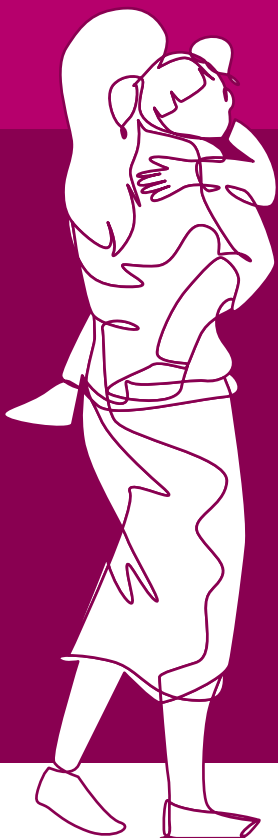


Are you listening?

7 Pillars for a survivor-led approach to mental health support



“The most important thing is to be heard...”

A report by Women’s Aid



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The impact of domestic abuse on the mental health of women and their children

Authors

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Published by

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

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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 just under 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 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: www.womensaid.org.uk/deservetobeheard

Acknowledgements

Thank you to all the domestic abuse survivors and support services who contributed to this research. Special thanks to the Survivor Advisory Board, for their vital contribution to this research and the wider Deserve To Be Heard campaign.

Thank you to Bally's for funding the Deserve To Be Heard campaign.

This report was independently researched and written by Women's Aid. Thank you to the staff at Women's Aid for all their support.

The title of this report uses part of a quote from a domestic abuse survivor responding to our survey. The full quote is:

“The most important thing is to be heard and for those professionals to really understand the dynamics and impact domestic abuse has on survivors not just whilst in the relationship but for a lifetime.”

Please cite this report as:

Women's Aid. (2022) *“Are you listening? 7 Pillars for a survivor-led approach to mental health support.”*
Bristol: Women's Aid.

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Executive Summary

The perpetration of domestic abuse is a key driver of women's mental ill health. 45.6% of women in refuge services in 2020-21 reported feeling depressed or having suicidal thoughts as a direct result of the domestic abuse they had experienced (Women's Aid, 2022). Yet two literature reviews on mental health and domestic abuse published by Women's Aid in late 2021 highlighted the many barriers that survivors face in accessing effective mental health support, and the heightened

barriers for survivors from Black and minoritised or marginalised groups who face intersecting forms of structural oppression.

We conducted research to better understand what domestic abuse survivors want and value when it comes to mental health support, and what an effective response looks like. This report outlines the seven key findings, and our priority recommendations for change.

What are survivors of domestic abuse telling us?

Our research identified seven key elements of a good mental health response for survivors of domestic abuse (the "7 Pillars"). These were:

1. An empathetic and understanding response

Survivors want mental health support to be delivered by someone who shows an understanding of the trauma caused by domestic abuse. A sensitive, empathetic approach towards survivors, free of any judgement or blame, is very important. Survivors want to be listened to with compassion.

"I would hope they would have experience and training in communicating, sympathising, empathising with victims of domestic abuse/violence which hopefully would enable them to delve and ask the questions to address and assist recovery."

2. Expertise on the dynamics and impact of domestic abuse

Survivors want mental health support to be delivered by someone with expertise on domestic abuse. Those delivering support need to have an in-depth understanding of the dynamics of domestic abuse, including coercive and controlling behaviour, and of the impact on women and children.

"The most important thing is to be heard and for those professionals to really understand the dynamics and impact domestic abuse has on survivors not just whilst in the relationship but for a lifetime."

3. A space to talk

Survivors value having a space to talk about their mental health and in which to develop coping strategies. This could be one-to-one with a female therapist who is a specialist in domestic abuse, in a group therapy setting with other female survivors or through other forms of peer support.

“Emotional support. Just someone to talk to about what’s going through your mind.”

4. Support for children and young people

Survivors want the mental health impact of domestic abuse on children to be recognised and mental health support specifically for children and young people to be available (delivered by professionals with expertise in domestic abuse).

“...my children grew up hearing the abuse and witnessing the abuse, they never got much support, now they’re adults they struggle because of the past and what they witnessed and heard.”

5. Practical support

Survivors want mental health support that recognises that domestic abuse affects many aspects of their lives. Survivors value practical support that addresses their safety, housing and other needs, as well as specialist mental health support. A survivor cannot progress in her mental health recovery without these practical needs being addressed.

“Much of the trauma support required is ultimately dependent upon the women’s practical needs and home/life stability. I have heard, and myself experienced, lack of practical needs being met so that recovery cannot even be started.”

6. Women-only spaces, including support led by and for marginalised groups of women

Female survivors value receiving support within women-only spaces, and from female professionals. They equate women-only spaces to safe spaces, conducive to recovery. Survivors also want support that is delivered by women who share their background or identity, such as services run by and for Black and minoritised women.

“I prefer certainly a women-only space, where there would be minimal triggers.”

“...the experience of abuse is not the same for all women and race, culture and religion also play into that cycle of abuse.”

7. Timely and long-term support

Survivors want their mental health support needs to be prioritised, without having to face long waiting times. They also want it recognised that recovery is often not short-term, so support options shouldn't be either.

“The mental abuse suffered within a toxic relationship causes ongoing problems many years after the escape from abuse so there should be no time limit.”

What needs to change?

We are calling on healthcare professionals, mental health specialists, commissioners and local authorities to familiarise themselves with the 7 pillars of an effective mental health response for survivors of domestic abuse, as outlined above, and to reflect these in their policies and practices.

Among our priority recommendations for change are:

- ▶ Training on the dynamics of domestic abuse, and how it affects the mental health of survivors, to be mandatory and continuous for healthcare professionals. This should include awareness of the additional challenges faced by Black and minoritised and other marginalised (eg Deaf or disabled) survivors in accessing services, as well as the specific needs of child survivors.
- ▶ Commissioners to ensure that mental health support reflects what survivors want and value, and local authority approaches to commissioning must include survivors' voices in their practices.
- ▶ Provision of sustainable, multi-year funding for community-based services is required to ensure that a sufficient and sustainable level of mental health and wellbeing support can be provided by these services. This should include ring-fenced funding for by and for services, who remain chronically under-funded under the current commissioning model.
- ▶ Specialist mental health support to be provided to meet the specific needs of child survivors.

Maria's story:

A negative mental health support journey

Maria¹ is a 29-year-old woman who lives with her male partner and their child. Her partner has been physically and sexually violent towards her for more than two years, and is coercively controlling. He monitors Maria's phone, dictates what she can wear and who she can talk to. He forced her to stop taking their child to a toddler group, to isolate her as much as possible. He frequently threatens violence against her and her parents if she "even thinks" about leaving him.

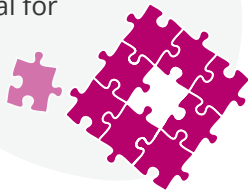
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Maria visits her GP nine times in one year, presenting with minor physical injuries and symptoms of depression and anxiety. She is prescribed anti-depressants but never asked about her home-life or her relationship with her partner. She is not directed to any specialist domestic abuse support.



3

Maria shares her experience of abuse, but the therapist treats her mental health problems as separate to the abuse and doesn't make a referral for domestic abuse support.



2

On her tenth visit to her GP, Maria is referred to a talking therapy service she has to wait four months to start. The therapist offers Maria some good general coping strategies to help manage her depression and anxiety but lacks specialist knowledge of domestic abuse. Maria's partner continues to abuse her.



4

The therapist shows no understanding of the dynamics of domestic abuse, and inappropriately asks Maria how she can let her child live in a home with a violent man, and other victim-blaming remarks.



5

Maria ends the therapy early. Her partner frequently tells her that she is to blame for his violence and abuse, and some of the therapist's comments have reinforced this.



6

Maria feels trapped in the relationship with her partner. Her anxiety and depression have worsened to the extent that she is unable to work. The abuse doesn't stop.



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¹ This is not a true story, but an example of what survivors often experience and perceive as negative based on our review of the evidence and primary research with survivors (conducted as part of the Deserve To Be Heard campaign). We also draw on our previous research, such as the research conducted with the University of Bristol in 2021 (Women's Aid et al., 2021).

Priya's story:

A positive mental health support journey

Priya² is a 54-year-old woman. Her husband is very controlling, and over the 24 years of their marriage has isolated her from her friends and family. He frequently subjects her to sexual violence and falsely accuses her of having sexual relationships with other men.

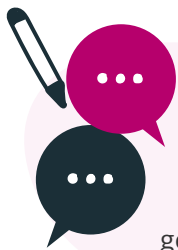
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Priya visits her GP and talks about the panic attacks she has been experiencing. The GP has had specialist training on domestic abuse. They ask if anything is triggering this anxiety at home and mention local domestic abuse support services. Priya does not feel she can open up about the abuse but makes another appointment.

2

At her second appointment, Priya asks about domestic abuse support services. She tells the GP that her faith is very important to her and the GP shares the contact details of a specialist support service run by and for women that share her ethnic background, and will understand the role of faith in Priya's life.



Priya is assigned a female specialist advocate who works with her to devise a safety plan for leaving her husband. She gets practical help and advice about accommodation and financial matters.

4

Priya uses the GP Practice phone in a private room to call a 'by and for' domestic abuse service and feels they believe her. They understand that her panic attacks are the result of being subjected to abuse over many years.



3

5

The service works closely with local mental health services staffed by professionals who have been trained on the dynamics and impact of domestic abuse. Priya is referred to the clinical psychologist who diagnoses her with post-traumatic stress disorder (PTSD).



6

Priya takes part in one-to-one therapy with a female specialist domestic abuse counsellor who shares her ethnic background. She also meets other survivors through group therapy, all women who share her ethnic background and some share her faith.

7

One year after the first GP appointment, Priya lives separately from her husband. He still sends threatening messages and Priya's advocate at the specialist domestic abuse service is supporting her with this, including helping her report this to the police. The panic attacks are less frequent than before and her group therapy is ongoing. She feels hopeful for the future.



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² This is not a true story, but an example of what survivors often experience and perceive as positive based on our review of the evidence and primary research with survivors (conducted as part of the Deserve To Be Heard campaign). We also draw on our previous research, such as the research conducted with the University of Bristol in 2021 (Women's Aid et al., 2021).

Introduction

This research was conducted with a view to understanding what domestic abuse survivors want from mental health support, and what an effective response looks like. The findings will inform Women's Aid's work to ensure that mental health support commissioned for survivors of domestic abuse meets the needs of survivors and is informed by their voices. The research will also inform future iterations of the Women's Aid **Deserve To Be Heard** campaign.³ The campaign is calling for greater recognition of the impact that domestic abuse has on the mental health of women and their children, and the importance of providing support that meets their needs.

The perpetration of domestic abuse is a key driver of women's mental ill health. 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, 2022). Being subjected to domestic abuse can have devastating consequences for a survivor's mental wellbeing, some long-term in their duration. The psychological impact can be so severe that it is thought to be equal to the trauma of being taken hostage and tortured (Howard et al., 2010:527). Specific mental health impacts can include anxiety, depression, symptoms of post-traumatic stress, lowered self-esteem, an erosion of a sense of identity, eating and

sleeping-related problems and suicidal ideation (see Women's Aid, 2021; Thiara & Harrison, 2021).

In late 2021 Women's Aid published two literature reviews on mental health and domestic abuse.⁴ These reviews highlighted the many barriers that survivors face in accessing timely and effective mental health support. All of these barriers are heightened for survivors from Black and minoritised or marginalised groups who face intersecting forms of structural oppression (for example, the intersection of sexism and racism). Thiara and Harrison (2021:27) highlight issues of stigma and shame:

“It is widely acknowledged in research that mental ill-health compounds stigma and shame in some communities, leading to pressure to cover up issues of [domestic violence and abuse] and mental ill-health within their social networks⁵. Arguably, such stigma exists in all majority and minoritised groups. For Black and minoritised women, the far-reaching ramifications of disclosing mental ill-health results in a silencing that creates a greater sense of helplessness, isolation and entrapment.”

³ See www.womensaid.org.uk/deservetobeheard

⁴ Women's Aid. (2021) *Mental health and domestic abuse: A review of the literature*. Bristol: Women's Aid.

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.

See also [The reality of the barriers to mental health support - Women's Aid \(womensaid.org.uk\)](http://www.womensaid.org.uk)

⁵ Anand and Cochrane, 2005; Moller et al., 2016; Synergi Collaborative Centre, 2018

The authors also emphasise that:

“Black and minoritised women have a deep fear of contributing to essentialist attitudes towards their communities through disclosing [domestic violence and abuse] and/or mental ill-health and, alongside language barriers, is a commonly cited barrier to accessing services⁶.”

