



Domestic Abuse & Mental Health

**What Women Want Group/
Domestic Abuse & Mental Health Task & Finish
Group**

March 2014

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Summary

Aims

Liverpool Mental Health Consortium's What Women Want group set up a Task & Finish Group on Domestic Abuse & Mental Health. The group met 3 times between January & March 2014 with the aim of improving the relationship between statutory health care services & voluntary/community organisations in relation to the mental health support needs of women who are experiencing or have experienced domestic abuse; exploring opportunities & levers for change; & producing an evidence-based report & recommendations based on local women's experiences of domestic abuse & use of services.

Methods

- Reviewing relevant reports & research
- Holding 3 Task & Finish Group meetings bringing together NHS & voluntary sector service providers, service users/survivors, & other stakeholders, with discussions based on a wealth of local knowledge & experience
- Collating the voices of local women who have experienced domestic abuse by facilitating 4 focus groups, & providing a questionnaire & on-line survey, reaching 42 women in total

Findings

- Women described various forms of psychological, emotional, financial, sexual & physical control used by partners to subordinate, threaten & isolate them
- Psychological control & emotional abuse was experienced as the worst aspect of the abusive relationship, with the lasting psychological impact of that abuse being loss of identity, confidence & self-esteem, anxiety, depression, social isolation, eating problems, harmful use of alcohol & substances, self-harm & suicidal ideation

- The women had used a wide range of primary & secondary health care services with the first port of call for most women being their GP
- There were few examples of health professionals asking women if they had experienced domestic abuse; very few professionals saw their presenting symptoms, other than physical injury, as signs of abuse; & only 2 out of the 42 women we engaged with had been given information about or directly referred to a specialist domestic abuse support service.
- Inappropriate responses by health professionals are a significant barrier to disclosure, as are fears that 'mental health' issues will be used against them by the perpetrator, community & courts
- Not all organisations & agencies collect data on domestic abuse in the same way. This has implications for knowing where to target resources.
- Pre-qualifying training for health & social care professionals does not currently include adequate training on the prevalence, impact & root causes of domestic abuse, barriers to disclosure, being able to spot the signs, question sensitively & respond appropriately. Consequently, there are too many gaps for women to fall through.
- There is a rise in demand for specialist domestic abuse support services against a backdrop of public funding cuts

Section 1: Introduction

Liverpool Mental Health Consortium aims to improve mental health services in Liverpool by offering opportunities for those who have experienced mental distress to develop a collective voice about their experiences, share opinions & insights, & influence the planning, delivery & evaluation of mental health services. The Consortium's What Women Want group has been providing a platform for the views & aspirations of women service users for several years, with the membership bringing together a wide range of organisations & women service users in order to give a strategic lead on improving mental health services for women.

1.1 Aims

As a consequence of reviewing the group, The What Women Want group is holding 3 Task & Finish Groups this year, in order to focus on identified topics & increase service user & provider involvement. The first of these topics is Domestic Abuse & Mental Health, & the Task & Finish Group has met 3 times between January & March 2014. The group agreed the following aims for the work:

- To improve the relationship between statutory health care services & voluntary/community services in relation to the mental health support needs of women who are experiencing or have experienced domestic abuse.
- To explore the opportunities & levers for change
- To produce an evidence-based report & recommendations for presentation to strategic decision makers, commissioners & service providers, taking into account the views & experiences of women who have experienced domestic abuse.
- To launch the report, as a working document that will be reviewed in terms of progress, at an event during March 2014 (International Women's Month)

1.2 Method

In order to achieve the above aims, the group agreed that the work should:

- Collate evidence relating to the links between domestic abuse & mental distress
- Identify local services & sources of support
- Collate relevant local data, including equalities data
- Conduct focus groups with local service users & survivors

1.3 Definitions

The group recognises that:

‘Violence against Women is a human rights violation that prevents women from fully participating in public life & is a major impediment to equality between men & women.

Violence against Women is also an equalities issue. It is prevalent, systemic & rooted in longstanding inequality between men & women

Violence against Women affects women of every age, socio-economic class, ethnicity, sexuality, religion or belief & ability

Apart from the physical, emotional & psychological trauma sustained by women experiencing violence, there is also a substantial cost to society as a whole.’

(Crown Prosecution Service, 2008)

Domestic abuse sits within the wider framework of violence against women & girls. Violence against women is one of the main causes & consequences of gender inequality, & represents a violation of women’s & girl’s fundamental human rights. The United Nations Declaration on the Elimination of Violence against Women, accordingly, uses a gender-based definition: ‘Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life’ (UN, 1996)

The UK government's recently updated definition of domestic violence & abuse now states: 'Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality. This can encompass but is not limited to psychological, physical, sexual, financial, & emotional abuse. Controlling behaviour is defined as a range of acts designed to make a person subordinate &/or dependent by isolating them from sources of support, exploiting their resources & capacities for personal gain, depriving them of the means needed for independence, resistance & escape, & regulating their everyday behaviour. Coercive behaviour is defined as an act or a pattern of acts of assault, threats, humiliation & intimidation or other abuse that is used to harm, punish, or frighten their victim'. This definition, which is not a legal definition, includes so called 'honour'- based violence, female genital mutilation (FGM), & forced marriage, & is clear that victims are not confined to one gender or ethnic group (Home Office, 2012).

Whilst the government's definition is gender-neutral, it could be seen as misleading in that domestic abuse is systematic, purposeful & patterned behaviour designed to exert power & control over another person & it is most commonly experienced by women & perpetrated by men (Refuge 2007, Home Office 2010). Likewise, women are far more likely to be victims of forced marriage. A recent report by Eaves showed that 82-86% of victims are female, & that women are more likely than men to suffer harms related to loss of autonomy & education, forced sex, physical violence & related mental health issues (Eaves, 2013). Although a number of myths exist about domestic abuse, such as it being caused by alcohol, drugs, mental distress, unemployment or stress, it is, in fact, a gendered issue & has its roots in unequal power relations between men & women (Refuge 2007).

