The Road to Recovery

Meeting the Mental Health Needs of Domestic Abuse Survivors

An Inquiry into Domestic Abuse and Mental Health by the All-Party Parliamentary Group on Domestic Violence and Abuse

appg
All-Party Parliamentary Group on
Domestic Violence and Abuse

women's aid
until women & children are safe

About the All-Party Parliamentary Group on Domestic Violence and Abuse

The All-Party Parliamentary Group (APPG) on Domestic Violence and Abuse provides a forum for discussion on how policy and legislation relating to domestic violence and abuse is affecting survivors and specialist support services. Women's Aid provides the secretariat to this group and supports the group in an administrative and operational capacity. The Chair of the APPG is Apsana Begum MP, and the Vice-Chair is Baroness Bertin.

This is not an official publication of the House of Commons or the House of Lords. It has not been approved by either house or its committees. All-Party Parliamentary Groups are informal groups of members of both houses with a common interest in particular issues. The views expressed in this report are those of the group.

The report was informed by evidence submitted to APPG inquiry and compiled by Women's Aid Federation of England.

Acknowledgements

The APPG on Domestic Violence and Abuse would like to thank all the survivors who have contributed to this inquiry – either in speaking at or attending the oral evidence sessions, submitting their own written evidence, or contributing to the submissions made by organisations. Your insight and expertise are vital to our efforts to bring about meaningful change, and we commend your strength and bravery in using your personal experience to improve support for others in the future.

We would also like to thank the organisations and decision makers who provided oral and written evidence to this inquiry (please see Appendix A for full list).

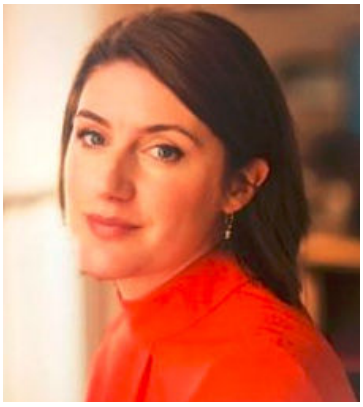
Published by:

Women's Aid Federation of England, PO Box 3245, Bristol, BS2 2EH

Contents

Foreword

Apsana Begum, MP
Chair of the APPG



Baroness Bertin
Vice-Chair of the APPG

The last year or so has been challenging and devastating for people around the country due to the Covid-19 pandemic, but particularly for survivors of domestic abuse. That is why it has been crucial for the APPG on Domestic Violence and Abuse to continue examining the key issues facing survivors.

Despite not being able to meet physically in Parliament, the group has been able to continue working not just cross-party, but with survivors of domestic abuse and the organisations who represent them. This has not only enabled the Group to ensure that post the Domestic Abuse Act, domestic abuse does not slip from the political agenda but also that we continue to build on this momentum and secure further changes for survivors.

With an ongoing global health pandemic, it has been a pertinent time for the APPG to focus on the life-long impact domestic abuse has on the mental health of survivors. Whilst nationally there has been a shift in the attention given to mental health, the Group was aware that survivors continued to struggle to access the support they need. That is why we launched an inquiry to examine these barriers and to understand from experts what is needed to address these.

It is clear that survivors continue to face an array of barriers when trying to access mental health support, however we are equally disappointed that for those who do, this support often does not meet their needs and can sometimes be re-traumatising and do further harm. The evidence is clear on what changes are needed to address this, including legislative changes in the Health and Care Bill and the upcoming Victims Bill, and how urgently these changes are needed.

It is our honour to serve as the Chair and Vice-Chair of the APPG on Domestic Violence and Abuse, working with survivors and voices from across the sector. We look forward to working with government, NHS trusts and other partners to implement these recommendations. Together, we can get survivors on the right road to recovery.

Foreword

Farah Nazeer
Chief Executive
Women's Aid Federation of England

The Covid-19 pandemic has had a significant mental health impact for many of us, but no more so than for survivors of domestic abuse. The pandemic has not only restricted survivors' routes to safety and been manipulated by perpetrators in their abuse, it has also exacerbated the mental health impact of domestic abuse. At Women's Aid, we have heard from many survivors who have continued to suffer the on-going trauma of living with abuse, whilst others have had past memories triggered. Survivors experienced restricted access to their support network or faced even more barriers to the sparse provision of mental health support.

However, although the pandemic may bring these experiences into sharp focus, they are by no means new. Survivors, including child survivors, have long since suffered the severe and often life-long impact of abuse on their mental health. Yet they continue to face significant barriers to getting support that is able to meet their mental health needs and ensure long-term healing. Urgent action is long overdue.

It is truly shocking reflecting on many of the statistics outlined in this report, particularly that 60-70% of women accessing mental health services have experienced domestic abuse[1]. Domestic abuse and the impact on mental health is a public health crisis – the evidence is clear. As such, it was positive to see both mental health and violence against women recognised as two of the six priority areas in the government's vision for the upcoming Women's Health Strategy[2]. We hope to see these priorities reflected in the funding landscape for mental health and domestic abuse services, and in frontline healthcare professionals' understanding and training on domestic abuse.

The APPG has heard powerful accounts from survivors, and the specialist domestic abuse services that support them, on what needs to change. What is noted by many, however, is both the shortfall of political will from within government, and the lack of strategic prioritisation of domestic abuse within health services - both of which are needed to make this change happen. This All-Party Parliamentary Group Inquiry report is a critical call to action to those power-holders in government and parliament to do more. We have a societal responsibility to help survivors on their road to recovery.

1 Trevillion, K., Oram, S., Feder, G., Howard, L.M. (2012), 'Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis.' *PLoS ONE* 7(12): e51740.

2 Department of Health and Social Care (2021), *Our Vision for the Women's Health Strategy for England.* DHSC. Available online: https://www.gov.uk/government/publications/our-vision-for-the-womens-health-strategy-for-england

Terminology

Survivor/victim: in this report, the term 'survivor' is predominantly used to describe individuals who have experienced domestic abuse. However, there are some references to 'victims' (e.g. victim-blaming) and these terms are therefore sometimes used interchangeably. The primary focus of this report is on women survivors and victims, as domestic abuse is a gendered crime which is deeply rooted in the societal inequality between women and men. It takes place "because she is a woman and happens disproportionately to women."[3]

Black and minoritised: the term 'Black and minoritised' is used to describe 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 survivors from a wide range of backgrounds and therefore can overlook differences within these groups[4]. Black and minoritised survivors are often defined in policy terms as Black and 'Minority Ethnic' (BME).

Domestic abuse/violence: the APPG's default position is to talk about 'domestic abuse' in line with the statutory definition in the Domestic Abuse Act 2021. However, we know that within the violence against women and girls (VAWG) sector and civil society 'domestic violence' is still used and there will be circumstances where this is the most appropriate terminology.

Violence against Women and Girls (VAWG): The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[5] Domestic abuse is recognised as a form of violence against women and girls[6].

Trauma-informed: Elliot et al. (2005)[7] define trauma-informed services as "those in which service delivery is influenced by an understanding of the impact of interpersonal violence and victimisation 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."[8]

3 United Nations (UN) (1993) Declaration on the elimination of violence against women.

4 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.

5 United Nations (UN) (1993) Declaration on the elimination of violence against women.

6 United Nations (UN) (1993) Declaration on the elimination of violence against women.

7 Elliot, D., Bjelajac, P., Fallot, 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.

8 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.* Available online: https://www.wgn.org.uk/sites/default/files/2020-05/Good-Practice-Briefing-TIA-Model-1.pdf

Executive Summary

The findings from this inquiry make clear the urgent need to meet the mental health needs of survivors of domestic abuse. Evidence to this inquiry has illustrated that survivors not only face a myriad of barriers in trying to access support, but the support available often falls short of meeting their needs. Statutory health services lack sufficient understanding of domestic abuse and trauma-informed practice; and there is an inadequate level of partnership work with – and funding for – the specialist domestic abuse services who hold such expertise. This APPG is clear that all survivors should be able to access the long-term mental health support needed to recover from the trauma of domestic abuse. With 60-70% of women accessing mental health services having experienced domestic abuse[9], this is a public health crisis and must be prioritised as such.

Barriers to support experienced by survivors as a result of domestic abuse (for example, feelings of fear and shame) are often reinforced in their experiences with statutory services. This is due to the societal stigma and poor understanding of both domestic abuse and mental ill-health, as well as a lack of knowledge about the links between the two. Consequently, survivors often receive inadequate or even 'victim-blaming' responses from statutory services, and see their mental ill-health used as a way of discrediting them, for example, in the family or criminal courts. When overcoming such barriers, it is clear that the support available is insufficient to respond to the significant and long-term impact of domestic abuse.