(Thiara and Harrison, 2021: 35)

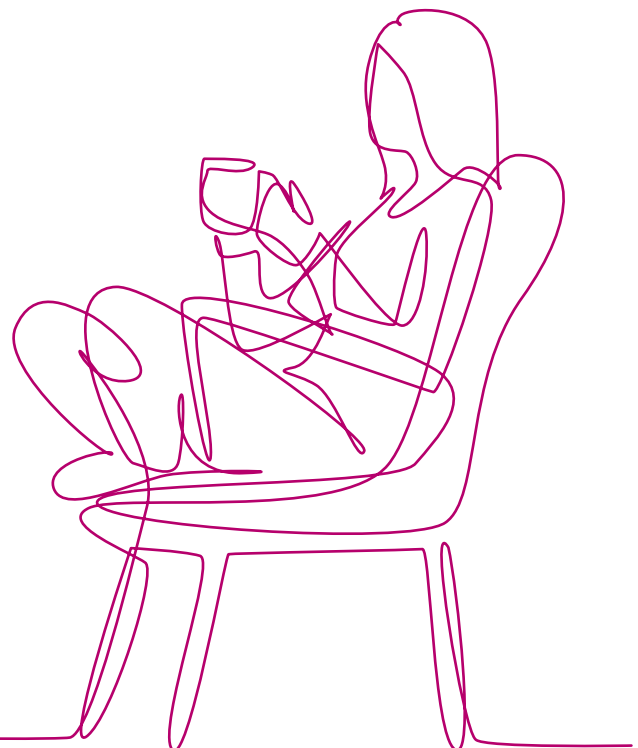
There is a strong body of evidence highlighting the inadequacy of many of the current mental health models and practices in providing appropriate support for survivors of domestic abuse. The literature reviews draw attention to existing evidence on what survivors want and need from mental health support, and emerging evidence on good practice in addressing these needs.

This research builds on the evidence from the literature reviews to explore what domestic abuse survivors want and value when it comes to mental health support, with a view to informing future provision.



The guiding questions for the research are as follows:

- ▶ What do female domestic abuse survivors want in terms of mental health support (relating to the abuse they have experienced/ are experiencing)?
- ▶ What examples are there in the women’s sector of meeting female domestic abuse survivors’ mental health needs (including work in partnership with health services)?



6 Anitha et al., 2009; Thiara and Roy, 2020

Methodology and limitations

The research approach included data collection activities with female survivors of domestic abuse, and staff from Women's Aid member organisations and other women's organisations involved with the Deserve to Be Heard campaign. Research methods used to solicit views of female survivors comprised an online survey, two focus group discussions and one semi-

structured interview. Responses were analysed using Microsoft Excel and NVIVO software, and this analysis forms the basis of the key findings presented in this report. In addition, an online practice survey was used to learn about the services and approaches of Women's Aid member organisations and to inform examples of practice presented in the report.

Online survivor survey

A questionnaire was designed with a mix of open and closed questions. The survey was promoted in February/March 2022 on the Women's Aid's online Survivors' Forum, on the Women's Aid website and social media channels; and through Women's Aid member organisations (including 'by and for' members), and organisations on the Deserve To Be Heard Campaign's expert advisory group⁷.

Respondents to the survey were self-selecting. They had all experienced or were experiencing abuse from an ex/intimate partner(s) or from a family member(s). We received 228 complete responses. For demographic information on respondents, see **Appendix One**. The survey questions are available in **Appendix Two**.

Focus group discussions

These served as 'deep-dives' into key issues identified in the initial analysis of survey data. An online focus group was held in March 2022 with six members of the campaign's Survivor Advisory Board, all survivors of domestic abuse. A second focus group was held in April 2022 as a space for Black and minoritised women

only; three members of the campaign's Survivor Advisory Board attended, all Black and minoritised survivors of domestic abuse. A further interview was conducted via video link with one survivor who had been unable to attend this focus group but wanted to contribute to the research.

⁷ Agenda, AVA, Faith and VAWG Coalition, Galop, Imkaan, LAWRS, Sign Health, Stay Safe East, Welsh Women's Aid and Women and Girls Network <https://www.womensaid.org.uk/deservetobeheard/>

Online practice survey

A short survey was shared with Women's Aid member services and other women's organisations involved with the Deserve To Be Heard campaign in February 2022. Respondents were self-selecting. The questionnaire (see **Appendix Three**) asked for their own examples of meeting survivors' mental health needs.

Respondents were invited to include any partnership work with external organisations/ services (for example, with NHS professionals); any interventions or projects piloted or run by the organisation; descriptions of the organisation's day-to-day work in supporting survivors, and the approach taken to meeting mental health needs.

Limitations

The response rate of respondents with a Black or minoritized ethnic background was low (see **Appendix One**), and there were no survey respondents who identified as Black.⁸ The focus group discussion and interview provided opportunities to explore in more depth (and in a separate space) the experiences of a small number of Black and minoritised survivors. The

research also draws extensively on evidence from other studies that have focussed on the experiences and insights of Black and minoritised survivors, - and especially from Thiara and Harrison's report: *Reframing the Links: Black and minoritised women, domestic violence and abuse, and mental health - A Review of the Literature* (published by Women's Aid in 2021).

All the quotes used in this report (unless otherwise indicated) are from survivors who took part in the survey, in a focus group or in an interview. Survivors participating in our research gave their consent for quotes to appear and we have redacted anything that could be identifying.

⁸ Whilst there are many structural inequalities and associated experiences of discrimination that might prevent Black and minoritised women from coming forward to take part in research about mental health and/or domestic abuse, we recognise as Women's Aid that in future we will need to proactively explore alternative strategies for engaging with Black and minoritised women in surveys of this kind.

Terminology

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 refer to 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."

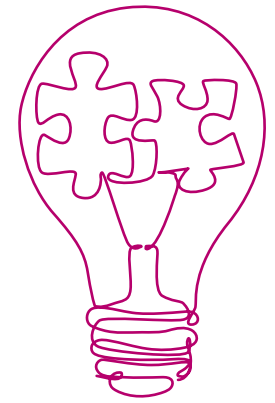
Pathologisation

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.



Specialist domestic abuse services

Organisations/services that are delivered independently from the state (i.e. third sector), whose core business it is to support survivors and/or children and young people impacted by domestic abuse and other forms of VAWG - including sexual violence, forced marriage, so called 'honour based' violence, FGM, sexual exploitation, trafficking and modern day slavery. These providers will have specialist expertise on the nature of domestic abuse and the experience and support needs of survivors.



Trauma

"Trauma" 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]

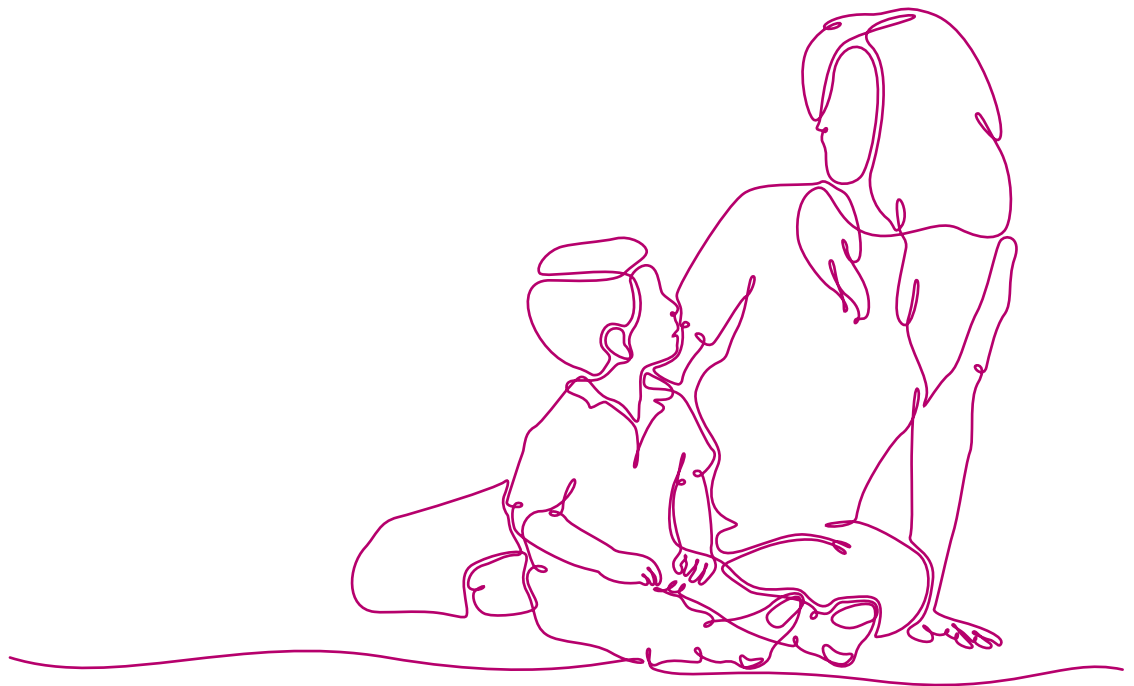
Trauma-informed

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).

Findings

Analysis of the survey results, focus groups and interview show us what survivors of domestic abuse value in a mental health support response. Expertise on the dynamics and impact of domestic abuse was a clear priority, though responses stressed that this must be accompanied by the necessary skills to deliver support with empathy and understanding. Further, survivors were clear that professionals should recognise the impact of domestic abuse on children and young people and provide dedicated support to them. Whether support is offered in a group or a one-to-one setting, survivors value the space to talk through their emotions and develop coping strategies, as well as being offered practical support. The availability of timely and long-term support is vital for effective recovery, survivors point out that recovery from domestic abuse is long-term and this should be reflected in the mental health support available.

The findings section of this report sets out the seven key priorities for survivors describing what they want from mental health support.



I An empathetic and understanding response

Survivors want mental health support to be delivered by someone who shows an understanding of the trauma caused by domestic abuse. A sensitive, empathetic approach towards survivors, free of any judgement or blame, is very important. Survivors want to be listened to with compassion.

“I would hope they would have experience and training in communicating, sympathising, empathising with victims of domestic abuse/violence which hopefully would enable them to delve and ask the questions to address and assist recovery.”

The importance of empathy

It is clear from survivors' responses to our research that the style or approach of any mental health support is just as important as the content of that support. In response to a question in the survey around what knowledge and experience survivors would like professionals supporting them to have, empathy and understanding was by far the most recurring theme. Such responses emphasised the importance of empathy, compassion, listening skills, patience, and taking a non-judgemental approach. This continued to be a theme through the focus groups and interviews, further illustrating this to be something survivors find extremely valuable. As one survivor put it, it is about the importance of:

“Understanding the hidden signs of abuse, the non-violent signs as well as the violent ones, someone who shows compassion, understanding, patience and empathy. Someone who is not set by a clock on how long they can give you.”

— “

“Empathy and patience is more important and can go a long way when we are feeling alone.”

“Empathy and more concern for victims wanting to feel believed and anonymous ...”

“How to deal with trauma and fluctuating emotions/feelings, to not judge others. How to be sensitive, compassionate and understanding.”

“Listening skills- active- I want you to know when something doesn't seem quite right.”

— ”

An empathetic approach should include recognition that for many survivors, reaching out for help and talking about abuse is very difficult, and survivors from marginalised groups may face additional barriers in doing so. Black and minoritised women taking part in the focus group talked about issues with trusting others (including services) with information about their personal mental health or experiences of abuse. One survivor said, **“Even if it is a domestic abuse service it is still ingrained in my head that we don’t tell other people our business so it’s hard.”**

Thiara and Harrison (2021) highlight how racism perpetuates health inequalities and that “There is strong evidence suggesting that Black and minoritised women take longer to seek help and suffer abuse for longer” (Thiara & Harrison, 2021:16). As one survivor taking part in our research put it, **“Reaching out for help is HARD.”** The same survivor highlighted that professionals responding to domestic abuse should have, **“An understanding of how isolating abuse can be and how survivors often lack any form of support network, or may still feel reliant on their abuser.”** Another survivor told us how vulnerable she feels as someone who has mental health issues and also does not have a UK passport. There are barriers to her reaching out for mental health support, for example she worried that going to the GP could be used against her and that she is very aware that she could be deported from this country.