Section 2: Background

2.1 Prevalence

Domestic abuse & violence is an international public health problem, affecting the lives of hundreds of thousands of people every year. Globally, prevalence estimates of lifetime experiences of physical or sexual partner violence among women range from 15% - 71%, with 2012 estimates ranging from 4% - 54% (McClennon, 2005). In the UK, the Home Office reports that, in 2012, at least 1.2 million women suffered domestic abuse, over 400,000 women were sexually assaulted, 70,000 women were raped & thousands more were stalked (Home Office, 2013). Almost one third of women & 17% of men in England & Wales have experienced it at some point in their lives. Both men & women can perpetrate & experience domestic violence & abuse, & both genders are likely to require specifically tailored support & access to services. However, it is most often inflicted on women by men. This is particularly true for severe & repeated violence, & sexual assault (Smith et al. 2012).

Partner abuse is the most prevalent form of abuse, with at least 26.6% of women having experienced this since they were 16 (Smith et al. 2012). Partner violence is also prevalent in young people's relationships, with 72% of girls in the UK aged 13-16 reporting emotional violence, 31% reporting sexual violence, & 25% reporting physical violence (Meltzer et al. 2009). In England, 1.6% (over 250,000) of people aged 66 years & over reported experiencing abuse (psychological, physical, sexual & financial) in the past year from a family member, close friend or care worker (O'Keefe et al. 2007).

Lesbian & bisexual women experience domestic abuse at a similar rate to women in general (1 in 4). Two thirds of this abuse is perpetrated by women on women (Hunt & Fish, 2008), & this raises particular issues for health services targeted at women. The majority of transgender people (80%) experience emotional, physical or sexual abuse from a partner or ex-partner (Roch et al. 2010). The prevalence of 'honour'-based violence & forced marriage are difficult to estimate. Both often involve wider family members. It is estimated that between 5,000 & 8,000 cases of forced marriage were reported to local & national organisations in England in 2008 (Kazmirski et al. 2009).

2.2 Domestic Abuse & Mental Health

Since 2003, the Department of Health has acknowledged that women's experiences of domestic violence & other forms of abuse are linked to long-term mental, physical & sexual health problems (Department of Health, 2003 & 2006). In 2007, the cross-government sexual violence action plan recognised that the impact of recent & historic sexual abuse includes anxiety & panic attacks, depression, problematic substance use, eating disorders, post-traumatic stress, self-harm & suicide (HM Government, 2007). Women who experience domestic violence have twice the level of usage of general medical services & between 3 - 8 times the levels of usage of mental health services. The figures for women from Black, Asian, Minority Ethnic & Refugee communities are even higher e.g. half of women of Asian origin who have attempted suicide or self-harm are domestic violence survivors & British Asian women are 3 times more likely than the national average to commit suicide (Chantler et al. 2001).

Prolonged exposure to threatening life events, including domestic abuse, is associated with the onset, duration & recurrence of mental health issues. Research has consistently found evidence that women with all types of mental health problems report a high prevalence & increased odds of abuse compared to people without such issues (Trevillion et al. 2012). According to research by Oram, between 25%-56% of female psychiatric patients report experiencing domestic abuse in their lifetime (Oram, 2013). The 2013 Women's Aid survey found that the number of women staying in refuge accommodation affected by mental health issues was 47%, an increase of over 10% since 2012 (Women's Aid, 2013).

However, the last decade has also seen a significant growth in the understanding of survivors' mental health problems as being a 'symptom of abuse' (Humphreys & Thiara, 2003). Female survivors of domestic violence experience markedly higher levels of depression, anxiety, eating disorders, self-harming & suicidal ideation (Campbell 2002, Dutton et al 2005, Howard et al. 2010a). Research carried out by Southall Black Sisters found that most of the women using their service had contemplated suicide at least once in their lives, many attempted suicide & self-harm, & some had committed suicide. Over 30 years, 18 cases of suicide or death due to unknown causes were dealt with. The report concluded that in virtually all

cases, domestic abuse had been the causal or contributory factor, rather than any diagnosed pre-existing psychiatric illness (Siddiqui & Patel, 2010).

2.3 Women's Experience of Services

In Sept 2009, the Department of Health commissioned the Women's National Commission to organise & facilitate 14 focus groups across England with women survivors of domestic abuse who had recently used health services. Focus groups were held between September & November 2009 with 211 women participating. Women raised common issues, with many talking of GP receptionists acting like 'gatekeepers' by preventing them from registering with GPs, not giving them appointments, not providing access to appropriate interpreters, & by requiring women to say why they needed the appointment in public areas. Women felt that health professionals taking time to identify the root cause of their symptoms would have had a longer-lasting effect, obviate the need for medication, & avoid situations where abuse could continue. In contrast, the women consulted unanimously spoke highly of women-only services, often in the third-sector, & of the life-saving, preventative & unique support they had received from these organisations (Women's National Commission, 2010). This reflected earlier research that found the following interventions to be helpful: helping women name domestic violence, actively asking about the abuse, safety planning, responding to specialist needs, support for children, & actively working with women to recover from abuse experiences (Humphreys & Thiara, 2003).

Practice-based evidence collated by the Stella Project Mental Health Initiative suggests that neither the links between experiences of abuse & service users' current mental health problems nor the risks of further abuse are routinely assessed within mental health services in England. Of the 56 mental health trusts in England, only 5 trusts had a domestic violence strategy. In all trusts, domestic violence was viewed first & foremost as a safeguarding issue. 7 trusts had a standalone Policy, & 15 covered the issue in safeguarding policies. Little guidance was provided about routine enquiry (30% of trust policies) & guidance provided was often generic advice. Only 3 trusts referred explicitly to supporting survivors to recover from their

experiences (Holly & Scalabrino, 2012). It is worth noting that Mersey Care has a stand-alone policy on Domestic Abuse.

This research is backed up by a meta-analysis carried out in 2012 showing that approximately one third of women who use mental health services have experienced domestic violence, yet mental health professionals are unaware of the majority of these experiences. 'Our research showed that mental health professionals often don't discuss violence with service users', said Louise Howard, one of the authors. 'We found that staff are often reluctant to ask because they lack expertise & lack confidence. If people do tell them they are the victims of violence at home, professionals are not sure what to do with that information. Professionals identify less than 30% of service users' experiences' (Trevillion et al. 2012).