Many of the barriers to accessing effective mental health support are compounded by structural inequalities including the impact of sexism, racism, ableism and homophobia. This APPG recognises that survivors need specialist responses to meet their different needs. A 'one size fits all' approach cannot be taken if we are to tackle health exclusion and meet the needs of survivors, whether they be a Black and minoritised survivor, a Deaf or disabled survivor, or an LGBT+ survivor; and the importance and value of the specialist 'by and for'[10] sector in meeting such needs must be recognised.

Whilst mental health has seen a welcome increase in attention by both the UK government and the public, it is vital that this includes survivors of domestic abuse and their needs. It is also important that the impact of the last 18 to 20 months on survivors is not overlooked. It is well evidenced that survivors' experience of abuse worsened during the Covid-19 pandemic[11], and their routes to support restricted, as recognised in the introduction to this report. Frontline domestic abuse services have reported an increase in the complexity of cases[12], however this has not been sufficiently reflected in the funding they receive or the response that survivors receive from statutory health services.

9 Trevillion, K., Oram, S., Feder, G., Howard, L.M. (2012) 'Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis', *PLoS ONE* 7(12): e51740.

10 As defined by Imkaan, 'by and for' sector or services are terms used to refer "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." Imkaan (2018) *Summary of the Alternative Bill: From the Margin to the Centre Addressing Violence Against Women and Girls.* Published online: https://www.imkaan.org.uk/updates/2018/alternative-bill

11 Women's Aid (2020) A *Perfect Storm: The impact of the Covid-19 pandemic on domestic abuse survivors and the services supporting them.* Bristol: Women's Aid. Available online: https://www.womensaid.org.uk/evidence-hub/research-and-publications/evidence-briefings-the-impact-of-covid-19-on-survivors-and-services/

12 Ibid.

The APPG on Domestic Violence and Abuse examined these barriers and the wider challenges that survivors and services face in responding to the mental health impact of domestic abuse by conducting a Parliamentary hearing. The APPG also explored and investigated the solutions that are needed to deliver a step-change in the response received by survivors, and heard encouraging examples of best practice and workable solutions that illustrate the most significant barrier remains the lack of political will and the need for strategic prioritisation of domestic abuse within health services.

There are clear recommendations to be implemented nationally by government and locally by health commissioners, but also within the specialist domestic abuse sector too. This APPG is determined to ensure the changes needed are delivered, so that survivors of domestic abuse can receive the mental health support they urgently need.

Summary of recommendations

1. Domestic abuse, and its impact on survivors' mental health, should be recognised as a public health priority:

- The Health and Care Bill should embed tackling domestic abuse and other forms of VAWG (and its impact on mental health) firmly within the role of health commissioners. This should involve working with specialist domestic abuse and VAWG services, including specialist 'by and for' services, and ensure they have a voice in the new Integrated Care Partnerships (ICPs).
- The Department of Health and Social Care (including in the delivery of the upcoming Women's Health Strategy[13] and the new Integrated Care Systems), and NHS England, should recognise domestic abuse as a key driving factor in survivors' mental ill-health, and make it a strategic priority.

13 The Department for Health and Social Care published a 'Vision for the Women's Health Strategy for England' in December 2021as a precursor to the full strategy due for publication in Spring 2022. This APPG welcomes that both mental health and 'the health impact of violence against women and girls' were noted as two of the six priority areas within their vision, as well as 'Women's Voices' being a key theme underpinning the strategy, and the planned appointment of a Women's Health Ambassador. The full strategy, and the work of the newly appointed Ambassador, must ensure they explicitly draw links between mental health and domestic abuse in their strategic prioritisation, and ensure that the upcoming delivery plans and concrete proposals (which the government plan to set out in the full strategy) takes heed of this APPG's wider report recommendations – most notably those relating to the need for joint work with the domestic abuse sector, the importance of funding, and training for health professionals.

14 Department of Health and Social Care and Agenda (2018) *The Women's Mental Health Taskforce, Final report.* Available online: https://www.gov.uk/government/publications/the-womens-mental-health-taskforce-report

2. Embed a whole-system approach to prioritising domestic abuse across NHS Trusts, with a focus on tackling victim-blaming culture and structural inequalities, and setting a clear vision for success.

To include:

- **Local Women and Girls' Mental Health Strategies which incorporate:**
  - i. A vision for addressing the mental health impacts of domestic abuse and VAWG;
  - ii. A focus on addressing health inequalities;
  - iii. The gender and trauma-informed principles set out in the Women's Mental Health Taskforce report[14].
- **Specialist training for general practitioner (GPs), frontline health professionals and medical students**[15] – ensuring an understanding of domestic abuse and other forms of VAWG, and developed in partnership with the specialist domestic abuse and VAWG sector.
- **Duties for 'routine enquiry' in health settings in England.** For example, implement legislation that mirrors Wales' 'Ask and Act'[16] in health settings in England – which includes a national training framework and 'Ask and Act' duties for routine enquiry.
- **Partnership work with the domestic abuse and VAWG sector** – for example, integrated care pathways and co-located domestic abuse support workers. To support better partnership work, NHS trusts would benefit from Domestic Abuse Coordinator posts.

15 In 2019, the APPG's annual report recommended that all frontline healthcare staff are trained in understanding VAWG and advanced training is given to professionals who are in frequent contact with survivors (such as GPs and midwives).

The All-Party Parliamentary Group on Domestic Violence and Abuse (2019) *The All-Party Parliamentary Group on Domestic Violence and Abuse Annual Report 2018-2019.* Bristol: Women's Aid. Available online: https://www.womensaid.org.uk/appg-reports/

16 'Ask and Act' was brought in as part of the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015. Available online: https://www.legislation.gov.uk/anaw/2015/3/2016-04-01

3. Improve the data collection and monitoring of the mental health needs of survivors by requiring:

- The Care Quality Commission (CQC) to routinely collect and report on data regarding domestic abuse and VAWG
- NHS trusts to gather and report on data relating to policies, training, enquiries and referrals
- The Domestic Abuse Commissioner's office to utilise its powers to request data from the DHSC, Public Health England and NHS England on suicides and domestic abuse, including data before and after a death occurs
- The Domestic Abuse Commissioner's office to utilise its power to ensure the DHSC, Public Health England and NHS England capture domestic abuse in national suicide surveillance data.

4. Ring-fenced funding for specialist community-based services and 'by and for' services in the forthcoming Victims' Bill, and increased funding for specialist refuges through Part 4 of the Domestic Abuse Act.

- The upcoming Victims' Bill should deliver a sustainable, long-term and secure funding model for specialist community-based domestic abuse services, including ring-fenced funding for 'by and for' services. Funding for Part 4[17] of the Domestic Abuse Act must also be increased to ensure survivors are not turned away from specialist refuges. Both sets of funding must cover counselling and support for mental wellbeing, and the investment in the wellbeing and development of staff.

17 Which places a duty on local authorities in England to provide accommodation-based support to victims of domestic abuse and their children in refuges and other safe accommodation.

Introduction

"My mum…died… [last year]. The cause of death, as found by the coroner, is that 'she took her own life whilst suffering anxiety precipitated by a domestic violence incident'… Prior to the [domestic abuse], [she] was healthy, happy and stable. She was an NHS GP, had two sons and a stepdaughter. She had a large network of friends…The [mental health teams] seemed clueless about how to help her."

Family member of a victim of domestic abuse – written submission

"Domestic abuse is a mental health crisis; it is endemic in our society".

Woman's Trust – written submission

In the wake of the Covid-19 pandemic, there has been increased public and political attention on domestic abuse and mental health. However, as shared in powerful testimonies from survivors and their families, and concerns raised by specialist services, the response to survivors is failing to address the long-term and devastating impact domestic abuse has on their mental wellbeing.

This APPG on Domestic Violence and Abuse report outlines the barriers and issues currently faced by survivors when seeking support for their mental health, alongside expert recommendations about how to address these.

Background

Domestic abuse can have a devastating and long-lasting impact on survivors' mental health, and causes significant trauma. For groups facing additional forms of discrimination and inequality, these impacts are compounded still further. As a response to the trauma of domestic abuse, many survivors develop mental health problems – or any existing mental health problems are made worse by the abuse, including post-traumatic stress disorder (PTSD), severe anxiety, severe depression, eating disorders, self-harm and suicidal thoughts and actions[18].

Furthermore, mental ill-health is frequently weaponised against survivors and often survivors experience re-traumatisation by the very systems that are meant to support them. Survivors' experiences are too often dismissed and for some, additional forms of inequality make it even more difficult to be heard. Moreover, the Covid-19 pandemic has had a significant impact on not only the physical safety of survivors, but also their mental health. 53% of survivors surveyed in the first lockdown stated that the impact of the pandemic on their mental health had worsened

18 Department of Health and Social Care and Agenda (2018) *The Women's Mental Health Taskforce, Final report.* Available online: https://www.gov.uk/government/publications/the-womens-mental-health-taskforce-report

their experiences of abuse, and for many triggering difficult memories – once again feeling like prisoners in their own home, bringing back feelings of fear, loneliness and isolation[19].