The wider literature also highlights the importance of an empathetic approach. There is evidence showing how victim-blaming attitudes and unsympathetic responses from professionals (and others) pose a significant barrier to survivors talking about abuse and being able to access related mental health support (see Women’s Aid et al., 2021; and the discussion of the literature in Women’s Aid, 2021). An example of this is the evaluation conducted on the impact of the IRIS (Identification and Referral to Improve Safety) intervention⁹ which showed the importance of an “empathetic encounter” between a survivor and healthcare professional or a professional advocate: “The empathetic encounter helped

them to realise they had choices and that a future without DVA was possible” (Feder et al., 2016:7).

Avoiding retraumatisation

An empathetic approach can go some way to undo the impact of the abusive actions of perpetrators, who have used violence and abuse to lower survivors’ self-esteem and make them feel isolated and unlovable. As one survivor wrote, **“Challenging the beliefs, about themselves, and world view, implanted by an abuser, is core to a woman’s recovery.”**

The consequences of getting this approach wrong are significant, and could potentially add to the trauma the survivor is experiencing or has experienced at the hands of an abuser. In turn, such poor experiences of support can prevent survivors from seeking further help. One survey respondent wrote about professionals needing to, **“...have specialist (...) in depth knowledge as their actions [cause further harm, thereby] adding to traumatic experience.”** A survivor taking part in a focus group said, **“If they [professionals] don’t have any experience that’s when they can do more damage than good. If they just think they can do it.”**

Survivors told us of the importance of a professional response being non-judgemental and avoiding any sort of victim-blaming. One survivor told us, **“It is hard to speak out to begin with so experience in being a non-judgemental service is extremely important.”** Another emphasised that, **“we [survivors] need to be met with non-judgement and empathy on an ongoing basis because each day is different.”** The findings of Women’s Aid’s recent research with the University of Bristol set out the unsympathetic, pejorative discourses around mental health and domestic abuse that label female survivors as problematic (rather than the abuse and violence committed against them being the problem) (Women’s Aid et al., 2021). It is critical that professional responses to domestic abuse and mental health do not replicate these discourses.

⁹ This intervention involves collaboration between primary care and domestic abuse specialist organisations.

Drawing on personal experience

Some survivors taking part in our research felt that the professional having personal experience of abuse is particularly helpful in achieving this empathetic and non-judgemental approach, **“someone that genuinely understands”**.

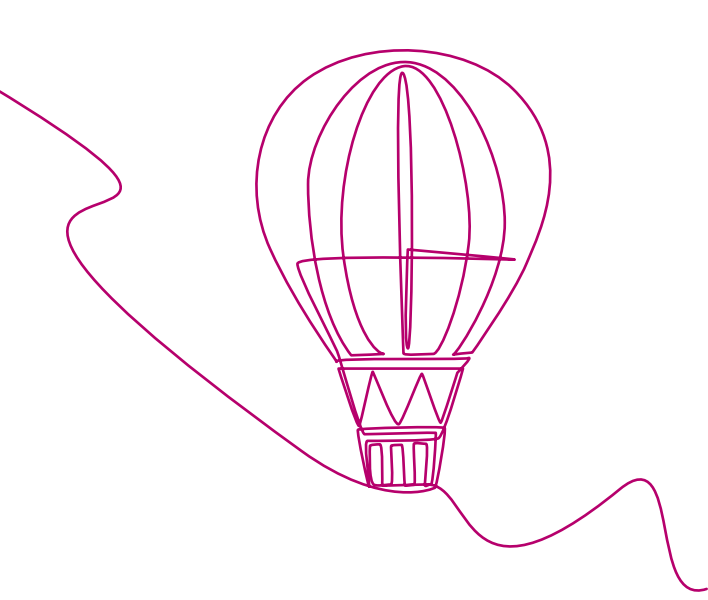
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“Personal experience is good - they genuinely know how you’re feeling ...”

“Know what it’s like to feel empty alone worthless. Know how to help a person find their spirit how to teach a person to be kind to like them self...”

“I think will be a person who themselves have experienced domestic abuse, and are now trained to support people with mental health issues they will have a full understanding of abuse and how it makes you feel and it never gets easy.”

— ”



For other survivors, it was actually something that they perceived as not necessary or maybe even a disadvantage. One survivor described how first-hand experience can be helpful only if the professional has already worked through their own trauma, **“... I’ve had an IDVA share way too many details and clearly in trauma still.”**

— “

“I would want them to have a deep knowledge of mental health but I don’t believe experience is necessary.”

“A professional sometimes experiencing it themselves doesn’t always equal compassion.”

— ”



Meeting survivors' mental health needs: **Example 1 - nia**

nia is an organisation in East London which specialises in providing services for women using substances (drugs, alcohol, or both), and women exploited through prostitution and other forms of sexual exploitation. nia aims to meet women's mental health support needs by maintaining good relationships with local statutory and voluntary sector organisations and appropriately signposting and referring. Recently they have introduced two Mental Health IDVAs [Independent Domestic Violence Advisors], who work in partnership with Barnet, Enfield, Haringey Mental Health Trust & Great Mental Health Project in the London Borough of Haringey.

Staff member at nia:

"Our day to day work with survivors is informed by the understanding that each woman we support has her own individual response to the trauma she has endured. Behaviours that could be described as 'challenging' are not taken at face value. Our woman-centred, strengths-based approach reinforces women's survival strategies, agency and self-determination.

"We provide a range of activities designed to improve life skills and boost self-esteem among the women we support, as well as activities that are purely for recreation. One example of this are the regular therapeutic art sessions delivered by a particularly creative staff member. We involve women in our refuges in our Health & Safety checks, particularly when a woman may be anxious about the safety and security of the building. We ensure that each woman we support is an active participant in risk assessment, safety planning, and support planning and consider her to be an expert in her own experience.

"Our staff are skilled in, and regularly employ, grounding techniques when supporting women through periods of high anxiety or crisis. We have a shared understanding of the compounding factors that impact women's mental health. Our services are trauma informed, recognising that victim-survivors are likely to be experiencing trauma effects, as a direct result of male violence, including loss of; self-esteem, sense of agency, trust in others, self-belief and may experience attachment difficulties affecting the 'choices' they make. Trauma-survivors are routinely pathologised, bounced between services - deemed 'too complex' or 'hard to reach'."

2 Expertise on the dynamics and impact of domestic abuse

Survivors want mental health support to be delivered by someone with expertise on domestic abuse. Those delivering support need to have an in-depth understanding of the dynamics of domestic abuse, including coercive and controlling behaviour, and of the impact on women and children.

“The most important thing is to be heard and for those professionals to really understand the dynamics and impact domestic abuse has on survivors not just whilst in the relationship but for a lifetime.”

An in-depth understanding of domestic abuse and specialist training

Survivors want whoever supports them with their mental health needs (whether this is a health professional or a domestic abuse support worker) to have the in-depth knowledge and understanding of domestic abuse that comes with specialist training. As one survivor described it, they need to have **“A wealth of knowledge and understanding of various types of abuse and how to support victims to get through it.”** Another survivor described this level of comprehension as, **“Full understanding of how importantly mental abuse can and does affect the way you act, feel and move forward. All forms of abuse change your mental health in so many ways...”** This in-depth understanding should be coupled with a personal approach that treats everyone as an individual: **“I would want them to understand that not all cases are the same and one person’s experience may differ from another and that not all answers are text book that are just repeated to all patients.”**

Almost all (98.2%) of the survivors responding to our survey indicated that receiving mental health support from a service or professionals that understand the dynamics of domestic

abuse is very important to them. Out of all the options given to survivors to evaluate in terms of importance in our survey, this was the most highly rated. Access to a service that can give a mental health diagnosis was also important to a large proportion of respondents to our survivor survey (but not to the extent of domestic abuse expertise); 53.9% indicated that it was very important to them, 24.6% ticked that it was quite important. (See **Appendix Four** for full data.)

Some survivors also talked about the importance of professionals having experience of working with survivors. One survivor wrote, **“I think professionals would need to have experience with domestic abuse survivors specifically rather than general mental health experience.”** Another survivor commented:

“I’d want them to have in-depth experience with working with victims of any kind of abusive or all (coercion, emotional, physical, sexual etc.). I’d want them to have a background [in] mental health.”

In order to ensure consistency in knowledge and understanding, survivors told us they wanted professionals responding to their mental health needs to have undergone training delivered by specialist services. Survivors taking part in a focus group stressed that specialist training on domestic abuse with input from survivors can be very valuable. One survivor responding to our survey commented:

“Mental health services is where I personally ended up but they are definitely very lacking in understanding domestic abuse as an issue, despite claiming to have had training. I’d say there’s a lot of staff that need training from a specialist service, rather than whatever training they actually get in the NHS, because it doesn’t equip them to relate to survivors effectively and without re-traumatising them.”

Professionals supporting survivors with their mental health needs should have knowledge and understanding of the following:

- ▶ the impact of domestic abuse on mental health, and that this impact can be long-term;

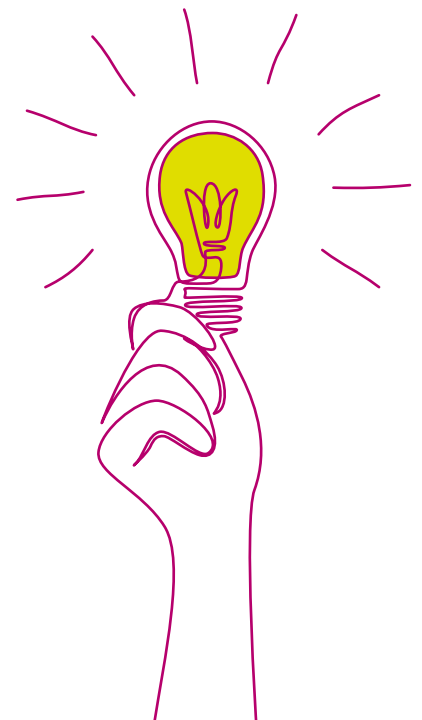
“I would want them to have a really good understanding of all aspects of domestic abuse and its impact on mental health...”

- ▶ the different types of abusive behaviours and that domestic abuse is not limited to physical violence;

“The different types of abuse. It’s not all about being hit. Mental abuse and control is invisible but very serious.”

- ▶ the different ways in which being subjected to domestic abuse negatively impacts mental health;

“They [professionals] would need to have personal experience of some kind and / or medical knowledge and education in the mental health issues surrounding and caused by domestic abuse. Women like myself need to understand why they feel the way they do and be able to join the dots.”



- ▶ post-separation abuse;

“Understanding of the depth of abuse that continues after separation, especially when co-parenting.”

- ▶ coercive and controlling behaviour;¹⁰

“I would want someone who understands coercive control and how the perpetrator has gotten into your head.”

- ▶ that survivors are facing structural and intersecting forms of inequality and discrimination (such as racism, sexism, ageism, discrimination against disabled people and against LGBT+ people) and that these create additional barriers for marginalised groups in accessing support;

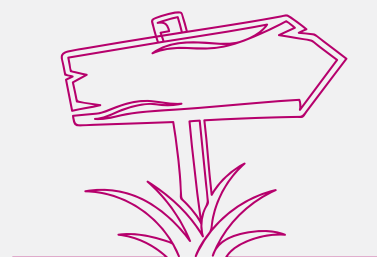
“We’re also being impacted [by] what’s happening in the world, like the racism. We’re having to navigate racism, we’re having to navigate sexism, and we’re having to navigate misogyny, we’re having to navigate the fact that our children are being abused.”

- ▶ the impact on children and their mental health;

“Impact of domestic violence on children’s mental health and what support is available for children in the local area and how to access support.”

- ▶ where to direct survivors for domestic abuse support (including local services);

“...knowledge of systems and structures in place to support victims...”



¹⁰ The Government’s statutory guidance describes coercive control in the following way: “Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another.” (Home Office, 2015:3)

- ▶ the skills needed to interact with survivors (including helping survivors to feel validated in what they are feeling);

“A lot of training in believing us; that was my fear that I wouldn’t be believed.”

- ▶ and (if relevant to the professional’s role) how to effectively facilitate group work;

“Group facilitators need to be able to manage a group and understand how to hold a difference of opinion within a group. There could be more training on running groups and helping people to feel safe to share openly within the group even if their experiences differ from other group members within it.”

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“The dynamics of domestic abuse, particularly when it comes to minoritised women. There are certain types of abuse, like honor-based abuse, forced marriage, FGM [...] which is slightly different dynamics, slightly different to the mainstream training and awareness that is provided, and I think having a knowledge of that, and also a knowledge of the barriers and how they might differ from non-minoritised women.”

