a recognition of the impacts of structural inequalities on women’s mental health outcomes.

Training for healthcare professionals should also include specialist guidance on understanding the intersecting inequalities that compound poor mental health outcomes, and strong referral pathways must be established between healthcare providers and specialist domestic abuse services led ‘by and for’ Black and minoritised women as part of the new ICSs. These services, which remain chronically underfunded (see Key finding 4), need to benefit from ring-fenced and sustainable government funding to ensure that they are able to meet the breadth of survivors’ needs, including through community-based and therapeutic support where formal healthcare pathways are not preferred or appropriate.

- 4. Key finding: Specialist domestic abuse services (including partnership work with healthcare professionals) are an important part of the response to survivors' mental health needs, but these services are often under-funded. For specialist services 'by and for' minoritised groups of survivors, this underfunding is even more acutely felt.**

Recommendation: Investment in mental health services must be accompanied by investment in specialist domestic abuse support services, including ring-fenced funding for specialist services led by and for Black and minoritised women, Deaf and disabled women and LGBTQ+ survivors.

The emerging evidence indicates that when specialist domestic abuse services are funded and supported to provide mental health and trauma support for survivors (including important partnership work with health services), they are successful. It also highlights the demand for specialist services that can provide holistic care for diverse groups, including Black and minoritised women, LGBTQ+ survivors, disabled women, and women who are mothers and carers. The specialist support that domestic abuse services offer is likely to reduce pressures on the NHS and ensures that survivors receive the right response first time. However, despite the introduction of the statutory funding allocated in the Domestic Abuse Act 2021 for safe accommodation for domestic abuse survivors, domestic abuse services (including refuges and those based in the community) remain chronically underfunded. For 'by and for' specialist services, this underfunding is even more acutely felt.

While Women's Aid welcomes the announced £185 million in the Autumn Budget 2021, which will increase the number of Independent Sexual and Domestic Violence Advisors to over 1,000 and fund other key services such as helplines, we were disappointed to not see the level of investment needed to prevent domestic abuse and violence against women and girls. Investment in mental health services needs to be accompanied by investment in the specialist domestic abuse support sector which plays a vital part in women's recovery. Women's Aid estimates the annual investment needed for the sector at £409m (Women's Aid, 2021f). It is essential that specialist domestic abuse services are adequately and sustainably funded so that they can provide important therapeutic and recovery work, including partnership work with health services. This investment should include ring-fenced funding for specialist services led by and for Black and minoritised women (see above), Deaf and disabled women and LGBTQ+ survivors, and be delivered alongside sustainable investment in wider VAWG services. Funding for domestic abuse specialist services providing mental health and trauma support should also include

funds for evidence gathering, evaluation and knowledge sharing, so that good practice can be further identified and shared.

5. Key finding: Perpetrators weaponise survivors' mental ill health as part of their coercive and controlling behaviour and as a way of discrediting survivors.

Recommendation: Professionals responding to domestic abuse (including healthcare professionals, police, legal professionals) need specialist domestic abuse training that strengthens their understanding of perpetrator tactics in weaponising mental ill health.

Improving professionals' knowledge, awareness and confidence around supporting survivors of domestic abuse must include strengthening their understanding of the strategies of perpetrators, who may weaponise psychological distress as part of their coercive and controlling behaviour. As the qualitative studies focusing on survivors' perspectives discussed above demonstrate, many survivors live in fear of disclosing the mental health challenges they are facing, in case they themselves are blamed or judged. Survivors are also fear that perpetrators (as well as, in some cases, professionals), will use their mental ill health as a reason to criticise survivors' parenting abilities and even to remove their children.²² The distress and trauma caused by domestic abuse must never be used as a weapon against survivors. It is important that health services have policies on how to engage with perpetrators that are informed by the work of the charity Respect.²³ As well as being able to call out and avoid victim-blaming attitudes, professionals, including police (for example, through the Domestic Abuse Matters training), the judiciary and other statutory services need to be equipped through specialist training with the tools to recognise and challenge perpetrators' behaviours around weaponisation, so that survivors are listened to and believed, and receive the right response first time.