Despite the intrinsic links between domestic abuse and mental health, and the staggering £2.3 billion government estimation of the cost of domestic abuse to the health service[20], domestic abuse is often viewed by government as exclusively a criminal justice issue rather than also as a key public health priority. Survivors have shared numerous barriers they face when seeking support for their mental wellbeing, including victim-blaming, stigma, structural inequalities, waiting lists, fragmented support and inappropriate interventions, such as short-term Cognitive Behavioural Therapy (CBT), medication and a lack of trauma-informed care. Furthermore, expert witnesses have highlighted the lack of political will, strategic prioritisation and funding needed to deliver the type of services that are able to respond to the long-term mental health needs of survivors, and create the cultural and whole-system change required:

> "We are nowhere near the kind of work we need to see in mainstream mental health services around domestic abuse... It is one of the most underdeveloped areas of work in terms of our coordinated response to domestic abuse."
>
> **Nicole Jacobs, Domestic Abuse Commissioner for England and Wales – oral evidence**

In light of this reality, the APPG on Domestic Violence and Abuse launched an inquiry into domestic abuse and mental health in July 2021.

Inquiry hearings and call for evidence

The inquiry took place over two parliamentary hearings and included a written call for evidence. The first hearing, held on 7th July 2021, focused on the barriers survivors face in accessing mental health support[21]. The second hearing on 8th September 2021 focused on best practice and recommendations on how to meet the mental health needs of survivors[22]. These oral evidence sessions were accompanied by a written call for evidence, which ran from 7th July until 24th September 2021.

Survivor voice and expertise were central to this process, and during the oral evidence session we heard from Experts by Experience (survivors), as well as receiving a number of written submissions from survivors. We also heard evidence from policy makers and the specialist domestic abuse sector. For a full list of those who provided evidence to the inquiry, please see Appendix A.

The evidence was collated and analysed by the Secretariat of the APPG – Women's Aid Federation of England.

19 Women's Aid (2020) *A Perfect Storm: The impact of the Covid-19 pandemic on domestic abuse survivors and the services supporting them.* Bristol: Women's Aid. Available online: https://www.womensaid.org.uk/evidence-hub/research-and-publications/evidence-briefings-the-impact-of-covid-19-on-survivors-and-services/

20 Home Office (2019) *The economic and social costs of domestic abuse.* Available online: https://www.gov.uk/government/publications/the-economic-and-social-costs-of-domestic-abuse

21 Minutes of the hearing on the 7th July 2021. Available online: https://www.womensaid.org.uk/appg/

22 Minutes of the hearing on the 8th September 2021. Available online: https://www.womensaid.org.uk/appg/

Chapter One

Barriers to accessing support

In light of the significant and often devastating impact of domestic abuse on survivors' mental health, this inquiry sought to understand the barriers survivors face in getting the support they need. These can be summarised as follows:

i) Stigma and victim-blaming

The vast majority of evidence relating to barriers referenced the profoundly damaging impact of victim-blaming, a culture of disbelief and societal stigma linked to both domestic abuse and mental health. Evidence also highlighted how these narratives can then be weaponised by a perpetrator in their abuse, resulting in fear being a key barrier for survivors. For example, perpetrators may describe a survivor as 'crazy' and weaponise mental ill-health (either real or fictitious) to depict survivors as, for example, unfit mothers in the family courts, or unreliable witnesses in criminal proceedings. As highlighted by Women's Aid through oral evidence, this perpetrator tactic is often very effective as the label of 'mentally ill' frequently negatively impacts the response from statutory services. Furthermore, experts such as Women in Prison emphasised how this is even more pronounced for those survivors facing multiple disadvantage[23] as they are seen as 'undeserving victims', which is often compounded further still by racism. Survivors and expert witnesses also shared how victim-blaming narratives can intensify a sense of isolation, particularly when there is a lack of understanding from friends, families and communities.

Stigma attached to mental ill-health, and approaches which seek to locate the issue with the victim/survivor rather than with the abuser, also link to concerns raised around the pathologisation of survivors' responses to trauma and concerns with misdiagnosis. Pathologisation (in this context) refers to the reduction of a survivors' response to domestic abuse to a medical condition or disorder, instead of recognising the mental distress as a direct result – or even coping mechanism – of abuse. A number of submissions raised concerns about the misdiagnosis of survivors' responses to trauma – for example, survivors being diagnosed with personality disorders. An Expert by Experience (survivor), Helen*[24], described how she was wrongly diagnosed when she first received support, which subsequently meant that she was often not believed and decisions were made without her. This compounded her trauma as her experiences were met with responses such as "someone with your diagnosis would think like that...". Helen* stated that reducing her

23 AVA defines the term multiple disadvantage as referring 'to those people who face multiple and intersecting inequalities including gender-based violence and abuse, substance use, mental ill health, homelessness, being involved in the criminal justice system and the removal of children'. Available online: https://avaproject.org.uk/ava-services-2/multiple-disadvantage/

24 *Pseudonym.

experience to a mental health diagnosis did not help her work through her trauma. Furthermore, expert witnesses such as Imkaan, Stay Safe East and Birmingham LGBT highlighted that this pathologisation and misdiagnosis of trauma was even more pronounced for Black and minoritised, disabled and LGBT+ survivors. The gendered narratives of stigma and mental ill-health were also explored by Women's Aid who set out that "showing signs of emotional distress were often linked to wider stereotypes about women being unstable, over-emotional or hysterical"[25].

ii) Structural inequalities and responding to different needs

A significant proportion of the evidence emphasised the role of structural inequalities (such as of gender, race and disability) the intersections of these inequalities and the importance of recognising and responding to different groups of survivors when seeking to improve support to meet their mental health needs. This evidence also highlighted wider health inequalities and health exclusion, with expert witness Imkaan urging for a rights-based approach to ensure everyone has access to services that meet their needs.

Gender

The vast majority of evidence submitted to the inquiry stressed the importance in recognising the gendered dynamics of domestic abuse:

> "Domestic abuse is a gendered crime; with women and girls being most likely to be affected, having the highest rates of repeated victimisation and being more likely to experience serious harm or death".
>
> **Royal College of Psychiatrists**

A lack of understanding of these gendered dynamics of domestic abuse in the commissioning, design and delivery of domestic abuse and mental health services was noted as a key barrier for survivors. Expert witness Birmingham LGBT highlighted the importance of understanding how patriarchal structures affect women, girls and LGBT+ people. One submission emphasised the need to have more awareness-raising targeted at male survivors.

LGBT+

Expert witness, Birmingham LGBT, stressed that the biggest barriers for LGBT+ survivors of domestic abuse is the dominant discourse of heteronormativity meaning that LGBT+ survivors' experiences are often hidden. It is important to also consider that the LGBT+ community already carries a high burden of mental health problems as they face discrimination and micro-aggressions on a daily basis.

Deaf and disabled survivors

Stay Safe East emphasised the role of "institutionalised inequality and the specific issues faced by disabled survivors. For example, less access to life opportunities, poverty, daily

25 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. Available online: https://www.womensaid.org.uk/evidence-hub/research-and-publications/

discrimination, marginalisation and denial of who they are" – as major factors which contribute to disabled survivors' poor mental health. Stay Safe East also drew particular attention to the lack of appropriate and confidential psychological support for survivors with learning difficulties.

A key theme in SignHealth's evidence was communication barriers[26], which was also noted as a prominent barrier for migrant survivors. For example, SignHealth emphasised the lack of support available to Deaf survivors in British Sign Language, noting that information in written English is inaccessible to many Deaf survivors. SignHealth highlighted that communication barriers go beyond language, and emphasised the importance of a shared cultural understanding. For example, receiving therapy directly in sign language, rather than via an interpreter, means the therapist has a deeper understanding of Deaf culture and will have a greater understanding of how audism[27] will have a significant impact on a person's mental wellbeing.

Black and minoritised survivors

As stated in an oral evidence hearing by Paulette, an Expert by Experience (survivor), she was often not seen as a 'victim' because she is a Black woman. This powerful statement highlights the barrier of racism survivors face when trying to access support, and was supported by numerous other submissions which noted the role of structural and racial inequalities.

Imkaan, alongside Latin American Rights Service (LAWRS) and other evidence submissions, illustrated how domestic abuse interlocks with "diminished health care outcomes, socio-economic marginalisation and exclusion which is often based on immigration status or perceived immigration status for Black and minorities survivors". As stressed by Imkaan, hostile immigration policies are having an impact on women's access to mental health support and there continues to be entrenched institutional racism which exacerbates the issues around health exclusion, misdiagnosis and appropriate responses. LAWRS argued that hostile immigration polices also enable perpetrators to weaponise a survivor's status so that they fear seeking help from authorities, and inhibit sufficient knowledge of entitlements and rights including access to healthcare.