“Full training on domestic abuse, what it is, the signs including coercive control and how that manifests in victims behaviour and impacts victims’ mental health.”

“Training in coercive control, mental, physical, sexual, and emotional abuse, financial abuse and family court/law process awareness. There are often gaps in knowledge where professionals may know about one aspect of abuse, such as the emotional side but are sketchy on others such as how legal issues with abusers are used to continue abuse after the survivor leaves and the ways in which abusers can use the legal system to do so, this lack of across the board knowledge leaves the advice/support they are able to offer incomplete.”

“Training on the types of domestic abuse and the potential effects on those struggling.... How subtle it can be. My husband can say something in a certain way or tone of voice or give me a look which I just know means something is wrong. Even behaviour others view as reasonable or considerate outside our relationship can be a form of control.”

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Where to go for support

We asked survivors where they would want to go to seek support around mental health issues related to domestic abuse, and their answers reflected the importance of specialist domestic abuse expertise and knowledge: **“I would want support from someone who knows about domestic abuse, ideally from an organisation that supports abused women because they will understand what I have gone through.”** Many respondents said they would want to go to a specialist domestic abuse service, with some citing Women’s Aid or local specialist domestic abuse services. They want to go **“Somewhere specifically for domestic abuse survivors”** and **“To a specialist service who understands the complexity.”** One survivor praised the support she had received:

“Women’s Aid are the only support I felt genuinely helped me undo all the survival tactics I acquired from the physical and mental abuse I endured. I’m ashamed to say that it was my ‘normal’ and Women’s Aid helped me to understand how wrong what was happening to me it was. It also helped me realise what abuse was even when I didn’t realise I was being abused.”

Another survivor wrote that she would want to seek support from Women’s Aid because: **“... they really understood the long lasting psychological damage. And also the impact on the kids mental health.”**

Some respondents stressed that this should be a women-only space, run by women for women. And some wrote about wanting to go to a service that was run by women who shared their background or identity, known as ‘by and for’ expert services. (See the discussion later in this report in the section called **‘Women-only spaces, including support led by and for marginalised groups of women’**.)

In addition, some respondents mentioned that they would want to go to other charities for support, such as Relate and Mind, both known for their mental health service provision. Some told us that they would seek help from friends and family.

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“Through Women’s Aid or another similar domestic abuse charity.”

“...a mental health worker available in all refuges.”

“I want to go to a space that is dedicated to domestic violence/ sexual assault etc.”

“I would like to be able to go to a local charity or specialist that understands domestic abuse and mental health.”

“A domestic abuse charity or any organisation that understands the impact that abuse has on a person and how it seriously effects your mental health. Going to your GP or police will not fully understand how your mental health has been effected by domestic abuse.”

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One survivor was keen to emphasise that a primary barrier to accessing these domestic abuse services is a lack of awareness.

“The main barrier is lack of awareness around the fact that such support exists and not knowing that such support exists.”

This may be something that disproportionately impacts disabled survivors, where a lack of accessible information can make it harder for them to be aware of these support services. However, this is also something that Black and minoritised women may face, who for a range of reasons such as language barriers, racial discrimination or having no recourse to public funds (NRPF), may experience unequal barriers to accessing VAWG services.

Another common theme in the responses was wanting to go to a healthcare professional or healthcare service for mental health support. Some mentioned that being prescribed medication (or given options/explanations about possible medication) would be useful, but others felt medication was not helpful or should only be given along with talking therapy options. Survivors mentioned healthcare providers such as GPs (General Practitioners), practice nurses, mental health specialists (for example, psychologists, mental health nurses) and health visitors. GPs were commonly mentioned, sometimes as the first ‘port of call’, a gateway to further support (through referrals or signposting); **“I would like to be able to speak to my GP about it and I would like to be referred to a specialist service.”**

However, some survivors told us about concerns about going to their GP, including:

- ▶ concern that the GP might not have sufficient domestic abuse knowledge or expertise, or be sympathetic;

“I struggle being able to go to the GP or general counselling services out of fear of not understanding what I’ve been through. It’s difficult to put into words how you are feeling to somebody who may not understand the detriment that domestic abuse causes.”

- ▶ fear that confidentiality might not be upheld;¹¹

“For some people, their GP is the same GP for that other family member, or community members (...).”

- ▶ GP appointments are short in time;

“I don’t know what their response would be. You can barely get your ten minutes in.”

- ▶ it can be difficult to access an appointment.

“...it could take you two weeks to get an appointment, and the receptionists are now really gatekeepers. They won’t put you through or anything like that.”

Some survivors wanted a mixture of different settings for support: healthcare and specialist domestic abuse services. Some survivors told us they would not know where to turn for support: **“I don’t even know where I would start.”**

¹¹ This concern was expressed in the first focus group discussion, and echoed by survivors in the Black and minoritised focus group.

Avoiding unhelpful responses

The two literature reviews published by Women's Aid in 2021 identified evidence of unhelpful professional responses that included the pathologisation of survivors of domestic abuse. This lack of understanding of the link between domestic abuse and mental ill health leads to survivors being perceived as problematic or disordered, rather than the perpetrator of domestic abuse (and indeed, the perpetrator) being identified as the cause. (See the discussion in Women's Aid, 2021, especially pp. 11-13 and pp. 23-25.). Survivors' reactions to being abused often manifest in signs of mental distress and ill health and, as one survivor responding to our survey wrote, **"... the experience of trauma and its effects are all a normal part of recovery from abnormal treatment at the hands of an abuser..."**

One survivor also told us her story of healthcare professionals not making the links between abuse and mental ill health, **"They misdiagnosed me with psychosis because they simply didn't believe me when I recounted the gravity of the abuse I experienced and was experiencing with ongoing online stalking/post separation abuse."**

It is also important to recognise the harm caused when professionals apply stereotypical assumptions about Black and minoritised women and about other marginalised groups of women. (Thiara & Harrison, 2021:35, citing AVA, 2021) - for example the "Strong Black Woman" stereotype which makes it difficult for Black women to disclose or talk about abuse due to the perceived need to be seen as strong, resilient and independent and this can add to negative mental health outcomes as a result. (Donovan & West, 2015) One survivor participating in our research told us that, **"In the past, I have been treated like a hypochondriac, lazy and ignored. This is worsened by being Black and for women who have a different accent or English as a second language."**

Disabled survivors may also face "diagnostic overshadowing", where healthcare professionals make assumptions that their mental ill health is a consequence of being disabled, rather than as the result of abuse (Stay Safe East, 2021a & 2021b – cited in Women's Aid, 2021).

Understanding trauma

Survivors often used the word "trauma" during our research and talked of the importance of professional knowledge about trauma resulting from domestic abuse. One survivor wrote:

"We need to be specific about trauma so it appears on more people's agenda and garners greater understanding from the greater population, as no one knows what 'mentally ill' means, and it conjures up such very old tropes of what 'mentally ill' looks like, whereas knowing that the vast majority of women in secure accommodation are there purely from physical and psychological trauma would be a revelation to many outside of this profession/experience."

Interventions that show an understanding of the trauma caused by domestic abuse present a positive alternative to the pathologisation of women and their mental health symptoms (described previously in this report). The trauma that survivors experience is not easily recognised or understood without specialist knowledge of the impact of domestic abuse. A survivor in one of the focus groups explained that after someone punches you, you will see a bruise develop, but with emotional trauma you can't see the damage so clearly. Thiara and Harrison (2021:12) also emphasise the role that racism in society plays in adding to the mental health trauma that survivors from marginalised groups experience:

“When the relationship between social inequalities and mental health is examined, the evidence about the interface between racism and mental health conditions (particularly depression) is compelling (Synergi Collaborative Centre, 2018; Khan, 2017; Moller et al., 2016; Wallace et al., 2016), and the role of racism in eroding mental health and wellbeing and reproducing intergenerational trauma is repeatedly underlined (AVA, 2021; Bignall et al., 2019).”

Some survivors also talked about the importance of trauma-informed practices that recognise the impact that domestic abuse has on many aspects of women’s lives (see section on **‘Practical Support’** later in this report) and the coping strategies that survivors may employ (for example, use of alcohol or drugs). One survivor wrote about the importance of professionals understanding:

“...domestic abuse / violence and the impact it has on survivors, trauma informed therapy, understanding complex issues and how they intersect (e.g. using alcohol and drugs to cope with trauma experienced from domestic violence).”

A trauma-informed approach also rejects a ‘deficit model’ approach (concentrating what is “wrong” or “disordered” with the survivor), but rather focusses on a survivor’s strengths (see Women’s Aid, 2021:12-13). As one survivor put it, **“Focus on and encourage the resilience and courage of the survivor.”** Some survivors also mentioned the usefulness of particular therapies designed to help people with trauma, for example, Eye Movement Desensitization and Reprocessing (EMDR).

One survivor described the importance of understanding trauma, and not designating the survivor as ‘problematic’, in the following way:

“Understand that abuse related mental health is often used to reduce women and can lead to misdiagnoses/medicalisation of BPD [borderline personality disorder]. Understand the contributing factors. That the mental health may have been not just a result of, but a factor of the abuse and is a result of long term, many traumatic events. That it is a long and slow process to recovery. That it is trauma.”

Another survivor also highlighted the consequences of not understanding trauma:

“Not understanding domestic abuse and misdiagnosing people, through not recognising the symptoms they’re displaying are symptoms of trauma rather than a fundamental mental health diagnosis that was just there all along and I think that causes way more problems. Speaking for myself it took me years to get my misdiagnosis addressed properly and it actually caused me more harm than good. It really upsets me that the mental health training or whatever goes on in those professions doesn’t seem adequate to understand the reality of women; the highest proportion of women in the mental health system have experienced domestic abuse or some sort of violence, so it’s really important.”



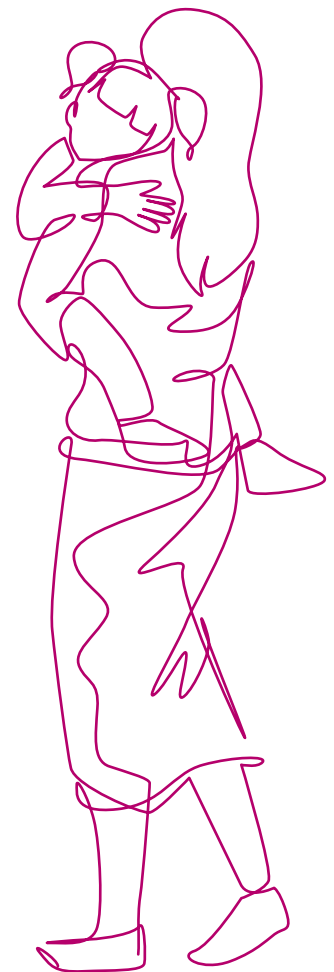
“I would want them to have a bigger understanding of domestic abuse, perpetrator cycles of abuse and the trauma it leaves behind to help survivors heal from what they’ve been through.”

“Be trauma-informed. Trauma therapies. Support with managing overwhelming emotions. Evidence-based positive psychology interventions to rebuild self-esteem, etc.”

“They’d need to... fully understand the impact [domestic abuse] can have and the PTSD [post-traumatic stress disorder] it can cause.”

“Ensuring their practice is trauma-informed and... not being quick to pathologise women and girls with a mental illness (which could then be used against them in Court) when in reality they are experiencing trauma because of domestic abuse.”

“Trauma awareness. How the body reacts to everyday situations after the abuse stops”





Meeting survivors' mental health needs: **Example 2 - My Sister's Place**

My Sister's Place has been delivering trauma informed and trauma specific therapeutic practice to survivors in Middlesbrough for 20 years. Their work draws upon their own evidence-based practice, research addressing trauma, domestic abuse and the importance of working within trauma-informed principles when supporting those impacted by interpersonal trauma.

Clinical Lead at My Sister's Place:

"The impact of trauma on survivors' mental health is well documented and therefore the need for increasing access to trauma informed practitioners, services and practice is essential to support survivors in their recovery from domestic abuse and IPV [intimate partner violence] trauma."

My Sister's Place has developed a model entitled TIME (Trauma Informed Model of Empowerment), along with a programme of specialist trauma informed training to support practitioners and services working with survivors. The TIME model and training recognises the need for a whole organisational approach to trauma informed practice with all parts of an organisation increasing knowledge and awareness around the impacts of trauma on survivors to reduce the risk of re-traumatising survivors and to support recovery from trauma.

"Our vision is that all services supporting survivors of domestic abuse and interpersonal trauma should be trauma-informed, and we want to empower service communities to implement trauma-informed approaches when supporting those impacted by domestic abuse and interpersonal trauma."