²² See Women's Aid's **Child First: Safe Child Contact Saves Lives** campaign <https://www.womensaid.org.uk/childfirst/> [Accessed November 2021]

²³ <https://www.respect.uk.net/pages/42-work-with-perpetrators>

References

* = part of the literature identified by the search terms set out in the methodology section

*Abbott, M., Woodhouse, T. and Hunter-Whitehouse, I. (2020) *Highlighting the relationship between domestic abuse and suicide, presentation of research findings.*

[Published online](#)

*Abrahams, H. (2007) *Supporting Women after Domestic Violence: Loss, Trauma and Recovery.* London: Jessica Kingsley Publishers

*Agenda. (2018) *Women in crisis: How women and girls are being failed by the Mental Health Act.* Published [online](#): Agenda

*Agenda. (2019) *Ask and take action: Why public services must ask about domestic abuse.* Published [online](#): Agenda

Agenda. (2021) *Voices from lockdown: One year on, a way forward for women and girls.* Published [online](#): Agenda

*Aitken, R. and Munroe, V. (2018) *Domestic abuse and suicide: Exploring the links with Refuge's client base and work force.* Published [online](#): Refuge and Warwick Law School

*Against Violence & Abuse (AVA) and Solace Women's Aid (SWA). (2017) *Peace of mind: An evaluation of the refuge access for all project.* Published [online](#): AVA and Solace Women's Aid

*Bachmann, C. and Gooch, B. (2018) *LGBTQ+ in Britain: Health Report.* Published [online](#): Stonewall

*Bailey, K. (2017) *Taking a forward view on women and mental health: Key messages for government.* Published [online](#): Women's Health and Equality Consortium

*Barbosa, E., D'avo, G., Howell, A. and Johnson, M. (2020) *Improving the general practice response to domestic violence and abuse: A review of IRIS programmes in England, Wales and Northern Ireland to March 2020 and early findings from the COVID-19 pandemic.* IRIS, University of Bristol and The Health Foundation

*Barron, J. (2003) *Struggle to survive: Challenges for delivering services on mental health, substance misuse and domestic violence.* Bristol: Women's Aid

*Bates, L., Hoeger, K., Stoneman, M. and Whitaker, A. (2021) *Domestic homicides and suspected victim suicides during the Covid-19 pandemic 2020-2021*. Published [online](#): Vulnerability, Knowledge and Practice Programme, National Police Chiefs Council and the College of Policing

Birchall, J. and Choudhry, S. (2018) *What about my right not to be abused? Domestic abuse, human rights and the family courts*. Bristol: Women's Aid

Bows, H. (2016) Why elderly deaths from abuse are part of wider pattern of violence against women, *The Conversation*, <https://theconversation.com/why-elderly-deaths-from-abuse-are-part-of-wider-pattern-of-violence-against-women-57529> [Accessed October 2021]

Bows, H. (2019) 'Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK', *The British Journal of Social Work*, Volume 49, Issue 5, July 2019, 1234–1253

*Bradbury-Jones, C., Duncan, F., Kroll, T., Moy, M. and Taylor, J. (2011) 'Improving the health care of women living with domestic abuse', *Nursing Standard*, 25 (43) 35-40

Cascardi, M. and O'Leary, K. D. (1992) 'Depressive symptomatology, self-esteem, and self blame in battered women', *Journal of Family Violence*, 7, 249–59.

Coy, M., Perks, K., Scott, E. and Tweedale, R. (2012) *Picking up the pieces: domestic violence and child contact*. London: Rights of Women and London Metropolitan University

*Crenna Jennings, W. and Hutchinson, J. (2020) *Access to child and adolescent mental health services in 2019*. Education Policy Institute <https://epi.org.uk/publications-and-research/access-to-child-and-adolescent-mental-health-services-in-2019/>

*Dheensa, S. (2020) *Recording and sharing information about domestic violence/abuse in the health service: Research report and good practice recommendations for healthcare*. University of Bristol

*Donovan, C., Magić, J. and West, S. (2021) *LGBT+ domestic abuse service provision mapping study*. [Published online](#): Galop, The Domestic Abuse Commissioner and Durham University

Dutton, M.A. (1992) *Empowering and healing the battered woman: A model for assessment and intervention*. New York: Springer

Elliot, D., Bjelajac, P., Falloot, R., Markoff, L. and Reed, B. (2005) 'Trauma-informed or trauma-denied: principles and implementation of trauma-informed services for women', *Journal of Community Psychology*, 33 (4) 461-477

*Evans, M., Malpass, A., Agnew-Davies, R. and Feder, G. (2018a) 'Women's experiences of a randomised controlled trial of a specialist psychological advocacy intervention following domestic violence: A nested qualitative study', *PLOS ONE*, 13 (11)

*Evans, M., Malpass, A., Agnew-Davies, R. and Feder, G. (2018b) 'Women's experiences of a randomised controlled trial of a specialist psychological advocacy intervention following domestic violence: A nested qualitative study. Supporting information: verbatim quotations from participants.' *PLOS ONE*, 13 (11)