Communication barriers were highlighted as a significant obstacle for many Black and minoritised survivors. Reaffirming the evidence put forward by SignHealth, it is clear that the answer to these communication barriers goes beyond mere translation, and includes the importance of cultural understanding, an understanding and language for domestic abuse, and of shared experience. For example, evidence pointed to not only language barriers worsened by a lack of interpreters, but also in regard to poorly trained interpreters who do not have sufficient understanding or language to talk about domestic abuse; or conversely support workers (whose words are being translated) not having the relevant cultural understanding to speak to the survivor's experience. Therefore, highlighting the invaluable nature of services led 'by and for' Black and minoritised women to provide culturally and linguistically specific support e.g. counsellors providing support directly in the first language of the survivor (please see page 26 for example of such work).

26 'Communication means sharing meaning. With no sharing, there is no communication. To communicate successfully in a team or with others, at work or in the community, we have to understand the communication environment and the barriers which prevent messages being sent and received successfully. A communication barrier is anything that prevents us from receiving and understanding the messages others use to convey their information, ideas and thoughts. They can interfere with or block the message you are trying to send'.

Kumbakonam, U. (2016) Communication Barriers, *Veda's Journal of English Language and Literature (JOELL)*. Vol. 3, issue 2.

27 Audism is the discrimination or prejudice against people who are Deaf or hard of hearing.

Additionally, expert witness Agenda Alliance (Agenda) noted that Black and minoritised survivors have reported that "often Western models of therapy fail to connect their experiences of oppression with mental ill health they face".

Faith

The Faith and VAWG Coalition provided oral evidence which highlighted the barriers faced by survivors of faith, whose experiences are seldom heard, and the Coalition flagged the lack of literature in this area. Critically, the Coalition illustrated how faith can be viewed as a manifestation of mental ill-health rather than a source of support and strength for those who have experienced trauma. This means that religion and faith communities are often marginalised and are not seen as a part of the solution and recovery of survivors. It is also important to note how faith can be used by perpetrators as part of their abuse, however faith abuse is not recognised by the Domestic Abuse Act, in health strategies or in generic services, meaning that the support many survivors of faith receive is not holistic or appropriate.

Multiple-disadvantage

The experiences of survivors who face multiple-disadvantage was a common theme throughout both the oral and written evidence – for example, survivors who have experienced not only abuse, but also mental ill-health, substance misuse, poverty and encounters with the care system and with the criminal justice system. This included evidence from Agenda, AVA, The Nelson Trust, and Women in Prison. AVA highlighted that "due to the complexity of the issues they face, many women and girls experiencing abuse, mental ill-health and other types of disadvantage are excluded or overlooked by services, which don't see them as victims or survivors, but as 'problems'."

Age

The APPG received evidence bringing attention to the experiences of survivors of all ages – including babies, children, young women and older women – which emphasised the need to do more to meet the different needs of these survivors. Many submissions noted the severe lack of support for children affected by domestic abuse, whilst one submission noted that girls and young women aged 16–24 experience the highest rates of domestic abuse of any age or gender group[28]. Furthermore, psychologists from Teesside University and North Yorkshire Psychological Therapies shed light on the experiences of older women. Their research revealed that therapists doubted their ability to work meaningfully with older women experiencing domestic abuse, and therefore avoided asking questions about partner abuse. Instead, they argued therapists preferred to address the symptoms rather than the cause of the mental health issues, which was often domestic abuse related.

Impacts of the Covid-19 pandemic

It is important to note that numerous expert witnesses highlighted how the Covid-19 pandemic has exacerbated many of the issues outlined in regard to structural inequalities, as well as the increased strain on the NHS and staff burnout. For example, Imkaan noted Gypsy and Roma women, who already experienced significant barriers to accessing mental health services, have seen barriers increase due to the move to

28 Crime Survey for England and Wales (2020) *Domestic abuse victim characteristics, England and Wales: year ending March 2020.* Office for National Statistics. Available online: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2020

online service provision. This is a barrier also experienced by older survivors, and similarly for Deaf survivors in regard to the rise of support delivered over the phone. As noted from IRISi in their evidence submission, "telemedicine and virtual health consultations, which have been accelerated and increased during the pandemic, do not best support women affected by domestic abuse or their mental health. This must be recognised and women offered more timely access to a face-to-face appointment without the need to justify or evidence why".

iii) Waiting lists, fragmented support and inappropriate interventions

Reaching out for support is a significant, difficult and often dangerous step for a survivor to take, a challenge exacerbated by the many barriers outlined in this report. However, this APPG has heard that even after a survivor has found the strength to take such a step, which can in some cases be life-threatening, they face barriers in accessing support that meets their needs. A number of survivors and organisations highlighted how overwhelming 'the system'[29] is to navigate and the fragmented nature of support. Helen*, survivor and expert witness, described how life as a survivor is "exhausting", noting how she had to "struggle to survive, being moved from one service to the next whilst trying to put [her] life back together". Many survivors and services also noted the re-traumatisation of having to continuously re-tell their story when undergoing numerous assessment processes and accessing different services.

Evidence to this inquiry highlighted the challenges faced by survivors due to strict eligibility criteria for services, highlighting a lack of understanding of the multiple and intersecting needs of many survivors, as well as the long-term and non-linear nature of survivor journeys. A number of organisations indicated concerns about the multitude of survivors who fall between the gaps of services:

> "Women are forced to fit into services rather than services adapting to fit around the reality of a woman's life and understanding their trauma".
>
> **Agenda – written submission**

Even when survivors are successfully referred into a service, they are still faced with lengthy waiting times. Survivors shared experiences of waiting times from six weeks up to three years to access therapeutic support. It was noted how these waiting times compound the complexity and severity of survivors' needs. One survivor stated:

> "[There are] very long waiting lists for counselling. [I was] referred for trauma therapy, [but it] became clear I was not in the right headspace. [I] was then told I could not be referred ever again."
>
> **Survivor – Nelson's Trust written submission**

29 'The system' in this context refers to the myriad of services and professionals survivors may come into contact with. For example, GPs, mental health professionals, other health professionals, housing services, the criminal justice system, social services, and domestic abuse services.

In response to the issue of waiting times, SafeLives argued the government should ensure shorter waiting lists for mental health services for victims of trauma, in line with the current 'fast track' for veterans and members of the armed forces. However, concerns have been raised about the impact of creating a hierarchy of need within mental health service provision.

There was also significant evidence which illustrated that even if a survivor was offered support for their mental wellbeing, the provision was often wholly unsuited to their needs. A number of survivors raised how quick medical professionals were to prescribe medication without an exploration of the cause of their mental distress, with one survivor stating:

> "The Mental Health team don't listen; they just give me medication. I have been passed around different doctors. My current GP doesn't know what to do with me. She is not supportive and has just given me more medications. They won't listen to what I want but tell me what I need. None of them took my suicide threats seriously."
>
> **Survivor – Nelson's Trust written submission.**

A significant number of submissions noted the inadequacy of the length of therapeutic support on offer when working with those who've experienced trauma – for example, a maximum of six to 12 sessions. Survivors, IRISi and Woman's Trust also highlighted the pitfalls in offering survivors generic CBT via the NHS's Improving Access to Psychological Therapies (IAPT) pathway. The APPG heard how this type of intervention is not tailored to respond to the dynamics of domestic abuse, as it puts the onus on changing the survivor's response to the mental impact of abuse, rather than locating the issue with the abuse and perpetrator. Furthermore, counsellors accessed via this route are often not specialists in domestic abuse, nor will female survivors necessarily be paired with a female counsellor – which Woman's Trust noted is of great importance for female survivors. Unsurprisingly, submissions concluded that money spent on these interventions was a poor investment and ineffective use of taxpayers' money.

iv) The wider picture

It is essential to position survivors' mental wellbeing within the context of their wider situation and recognise that unmet needs, such as housing or physical safety, can form a barrier to accessing support around their mental health. This illustrates the critical need to join up efforts to improve support for survivors as holistically as possible. This includes, but is not limited to, safe housing; financial independence and security; safe child contact arrangements; support with parenting; support in work and educational settings; supportive and safe journeys through the family court and criminal justice systems; immigration support, and access to public funds and services; and connection to community. All of which are referenced by submissions made to this inquiry, and heavily underlined by survivors themselves.