Experiences of mental health services are often found to be negative. Research by Humphreys & Thiara - 'I call it symptoms of abuse' - found a number of practices within the medical model of mental health to be unhelpful, including: 'the lack of recognition of trauma or provision of trauma services; making the abuser invisible through focusing on the women's mental health reified from her experiences of abuse; blaming the victim; offering medication rather than counselling & support; & consequent effects on child contact child protection proceedings if the woman is labelled with mental health problems' (Humphreys & Thiara, 2003)

More recent research looking specifically at the barriers & facilitators of disclosure, found that fear was found to be an important theme for service users/survivors, encompassing fear of social services involvement & consequent child protection proceedings, that they will not be believed, that it will result in further violence, disruption to family life, & consequences for immigration status. Other barriers to disclosure were the hidden nature of the violence, actions of the perpetrator & feelings of shame. The main themes for professionals concerned role boundaries, competency & confidence. Service users & professionals both reported that the medical diagnostic & treatment model, with its emphasis on symptoms, could act as a barrier to enquiry & disclosure. One professional made the point that professionals were used to asking people whether they had ever been violent or had a propensity

to violence as this is a routine part of a mental health risk assessment, but felt that professionals were less comfortable enquiring whether a client had been the victim of violence. The emphasis on the risk of violence by people with mental health problems, rather than on their (higher) risk of experiencing violence appears to be related to stigma (Rose, 2010).

Domestic abuse does not discriminate & happens in all groups & sections of society. It can happen to anyone regardless of race, gender, disability, age, culture, mental health, religion, socio-economic level, or sexual orientation. All of these may have an additional impact on the way domestic abuse is experienced, dealt with & responded to. Many Black, Asian, Minority Ethnic & Refugee (BAMER) women are unable to access language or culturally appropriate services within a context that recognises & addresses their specific needs around social identity, discrimination & inequality. BAMER women are likely to stay in abusive situations for longer before seeking help, are more likely to experience abuse from multiple perpetrators, are more prone to ongoing violence from extended family members & pressure from the wider community after they leave an abusive situation, & often experience higher levels of isolation & marginalisation. Women with insecure immigration status or no recourse to public funds will also experience additional barriers to seeking help. They are often coerced into remaining in an abusive relationship or face destitution. Disabled women are at higher risk of sexual violence, are less likely to escape & more likely to be isolated. Physical barriers, racism or homophobia are further examples of discrimination that make it even more difficult for women to seek help & support (IRIS 2012, Siddiqui & Patel 2010, Moglione & Qassim 2012)

The Safe & Sane report highlighted the work of the Domestic Violence & Mental Health Project at Southall Black Sisters as preventing medicalization or over-medication of BAMER women by recognising & eradicating or reducing the social causes, namely domestic violence & abuse, of mental illness. The report suggests that policies focusing on multicultural, social cohesion & multi-faith issues, combined with institutionalised racism, have prevented effective action against violence against BAMER women or treatment of their mental health problems: 'women continue to remain invisible because of their position at the intersection between race & gender

where health & social care initiatives do not meet their multiple & overlapping needs, resulting in systemic failures' (Siddiqui & Patel, 2010)

2.4 The Effect of Public Sector Funding Cuts

The national campaigning coalition, End Violence against Women, published a report in 2007 (Coy, 2007) documenting uneven distribution of support service for women experiencing domestic abuse, with a third of local authorities providing no services at all. The second Map of Gaps report in 2009 highlighted that 1 in 4 local authorities had no specialised support services at all, with just 1 in 10 having a specialised service for ethnic minority women (Coy, 2009). Of the new services opened in 2008, 60% were in the statutory sector (such as SARC & Specialist Domestic Violence Courts), responding to incidents reported to the criminal justice system, & thus only dealing with a tiny fraction of the problem. Levels of provision in the voluntary sector have remained static or in some cases diminished. The funding crisis faced by local women's services means not only that current gaps are unlikely to be filled, but also that there will be a significant decline in services to respond to women's needs (Home Office, 2013).

In February 2012, a report by Prof. Sylvia Walby (UNESCO Chair in Gender Research) & Jude Towers (Lancaster Uni.) looked at the impact of current public expenditure cuts on specialist services for women who have been victims of violence. Its key findings were that substantial reductions in national budgets are leading to cuts in local services that prevent & protect against gender-based violence. This is expected to lead to increases in this violence. 31% of the funding to the domestic abuse & sexual abuse sector was cut between 2010/11 - 2011/12, from £7.8 million to £5.4 million. Organisations with smaller budgets from local authorities had more substantial funding cuts than larger ones, & statutory provision has also been cut (Towers & Walby, 2012).

Reports from Women's Aid underline these concerns. The Women's Aid annual survey found that, on the census day (27 June 2013), 155 women with 103 children were turned away from the first refuge they approached by responding organisations. In their report, A Growing Crisis in Unmet Need, Women's Aid highlight that time-limited, high-risk targeted support has come at the cost of

specialist refuge provision, longer-term community-based support, resettlement & family support services. In addition to the type of service provided, cutbacks have also altered who provides the service; there has been a distinct move away from commissioning specialist gender- & black & minority ethnic-specific domestic violence providers, towards buying (immediately) cheaper generic services from non-specialist housing associations & generic charities (Women's Aid, 2013).

A recent Court of Appeal case has also highlighted the effects of the 'benefit cap'. Both families in the appeal had fled violent marriages with their children, living in overcrowded privately rented accommodation as they had not been able to obtain council housing. Because of this, they found themselves caught by the £500 per week benefit cap. The Court of Appeal held that the government's flagship 'benefit cap' policy discriminates against women, but that the discrimination is justified because it 'reflects the political judgment of the Government'. The Court of Appeal also described as 'a matter of some concern' the Government's delay in addressing recognised problems with the benefit cap's application to many women's refuges (HMB Solicitors, 2014).