3 A space to talk with a range of approaches to support

Survivors value having a space to talk about their mental health and in which to develop coping strategies. This could be one-to-one with a female therapist who is a specialist in domestic abuse, in a group therapy setting with other female survivors or through other forms of peer support.

“Emotional support. Just someone to talk to about what’s going through your mind.”

It is clear from our research that talking therapies are highly valued by survivors, whether this is one-to-one support or in a group setting (or both): **“Being able to talk on a one-to-one basis and also being referred to group meetings consisting with similar people to enable experiences to be shared and for acceptance.”**

There are clear links between this section and the issues discussed in the previous sections of this report. Survivors in our research value a space to talk where they are treated with empathy and compassion. They also value a space where they can talk to a woman or women who understand the trauma they are experiencing or have experienced (through lived experience or professional expertise). Survivors told us that they wanted **“A safe space to talk, no judgement”,** and to be able to access a **“Domestic abuse agency or an organisation that would understand without any fear or judgement or questioning.”**

This is backed up by other studies that found that survivors need access to trauma-informed services (see the discussion in Women’s Aid, 2021, especially pp. 32-33). One study found that some 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, cited in Women’s Aid, 2021). Thiara and Harrison (2021:37) note that this issue is even more pronounced for Black and minoritised women:

“...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.”

One-to-one support

Many survivors responding to our survey mentioned counselling or another form of one-to-one talking therapy as being helpful, although some also emphasised that this was dependent on having a female therapist (see the section on women-only spaces later in this report) who has expertise in domestic abuse. This survivor's response highlights the importance of one-to-one support from a domestic abuse specialist:

"Most [counsellors] don't have specific counselling skills to deal with domestic violence. I had counselling which was generic provided by my work. I then had counselling 18 months later from Women's Aid and there was no comparison. Women's Aid provided an outstanding service."

In our survey, 83.3% of survey respondents rated one-to-one support as very important, and 13.6% rated it quite important (see **Appendix Four** for full data). One survivor described the value of counselling in the following way: **"...counselling by a professional also helps untangle the mess your brain is after abuse."** One survivor's response highlights the importance of making sure that the counsellor is a specialist in domestic abuse:

"I found 'traditional' counselling, which I paid for privately, was ineffective and very triggering. It resulted in me reliving my abuse experiences and unpleasant experiences on a weekly basis. The emotional impact [of domestic abuse] is extensive, yet I found therapy was ineffective in helping me process the normal emotions associated with domestic violence."

Our findings echo those of other studies which have found that survivors rate specialist domestic abuse counselling highly (often delivered as part of a specialist domestic abuse service) (Humphreys & Thiara, 2003; Kelly et al., 2014).

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"Counselling that is specific to domestic abuse and survivors, most counselling offered is a one size fits all and is not beneficial."

"I think different things work for different people and it's about what works for you[...] I guess for me I would want more holistic and person-centered and value like a combination of all those and looking at kind of different approaches to look at what's tailored to that person because everybody is individual."

"I think counselling... just time and space to reflect...not necessarily get advice but just to be....to offload."

"Safe space. Female counsellor."

"Specialist counsellors for domestic violence and sexual violence."

"1:1 sessions, opportunity to talk freely, opportunity to bring somebody with you if you want maybe even for the initial visit."

"...Specialist trauma therapy. Provided by NHS."

"Access to psychotherapy. Advice and information about mental health specific to domestic abuse is important. Often mental health is used as a tool by abusers to keep victims in their power so information about how mental health is impacted by abuse, that it's normal, can get better and doesn't justify abuse, is important."

"It should include counselling, therapy and meditation. Help us to understand how we are feeling as we are so confused about the abuse. Also support around understanding what coercive control is as I didn't know."

”

Group therapy and other forms of peer support

Peer support, the chance to interact with other female survivors, plays an important role in survivors' emotional recovery from domestic abuse (Abrahams, 2007; Humphreys & Thiara, 2003; Sweeney et al., 2019 – cited in Women's Aid, 2021:39; Thiara & Harrison, 2021). Thiara and Harrison (2021: 40)¹² highlight that peer support spaces for survivors in Black and minoritised VAWG organisations have 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." As one Black and minoritised survivor told us **"I think peer support for Black and minority survivors is really important, because it's somebody that understands, you know, what their experience is."**

Peer support was valued by many survivors taking part in our research. One survivor commented that she would value, **"Help finding groups to share experiences and heal."**

Another wrote that, **"I feel maybe a group support would help with fellow survivors. Listening to others stories can be very therapeutic and help you release patterns."**

Some survivors mentioned that peer support should be offered with or after one-to-one therapeutic support. Peer support was not rated as highly as some other options, but it was still clearly a valued part of mental health support. 53.9% of respondents rated 'A service where I can meet/talk to other survivors of domestic abuse' as very important, and 25.9% as quite important (see **Appendix Four** for full data). This peer support could take the form of group therapy, but also other ways of connecting with survivors, such as through group outings or exercise groups.

Peer support aids mental health recovery in creating **"a community of support"** and offering opportunities to:

- ▶ share coping strategies;
- ▶ feel less isolated;
- ▶ be able to talk about abuse and its mental health impact with others who understand through lived experience.

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"Both 1-1 and group therapies. Self-esteem workshops. Outings with other women to learn to trust again."

"A shared forum for discussion."

"Group/peer support with other survivors. A space to be able to explore new things such as exercise, healthy eating, meditation and yoga."

"To a forum/group of other women who understand the issues but who also have specific counselling/therapist skills to help counteract the mental health problems."

"Some group work to normalise the experiences, to vent, to build each other up. One-on-one therapy."

"One-to-one support, backed up by group sessions with other victim/survivors."

"Alongside talking therapies, having support from another survivor would definitely be valuable."

”

¹² Citing Thiara and Roy, 2020.

Developing coping strategies

Survivors told us that they wanted to be supported to develop strategies to help manage their mental health symptoms: **“I would seek out help from domestic abuse charities, I would want to find positive ways to overcome the trauma, and share stories and advice with other women.”**

The ultimate aim of such support is to empower survivors in focussing on their strengths and help them move towards independence and recovery: **“Coping mechanisms for trying to move forward.”** These coping strategies must be appropriate for survivors of domestic abuse and

tailored to each individual. These could include strategies to:

- ▶ manage anxiety;
- ▶ manage intrusive, negative thoughts;
- ▶ deal with flashbacks and nightmares;
- ▶ deal with feelings of shame;
- ▶ improve self-esteem;
- ▶ cope with panic attacks.

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“Coping mechanisms around nightmares, panic attacks, regrets, blame, how to move on, self-esteem.”

“Basic panic attack calming training. Being able to listen and give appropriate advice or support.”

“Confidence building. Financial advice. Rebuilding friendships lost or advice on how to build new ones.”

“Coping strategies around being alone after being so dependent on someone else. Help to understand healthy relationships. Holistic approach that doesn’t have to include medications. Other methods of treatments should be explored first.”

“Practical help to manage the day and mental health symptoms- someone to check in with- a mentor?”

“Online education programs you can do in your own time around what constitutes abuse, how to help yourself, plus advice on what can be done practically for the survivor.”

“Help with negative thinking patterns.”

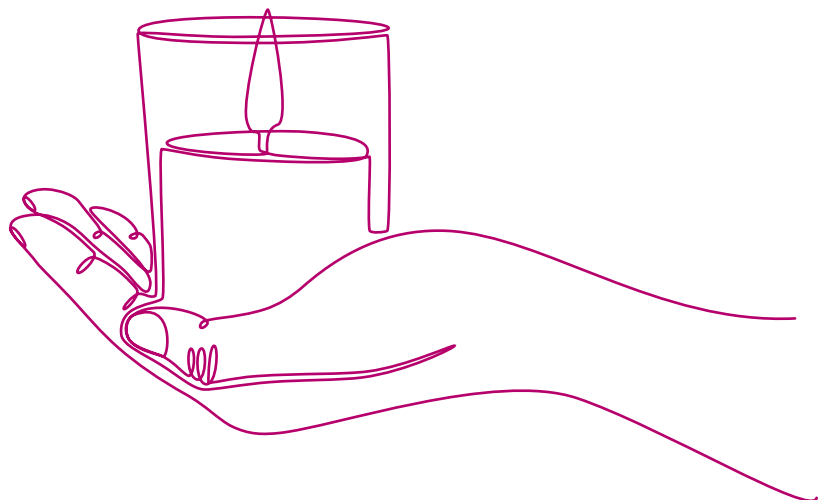
“I guess if there was handbook... So I know there’s a survivors’ handbook from Women’s Aid but if there was like an introductory or just a brief outline of techniques survivors could use when feeling anxious or low.”

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Alternative or complementary therapy

Some survivors told us about wanting access to alternative or complementary therapies to address the trauma they have experienced. Examples given by survivors included:

- ▶ art therapy;
- ▶ drama therapy;
- ▶ breath work;
- ▶ yoga;
- ▶ meditation;
- ▶ relaxation therapy;
- ▶ Indian head massages;
- ▶ aromatherapy.



“Counselling saved me but some people don’t get on too well with it so maybe some form of art therapy? Anything that will help people process and realise that this wasn’t and isn’t their fault.”

“Access to creative activities.”

“Trauma related therapeutic groups such as yoga, art, drama groups that support community and help to safely engage the body.”

“I believe trauma support needs to be very holistic with lots of empathy and compassion. For example: Having head massages from the by and for service I attended was extremely calming and relaxing and also helped with the feeling of being listened to as we would have a brief chat before starting.”



Meeting survivors' mental health needs: **Example 3 - Cambridge Women's Aid**

Cambridge Women's Aid identified a gap for women who are struggling with their mental health due to experiences of domestic abuse, yet cannot easily access other mental health services. The barriers that Cambridge Women's Aid identified include survivors who don't meet the criteria for IAPT (Improving Access to Psychological Therapies); those who are unable to afford long-term private counselling or psychotherapy; the short-term nature of free/subsidised counselling, and long waiting lists to get support.

Cambridge Women's Aid is developing a collaboration with a local organisation that offer affordable group therapy to support people with their mental health, to pilot a fortnightly mental health support group for survivors over 18 months. The group will focus on containment, coping strategies, self-esteem, self-care, reducing isolation, moving forward, and self-soothing strategies. The emphasis will be on peer support, empowerment and positive strategies to improve mental health.

Staff member of Cambridge Women's Aid:

"Our intended outcomes are that through attending the group, women will feel less isolated, have improved self-esteem, be more confident to access other group-based support, and feel more able to manage depression and anxiety."



Survivors want the mental health impact of domestic abuse on children to be recognised and mental health support specifically for children and young people to be available (delivered by professionals with expertise in domestic abuse).

“...my children grew up hearing the abuse and witnessing the abuse, they never got much support, now they're adults they struggle because of the past and what they witnessed and heard.”

Survivors want the impact of domestic abuse on children to be recognised and addressed through support and therapeutic options. However, adult survivors of domestic abuse are often reluctant to seek help for themselves and their children because they are afraid of mental health diagnoses being 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 – cited in Women's Aid, 2021:25; Thiara & Harrison, 2021). As one survivor told us, **“Even talking to a GP now is a negative thing against me, that's evidence I am creating [that can be used against her in any child contact matters]. So what good is going to come from talking to a GP?”**

Mental ill health can be weaponised by perpetrators to discredit and undermine survivors as mothers in many settings, including in proceedings with the family court and any contact with social services (Birchall and Choudhry, 2018; Coy et al., 2012; Katz, 2014; Safelives, 2019; Thiara & Harrison, 2016 – cited in Women's Aid, 2021:26; Women's Aid et al., 2021; Thiara & Harrison, 2021). One survivor responding to our survey wrote,

“Perpetrators are very cunning and can try and use mental health and the stigma surrounding it to get the children away from the mother.”

A survivor in one of our focus groups told us that she would have sought out help sooner if she hadn't felt shame and fear of losing her children.

Instead of facing barriers to getting support, survivors want to be able to access specialist support and information that helps them in their role as mothers and helps them in turn to support their children. One survivor in response to our survey wrote about wanting **“Somewhere to get advice about the kids.”** Another survivor wrote that she would value support with:

“How to manage children and an abuser to support their experiences of trauma, and where you fit as a mother also under the trauma. Women need to know how to handle this, they do their best without help or often knowledge. Addressing the guilt of parenting in abuse situations.”