Chapter Two

The health sector - what needs to change? From government and NHS England to local health commissioners and trusts

The APPG's call for evidence asked what more health services could do to better meet the mental health needs of survivors – five overarching themes were prominent in submissions.

i) Prioritisation of domestic abuse and mental health with a focus on inequalities

A number of submissions highlighted that current health policy does not adequately prioritise domestic abuse, and the tendency by government to frame (and respond to) domestic abuse exclusively as a criminal justice issue, rather than also as public health priority. As stated by the Domestic Abuse Commissioner, Nicole Jacobs, this issue lacks "the political will and leadership that is needed from leaders in the health system", and "need(s) to see a much clearer and proactive expectation from government around domestic abuse and mental health." Furthermore, Imkaan emphasised the need to take a rights-based approach to address the structural inequalities previously outlined, through the 2010 Equality Act and various international conventions on human rights ratified by the UK.

Many submissions called for the strategic prioritisation of domestic abuse and mental health, with a focus on inequalities and access to support – a recommendation also made by this APPG in 2019[30]. The strategic prioritisation of domestic abuse must be met with sufficient funding and leadership, and be seen at both national and local level – from the government, NHS England and other national health bodies, to the new Integrated Care Systems, local health commissioners and trusts. The Royal College of Psychiatrists (RCPsyc) in their evidence submission highlighted their plans to develop a formal strategy for domestic abuse, and to assign a formal domestic abuse lead within the RCPsyc "to allow the appropriate resource and leadership to ensure that there is meaningful cultural change".

30 The All-Party Parliamentary Group on Domestic Violence and Abuse (2019) *The All-Party Parliamentary Group on Domestic Violence and Abuse Annual Report 2018-2019.* Bristol: Women's Aid. Available online: https://www.womensaid.org.uk/appg-reports/

This APPG therefore recommends that:

- **Domestic abuse, and its impact on survivors' mental health, should be recognised as a public health priority:**
  - The Health and Care Bill should embed tackling domestic abuse and other forms of VAWG (and its impact on mental health) firmly within the role of health commissioners. This should involve working with specialist domestic abuse and VAWG services, including specialist 'by and for' services, and ensure they have a voice in the new Integrated Care Partnerships (ICPs).
  - The Department of Health and Social Care (including in the delivery of the upcoming Women's Health Strategy and the new Integrated Care Systems), and NHS England, should recognise domestic abuse as a key driving factor in survivors' mental ill-health, and make it a strategic priority.

ii) Culture change and a whole-system approach

A number of expert witnesses stressed the importance of culture change and a whole-system approach within health to better meet the mental health needs of survivors. This was deemed particularly crucial in light of the current piecemeal approach and pockets of good practice across the UK, often dependent on the work of a few committed individuals. Evidence submitted to the inquiry noted the importance of training, routine enquiry, policies, domestic abuse champions, robust multi-agency work and stronger relationships with the specialist domestic abuse sector to embed culture change across health.

The inquiry heard from several partners of the Pathfinder project[31], noted as key example of this whole-system approach. Pathfinder was a pilot project that brought together expertise and funding to embed a 'Whole Health' approach to domestic abuse in eight sites across England, engaging nine Clinical Commissioning Groups (CCGs) and 18 NHS Trusts. The Pathfinder project helped to embed governance and policies, coordination, data collection, specialist interventions and training – bringing together all these key elements to achieve a joined up approach, which is outlined in the Pathfinder toolkit[32]. Key achievements in embedding this approach included training approximately 2,738 health professionals, setting up nine domestic abuse champion networks across the participating NHS trusts, and securing funding for 10 hospital-based Independent Domestic Violence Advocates (IDVAs), three domestic abuse coordinators, and two IRIS programmes across 64 GP practices[33].

The majority of evidence submissions referenced the current lack of training for medical professionals. Significant and detrimental gaps in knowledge were highlighted, including:

- Poor understanding of the domestic abuse, and limited ability to recognise it – particularly coercive control and so-called 'honour-based' abuse

31 Pathfinder Project. Available online: https://www.standingtogether.org.uk/pathfinder

32 Standing Together, AVA, Imkaan, IRISi and Safe Lives (2020) *Pathfinder Toolkit*. Available online: https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5ef35f557271034cdc0b261f/1593007968965/Pathfinder+Toolkit_Final.pdf

33 Ibid.

- Poor understanding of the relationship between domestic abuse and mental health, including a lack of understanding of trauma and its long-term impact
- Poor understanding of what trauma-informed care looks like in practice
- A lack of confidence in identifying and responding to perpetrators
- A poor grasp of intersectional barriers, needs and experiences, such as those relating to race, culture, disability, gender and sexuality.

A number of submissions highlighted the need to ensure sufficient and meaningful training around domestic abuse is included in the curriculum for all medical students, as well as the value of hosting training between different medical professionals and with the specialist domestic abuse sector. The Royal College of Psychiatrists highlighted the impact of the optional nature of domestic abuse training currently, and argued that whilst training must be made mandatory for frontline staff it should be covered within existing mandatory training on safeguarding vulnerable adults. The call for mandatory training was noted by a number of other organisations – a recommendation echoed by this APPG in 2019[34]. Furthermore, Agenda called for Health Education England and all health trusts, in line with NICE guidelines, to ensure that training about gender-based violence and abuse and trauma is embedded in training programmes.

Sufficient training and competency among health professionals on domestic abuse would also enable greater and safer routine enquiry, which was a recommendation made in many submissions. As heard by the APPG, health professionals are in a unique position to enquire about domestic abuse, however evidence suggests domestic abuse and sexual violence are acutely under-detected in health services. As noted by AVA, "At present just 10-30% of cases are identified and levels of enquiry are low [in mental health settings]. Without direct inquiry survivors are not likely to disclose abuse"[35]. Recommendations relating to routine enquiry were referenced across all health settings, including primary healthcare as well as hospital and mental health settings. There was also reference to the need for similar programmes to help identify perpetrators, and the importance of training in how to respond.

Recommendations calling for routine enquiry made reference to 'Ask and Act' in Wales, which was also referenced by this APPG in 2019[36]. 'Ask and Act' is a process of targeted enquiry to be practiced across the Public Service to identify violence against women, domestic abuse and sexual violence. The term 'targeted enquiry' describes the recognition of indicators of violence against women, domestic abuse and sexual violence as a prompt for a professional to ask their client whether they have been affected by any of these issues.

The aims of 'Ask and Act' are:

- to increase identification of those experiencing violence against women, domestic abuse and sexual violence
- to offer referrals and interventions for those identified which provide specialist support based on the risk and need of the client
- to begin to create a culture across the Public Service where addressing violence against women, domestic abuse and sexual violence is understood in the correct context, where disclosure is accepted and facilitated and support is appropriate and consistent

34 The All-Party Parliamentary Group on Domestic Violence and Abuse (2019) *The All-Party Parliamentary Group on Domestic Violence and Abuse Annual Report 2018-2019.* Bristol: Women's Aid. Available online: https://www.womensaid.org.uk/appg-reports/

35 Oram, S., Capron, L., and Trevillion, K. (2016) *Promoting Recovery in Mental Health: Evaluation Report.* Available online: https://avaproject.org.uk/wp/wp-content/uploads/2017/01/PRIMH-Evaluation-Full-Report-1.pdf

36 The All-Party Parliamentary Group on Domestic Violence and Abuse (2019) *The All-Party Parliamentary Group on Domestic Violence and Abuse Annual Report 2018-2019.* Bristol: Women's Aid. Available online: https://www.womensaid.org.uk/appg-reports/

- to improve the response to those who experience violence against women, domestic abuse and sexual violence with other complex needs such as substance misuse and mental health; and
- to proactively engage with those who are vulnerable and hidden, at the earliest opportunity, rather than only reactively engaging with those who are in crisis or at imminent risk of serious harm[37].

Submissions also voiced support for Agenda's 'Ask and Take Action' Campaign, which demands that there is "a duty on public authorities to ensure frontline staff make trained enquiries into domestic abuse, backed by sufficient funding to make this a reality"[38].

It is clear that action is required, and this APPG therefore recommends:

- **Embed a whole-system approach to prioritising domestic abuse across NHS Trusts, with a focus on tackling victim-blaming culture and structural inequalities, and setting a clear vision for success.**

To include:

- **Local Women and Girls' Mental Health Strategies which incorporate:**
  - i. A vision for addressing the mental health impacts of domestic abuse and VAWG;
  - ii. A focus on addressing health inequalities;
  - iii. The gender and trauma-informed principles set out in the Women's Mental Health Taskforce report[39].
- **Specialist training for GPs, frontline health professionals and medical students**[40] – ensuring an understanding of domestic abuse and other forms of VAWG, and developed in partnership with the specialist domestic abuse and VAWG sector.
- **Duties for 'routine enquiry' in health settings in England.** For example, implement legislation that mirrors Wales' 'Ask and Act' in health settings in England – which includes a national training framework and 'Ask and Act' duties for routine enquiry.
- **Partnership work with the domestic abuse and VAWG sector** – for example integrated care pathways and co-located domestic abuse support workers. To support better partnership work, NHS trusts would benefit from Domestic Abuse Coordinator posts.