Locally, research carried out in 2013 on public sector funding cuts as a gender equality issue found that spending cuts to domestic abuse services are occurring at the same time as an increase in demand for those services & reports from Merseyside police indicating a rise in domestic-related violent crime & homicide. Concerns were raised about cuts to the IDVA service, lack of funding for one-to-one counselling, a reduction in the number of services able to offer the Freedom Programme (despite this often being a compulsory aspect of a Child Protection Plan), inadequate resourcing of independent Rape Crisis Centres, lack of funding to carry out vital preventative & awareness-raising work, & short-term contracts impeding long-term planning (An excellent detailed analysis can be found at www.ljmu.ac.uk/HSS/HSS.../Women_at_the_Cutting_Edge_2013.pdf (James/Patiniotis, 2013).

Section 3: Findings from LMHC's Task & Finish Group

3.1 Task & Finish Group

The group brought together NHS & voluntary sector service providers, service users/survivors, & other stakeholders (See App. 1). Discussions within the group, based on a wealth of local knowledge & experience, raised the following issues:

- Experience would suggest that even if women have visited their GP surgery multiple times, the issue of domestic abuse is often missed by GPs. If GPs were to ask the question directly, research suggests that many women would disclose. If disclosure is made, the response to that is crucial.
- Within secondary mental health care, the Care Programme Approach does not specify 'domestic abuse', instead talking about 'abuse & vulnerability'. Professionals often find ways not to ask sensitive questions, so the issue is how to support people to engage in the discussion. Within Mersey Care Trust, there is currently a lack of clarity around who asks the question about domestic abuse & at what point.
- Domestic abuse awareness training within Mersey Care is offered to nurses & psychologists, but not to doctors. University nursing courses do not specifically include issues surrounding domestic abuse within the curriculum. No profession currently receives adequate training &, consequently, there are too many gaps for women to fall through.
- In cases where women are referred for psychological therapies or counselling, the issue of domestic abuse is not always raised by the therapist
- Local specialist organisations have found it more difficult to engage with LGBT communities. Stigma is a factor here, as there is a perception of violence only being perpetrated by males on women.
- The local women's sector has the expertise needed in this area & any learning needs to come from here, but there is a lack of capacity within the sector
- Not all organisations & agencies collect data on domestic abuse in the same way. Further to this, postcode information used to be routinely asked for by Liverpool City Council whereas this is no longer the case - this has

implications for knowing where to target resources. The IAPT service has nowhere to record disclosure of domestic abuse.

- 30-39% of women using local specialist domestic abuse services go on to access counselling, though it is not necessarily seen by women as a 'mental health' issue. There is some stigma attached to the term 'mental health'. Even within secondary care mental health services, it is not always seen by women or practitioners as contributing to mental health needs.
- It is often the case that having 'mental health' needs can be used against women in legal/court proceedings as 'mental instability'. This can leave women in the position of being blamed for being abused, blamed for any consequent mental health issues & blamed for any impact on their children. This leaves women reluctant to seek 'mental health' support.
- There is a rise in demand for specialist domestic abuse services at the same time as a reduction in public funding
- There are issues concerning the provision of appropriately trained interpreters from BAMER communities
- There are particular issues for asylum seeking & refugee women around fears of being sent back to their country of origin, not wanting to alert the authorities, not knowing the language (particularly for those women on spouse visas), lack of knowledge regarding free health services, cuts to legal aid funding, & having no recourse to public funds. Support for asylum seekers & refugees is typically all in one place & this can present particular problems for LGBT asylum seekers & refugees who fear the stigma of being 'out' within their community, but can also feel excluded from the mainstream LGBT community due to prejudice.

Discussions by the group led to a series of actions, as listed below:

Actions by the Group

- Review of relevant research/reports
- Facilitated focus groups with women survivors
- Set up on-line survey for wider dissemination
- Issue of collecting postcode data referred to Liverpool City Council analytical team
- Issue of who asks the question about domestic abuse & at what point taken to Mersey Care Women's Project Group
- Issue of therapists asking the question about domestic abuse taken to Step 3 practitioners within Inclusion Matters Liverpool
- Colleagues from Inclusion Matters Liverpool & specialist organisations meeting to discuss pathways between services
- Issue of women's negative experience of family courts taken to Merseyside Criminal Justice Board sub-group & discussed at the Courts sub-group

3.2 Findings from Focus Groups & Questionnaire

Four focus groups with women survivors of domestic abuse were arranged in February 2014 with 22 women participating in total. Two focus groups took place with women using a specialist women-only domestic abuse support organisation (Liverpool Domestic Abuse Service, South Liverpool Domestic Abuse Service), with 5 participants per focus group, facilitated by a member of Liverpool Women's Network. Two focus groups took place within Women's Turnaround with women attending the Freedom Programme & a workshop on emotions, with 4 women in one group & 8 in the other, facilitated by staff from the project. The women were from a range of backgrounds, ages & ethnicities.

The focus groups were facilitated following ethical principles of research relating to keeping women safe & of not causing further harm to women who have been damaged or abused. This included informing the women about the purpose of the

focus groups, stressing confidentiality in terms of what is said in the room & the storage & sharing of data, the right of participants to not answer questions & to be able to leave the room at any time, having support available should women become distressed, & gaining permission before taping the conversation. All 4 focus groups used the same set of questions (see App. 4), but the 2 focus groups within Women's Turnaround used a structured approach to elicit responses, whilst the 2 focus groups within the specialist domestic abuse support services were less structured, allowing in-depth exploration of both the scale & impact of domestic abuse & women's experiences of using mental health services. Both ways of working provided valuable information on women's experiences but, due to the different methods used, any quotes used are from the focus groups held in specialist domestic abuse support services.

In addition to the focus groups, this section draws upon feedback from a paper questionnaire that was distributed amongst women unable to attend a group; 6 women chose to respond via questionnaire. The voices of the women in the focus groups & questionnaires are at the heart of this section, & the following themes are those that emerged from women's views & experiences.