*Feder, G., Davies, R.A., Baird, K., Dunne, D., Eldridge, S., Griffiths, C., Gregory, A., Howell, A., Johnson, M., Ramsay, J., Rutterford, C. and Sharp, D. (2011) 'Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial.' *Lancet*. 2011 Nov 19; 378(9805):1788-95*Feder, G., Taylor, A. and Johnson, M. (2016) 'The impact of IRIS: From research trial to commissioned programme', *Safe: The domestic abuse quarterly* 57

*Ferrari, G., Feder, G., Agnew Davies, R., Bailey, J., Hollinghurst, S., Howard, L., Howarth, M., Sardinha, L., Sharp, D. and Peters, T. (2018) 'Psychological advocacy towards healing (PATH): A randomized controlled trial of a psychological intervention in a domestic violence service setting', *PLOS ONE*, 13 (11)

*Ferrari, G., Agnew-Davies, R., Bailey, J., Howard, L., Howarth, E., Peters, T., Sardinha, L. and Feder, G. (2016) 'Domestic violence and mental health: a cross-sectional survey of women seeking help from domestic violence support services', *Global Health Action* 9 (1)

Glass, D.D. (1995). *All My Fault: Why Women Don't Leave Abusive Men*. London: Virago

*Hailes, A., Sterling, A., Girling, A., Winfield, C., Sharpen, J., Rigby, M., Iqbal, N., Williams, P., White, R., Braham, S., Edwards, S. and Collins, V. (2018) *Hand in Hand: Survivors of multiple disadvantage discuss service and support*. Agenda, AVA and the Lloyds Bank Foundation

*Hague, G., Thiara, R.K., Magowan, P. and Mullender, A. (2008) *Making the links: Disabled women and domestic violence Final report*. Bristol: Women's Aid

*Harvey, S., Mandair, S. and Holly, J. (2013) *Case by Case: Refuge provision in London for survivors of domestic violence who use alcohol and other drugs or have mental health problems*. London: AVA and Solace Women's Aid

Herman, J. (2001) *Trauma and recovery: From domestic abuse to political terror*. New York: Rivers Oram/Pandora.

HMICFRS, the College of Policing and the Independent Office for Police Conduct. (2020) *Safe to share? Report on Liberty and Southall Black Sisters' super-complaint on policing and immigration status*. Published [online](#): Her Majesty's Chief Inspector of Constabulary

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

House of Commons Health and Social Care Committee. (2021) *Workforce burnout and resilience in the NHS and social care. Second report of session 2020-2021*. London: House of Commons

*Howard, L., Oram, S., Galley, H., Trevillion, K. and Feder, G. (2013). 'Domestic violence and perinatal mental disorders: A systematic review and meta-analysis', *PLOS Med*, 10 (5)

*Howard, L., Trevillion, K. and Agnew-Davies, R. (2010) 'Domestic violence and mental health', *International Review of Psychiatry* 22 (5): 525-534

*Humphreys, C. and Thiara, R. (2003) 'Mental health and domestic violence: "I call it symptoms of abuse"', *British Journal of Social Work*, 33 209-226

*Imkaan. (2018a) *From survival to sustainability: Critical issues for the specialist black and 'minority ethnic' ending violence against women and girls sector in the UK*. Published [online](#): Imkaan

Imkaan. (2018b) *Summary of the Alternative Bill: From the Margin to the Centre Addressing Violence Against Women and Girls*. Published [online](#): Imkaan

*Jonas, S., Khalifeh, H., Bebbington, P., McManus, S., Brugha, T., Meltzer, H. and Howard, M. (2014) 'Gender differences in intimate partner violence and psychiatric disorders in England: results from the 2007 adult psychiatric morbidity survey', *Epidemiology and Psychiatric Sciences*, 23 (2) 189-199

Katz, E. (2014) *Strengthening mother-child relationships as part of domestic violence recovery*. Centre for Research on Families and Relationships Research Briefing 72. Published [online](#): University of Edinburgh

*Kelly, L., Sharp, N. and Klein, R. (2014) *Finding the Costs of Freedom: How women and children rebuild their lives after domestic violence*. London: Solace Women's Aid and London Metropolitan University

*Khalifeh, H., Moran, P., Borschmann, R., Dean, K., Hart, C., Hogg, J., Osborn, D., Johnson, S. and Howard, L. (2015) 'Domestic and sexual violence against patients with severe mental illness', *Psychological Medicine*, 45 (4) 875-886

Latin American Women's Rights Service (LAWRS). *Step up migrant women* <https://stepupmigrantwomen.org/> [Accessed September 2021]

Lev, A.I. (2004) *Transgender Emergence: Therapeutic guidelines for working with gender-variant people and their families*. Binghamton, NY: Haworth Press.