37 Welsh Women's Aid, *What is Ask and Act?* Available online: https://www.welshwomensaid.org.uk/training/ask-and-act/ (Welsh Women's Aid were contracted by the Welsh government to train the trainers to deliver the Ask and Act programme).

38 Agenda, *Ask and Take Action*. Available online: https://weareagenda.org/askandtakeaction/

39 Department of Health and Social Care and Agenda (2018) *The Women's Mental Health Taskforce, Final report*. Available online: https://www.gov.uk/government/publications/the-womens-mental-health-taskforce-report

40 The All-Party Parliamentary Group on Domestic Violence and Abuse (2019) *The All-Party Parliamentary Group on Domestic Violence and Abuse Annual Report 2018-2019.* Bristol: Women's Aid. Available online: https://www.womensaid.org.uk/appg-reports/

iii) Long-term, trauma-informed and flexible support

There can be no one-size-fits-all response to survivors' mental health needs. Health services should show an understanding of trauma and the long-term impact of domestic abuse, and intersecting needs and structural barriers, when devising care pathways and services for survivors. As Helen*, a survivor and expert witness stated, "the medical model of treatment in the NHS needs to change to a recovery model and more person-centred. The treatments needed by survivors are lengthy." This was supported by numerous organisations, for example, Agenda stated that often survivors "are forced to fit into services rather than services adapting to fit around the reality of a woman's life and understanding their trauma".

The evidence called for long-term care for survivors, at the point in which they are ready, as stated by a survivor: "I left my ex 3.5 years ago and only just wanted to talk about it this year. So, it is up to the individual." Survivors accessing Al Hasaniya Moroccan Women's Centre also called for an increase in the number of sessions offered to survivors based on their needs, and recommended between six months to two years.

'Trauma-informed'[41] was a key term referenced throughout this inquiry, and is referenced in government and health reports and strategies, for example, the DHSC's Women's Mental Health Taskforce (a taskforce co-chaired by Jackie Doyle-Price MP) then Parliamentary Under-Secretary for Mental Health, Inequalities & Suicide Prevention, and Agenda, which included a set of gender and trauma-informed principles[42]. These can be found on the next page.

Many survivors noted the importance of trust, and feeling heard and empowered in regards to what 'good' support looks like. There were also calls for greater service user involvement in service design and delivery and policy making; and the importance of peer-support programmes and interventions that work with the local community and informal networks.

> "Commonly survivors respond best to relationships based on equality and shared power to feel safe as they have already experienced power being misused in domestic abuse and it is very alarming to experience more dynamics where they don't have a voice or are not listened to."
>
> **Survivor – written submission**

All of this aligns with key components of trauma-informed care, alongside an emphasis on strengths-based approaches[43] within the evidence. However, despite the publication of DHSC's Women's Mental Health Taskforce principles in 2018, there remains significant concern about the realities of support on the ground, and it is clear a greater understanding and urgency in implementing trauma-informed care is needed across government and health. It is also clear from the evidence that there is a high level of expertise in the specialist domestic abuse sector in providing trauma-informed support, and the critical role they must play in defining and delivering this support to meet the mental health needs of survivors.

41 Please see terminology section.

42 Department of Health and Social Care and Agenda (2018) *The Women's Mental Health Taskforce, Final report.* Available online: https://www.gov.uk/government/publications/the-womens-mental-health-taskforce-report

Summary of gender and trauma-informed principles from the Women's Mental Health Taskforce (2018)

Theme	Principle
Governance and leadership	There is a whole organisation approach and commitment to promoting women's mental health with effective governance and leadership in place to ensure this.
Equality of access	Services promote equality of access to good quality treatment and opportunity for all women, including LBTQ and BAME women.
Recognise and respond to trauma	Services recognise and respond to the impact of violence, neglect, abuse and trauma.
Respectful	Relationships between health and care professionals and women using services are built on respect, compassion and trust.
Safe	Services provide and build safety for women, creating a safe environment that does not retraumatise. Services respond swiftly and appropriately to incidents that put women's safety at risk, including robust processes for reporting and investigating sexual abuse and assault.
Empowerment through co-production	Services engage with a diverse group of women who use mental health services to co-design and co-produce services. Services promote self-esteem, build on women's strengths and enable women to develop existing and new capacities and skills.
Holistic	Services prioritise understanding women's mental distress in the context of their lives and experiences, enabling a wide range of presenting issues to be explored and addressed, including with a focus on future prevention. Services support women in their role as mothers and carers.
Effective	Services and treatments are effective in responding to the gendered nature of mental distress.

iv) Partnership work with the domestic abuse sector and greater recognition of its value and expertise

This inquiry heard from numerous expert witnesses and survivors who have pinpointed the specialist domestic abuse and women's sector (crucially including services led 'by and for' minoritised groups) as essential providers of trauma-informed support, and recognised the support they are currently providing on a shoestring budget. Expert witness IRISi emphasised the importance of recognising the sector as experts and specialists, and called for all work in this field to be in partnership with specialist domestic abuse sector organisations, and the need for this to be adequately funded.

LAWRS stressed that 'by and for' led services are often the only option for women who are marginalised due to the intersections of their gender, class, race and immigration status. LAWRS emphasised that these services are both culturally specialised as well as trauma-informed, however their wealth of knowledge is often unrecognised. Imkaan noted that The Angelou Centre, a service supporting Black and minoritised women in the North East, reported that 85% of their service users do not feel comfortable finding support from mental health services. Furthermore, Stay Safe East highlighted the value of their expertise as a 'by and for' led service for disabled survivors, stating they are "uniquely placed to enhance the mental health and self-worth of survivors". This clearly illustrates the importance of health services working with the specialist domestic abuse sector to meet survivors' mental health needs.

Good practice

The APPG heard many examples of good practice and partnership work between the health sector and the specialist domestic abuse sector. These included the co-location of domestic abuse specialists in health settings such as GP practices, A&E and Mental Health trusts; to the importance of independent advocates; the provision of therapeutic services based within community-based women's centres; recognition of the unique position and value of specialist 'by and for' services by local health commissioners; and the integration of specialist services into local referral pathways.

43 Strengths-based approaches focus on individuals' strengths (including personal strengths and social and community networks) and not on their deficits. Strengths-based practice is holistic and multidisciplinary and works with the individual to promote their wellbeing. It is outcomes led and not services led. Social Care Institute for Excellence. Available online: https://www.scie.org.uk/strengths-based-approaches/videos/what-is-sba

Case Studies

▶ London Black Women's Project

London Black Women's Project (LBWP) is a specialist and dedicated service run 'by and for' Black and minoritised women. LBWP were contracted by Newham NHS and the East London Foundation Trust to provide a bespoke counselling service for Black and minoritised women who were survivors of domestic abuse and other forms of VAWG. LBWP specifically targeted counsellors who were from Black and minoritised communities and who also spoke an additional language that was common to the area. LBWP stressed the importance of this approach, acknowledging that historically it is very difficult for women to access services that address intersectionality and that is trans-cultural in terms of its delivery. LWBP stated that you cannot create a sense of equality within the counselling session if you do not take account of people's race, language, religion and culture. LBWP wanted to acknowledge and celebrate Newham and the East London Foundation Trust in their evidence for investing in the third sector and bringing in services that could meet the diverse needs of their populations in Newham.

▶ IRISi

IRISi promotes evidence-based practice through their two programmes – IRIS (identification referral to improve safety) and ADVISE (assessing domestic violence and abuse in sexual health environments) which works in sexual health services. Their flagship work is in GP practices and has been going for 15 years.

The IRIS program aims to build a partnership between the health sector and the VAWG sector to deliver best practice and evidence-based gold standard support to women and patients affected by domestic abuse. IRISi seeks to ensure a tailored, trauma-informed, patient-centred response. There are five easy steps and they believe these are replicable across the health system:

- Recognising the impact of domestic abuse (recognising when a patient is affected)
- Ask and risk check
- Response
- Offer a referral
- Make a record.

▶ Birmingham & Solihull Women's Aid and Birmingham & Solihull Mental Health Foundation Trust

Birmingham & Solihull Women's Aid have a specialist Mental Health IDVA based within Birmingham & Solihull Mental Health Foundation Trust. The role works closely with the Safeguarding Team and named domestic abuse nurse, but serving the whole of the organisation. The Mental Health IDVA provides domestic abuse support to service users, carers of service users and the trust's staff.

This has proven to be an impactful partnership which has seen large numbers of healthcare staff receive training and advice from the specialist domestic abuse worker as well as women affected by domestic abuse having direct access to a specialist.