Survivors also told us about wanting professionals to understand the impact of domestic abuse on children and young people, and for their children to be able to access specialist mental health

support (designed for children). One survivor wrote about wanting professionals responding to domestic abuse to understand the **“Impact of domestic violence on children’s mental health and what support is available for children in the local area and how to access support.”**

This might take the form of one-to-one therapy or family therapy, or it could involve support from schools. One survivor wrote about wanting, **“Someone to talk to at a children’s school, not just a family liaison officer. A domestic support worker in the schools.”**

Support which addresses children’s needs was very important to the survivors answering our survey. Of those respondents who said the question was applicable to them (187), 84.0% rated ‘A service that also addresses the mental health needs of my children’ as very important, and 10.5% as quite important (see **Appendix Four** for full data).



Examples of support that survivors identified in the survey as being useful include:

“Techniques for coping, like with nightmares, with terror. Support groups to back up that match the stages of progression. The same and age appropriate for children.”

“Access to mental health support for any children also affected.”

“Ways to help and support my children.”

“Family support for children up to 20 year olds, individual and group support for children.”

“I need support of how to successfully co-parent with an abusive ex. He isn’t going to change so how can I change how I react to not let him frighten, control and intimidate me.”

“Family therapy for women and children once they’re out of the abusive relationship.”





Meeting survivors' mental health needs: **Example 4 - West Mercia Women's Aid**

West Mercia Women's Aid (WMWA) work in partnership with local hospitals, supporting clients who attend the hospital sites and who are referred into their service through the hospital staff. West Mercia Women's Aid has provided the mental health liaison team with training in domestic abuse awareness; and in turn, the mental health liaison team has trained West Mercia Women's Aid staff on various aspects of mental health.

West Mercia Women's Aid has set up a referral pathway to enable women in their refuge services to access counselling services from a local organisation much more quickly than via the standard referral route. They run an online survivors' network which enables peer support for survivors of domestic abuse, and offer a trauma-informed therapeutic intervention in their children's service for children between the ages of 5 and 18 who have witnessed or experienced domestic abuse. In addition, WMWA has a complex needs worker whose role includes strengthening relationships with external agencies in order to improve women's access to mental health services.



Survivors want mental health support that recognises that domestic abuse affects many aspects of their lives. Survivors value practical support that addresses their safety, housing and other needs, as well specialist mental health support. A survivor cannot progress in her mental health recovery without these practical needs being addressed.

“Much of the trauma support required is ultimately dependent upon the women’s practical needs and home/life stability. I have heard, and myself experienced, lack of practical needs being met so that recovery can even be started.”

Many survivors responding to our research told us that they wanted professionals supporting them with mental wellbeing to be able to see the bigger picture of domestic abuse. That it is to say, an understanding that domestic abuse impacts many areas of their lives and on the lives of children, and that support to promote mental health recovery cannot be disconnected from these many areas of impact. This links to previous discussions in this report about how it is important that professionals responding to survivors’ mental wellbeing are trauma informed and have an in-depth understanding of domestic abuse. As one survivor commented (talking about survivors of domestic abuse), **“...their mental health issue is not the only thing going on for them.”** For example, it is impractical and ineffective for a survivor to try to engage with mental health support, when the issues of her safety from violence and abuse, her insecure housing situation or financial challenges remain unaddressed. One survivor told us:

“I don’t think professionals in the main take domestic abuse seriously as a thing. They can deal with bits of it, so they can deal with the trauma, they can deal with the fact you might have a mental health condition, but they don’t see it as a whole thing [...] they don’t fully appreciate the complexity of it.”

It is clear that survivors value practical support that sees the entirety of their situation and focusses on addressing their needs: **“A strong team dynamic needs to exist between the psychological recovery and practical steps to be settled and safe, and a to and fro interdependency between the disciplines to attain the most effective outcomes.”** Any physical health needs should be met, as well as mental health ones. Practical support (or signposting/referrals to such support) is just as important as emotional support, and the two are in fact linked. Practical support (as one survivor put it, **“Help with real world issues”**) could include:

- ▶ support with how to escape abuse from a partner or family member;
- ▶ financial advice, including debt advice;
- ▶ housing assistance;
- ▶ advocacy in the criminal justice system and family courts;
- ▶ assistance in applying for protection orders;
- ▶ help with employment and training.



“An awareness of the extent to which domestic abuse/violence against women and girls impacts on women’s mental health, the long term effects, that women often cannot address their own mental health support needs while living in temporary accommodation, waiting for child contact and residency cases to be heard etc. their mental health issue is not the only thing going on for them.”

“Counselling, advice on how to escape, advice on how to move on and survive once you have escaped.”

“Practical advice and support in the journey towards safety.”

“Help with real world issues - bills, budgeting, getting out, skills and education.”

“Knowledge of the way abuse can affect all areas of life such as financial stability, accommodation, relationships with family and physical health.”

“Practical help and support; in making phone calls to support services, with filling in paperwork e.g. applications for non-molestation order, in collecting belongings from previous home. Explanations of what to expect from speaking with police, going to court, what my abuser might do etc.”

“Career coaching, financial counselling to sort the debt he left me with.”

“How to help people back into work and experience of this [among those] who are disabled or are victims of psychological abuse. Finance is a huge factor and there just isn’t enough support. A room in a shared house is not for people who have been through this and yet housing help is poor at best. It deters people from leaving.”



This is backed up by the wider literature that shows that practical help is a vital part of survivors' mental health recovery. Hilary Abrahams' research into women's experiences of refuge services highlights the holistic approach of refuges in addressing a range of survivors' practical and emotional needs.

“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 – cited in Women's Aid, 2021)

Thiara and Harrison (2021) also emphasise the value of a holistic approach:

“Individual trauma-informed counselling is valued by survivors, but this does not always address the complex realities of women's lives. It has been repeatedly found that Black and minoritised survivors value both practical and emotional support from interventions (Anitha et al., 2009; Thiara and Roy, 2020; Wright and Hutnik, n.d.). Practical help is vital, and also helps build the trust that may enable women to take up other forms of support from agencies.”

(Thiara & Harrison, 2021:36)



Example of practice: Eva Women's Aid

Eva Women's Aid offer a range of domestic abuse support services in Redcar, in the North East of England. Eva Women's Aid work closely with mental health support agencies in the local area and they can refer to them if needed. They also attend any medical appointments with women if support is required. Within their refuge accommodation they provide in-house counselling. All housing workers at Eva Women's Aid have had mental health training to ensure that women are supported appropriately.

6

Women-only spaces, including support led by and for marginalised groups of women

Female survivors value receiving support within women-only spaces, and from female professionals. They equate women-only spaces to safe spaces, conducive to recovery. Survivors also want support that is delivered by women who share their background or identity, such as services run by and for Black and minoritised women.

“I prefer certainly a women-only space, where there would be minimal triggers.”

“...the experience of abuse is not the same for all women and race, culture and religion also play into that cycle of abuse.”

A service that is women-only or that offers separate service to men and women is valued by survivors. 64.0% of our survey respondents indicated that this is very important to them; 13.6% that it was quite important. Survey respondents were also asked how important it was to them that a service understands the role that sex / gender plays in experiences of domestic abuse and/or seeking help. This was still generally seen as important by respondents, but not to the extent of women-only spaces/support delivered by a women. 48.7% considered understanding of the role sex/gender plays as very important; 26.3% as quite important (see **Appendix Four** for full data).

In the open text survey questions, some survivors gave comments about how they would prefer to have a female professional supporting them with their mental health: **“I also feel female professionals and survivors of abuse would be easier to accept for a female victim and male counsellors for male victims.”** A women-only space was sometimes described in terms of **“somewhere safe”**, an empowering space that is conducive to recovery: **“Having a woman to talk to you would make some women feel more at ease, depending on their experiences.”**

“



Thinking about if you were to seek support around mental health related to domestic abuse, where would you want to go?

“To someone who understood what I had been through and a female.”

“Having a woman to talk to you would make some women feel more at ease, depending on their experiences.”

“Somewhere safe, trauma informed and that was run by women.”

“To a female only safe space, run by survivors for survivors.”

“Somewhere free of adult men.”

“Safe space. Female counsellor.”

“I would like to be able to go to a women-only space that provide group support and 1-2-1 support for survivors.”

”



Thinking about if you were to seek support around mental health related to domestic abuse, where would you want to go?

“To a female counsellor who understands mental, emotional and financial abuse. Not a student but an experienced mental health professional.”

“Women only secure centre, specifically for domestic abuse survivors.”

“I would prefer women professionals for mental health support.”

Understanding a survivor’s background or identity

Many survivors value receiving support from women who share and understand their background or identity. As one survivor wrote, a service providing mental health support **“...would also need to be culturally aware and sensitive, the experience of abuse is not the same for all women and race, culture and religion also play into that cycle of abuse.”**

Of all survivors responding to our survey, 31.8% indicated that an organisation or service that is run by/led by people who share their background or identity was very important for them, and 24.2% told us it was quite important (see **Appendix Four**). This was of higher importance to Black and minoritised survivors, of whom 50.0% said this was very important and 20% quite important.

One survivor (in our focus group for Black and minoritised survivors only) pointed out that ‘by and for’ services for marginalised groups of survivors must of course also be able to offer expertise and understanding related to the dynamics and impact of domestic abuse. A survivor responding to our survey wrote about the value of this level of specialism:

“Specialist VAWG services are essential, those run by and for survivors. Further to that a service that understood and responded to different experiences and support needs such as protected characteristics. It is not enough to say the service welcomes everyone, the therapists need to have an understanding of different experiences of abuse, the dynamics for people with protected characteristics and gender focused response. A choice of therapist for example women therapist if that was the choice of the survivor, specialist Black/minoritised survivor services/ services for women with mobility/ disability/hearing or sight impairment/ LGBTQI+/migrant survivor services. Survivors should be made aware these are on offer.”



“ For a lot of [domestic abuse services which are not ‘by and for’ the group they support] there isn’t the trust that they will understand the specific barriers and challenges faced by minorities such as Black women, disabled women, and that specialist understanding of the unique barriers that put them at a disadvantage.

“...as a woman of faith I would be able to connect with someone who understood my beliefs even if they didn’t share them.”

“I would want to speak to someone who is from a similar background to mine as they would have a deeper understanding of Asian stigmas and issues.”

“Experience and specialist knowledge of same sex domestic abuse, especially female to female abuse perpetrators.”



The wider literature highlights the importance of a shared understanding and experience between professionals and survivors from marginalised or minoritised groups.¹³ This context of shared understanding could involve understanding the barriers that survivors face in terms of structural inequalities and intersecting inequalities (such as the intersection of racism and sexism); an understanding of cultural identity; an understanding of religious identity; being able to communicate in the survivor’s first language; or being able to understand the nuances of different communication styles (see the discussions of the literature in Thiara & Harrison, 2021 and Women’s Aid, 2021).

Thiara and Harrison (2021: 39) note that:

“Research indicates that the availability of sensitive and sympathetic support in appropriate languages with ‘unspoken’ understanding is crucial to enable women to rebuild their lives (Parmar et. al., 2005; Rai and Thiara, 1997; Thiara and Hussain, 2005)”

Another survivor from an interview talked about how help in the community, such as community centres and other community groups that are also ‘by and for’ Black and minoritised groups of women, can be places that survivors may turn to for support. This is especially the case for women who, for a variety of reasons such as those outlined in the previous section, may not be aware of specialist VAWG services.

13 These include (but are not limited to) Black and minoritised survivors, disabled survivors, LBT survivors, older survivors and those facing multiple forms of disadvantage and discrimination.

7 Timely and long-term support

Survivors want their mental health support needs to be prioritised, without having to face long waiting times. They also want it recognised that recovery often is not short-term, so support options shouldn't be either.

“The mental abuse suffered within a toxic relationship causes ongoing problems many years after the escape from abuse so there should be no time limit.”

Waiting times

There are often long waiting times for mental health support for adult and child survivors; this can be distressing and add to the trauma survivors are already experiencing (Crenna Jennings & Hutchinson, 2020; Hailes et al., 2018; The National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019; Pathfinder, 2021; SafeLives, 2019 – cited in Women's Aid, 2021). There is strong evidence which suggests that Black and minoritised women typically face a number of additional barriers to reaching out for support relating to domestic abuse, and experience abuse for longer (Thiara & Harrison, 2021:16). As one survivor told us, **“The impact of the abuse that you suffer is going to be intensified as a result of being a disabled woman, or because say you're disadvantaged otherwise in the first place, and then experiencing this trauma kind of leaves you at a further disadvantage.”** After lengthy experiences of abuse, to then face long waiting times for mental health support may result in women who are already marginalised being disproportionately negatively affected. One survivor participating in our research also pointed out that after a long waiting time a survivor may end up talking to the therapist mostly about how distressing that period of waiting was, as opposed to concentrating on the abuse and its impacts.