*Liverpool Mental Health Consortium's What Women Want group. (2014) *Domestic abuse and mental health*. [Published online](#): Liverpool Mental Health Consortium

*London VAWG Consortium. (2020) *Good practice briefing. Developing a trauma informed approach: The importance and application of a trauma informed approach for working with survivors of gender based violence*. [Published online](#): London VAWG Consortium, Women and Girls Network and Ascent

*Ludwig Boltzmann Institute of Human Rights; queraum cultural and social research; & Mandl, S., Schachner, A., Sprenger, C. and Planitzer, J. (2014) *Access to Specialised Victim Support Services for Women with Disabilities who have experienced Violence. Final Short Report*. Published [online](#)

*Magić, J. and Kelley, P. (2019) *Recognise & Respond: Strengthening advocacy for LGBT+ survivors of domestic abuse*. London: Galop, the LGBT+ anti-violence charity

*Mantovani, N. and Allen, R. (2017) *Improving responses to domestic violence in secondary mental health services in Wandsworth, South West London. A mixed methods study to assess the recorded incidents of domestic violence and abuse (DVA) in secondary mental health services and to explore stakeholders' views on strategies to address DVA*. London: St. George's University of London

*McCarthy, M., Hunt, S. and Milne-Skillman, K. (2017) 'I Know it was Every Week, but I Can't be Sure if it was Every Day: Domestic Violence and Women with Learning Disabilities.', *Journal of Applied Research in Intellectual Disabilities*, 30: 269-282.

*McGarry, J. and Hinsliff-Smith, K. (2021) 'Silent voices: Exploring narratives of women's experiences of health care professional responses to domestic violence and abuse', *Journal of Medical Humanities*, 42: 245-252

*McGarry, J., Ali, P. and Hinchliff, S. (2016) 'Older women, intimate partner violence and mental health: a consideration of the particular issues for health and health care practice', *Journal of Clinical Nursing* 26, 15-16: 2177-2191

*McLaren, J. (2020) 'EVA trauma and abuse therapy service', *CBT Today*, May 2020

*McManus, S., Scott, S. and Sosenko, F. (2016) *Joining the dots: The combined burden of violence, abuse and poverty in the lives of women*. Published [online](#): Agenda

*Melendez-Torres, G., Pell, B., Buckley, K., Couturiaux, D., Trickey, H., Young, H., Evans, R. and Robinson, A. (2021) *Pathfinder: Full technical report*. Published [online](#): Standing Together

Mental Health Taskforce to the NHS in England. (2016) *The five year forward view for mental health*. Published [online](#): NHS

Mind. (September 2021) *Mind responds to new NHS data on the number of children and young people experiencing a mental health problem*. News release.
<https://www.mind.org.uk/news-campaigns/news/mind-responds-to-new-nhs-data-on-the-number-of-children-and-young-people-experiencing-a-mental-health-problem/>
[Accessed October 2021]

Mind. *Trauma* (web page) <https://www.mind.org.uk/information-support/types-of-mental-health-problems/trauma/about-trauma/> [Accessed November 2021]

*National Commission on Domestic and Sexual Violence and Multiple Disadvantage. (2019) *Breaking down the barriers: Findings of the National Commission on Domestic and Sexual Violence and Multiple Disadvantage*. London: AVA, Agenda and the Lloyds Bank Foundation

National Health Service (NHS). (2019) *The NHS long term plan*. Published [online](#): NHS

Office for National Statistics (ONS). (2020) *Domestic abuse victim characteristics, England and Wales: year ending March 2020*. Published [online](#): ONS

*Oram, S., Khalifeh, H. and Howard, L. (2017) 'Violence against women and mental health', *Lancet Psychiatry* (4) 159-70

*Pathfinder. (2021) *Pathfinder survivor consultation: Key findings report*. Published [online](#): Standing Together

*Pettitt, B., Greenhead, S., Khalifeh, H., Drennan, V., Hart, T., Hogg, J., Borschmann, R., Mammo, E. and Moran, P. (2013) *At risk, yet dismissed: the criminal victimisation of people with mental health problems*. London: Victim Support and MIND

Read, J. (2018) 'Making sense of, and responding sensibly to, psychosis', *Journal of Humanistic Psychology*. 59 (5): 672-680

*Rivas, C., Ramsay, J., Sadowski, L., Davidson, L., Dunne, D., Eldridge, S., Hegarty, K., Taft, A. and Feder, G. (2015) 'Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse', *Cochrane Database of Systematic Reviews* 2015, Issue 12. Art. No: CD005043. DOI: 10.1002/14651858.CD005043