It is important to note that, although this partnership work requires sufficient and sustainable funding, in the long-term, it will provide cost savings, including to the NHS, and help ensure survivors get the right response from the outset. A survivor who accessed support through the IRISi program noted: "I really want to highlight the amount the NHS would've saved if I was "spotted" earlier, I dread to think of the costs over the years, between the depression, injuries, addiction and so on".

v) Data, monitoring and research

The importance of data, monitoring and evidence was stressed by a number of expert witnesses, alongside current failings. As highlighted by AVA, "if the NHS does not collect data that shows that initiatives work, they do not get refunded". This was echoed by IRISi who stressed that it was important we begin to effectively collect data across health, analyse and use it to inform service design. This is particularly crucial when lack of evidence is often seen as a barrier by health services in regards to funding interventions. IRISi also noted the importance of identifying gaps for groups of women on whom data is not being collected, for example, Black and minoritised survivors, Deaf and disabled survivors, and survivors in same-sex relationships.

There were calls upon the Domestic Abuse Commissioner's office to utilise its powers to seek information from public bodies including NHS England and Public Health England, to help establish strong links with these public bodies and accelerate progress in this area. These public bodies have a duty to cooperate with the Domestic Abuse Commissioner's office and she is now able to make recommendations to these public bodies which have to be responded to within 56 days. In 2019, this APPG recommended the Domestic Abuse Commissioner maps and assesses the response of CCGs and local health bodies as an urgent priority. As the Domestic Abuse Commissioner's powers have now come into force (since October 2021), she restated her commitment to working out where the gaps are and to hold government and health systems to account.

Submissions called for the CQC to undertake a review of the implementation of National Institute for Health and Care Excellence (NICE) guidance, to routinely collect and report on data regarding abuse and violence; a requirement for trusts to gather and report on data relating to policies, training, enquiries and referrals; and calls for more independent complaints processes for both the health and domestic abuse sectors. Similarly, concerns were raised about gaps in research, including the impact of domestic abuse

on the development of dementia, Alzheimer's disease, acquired brain injury; and suicide. The APPG particularly wants to highlight a submission made by a son who recently lost his mother due to suicide following her experience of domestic abuse, and want to thank him for his strength to share his mother's story.

The work of the Kent and Medway Suicide Prevention Network identified this lack of evidence and wider understanding about the relationship between suicide and domestic abuse, and sought to address it locally. They submitted evidence to this inquiry which included the following data[44]:

- Real Time Suicide Surveillance which highlighted that between 20% and 25% of all deaths by suicide have been impacted by domestic abuse. (60 out of 240 in Kent and Medway during 2020 and the first eight months of 2021).
- Exploration of the levels of suicidality by analysing local domestic abuse providers DASH risk assessments, which found that 63% of victims had felt suicidal and 61% of perpetrators had attempted or threatened suicide (threatening suicide is a known tactic for maintaining power and control in cases of domestic abuse, and a key risk factor of further harm to victim/ survivors).
- Review of 93 nationally published Domestic Homicide Reviews (DHRs), which found that 26% of DHRs contained a suicide, either being that of the victim or the perpetrator (most domestic abuse related suicides do not result in a DHR).
- A Thematic Analysis of recent suicides amongst children and young people (CYP) in Kent was undertaken, which showed that some deaths amongst CYP who were living in a household that was impacted by domestic abuse.

It is crucial to ensure a strengthened understanding of the relationship between domestic abuse and suicide, and provide the evidence base for action on what further measures need to be taken to prevent such tragedies in the future.

This APPG recommends that:

- **Data collection and monitoring of the mental health needs of survivors is improved, by requiring:**
  - The CQC to routinely collect and report on data regarding domestic abuse and VAWG.
  - NHS trusts to gather and report on data relating to policies, training, enquiries and referrals.
  - The Domestic Abuse Commissioner's office to utilise its powers to request data from the DHSC, Public Health England and NHS England on suicides and domestic abuse, including data on before and after a death occurs.
  - The Domestic Abuse Commissioner's office to utilise its power to ensure the DHSC, Public Health England and NHS England capture domestic abuse in national suicide surveillance data.

44 Transforming health and social care in Kent and Medway (2021) *Highlighting the relationship between domestic abuse and suicide*. Available online: https://nspa.org.uk/wp-content/uploads/2021/04/Highlighting-the-link-between-domestic-abuse-and-suicide-1.pdf

Chapter Three

The domestic abuse sector - what needs to change?

As emphasised in an evidence submission from a survivor and academic – it is essential to "bring mental services into the spaces where women already are – and where they feel safe". This was echoed by numerous expert witnesses including Agenda, who noted the specialist domestic abuse sector and women's sector are often best placed to deliver tailored support to meet the mental health needs of survivors. The specialist domestic abuse sector's expertise in delivering trauma-informed support, which understands the gendered nature and dynamics of domestic abuse and intersecting needs of survivors, has been highlighted in the section of this report calling on health to work in partnership with the sector and show greater recognition of their value and expertise (page 19). However, the sector faces acute challenges in delivering this support to all survivors who need it.

Sustainable funding

An Agenda and AVA report highlighted that the women's sector currently delivers around 43% of all gender-specific mental health provision for women[45]. Furthermore, Imkaan noted that their members (services led 'by and for' Black and minoritised women) have, over the last decade, increasingly taken on the role of statutory services around mental health care. The postcode lottery of domestic abuse support services is well documented, and an issue raised to this APPG on numerous occasions. From the evidence heard during this inquiry, this issue is even more acute in regard to access to therapeutic support from the sector due to commissioning and funding models that are focused on crisis intervention and risk management, and do not reflect the long-term impact of domestic abuse. The funding landscape is failing to recognise the sector's role in meeting the mental health needs of survivors, and as Women's Aid notes, "the combination of austerity [and] a commissioning landscape which prioritises cost above quality… has created a crisis in the funding for the sector as a whole".

There is a severe lack of funding from health bodies to specialist domestic abuse services, despite their critical role in meeting the mental and physical health needs of survivors. Women's Aid research highlights that no refuge service was commissioned by their CCG, whilst just 10% of community-based services were funded by their CCG in 2019-20. Furthermore 43% of Women's Aid member services were running therapeutic services such as counselling and group work without any dedicated funding at all[46]. Imkaan echoed similar findings from their members – they do not receive health-related funding from CCGs despite up to 25% of referrals coming from the health sector.

The APPG is particularly concerned by the disproportionate impact of the funding crisis on

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

46 Women's Aid (2021) *The Domestic Abuse Report 2021: The Annual Audit.* Bristol: Women's Aid. Available online: https://www.womensaid.org.uk/evidence-hub/research-and-publications/the-domestic-abuse-report/

specialist led 'by and for' services. LAWRS noted how "specialist 'by and for' services are the last line of support for survivors, who would otherwise fall through the gaps. [Yet] despite their crucial role, specialist 'by and for' services are among the most poorly funded mental health services for survivors of domestic abuse, resulting from the move to commissioning". AVA illustrated how this model of funding has eroded the resilience of the 'by and for' led sector, stressing that organisations are forced to meet targets based on standards that do not respond to service users' needs. For example, targets overlooking the advocacy undertaken by counsellors to support women in overcoming structural barriers and ensure equality of access to publicly-funded mental health services.

There was also a number of submissions calling for greater provision of support for children and young people, including "dedicated funding for statutory Child and Adolescent and Adult Mental Health services to develop gender and trauma-informed services for survivors with complex needs in partnership with the women and girls' voluntary sector" (Agenda – written submission).

The vast majority of evidence heard by this APPG referenced the increased pressures on specialist domestic abuse services, and the need for sufficient and sustainable funding for the sector, which echoes an APPG recommendation made in 2018[47]. It is also important to note that the support provided by the specialist sector in addressing mental health cannot be separated from the support they provide in regard to issues such as safe housing, immigration support and support with child contact. As illustrated by the barriers shared in Chapter One, you cannot, for example, expect a survivor to recover from the impacts of trauma solely through counselling if she remains homeless or is having to navigate dangerous child contact arrangements. The costings work shared by Women's Aid sets out an assessment of the level of investment needed to effectively resource the specialist domestic abuse sector for women and their children across England, to a level which enables them to carry out their life-saving work – £409,307,879[48]. This investment covers all essential elements of provision including therapeutic support, as well as ensuring sufficient funding to support the mental wellbeing of staff (i.e. clinical supervision).

As noted by the Domestic Abuse Commissioner, "there is a huge raft of mental health support that is part of our community approach to domestic abuse that is not properly and sustainably funded even though 70% of survivors will access these services". The Commissioner noted the upcoming Victims' Bill and urged for this legislation to address the funding of community-based services for survivors, which must include counselling and support for mental wellbeing.

This APPG therefore recommends:

- **Ring-fenced funding for specialist community-based services and 'by and for' services in the forthcoming Victims' Bill, and increased funding for specialist refuges through Part 4 of the Domestic Abuse Act.**

The upcoming Victims' Bill should deliver a sustainable, long-term and secure funding model for specialist community-based domestic abuse services, including ring-fenced funding for 'by and for' services. Funding for Part 4 of the Domestic Abuse Act must also be increased to ensure survivors are not turned away from specialist refuges. Both sets of funding must cover counselling and support for mental wellbeing, and the investment in the wellbeing and development of staff.