The Psychological Impact of Coercive Control

'One of the impacts of living with domestic violence, & especially coercive control, is that women & children adapt their behaviour in an effort to prevent further outbursts: they ... live within the parameters the perpetrator sets' (Westmarland et al. 2010)

All 22 women in the focus groups said their mental health had been significantly affected by domestic abuse. The direct, causal connection between the abuse they had experienced & their symptoms of mental distress was a strong, recurring theme throughout the discussions, with women speaking about loss of identity, confidence & self-esteem, self-doubt, anxiety, depression, social isolation, suppressed emotions, eating problems, harmful use of alcohol & drugs, self-harm & suicidal

ideation. The women referred to many incidents of physical assault; however, they were clear in defining abuse as being about more than physical violence. They spoke about various forms of psychological, emotional, financial, sexual & physical control that male partners had used in order to subordinate, threaten, isolate & terrorise them. In all focus groups, every woman felt that psychological control & emotional abuse was the worst aspect of the abusive relationship. Men's control was systematic & purposeful & ranged from not letting women see their friends & family; not letting them go out; not allowing them to see their GP; keeping women under constant surveillance, e.g. calling women's mobiles constantly to check where they were; not allowing her to wear make up for work; asking her where she was going every time she attempted to leave the house; making her eat so she put on weight ('a feeder' in Freedom Programme terms); taking all bank & credit cards away. A common tactic used by perpetrators was telling women they were bad or unfit mothers, constantly calling women 'mad' & that he would make sure her children were taken away (by him or by social services); telling her that she was stupid, a slag, worthless; calling her thick, a 'pleb'; telling her everything she did was wrong.

'I wasn't allowed to go anywhere. Even if I wanted to go to see the doctor, my husband insisted on coming with me. I couldn't go to the shops on my own. I lost contact with my family for 11 years, he isolated me from my family. I had to lie to him to get to the doctors.'

'I think people still determine domestic abuse to be 'your eye's not black; your lip's not split; how bad is it really?' ... But I think the mental aspect of it is much more long-lasting & more crippling. I should never say this, but I will: I will take a punch any day than mental cruelty. And I have had both.'

'He tried to isolate me from my family. I was able to cling on to a little bit of control myself & I moved back to where my family was nearby.'

'You feel so alone. He takes away your friends, he takes away your family. You are on your own. You want to cry for help. You have got nowhere to go.'

'You are sick of telling your family. Sometimes you can have your family, but you are still alone ... Because families don't always understand. They are like, well leave him. But I have got nowhere to go. I have to think of my children. I have got no money; got nothing.'

'I think if you ask any abused woman, they would say, I would rather take a hit than suffer that'

'Because I was not getting a smack every day, it was hard for me to understand that I was in an abusive relationship. But I was in a violent relationship, it was like torture.'

'My husband wanted to be with me when I visited friends. He was controlling every area of my life. He even came into the bathroom when I was on the toilet & objected when I used the lock...It was very gradual though, & I didn't realise he was treating me negatively until it was too late.'

Most of the women said their abusive partners or ex-partners had frequently told them that they were mad, & that the abuse was either a product of the woman's imagination or else her fault. Being told repeatedly that they were mad &, in many cases, that they were unfit to look after their children, caused the women to believe what the abuser was telling them. Isolation from support networks, combined with a fear they were 'going mad' & risked losing their children, prevented women from being able to talk about domestic abuse to friends, family or health professionals.

'You start to think it's normal. That was the worst for me. I thought it was normal.'

'It's what it makes you feel about yourself. You get told so many times that you are not good enough, you're ugly, you're fat, no-one will ever want you - you start believing it. You get brainwashed into believing his beliefs.'

'He told me all the time that I was going mad. All the time. And you start to believe it'

'He told me I was bipolar, that was his one.'

'When you get told day in, day out that you've got postnatal depression & you are losing your mind, & you are getting tablets thrown at you, you tend to start believing it. And when the perpetrator is on you saying 'I'll get your kids taken off you', you've got no chance of speaking up because you are too scared.'

All of the women said that the constant undermining, threats & punishment had led them to believe the abuse was their own fault. The long-term psychological impact of coercive control continues to blight some women's daily lives:

'I blamed myself. For a long time. Still do to some extent.'

'I get frightened, & I would love to have an element of peace of mind. ... I would love to wake up one morning & say 'I am not going to check my car tyres today'. I check my car tyres & my house for graffiti every morning before I wake the children up. That's a habitual thing I do every day for 4 & a half years now. Because car tyres are slashed, windows are smashed, graffiti is painted across the front of the house. Car has been burned out. That has been a pattern of abuse for me, & I have to check every morning. I have done that this morning.'

Research shows that women are most often the victims of coercive control within a heterosexual relationship, with many abused women being the victims of violent assault, more likely to be injured, exhibit symptoms of Post-Traumatic Stress Disorder, use pain killers & tranquillisers, & have to take time off work (Johnson & Leone, 2005). In relationships characterised by coercive control, victims are likely to feel intense fear, helplessness & loss of control - 'They may have to face the threat of their own annihilation' (Women & Girls Network).

'I rang the police because I thought my life was in danger. He was swinging a hammer at me. I rang the police, they were there rapidly, & I was outside. They asked me what's gone on, & I told them, & then they went in & were speaking to him. But then they come outside & it's your word against his - 'There's nothing we can do about it'. And I am shaken up, having nightmares, flashbacks. I could have been dead.'

Self-Harm & Suicide

Every year, 500 recent victims of domestic abuse commit suicide
(Jarvinen et. al, 2006)

More than half of the women spoke of self-harm & attempting to take their own lives, as a direct consequence of domestic abuse.

'It was about 1 o'clock in the morning, I had no one to turn to, & nowhere to go. Because of domestic abuse. I drove to a garage & bought alcohol, & I had anti-depressants & paracetamol, & I tried to take my own life. And that was because of domestic abuse.'

'I sat in a car that day & wrote goodbyes to a number of people, knowing I couldn't do it anymore.'

The 'shame' of domestic abuse, & the inculcated belief that they were worthless, mad, & at risk of losing their children stopped women from talking to their doctor about suicidal thoughts. It was only when women reached crisis that they came to the attention of mental health professionals.