Waiting for support is clearly an issue that resonated strongly with participants in our research. One survivor responding to our

survey wrote that she had to wait from early October until the next July for her counselling appointment. Another survivor wrote that she had to wait 18 months for mental health support after fleeing a domestic abuser. When asked how they would rate 'A service that I don't have to wait a long time to access (wait more than a month)', 89.5% of respondents indicated that this was very important to them, and 8.8% that it was quite important (see **Appendix Four** for full data). After 'A service / professionals that understand the dynamics of domestic abuse', this was the question option that was most highly rated by survey respondents. As one survivor put it, **“Timely support is the most important!”**

— “

“More immediate support.”

“Less waiting time to be seen. More counsellors.”

“...easy access, not long wait times”

” —

Long-term support

When survivors are eventually able to access mental health support, there is sometimes only short-term support on offer (Hailes et al., 2018; Pettitt et al., 2013; The National Commission on Domestic and Sexual Violence and Multiple Disadvantage, 2019 – cited in Womens Aid, 2021:32). Hailes et al. (2018: 18) highlight the harm caused by this combination of long waiting times and then short-term support, **“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.”**

Survivors also told us that short-term therapy (for example, limited to six sessions, or for a few weeks or months) was often ineffective at helping them to recover from the trauma of domestic abuse: **“[Support] [s]hould be over sustained period to support long-term healing from coercive control, CPTSD [complex post-traumatic stress disorder].”** When asked to rate the importance of ‘A service that offers long-term support (more than six months)’, the responses to our survey were weighted towards ‘Very important’ (78.1%) and ‘Quite important’ (18.0%) (see **Appendix Four** for full data).

Support just for a short period of time could also potentially worsen the trauma survivors are experiencing. One survivor told us, **“Support should be one to one trauma counselling for a long period, 6 sessions was not enough, made me worse as it brought it all up but not enough time to process it.”** Another survivor emphasised that it was important to recognise that the impact of domestic abuse remains with you wherever you are in life. Survivors also stressed that recovery is not a quick nor a linear process, and so support should not be either. It is also important to bear in mind that many survivors experience ongoing abuse post-separation, and so even after the relationship has ended, the abuse has not.

— “

“Counselling for as long as is needed.”

“Long term access to counselling sessions - half a dozen sessions don’t always ‘cut it’”

“Long-term support. I didn’t start experiencing mental health issues until 5 years after leaving my abusive relationship.”

“Long term support is vital. I am four years into recovery and still have a way to go. I can be ok for months at a time and then go downhill.”

The access needs to be long term as the current 6 or 12 weeks available is insufficient to address embedded issues.”

“Support that is variable and inclusive and relaxed but not limited to a certain amount of sessions or the completion of a certain curriculum of support.”

— ”

Conclusion

Survivors of domestic abuse stressed the need for those providing professional support to demonstrate empathy, compassion, listening skills, patience, and a non-judgemental approach. Survivors face considerable challenges reaching out and talking about their experience of domestic abuse – and survivors from Black and minoritised backgrounds, or for example with uncertain immigration status, may face additional barriers also. The wider literature shows that an empathetic encounter can enhance a survivor's chances of recovery. Our research demonstrates that the consequences of getting this approach wrong are significant, and that the absence of empathy and understanding can potentially add to the trauma the survivor is experiencing or has experienced at the hands of a domestic abuser.

Female survivors value receiving support within women-only spaces, and from female professionals. They equate women-only spaces to safe spaces, conducive to recovery. Survivors also want support that is delivered by women who share their background or identity, such as services run by and for Black and minoritised women, helping survivors to feel connected and to heal. Any service providing mental health support needs to be culturally aware and sensitive, recognising that the experience of abuse is not the same for all women, and that culture and religion also play into that cycle of abuse.

Survivors experience long wait times to access mental health support services, and many find this detrimental to their mental health. A limited number of sessions with a mental health professional is insufficient to effectively support long-term healing from domestic abuse – and does not take account of the fact that many survivors continue to experience abuse even post-separation when a relationship has ended.

Overall, survivors value specialist domestic abuse services, but recognise also the importance of being able to access support from general healthcare providers and mental health specialists. Survivors identified critical areas of knowledge that service providers should have relating to the dynamics and impact of domestic abuse – including coercive and controlling behaviour, post-separation abuse, the trauma experienced by survivors, and the long-term impacts of domestic abuse on the mental health of survivors and of their children, as well as the additional barriers women from marginalised groups face in accessing services. Survivors also preferred that mental health specialists have previous experience of working with domestic abuse survivors.

Survivors value having a space to talk about their mental health without fear of judgement, and to be supported to develop coping strategies. This could be one-to-one with a female therapist who is a specialist in domestic abuse, in a group therapy setting with other female survivors or through other forms of peer support. Survivors also want the impact of domestic abuse on children's mental health to be recognised by professionals, and addressed through specialist support and advice – for example, on what services are available locally or in schools, and provision of specialist mental health support (including individual and/or family therapy) for children affected by domestic abuse.

Survivors highlight the importance of an integrated approach, with recognition of how domestic abuse impacts on multiple aspects of a survivor's life. Professionals need to understand that practical support (for example, assistance with accommodation, employment/finances, and navigating the criminal justice system) must be considered alongside any support to mental health.

Recommendations for a survivor-led approach to mental health support

This research identifies 7 pillars for an effective response based on what survivors of domestic abuse have told us they value in a mental health response designed for them.

- 1 An empathetic and understanding response**
- 2 Expertise on the dynamics of domestic abuse**
- 3 A space to talk with a range of approaches to support**
- 4 Support for children and young people**
- 5 Practical support**
- 6 Women-only spaces, including support led by and for marginalised groups of women**
- 7 Support that is quick to access and long-term**

In order to ensure an approach to mental health support for survivors of domestic abuse with the 7 pillars at its heart, Women's Aid has shaped the following recommendations informed by the voices of survivors in this research.

Recommendation 1: Ensure that healthcare professionals are trained and equipped to embed the 7 pillars

Training to be mandatory, specialist and continuous for healthcare professionals

Our research clearly shows that effective and meaningful support for survivors of domestic abuse must be based on a sound knowledge and understanding of the dynamics of domestic abuse. This includes its social and cultural context and most importantly, its often profound effects on survivors' mental health and wellbeing.

Any truly transformative work requires an effective co-ordination of responses with other relevant services in order for survivors to have a smooth journey to recovery. Whilst such a 'whole-system' approach promotes more effective relations between services to the benefit of survivors, it is consistently not available. To help address this gap, all healthcare professionals, including mental health specialists, should be required to undertake specialist, regular training to develop understanding of domestic abuse, as well as how to work with multiple agencies and make referrals as needed to promote survivors' healing and recovery.

For training to be effective, we need to see multiple opportunities available as part of professional qualifications and continuous professional development (CPD).

- ▶ All courses which prepare learners to work on mental health support should include compulsory training on domestic abuse which is created and delivered by specialists in the area. This should include both dedicated modules on courses and, where possible, placements in specialist domestic abuse services, (most frequently, degree student nurse placements and degree Social Worker placements).
- ▶ All qualified professionals involved in provision of, or referral to, mental health support should receive regular, mandatory CPD training on domestic abuse which has been developed and delivered by domestic abuse specialists. This should include training on the intersectional impact of structural inequalities on Black and minoritised, Deaf and disabled and LGBT+ survivors.
- ▶ All training should take a trauma-informed approach, include all aspects set out on pages 19-21 of this report and be informed and delivered by experts in the field who have experience of working directly with survivors of domestic abuse as well as formal teaching qualifications. See our accompanying paper outlining the training offer of the Women's Aid National Training Centre (NTC).

Recommendation 2: Ensure that mental health services for survivors meet the 7 pillars set out in this research

Commissioners to invest in support that works

To ensure that mental health support reflects what survivors want and value, local authority approaches to commissioning must include survivors' voices in their practices.

A) Women's Aid recommends that tenders and commissioning decisions should reflect the importance survivors give to a holistic approach to support (practical and emotional needs met, trauma-informed), peer support opportunities, understanding impact and dynamics of domestic abuse and an empathetic, trauma-informed approach to service delivery. Further, commissioners should ensure sustainable provision of support for female survivors in women-only spaces, including those run by and for Black and minoritised, and Deaf and disabled women.

To achieve this, local authorities and health commissioners should follow the guidance set out in Women's Aid's briefing for commissioners which accompanies this report. Recommendations for good commissioning practice informed by survivors participating in this research include:

- ▶ Survivors of domestic abuse should be involved in evaluating services designed for them and should be regularly consulted by Integrated Care Boards to ensure commissioning practice is informed by survivors' needs.

- ▶ Mental health support must always include dedicated, specialist support for children/young people and specialist mental health workers should be made available to all domestic abuse services.
- ▶ Fund women only spaces, to ensure these are always available to survivors of domestic abuse.
- ▶ Commissioning practice should reflect the importance of specialist domestic abuse services, including those run by and for marginalised groups, in delivering mental health support.
- ▶ Commissioning tenders and decisions should require evidence of meeting sector specific quality standards, such as the Women's Aid National Quality Standards for domestic abuse support services.

B) Changes in practice cannot happen without sustainable funding. We therefore recommend the provision of sustainable, multi-year funding for community-based services to ensure that a sufficient and sustainable level of mental health and wellbeing support can be provided by these services. This should include ring-fenced funding for by and for services, who remain chronically under-funded under the current commissioning model.

Develop accreditation to ensure professionals follow the 7 pillars outlined in this report:

A) NHS England and Care Quality Commission (CQC) should commit to developing guidance to ensure that health professionals deliver mental health support in line with the needs to survivors of domestic abuse, as shown in the 7 pillars set out in this report.

B) Domestic abuse support services should have successfully obtained the Women's Aid National Quality Standards which provide assurance of good practice. Commissioners should require this from services the award contracts to.

C) Research recognises the impact on staff of working with survivors on the mental health of staff, particularly those who are themselves survivors. There is a known risk of vicarious trauma for staff working in this field (Women's Aid, 2017: 57). We recommend that all support provision for survivors of domestic abuse is funded to include clinical supervision for staff to mitigate this risk.

Support for children and young people to be part of any mental health offer

Women's Aid knows that children experience domestic abuse in a very real way; they are not just witnesses to abuse, and the impact can be long-term lasting into adulthood. The Domestic Abuse Act recognises children survivors as victims in their own right and this must also be

reflected in mental health responses for survivors of domestic abuse. Women's Aid recommends that training for healthcare professionals (see **Recommendation 1**) should include the impact of domestic abuse on children and young people and how to offer them trauma-informed support.

Referral pathways to enable timely access to mental health support for survivors of domestic abuse

Survivors want to see more timely access to mental health support. For this to happen in a cost-effective way, a number of changes need to take place to strengthen referral pathways for survivors of domestic abuse and reduce waiting times.

The government's Tackling Domestic Abuse Plan commits funding for upskilling of healthcare professionals to identify and refer those experiencing domestic abuse. This is an important first step, however further measures need to be taken to ensure that the health sector is working more collaboratively with the specialist domestic abuse sector to strengthen the referral pathways between GPs and other healthcare services and specialist services. The Government should consider, for example in any future strategies, such as the proposed 10-year Plan for

Mental Health and Wellbeing and as part of the implementation plan for the Women's Health Strategy:

- ▶ Delivering a consistent model of partnership between the health system and the domestic abuse sector – for example, by creating integrated care pathways and ensuring co-located domestic abuse support workers within all ICSs (Integrated Care Systems), drawing on best practice examples. For example, 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 serves the whole of the organisation.

- ▶ Implementing the recommendation in the recent APPG on Domestic Violence and Abuse inquiry report (2021) to mandate local authorities to develop 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

Domestic abuse should be treated as a public health priority in order to ensure sufficient prioritisation by the health system. It is therefore disappointing that the 2022 Women's Health Strategy does not pledge any new funding to improving access to mental health services for survivors of domestic abuse, and that it does not explicitly recognise VAWG as a fundamental driver of ill mental health. Looking ahead, it is important

that adequate investment in specialist training for healthcare professionals and partnership working between ICSs and the specialist domestic abuse sector is committed, to ensure appropriate funding to ensure effective partnership work between health services and domestic abuse services, as proposed in the recommendations above. The new Women's Health Ambassador should be mandated to routinely consult with survivor networks, such as Women's Aid's Expert by Experience network to ensure that the needs of survivors directly inform her work.