47 The All-Party Parliamentary Group on Domestic Violence and Abuse (2019) *The All-Party Parliamentary Group on Domestic Violence and Abuse Annual Report 2018-2019.* Bristol: Women's Aid. Available online: https://www.womensaid.org.uk/appg-reports/

48 Women's Aid (2019) *Funding specialist support for domestic abuse survivors.* Bristol: Women's Aid [Revised estimate August 2021: https://www.womensaid.org.uk/wp-content/uploads/2021/09/Funding-Specialist-Support-Updated-estimates-August-21.pdf]

Upskilling and supporting frontline practitioners

The need to provide sustainable funding for the specialist domestic abuse sector is critical not only in regard to increasing the quantity of service provision, but also to meet skills gaps and improve support for staff. For example, evidence highlighted gaps in provision for survivors facing multiple disadvantage linked to staff skills and capacity – most notably mental ill-health and substance misuse forming barriers to accessing refuge. For example, mental health support needs remained the most common support need for women referred to Women's Aid's No Woman Turned Away project[49], at 51% of service-users[50]. Women's Aid's data shows that in 2019-20, just 15% of refuges and 10% of community-based services had specific mental health workers; and only around a third (35.7%) of refuges could provide a formal counselling service and over a quarter were unable to provide group work programmes[51].

A number of organisations called for greater resourcing to upskill their workforce to better meet the mental health needs of survivors, utilising their unique position to reach survivors and build trust. The specialist sector needs the investment in wellbeing, salaries, training and development to ensure that all services can deliver truly trauma-informed practice. This evidence also linked back to the value of partnership work between health and the domestic abuse sector – as explored on page 25. Additionally, evidence provided by IRISi on Psychological Advocacy Towards Healing (PATH): A randomised controlled trial of a psychological intervention in a domestic violence service setting[52], is of particular interest. The project involved training domestic abuse advocates to deliver psychological support to women experiencing domestic abuse in a randomised controlled trial led by researchers from the University of Bristol. Together with AVA, IRISi is currently working to determine which next steps are needed to develop PATH into a programme that can be commissioned, its relevance today (10 years on from the research) and how it could be funded and delivered. This is a model this APPG is keen to hear more about in regard to further recommendations linked to greater investment in the domestic abuse sector workforce and critical partnership work with health.

> "With the right level of support, the sector can successfully work in partnership with commissioners, to meet all women's needs. Mental health support is not an 'add-on', it is vital".
>
> **Woman's Trust – written submission**

49 The No Woman Turned Away (NWTA) project provides dedicated support to women who face barriers in accessing a refuge space. For more information: https://www.womensaid.org.uk/no-woman-turned-away/

50 Women's Aid (2021) *Nowhere to Turn: Findings from the fifth year of the No Woman Turned Away project.* Bristol: Women's Aid. Available online: https://www.womensaid.org.uk/wp-content/uploads/2021/09/Nowhere-to-Turn-2021.pdf

51 Women's Aid (2021) *The Domestic Abuse Report 2021: The Annual Audit.* Bristol: Women's Aid. Available online: https://www.womensaid.org.uk/evidence-hub/research-and-publications/the-domestic-abuse-report/

52 Ferrari, G., Feder, G., Agnew-Davies, R., Bailey, J.E., Hollinghurst, S., Howard, L., et al. (2018) 'Psychological advocacy towards healing (PATH): A randomized controlled trial of a psychological intervention in a domestic violence service setting'. PLoS ONE 13(11): e0205485. Available online: https://doi.org/10.1371/journal.pone.0205485

Conclusion

Evidence to this inquiry demonstrates a pressing need to recognise, prioritise and invest in addressing the long-term mental health impacts of domestic abuse. The failings found at this inquiry risk allowing a legacy of trauma to impact the lives of countless survivors, children and communities. The evidence also makes clear that many of the solutions already exist and many have even been called for by this APPG. What is needed is the political will to prioritise the issue of domestic abuse and mental health, and to fund support that is able to meet the needs of survivors. These actions should sit within wider efforts to ensure a cross-government approach to meet the wide range of survivor needs and hold perpetrators accountable, alongside challenging the societal and cultural norms which tolerate domestic abuse on such a vast scale.

Survivors have shared their stories:

> "It [domestic abuse] is a soul-destroying harrowing experience with no signs of any effective help."
>
> **Survivor – written submission**

It is therefore imperative that this government recognises domestic abuse, and its impact on mental health, as a public health priority to ensure survivors get the support they need. This APPG urges for the recommendations in this report to be implemented by the UK government.

Appendix A

Oral and written evidence submissions to the inquiry

Oral evidence - expert witnesses

- Helen*, Expert by Experience
- Jessi, Expert by Experience
- Paulette, Expert by Experience
- Carolyn Ball, IDVA Training and Consultation, West Mercia Women's Aid
- Donna Covey, Director, Against Violence and Abuse (AVA)
- Rehaila Sharif, Head of Membership, Women's Aid Federation of England
- Gisela Valle, Director, Latin American Women's Rights Service (LAWRs)
- Gudrun Burnet, CEO, Standing Together Against Domestic Abuse (STADA)
- Huda Jawad, Co-Founder, Faith and VAWG Coalition
- Lizzie McCarthy, Senior Policy and Research Officer, Women's Aid Federation of England
- Abigail Gorman, Policy and Public Affairs Manager, Sign Health
- Maithreyi Rajeshkumar, Policy Manager, Agenda
- Medina Johnson, Director, IRISi
- Meril Eshun-Parker, Director, London Black Women's Project
- Nicole Jacobs, Domestic Abuse Commissioner
- Dr Phillipa Greenfield, Consultant Psychiatrist and Domestic Abuse Lead, The Royal College of Psychiatrists
- Dr Rosena Allin-Khan MP, Shadow Cabinet Minister for Mental Health
- Rosie Lewis, Head of Policy, Imkaan
- Ruth Bashall, Policy and Projects Adviser, Stay Safe East
- Sara Kirkpatrick, CEO, Welsh Women's Aid
- Steph Keeble, Director (CEO), Birmingham LGBT

*Pseudonym

Written evidence submissions

- Anonymous, survivor of domestic abuse
- Anonymous, survivor of domestic abuse
- Anonymous, survivor of domestic abuse
- Anonymous, survivor of domestic abuse
- Anonymous, survivor of domestic abuse
- Anonymous, survivor of domestic abuse
- Anonymous, survivor of domestic abuse
- Anonymous, survivor of domestic abuse
- Anonymous, family member of domestic abuse victim
- A2 Dominion Oxfordshire and West Berkshire Domestic abuse services
- Against Violence and Abuse (AVA)
- Agenda Alliance
- Al Hasaniya Moroccan Women's Centre
- Birmingham and Solihull Women's Aid
- Professor Carol Fuller, University of Reading
- Daisy Best and Nikki Carthy, Psychologists, Teesside University and North Yorkshire Psychological Therapies
- The Disabilities Trust
- For the Baby's Sake Trust
- IRISi
- Karen Schucan Bird, EPPI-Centre, University College London
- Kent and Medway Suicide Prevention Network
- Latin American Women's Rights Service (LAWRS)
- The Nelson Trust
- Royal College of Psychiatrists
- SafeLives
- Safer Places
- SignHealth
- The Violence Abuse and Mental Health Network and The Lancet Psychiatry Commission on Intimate Partner Violence and Mental Health
- Woman's Trust
- Women's Aid Federation of England
- Women in Prison.

Appendix B

Officers of the APPG

- Apsana Begum MP, Chair of the APPG
- Baroness Bertin, Vice-Chair of the APPG
- Alex Norris MP
- Alison Thewliss MP
- Baroness Brady
- Baroness Hamwee
- Baroness Lister
- Baroness Thornton
- Baroness Verma
- Bell Ribeiro-Addy MP
- Caroline Lucas MP
- Emma Hardy MP
- Fleur Anderson MP
- Gavin Newlands MP
- Jess Phillips MP
- Kate Griffiths MP
- Kim Johnson MP
- Maria Miller MP
- Mark Fletcher MP
- Naz Shah MP
- Paula Barker MP
- Sir Peter Bottomley MP
- Theo Clarke MP
- Vicky Foxcroft MP

The Road to Recovery: Meeting the Mental Health Needs of Domestic Abuse Survivors
An Inquiry into Domestic Abuse and Mental Health by the All-Party Parliamentary Group on Domestic Violence and Abuse

Women's Aid Federation of England
PO Box 3245, Bristol, BS2 2EH
www.womensaid.org.uk