'I never told my GP I felt suicidal, although I have. I have never disclosed that to any health professionals. For the same reason I didn't want to take anti-depressants. I feel like I am putting myself in a vulnerable position by not telling anyone, but I feel like I am putting myself in a vulnerable situation if I do tell someone, because I am on my own with my daughter. Now if I am going there saying I feel suicidal, I don't know where that leaves me in terms of being a primary carer.'

'I went to my doctor, but I didn't go willingly - my mum took me. And he put me on antidepressants, which I'm still on. I was at a point when I thought, 'what's the point? Would anyone even miss me?' And it's because of the things he'd told me; how he made me feel about myself. I've got 3 kids, but it was like they would be better off without me. But I felt shame - that I had to take antidepressants; that I was not strong enough to cope. But at the same time, I felt that they would take my kids off me if I told them I was depressed.'

Abusers' threats to take children away from the women became reality for 2 women. In one case a daughter had chosen to reside with her father after he had told her that her mother was 'unfit'. Another woman had her mental health difficulties used against her in child contact proceedings. This woman also lost contact with her

family, friends & community, & has had thoughts about ending her life, perhaps due to additional cultural pressures faced by women from some BAMER communities.

'I've got friends but I have lost some friends as well. I stopped seeing 2 of my friends because they did not understand why I was the way I was, I couldn't tell them what was happening. ... In my culture you can't speak about [domestic abuse] they always blame woman. It doesn't matter, men, whatever they do. They always blame woman. ... Now, I don't socialise with any of my community. I don't even go to my supermarket, which is by my community. I go to one which is too far...'

Research indicates that Asian women have a disproportionate rate of suicide & self-harm compared to other women in the UK population, both of which are linked to abuse & violence within the family (Women's National Commission, 2010; Southall Black Sisters, 2010).

The Range of Mental Health Services which Women have used

Most of the women who participated in the focus groups had visited their GP about mental health issues directly relating to domestic abuse. All 6 women who completed questionnaires had likewise been to see a GP. 4 women had been referred to a psychiatrist because of mental distress caused by domestic abuse. 6 people had received support from a Crisis Team. 2 women were currently being supported by a Community Psychiatric Nurse. 7 women spoke about being referred to a mental health sector counselling service (as opposed to receiving counselling from a specialist domestic abuse service). 4 women had been hospitalized; 1 of whom had subsequently attended a mental health day hospital.

Health Professionals asking Women about Domestic Abuse

For most of the women, GPs were the first port of call when seeking help with mental distress. There were very few examples of GPs & other mental health practitioners asking women about domestic abuse; 1 GP was reported to be 'very good', & supported a woman by challenging social workers who were suggesting she could not cope with her children & should be put on anti-depressants. A minority of GPs did ask about domestic abuse, as did the Crisis Team in 3 out of 6 cases. In support

ranging over several years, 2 out of the 4 psychiatrists did not once ask about domestic abuse, even though information about domestic abuse was in the women's case notes. Only 4 women were able to initiate a conversation about experiencing domestic abuse with their GP. A minority of GPs were experienced as being helpful in terms of listening & understanding about domestic abuse. In general though, GPs, even when made aware of domestic abuse, did not offer support other than medication.

'I have been to the doctors a number of times & said I am feeling depressed & down. But I have never told them why. And they've just gone, do this, do that, & come back & see me. But I was never able to say what was happening until I done the Freedom Programme, & I felt confident about knowing I was being abused that I could tell them. But they never asked me the question. I told them.'

'I think realising that you have got something wrong & admitting it to yourself, & going to the doctors, is massive. Just getting through the door.'

Mental Health Services Responses to Women who are Experiencing or have Experienced Domestic Abuse

'The GPs' response to women & children who can be isolated & fearful as a result of their experiences is critical to their future wellbeing. The initial reaction of the person they tell & the follow up within & beyond the NHS can have a profound effect on their ability to re-establish their life, health & wellbeing' (Howell & Johnson 2011)

A significant finding from the focus groups & questionnaire is that unless a woman exhibits signs of physical injury, very few GPs or other health professionals see presenting symptoms as signs of domestic abuse. Most women felt that GPs & mental health professionals did not listen to them or understand the links between domestic abuse & mental distress. All the women wanted those professionals to

have a better understanding of the power dynamics of domestic abuse so that they can respond more appropriately to women seeking help. This requires all mental health practitioners to be able to identify & understand the psychological impact of coercive control, & to offer support that helps women leave abusive situations rather than providing treatment aimed at controlling symptoms:

'Most (MH professionals) think that domestic abuse is domestic violence. It's about having a smack. But it's not just that. It's the mental abuse. It does knock your confidence, it knocks your self-esteem, it's affected my appearance ... 16, 17 years of abuse has had a huge impact on me. Being controlled with his text messages, phone calls, checking up on me all the time. I don't trust anymore. I have barriers up all the time to stop me getting hurt again.'

'When I was going through it - I went through it for 7 years from my ex-husband - ... I kept things to myself. But when I fell pregnant with my eldest boy, obviously I sorted out a GP. I was downtrodden & was crying a lot, & they put it down to depression. But after the baby was born, they put it down to postnatal depression because of the symptoms I was having. But I was just depressed within that relationship. But if I had a GP who I felt comfortable with & who had helped me along the way, & who knew the signs, I could open up & say I am in a violent relationship ... But because some doctors have this stern manner about them ... you don't have the confidence to say anything to them.'

'They offered me counselling & I used to get more upset after so I stopped. It was not very helpful for me.'

The client felt that they [secondary mental health] seemed more worried about suicide than ongoing care.

'I have found that often it is quicker & easier for those in the mental health profession to give tablets & not look very deep into the causes. I have had most help from (domestic abuse support service)'

'People in institutions that are there to support the public, need to come up to scratch about domestic abuse, & forget about domestic violence. Start to think about domestic abuse as a whole. I felt he couldn't write that because I hadn't gone in with a black eye. But that takes away from us

women, people who have been abused - you are trying to tell yourself 'I have been abused' but that can knock you right back. You start to think, have I really been abused or am I overreacting?'