*Roch, A., Morton, J. and Ritchie, G. (2010) *Transgender people's experiences of domestic abuse*. Published [online](#): Scottish Transgender Alliance

*Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G. and Howard, L. (2011) 'Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study', *British Journal of Psychiatry*, 198, 189-194

Royal College of Psychiatrists. (RCP) (2020) Two-fifths of patients waiting for mental health treatment forced to resort to emergency or crisis services. Press release. <https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/10/06/two-fifths-of-patients-waiting-for-mental-health-treatment-forced-to-resort-to-emergency-or-crisis-services> [Accessed September 2021]

Royal College of Psychiatrists. (RCP) (2021) *Pandemic impact on mental health backlog catastrophic, says Royal College of Psychiatrists*. Press release. <https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2021/09/19/pandemic-impact-on-mental-health-backlog-catastrophic-says-royal-college-of-psychiatrists> [Accessed October 2021]

- *SafeLives. (2019) *Safe and well: Mental health and domestic abuse*. SafeLives
- *Scott, S., Williams, J., Kelly, L., McNaughton Nicholls, C., Lovett, J. and McManus, S. (2015) *Violence, abuse and mental health in England*. London: NatCen
- *Stay Safe East. (2021a) *Stay Safe East Response to the Home Office Call for Evidence on the Violence against Women and Girls strategy 2021-2024*. Published [online](#): Stay Safe East
- * Stay Safe East. (2021b) *Stay Safe East Response to the Reforming the Mental Health Act Consultation*. Published [online](#): Stay Safe East
- *Stay Safe East. (2021c) *Stay Safe East Response to the Women's Health Strategy Call for Evidence – June 2021*. Published [online](#): Stay Safe East
- *Sweeney, A., Perot, C., Callard, F., Adenden, V., Mantovani, N. and Goldsmith, L. (2019) 'Out of the silence: towards grassroots and trauma-informed support for people who have experienced sexual violence and abuse', *Epidemiology and Psychiatric Sciences* 28 (6) 598-602
- *Taskforce on the Health Aspects of Violence Against Women and Children. (2010) *Responding to violence against women and children: the role of the NHS*. Published [online](#)
- Thiara, R.K. and Harrison C. (2016) *Safe not sorry: Supporting the campaign for safer child contact*. Bristol: Women's Aid
- Thiara, R.K. and Roy, S. (2020) *Reclaiming Voice: Minoritised Women and Sexual Violence*. London: Imkaan and University of Warwick.
- 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
- *Trevillion, K., Hughes, B., Feder, G., Borschmann, R., Oram, S. and Howard, L. (2014) 'Disclosure of domestic violence in mental health settings: A qualitative meta-synthesis', *International Review of Psychiatry* 26 (4): 430-444
- *Trevillion, K., Corker, E., Capron, L. and Oram, S. (2016) 'Improving mental health service responses to domestic violence and abuse', *International Review of Psychiatry* 28 (5) 423-432

Tseris, E. (2013) 'Trauma theory without feminism? Evaluating contemporary understandings of traumatised women', *Journal of Women and Social Work* 28 (2) 153-164

VAWG Sector Working Group. (2021) *Draft definition of communication barriers*. (unpublished)

Women's Aid. (2021a) Women's Aid launches national campaign Deserve To Be Heard to highlight impact of domestic abuse on mental health of women and their children [press release]. Available from: <https://www.womensaid.org.uk/18382-2/> [Accessed on 15 September 2021]

*Women's Aid. (2021b) *The Domestic Abuse Report 2021: The Annual Audit*. Bristol: Women's Aid

*Women's Aid. (2021c) *Fragile funding landscape: the extent of local authority commissioning in the domestic abuse refuge sector in England 2020*. Bristol: Women's Aid.

*Women's Aid. (2021d) *Nowhere to Turn 2021: Findings from the fifth year of the No Woman Turned Away project*. Bristol: Women's Aid

Women's Aid. (2021e) *The Domestic Abuse Report 2022: Early Release*. Bristol: Women's Aid.

Women's Aid. (2021f) *Funding specialist support for domestic abuse survivors: revised estimates August 2021*. Bristol: Women's Aid

Women's Aid. (2020) Why data matters when talking about domestic abuse. Blog [published online](#): Women's Aid

*Women's Aid, Hester, M., Walker, S-J., and Williamson, E. (2021) *Gendered experiences of justice and domestic abuse. Evidence for policy and practice*. Bristol: Women's Aid

*Women's Mental Health Taskforce. (2018) *The Women's Mental Health Taskforce: Final report*. London: Department of Health and Social Care and Agenda

*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)*. King's College London.

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)