- ▶ The UK Government, for example through the proposed 10-year Plan for Mental Health and Wellbeing, should explicitly recognise VAWG as a public health priority and a key driver of women's mental ill-health. The proposed Plan should be underpinned by adequate funding to deliver on the recommendations in this report.

Resources for survivors to support development of coping strategies to be widely shared and used by professionals

Whilst not an alternative to professional support, survivors have said they would value access to resources around mental health and domestic abuse to support them in developing coping strategies.

- ▶ Women's Aid has developed a resource for survivors of domestic abuse to support them in developing coping strategies around mental health. We recommend that this tool is used by professionals and made widely available for use by survivors.

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Appendix 1: Survey Respondents

What is your age?		
Online survey, February and March 2022		
Age group	Number of respondents	% of total respondents (n=228)
16-17	2	0.9%
18-20	1	0.4%
21-25	9	3.9%
26-30	25	11.0%
31-35	23	10.1%
36-40	29	12.7%
41-45	41	18.0%
46-50	39	17.1%
51-55	32	14.0%
56-60	12	5.3%
61-65	12	5.3%
66+	2	0.9%
Prefer not to say	1	0.4%
Total	228	100.0%

How would you describe your ethnicity?

Online survey, February and March 2022

Ethnic group	Number of respondents	% of total respondents (n=228)
Asian/Asian British Bangladeshi	1	0.4%
Asian/Asian British Chinese	2	0.9%
Asian/Asian British Indian	4	1.8%
Asian/Asian British Pakistani	2	0.9%
Any other Asian/Asian British background	1	0.4%
Black/ African/ Caribbean/ Black British African	0	0.0%
Black/ African/ Caribbean/ Black British Caribbean	0	0.0%
Any other Black/ African/ Caribbean/ Black British background	0	0.0%
Mixed/Multiple ethnic groups White and Asian	3	1.3%
Mixed/Multiple ethnic groups White and Black Caribbean	3	1.3%
Any other Mixed/Multiple ethnic background	4	1.8%
White English/ Welsh/ Scottish/ Northern Irish/ British	181	79.4%
White Irish	5	2.2%
Any other White background	19	8.3%
Other ethnic group - Arab	0	0.0%
Any other ethnic group	0	0.0%
Prefer not to say	3	1.3%
Total	228	100.0%

Do you identify as trans/ transgender or have a trans history?		
Online survey, February and March 2022		
Do you identify as trans/ transgender or have a trans history?	Number of respondents	% of total respondents (n=228)
No	222	97.4%
Yes	1	0.4%
Prefer not to say	4	1.8%
Missing data	1	0.4%
Total	228	100.0%

How would you describe your sexual orientation?		
Online survey, February and March 2022		
Sexual orientation	Number of respondents	% of total respondents (n=228)
asexual	7	3.1%
bisexual	15	6.6%
heterosexual/straight	189	82.9%
homosexual/gay woman/lesbian	3	1.3%
pansexual	2	0.9%
Other	2	0.9%
Prefer not to say	10	4.4%
Total	228	100.0%

Do you have a disability or long term health issue (including mental health issues)?		
Online survey, February and March 2022		
Response	Number of respondents	% of total respondents (n=228)
Yes, I have a disability	15	6.6%
Yes, I have a disability and a long term health issue	30	13.2%
Yes, I have a long term health issue	71	31.1%
No, neither [disability nor long term health issue]	102	44.7%
Prefer not to say	10	4.4%
Total	228	100.0%

Do you have a faith or religion?		
Online survey, February and March 2022		
Faith or religion	Number of respondents	% of total respondents (n=228)
Bahai	0	0.0%
Buddhist	3	1.3%
Christian	80	35.1%
Hindu	2	0.9%
Jain	0	0.0%
Jewish	2	0.9%
Muslim	4	1.8%
No religion	106	46.5%
Shinto	0	0.0%
Sikh	0	0.0%
Zoroastrian	1	0.4%
Other	9	3.9%
Prefer not to say	18	7.9%
Missing data	3	1.3%
Total	228	100.0%

Appendix 2: Survey questions

This is a copy of the online survey that was open during February and March 2021.

Introduction

This is a Women's Aid survey for any woman who has experienced domestic abuse from a partner or ex-partner or family member, whether currently or in the past. The aim of this research is to find out more about what survivors want and value when it comes to mental health support. We won't be asking any questions about your mental health or your experiences of support, just your opinions on what you value in mental health support. This is a short survey and should only take you about 10-15 minutes to complete.

Your response

This survey response is anonymous. We won't ask for your name and we won't collect IP addresses (information related to your internet connection). This survey is not a way of getting information or support. We are unable to contact you about any issues you raise in your survey response.

If you need support, Women's Aid can help. Please go to the link below to find out more about the range of support available: <https://www.womensaid.org.uk/information-support/>

How we will use and store survey responses

What we find out from this survey will be published in a report as part of Women's Aid's Deserve To Be Heard campaign, on our web site, on social media and in media releases. We may also talk about the research findings in other Women's Aid work, including in our fundraising work. If we use any quotes from your survey responses we will make sure that we remove anything that we think may identify you, such as people's names, names of services/organisations or place names. However, please be aware that if you choose to talk about your experiences in your response it may still be possible for someone who knows you very well to identify any quotes we use from your responses.

Your response to this survey will be securely stored. Your survey response will be kept for one year after publication of the research report (in case we need to go back to your response to check anything), after which time it will be deleted.

Covering your tracks online

This survey will save your responses so you can move back and forth through the survey until you press 'DONE' at the end. Your answers may be saved on your computer (if you haven't pressed 'DONE') even after you have turned it off. If you are worried about someone seeing what you have been doing online, use a different computer, either at a local library, internet cafe, at a friend's house or at work. Please see our information on covering your tracks online: <https://www.womensaid.org.uk/cover-your-tracks-online>

*** 1. Please indicate your consent and show that your experiences are relevant to this survey by ticking all three of the following boxes. Please read each statement carefully.**

We will include your responses in our research, even if you have only answered some of the questions, as long as you have given us your consent (in this question).

- I am a female survivor of/am experiencing domestic abuse by a partner or ex-partner or by a family member
- I give my consent for the information I provide to be used in Women's Aid's research as described at the start of this survey
- I give consent for data regarding me to be securely stored as set out at the start of this survey

About you

We want to start with asking a few questions about you. The questions on this page won't be used to identify anyone in our research, they will allow us to look at the results in more depth and to make sure that our survey has reached diverse groups of survivors.

2. What is your age? (Please choose an option below)

- 16-17
- 18-20
- 21-25
- 26-30
- 31-35
- 36-40
- 41-45
- 46-50
- 51-55
- 56-60
- 61-65
- 66+
- Prefer not to say

3. How would you describe your ethnicity? (Please choose an option below)

- Asian/Asian British Bangladeshi
- Asian/Asian British Chinese
- Asian/Asian British Indian
- Asian/Asian British Pakistani
- Any other Asian/Asian British background
- Black/African/Caribbean/Black British African
- Black/African/Caribbean/Black British Caribbean

- Any other Black/African/Caribbean/BlackBritish background
- Mixed/Multiple ethnic groups White and Asian
- Mixed/Multiple ethnic groups White and Black Caribbean
- Any other Mixed/Multiple ethnic background
- White English/ Welsh/ Scottish/ Northern Irish/British
- White Irish
- White Gypsy or Irish Traveller
- Any other White background
- Other ethnic group - Arab
- Any other ethnic group
- Prefer not to say

4. Do you identify as trans/transgender or have a trans history? (Please choose an option below.)

- Yes
- No
- Prefer not to say

5. How would you describe your sexual orientation? (Please choose an option below.)

- asexual
- bisexual
- homosexual/gay woman/lesbian
- heterosexual/straight
- pansexual
- Prefer not to say
- Other (please specify)

6. Do you have a faith or religion? (Please select an option below.)

- Bahai
- Buddhist
- Christian
- Hindu
- Jain
- Jewish
- Muslim
- No religion
- Shinto
- Sikh

- Zoroastrian
- Prefer not to say
- Other (please specify)

7. Do you have a disability or long term health issue (including mental health)? (Please select an option below.)

- Yes, I have a disability
- Yes, I have a long term health issue
- Yes, I have a disability and a long term health issue
- No, neither
- Prefer not to say

What do you value in mental health support?

For the questions below, you can go into as much detail as you would like. Please give your answers in the comment boxes.

All of these questions are about mental health support related to domestic abuse.

8. Thinking about if you were to seek support around mental health related to domestic abuse, where would you want to go?

9. Thinking about the professionals who might support you around mental health, what knowledge or experience would you want them to have?

10. Thinking about the support you would like to receive around mental health, what do you think this should include?

11. Please indicate how important each of the following things would be for you personally in seeking mental health support related to domestic abuse (or pick 'Not applicable to me').

	Not at all important	Low importance	Neither important nor unimportant	Very important	Quite important	Not applicable to me
A service that understands the role that sex / gender played or plays in my experiences of domestic abuse and/ or seeking help						
A service / professionals that understand the dynamics of domestic abuse						
A service that is women-only or offers separate services to men and women						
A service where I can meet/talk to other survivors of domestic abuse						
A service that offers one-to-one support						
A service that can give me a mental health diagnosis (e.g. a formal diagnosis of depression, an anxiety disorder, Post Traumatic Stress Disorder)						
A service that addresses my safety, financial and practical support/ information needs alongside my mental health needs						
A service that also addresses the mental health needs of my children						
A service that offers long-term support (more than six months)						
A service that I don't have to wait a long time to access (wait more than a month)						
An organisation or service that is run by/led by people who share my background or identity (examples include services run specifically for LGBT+ women, Black women, Asian women, disabled women, or for women of a particular faith)						

Appendix 3: Practice survey

Meeting the mental health needs of domestic abuse survivors

Good practice examples

[Consent and contact details questions.]

Good practice examples

1. Please tell us about your good practice example in the comment box below – give any many details as you would like.

As we set out in the introduction, we are looking for information about any good practice in meeting survivors' mental health needs. This could include:

- Any partnership work with external organisations/services (for example, with NHS professionals)
- Any therapeutic interventions or projects related to mental health piloted or run by your organisation
- Descriptions of your day-to-day work in supporting survivors, and the approach you take to meeting mental health needs.

You might like to add an anonymous case study of how you have helped a survivor – if you have permission to do so from the survivor.

Please give details below.

2. Is / was the work given in your good practice example above funded?

- Yes (please give details in comment box below, including whether the funding is ongoing)
- No
- Unsure

3. Did you carry out an evaluation for the good practice example above?

- Yes (please give details in comment box below and if you are happy doing so, please send any evaluation report to us)
- No
- Unsure

Please give details of any evaluation outcomes below.

Appendix 4:

Data

How important to you?		Very important	Quite important	Neither important nor unimportant	Low importance	Not at all important	Not applicable to me	Missing data	Grand Total
A service / professionals that understand the dynamics of domestic abuse	224	2	0	0	1	1	0		228
A service that I don't have to wait a long time to access (wait more than a month)	204	20	1	1	1	0	1		228
A service that offers one-to-one support	190	31	3	1	1	1	1		228
A service that offers long-term support (more than six months)	178	41	5	2	1	0	1		228
A service that also addresses the mental health needs of my children	157	24	3	1	2	41	0		228
A service that is women-only or offers separate services to men and women	146	31	27	12	11	1	0		228
A service where I can meet/talk to other survivors of domestic abuse	123	59	26	15	5	0	0		228
A service that can give me a mental health diagnosis	123	56	23	13	8	4	1		228
A service that understands the role that sex / gender plays	111	60	31	11	2	13	0		228
An organisation or service that is run by/led by people who share my background or identity	63	48	55	18	13	30	1		228
An organisation or service that is run by/led by people who share my background or identity (Black and minoritised respondents only)	10	4	6	0	0	0	0		20

Notes:

- Survey respondents who indicated that this option was not applicable to them have been removed from the analysis, n=30.
- Full wording of survey option: An organisation or service that is run by/led by people who share my background or identity (examples include services run specifically for LGBT+ women, Black women, Asian women, disabled women, or for women of a particular faith)
- From responses to a multiple choice question (indicating how important factors are to the respondent on a five point scale). Those respondents who indicated that this questions was not applicable to them were removed from the analysis, n=30.

Are you listening? 7 Pillars for a survivor-led approach to mental health support.

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