Some GPs & 1 crisis team practitioner responded to a disclosure of domestic abuse in a way that was felt by women to be supportive & helpful:

'Because she knows me, she has known me since I was a baby. She is my family doctor. I felt I could talk to her & she understood. But I don't think I would have had the confidence if I hadn't done the Freedom Programme¹. The Freedom Programme helped me realise what I was going through. I was actually doing the course as he was doing things to me, so I was trying to be one step ahead of him. He kept breaking me down constantly - that's where he wanted me.'

'I have got another GP now who is fantastic, & he knows what I have been through because of referrals to agencies. But I had to move out of area to get this GP.'

Health Professionals Ignoring, Negating, Minimising or Not Understanding Domestic Abuse

In some cases, health professionals minimized or played down the impact of abuse. Two psychiatrists ignored information about domestic abuse in a woman's case notes. One GP refused to help a woman who had attempted suicide as a way of escape from domestic abuse, telling her she was wasting his time. The inadequate response of another GP caused one woman to identify a wider societal tendency to minimise the scale & overlook the structural causes of domestic abuse regarding gender-based power & control, with a (usually male) perpetrator & a (usually female) victim. Two women who had accessed the Crisis Team spoke about the abuse they

¹ The Freedom Programme is a 12 week rolling course which gives women an understanding of the beliefs & attitudes held by abusive men & the methods these men use to control women & children. It aims to give women the self-esteem & confidence to improve the quality of their & their children's lives. The course is most beneficial when delivered by specialist domestic abuse support services, alongside a range of other support that is specifically designed to empower & aid women to live safe, autonomous lives.

were going through, but felt that the information did not go anywhere, they were not signposted to services & did not receive follow-up after disclosure. One woman stated that she had been asked the question by an Inclusion Matters practitioner but that it was not then addressed during the therapy. For women survivors of domestic abuse, lack of understanding, or having the abuse ignored or minimized, by professionals in whom they place their trust, adds to their experiences of not being believed, compounds feelings of not being listened to & exacerbates stress, anxiety & despair.

'A couple of weeks ago I asked my GP to write a letter for me, for legal aid purposes. He had to follow a template, which clearly said what needed to be said about the domestic abuse. But he could not write domestic abuse in the letter. He wrote down 'relationship problems'. And I had to go back to him again, & say my solicitors said he had to write exactly what had happened. Domestic abuse. And I was quite angry about it, because it seems to me there are a lot of men out there in institutions who are not acknowledging the wide scope of domestic abuse. I do not have 'relationship problems'. I am not in a relationship. It was domestic abuse.'

'It's very important that people understand what domestic abuse is; what forms it can come in. 'Relationship problem' indicates that it is something happening between 2 people who are equally at fault, rather than that there is a perpetrator & a victim.'

'I think a lot of them (doctors) have an old-school attitude. It's 'get on with it, take it on the chin, here's your tablets'.'

'I went to my GP, & I had had a bad week, & I was feeling really down. And she made a comment: 'you are on your tablets now, & you are not with him anymore, so why are you still feeling like this?' I said well, it's still inside my mind. She said 'well you need to get out more & keep yourself busy. Stop thinking about it'. As if it's that easy.'

'The psychiatrist had all my notes, but every time I went to see him I had to tell him again... They are just not on the same level as us sitting here. He would say things to me like 'you just need to go back to work & carry on as normal'. He put me on medication [since 2009], but I haven't seen the same psychiatrist each time.'

'When I told my GP that I was in an abusive relationship & tried to take my own life, he said 'oh you need to go to hospital'. And rang the crisis team & he put me on loud speaker & he made me feel so little, while he asked the crisis team why I had come to see him. And he put the phone down & he said 'don't waste my time coming her for a note'. [Crisis Team subsequently made a complaint against GP on this patient's behalf]

What Stops Women Disclosing Domestic Abuse to Mental Health Professionals?

The above section clearly shows that inappropriate, ill-informed & unsympathetic responses are a significant barrier that deters women from disclosing abuse to a mental health professional. The other reasons that women cited were:

- Feelings of shame & self-blame
- Worried they would not be believed or taken seriously
- Worries about confidentiality
- Fear that the perpetrator might find out & the situation would get worse
- Fear that their children will be taken away by the perpetrator
- Fear that having domestic abuse on record will result in their children being taken into care or could be used against them in child contact hearings
- Worried about the health professional's reaction to what has happened to them (that they will be judged)
- Having to access services through a GP
- 'Mental health' issues being used against them by perpetrator, community & courts

'Yes, my GP asked me but I was scared to ask for help because I was not aware of confidentiality, I was scared if I told my GP they will let me husband know.'

'I felt shame - that I had to take antidepressants; that I was not strong enough to cope. But at the same time, I felt that they would take my kids off me if I told them I was depressed.'

'Getting up the courage ... you have this mind-set that no-one's going to believe you'.

'I think if you were to say to your partner that I am not feeling right, it's, 'you go to the doctors, & you won't have these kids again. You go to the doctors, & I will use it against you'. So rather than realising that going to your GP for help is a positive & proactive thing, you feel like you can't risk going through the door, you'll be seen to be crazy or unfit. And that is a conflict.'

'The doctor I am with now has sent me a questionnaire of mood. I find it frightening because I don't want to admit to anything on paper. But I will quite happily walk in here [domestic abuse support organisation] & talk to anyone in this room. But I won't put anything on paper because it will come back & haunt me, & I can't afford for it to turn up in family court, or for the school to get hold of it.'

The stigma of having a mental health 'problem' was another factor that prevented women from seeking support. The reluctance to acknowledge that they were struggling with their mental health was linked both to wider social stigma, & to fear that what the perpetrator was telling them about their being 'mad' was right.

'So not only are you thick, worthless, stupid, a slag, you are now getting the extra label, of mental health problems.'

'When I hear the words 'mental health' I automatically think of bi-polar. It's scary, & you don't want that label.'

'He has tried to control me, & when I was diagnosed that was an opportunity ... He uses my 'mental illness' as a weapon to either put me in my place or to control me.'

It is difficult for victims to disclose physical domestic abuse, & it can be almost impossible to express & explain to other people what is happening in terms of systematic, unrelenting, psychological abuse. It is hard for women themselves to understand & name this insidious abuse, & to speak about how they are constantly living on a knife edge, frightened that they may unwittingly do something that the

perpetrator deems to be wrong, bad, mad; while waiting for the next blow, (physical or mental) to fall.

'It would literally be me crying in front of a doctor, who'd be like 'listen love, tell me what's happening so I can fix it', but you can't articulate it as you are so belittled & so tired, you can't express what's going on.'

'We were isolated, & you have got no friends, no family, & you can't go to your GP for whatever reason; & so, you can't speak to anybody. Only your own thoughts, which gets worse & worse & worse; & you get lower & lower. You try to tackle it, but you have no energy levels. But I think if I did know there was somewhere to walk into, to say 'I need help'. I did think I was literally losing my mind.'

Not being believed by a range of agencies denies women their voices & agency, & can compound the original abuse by increasing anxiety, stress, fear & feelings of helplessness. The women in the focus groups spoke of not being listened to or believed by family courts, police, social services & health professionals. Women reported having 'mental health issues' used against them in family court proceedings; one woman spoke about losing her son to her abusive ex-partner for this reason. This corresponds to wider research which shows how statutory responses can leave women in the position of being blamed for being abused, blamed for any consequent mental health issues & blamed for 'failing to protect' their children (Featherstone & Peckover, 2007). This often results in women being reluctant to seek 'mental health' support.

'Everything I said was dismissed. I felt like I was being portrayed as someone who was playing the victim.'

It is important therefore that mental health services not only listen to, believe & respond appropriately to women who have experienced domestic abuse, but that they also understand the wider impact of inadequate responses by other agencies on women's mental health & safety.

Has using Mental Health Services Helped Women in Coping with Domestic Abuse?

The majority of women in the focus groups & who responded to the questionnaire felt that mental health services (including GPs) did not help them cope with the domestic abuse they were experiencing, or with the legacy of domestic abuse. This was because services did not ask the question, ignored information, responded inappropriately, lacked time to respond appropriately, offered only medication or mainstream counselling, & did not have information or knowledge about the specialist domestic abuse support available. Four of five women who completed the questionnaire said mental health services had not been helpful for them. Mainstream counselling (i.e. counselling that is not specific to domestic abuse support services) was rarely felt to be helpful because domestic abuse is rarely raised by the therapist.

'In domestic abuse, women need other support apart from counselling, & they never gave me any relevant agencies who work with women'

Most women in the focus groups felt they had not been helped by, or had received only limited support from, mental health professionals. Women who had been referred to mainstream counselling said they did not experience this as helpful. Some women felt that medication helped to a certain extent, in terms of alleviating trauma symptoms (but not as a long-term solution); some women were critical of the tendency of GPs to provide medication rather than attempt to explore the underlying causes of their distress.

[What I needed was] 'Practical help, someone to visit me, because I was really low. I was not eating. The doctors gave me anti-depressants when I was suicidal & they calmed me, but the side effects - I was very tired, I couldn't move, I couldn't go to work, I was lonely, I couldn't go out. After about 8 months I thought I should stop because I didn't want to become addicted, or have kidney damage or get cancer from the chemicals in my body. So I have stopped taking them now.'

'I don't think it (GP) helped me cope. I think services like this (domestic abuse support service) have helped me far more than anyone else. But she (GP) listened, & she talked. But then she did give me anxiety tablets.'

'Don't you think though that it is easy for doctors to throw anti-depressants at you & say 'you have got depression'? I said I was anxious, I was in an abusive relationship, & her answer was to put me on anti-depressants.'

Having a female GP enabled some women to feel more comfortable about disclosing, & was felt to be a factor in their receiving more understanding & appropriate support.

'I saw my male GP & then I had to see a locum, & although I think my GP is alright, as soon as I seen her [woman locum] & mentioned a few little things to her, she straight away said 'we have a life coach based in the surgery who can help refer you for counselling'. But no male doctor has ever suggested that.'

'I feel much better with a female doctor, definitely.'

For a minority of women in the focus groups the sex of their GP was not the main issue, the most important thing being whether or not doctors are alert to, & can help with, domestic abuse.

'I think it depends on the doctor, because there is a female doctor in my surgery who I refuse to see. She is so abrupt. So it could be a man or a woman, the main thing is that they are in tune to it' [domestic abuse].

The Need for Mental Health Services to have Information about Domestic Abuse & the Support Available

(It is) 'both valid & useful to conceptualise women's mental health problems as responses to damaging experiences that are rooted in their lived experiences of inequality & abuses of power' (Williams J, 2005)

None of the women who completed the questionnaire or who took part in the focus groups had been given information about, or been directly referred to, specialist domestic abuse support by a GP, mainstream counsellor, Crisis Team, hospital or psychiatrist. Many women suffered years of abuse before eventually finding the right support. They had found out about specialist services through friends, a family member who worked as a domestic abuse support worker, Sure Start workers, the Job Centre, & Rape Crisis.

'I mean some things do get triggered, like when I ended up going to the rape suite. That triggered [local Rape Crisis support]. That was an extreme situation. I was sexually assaulted by my husband in my own home. And it was only police intervention that then triggered the rape suite, which triggered [Rape Crisis support] where I had 18 months sexual abuse therapy, which then brought me here [domestic abuse support organisation], which then triggered the Freedom Programme. So it was a domino effect, but I had to have that extreme incident for the dominos to start to fall. We have all [here] experienced horrendous things. My personal experience is that I had to be raped for the relevant agencies to kick in.'

'If I had known about this place [domestic abuse support service] earlier, I would have been saved from so many years of pain.'

All of the women felt that it is crucial for GP surgeries & other mental health services to carry information about domestic abuse support services; to be able to recognize symptoms relating to abuse; to be able to sensitively ask about & appropriately respond to disclosure; to reassure women about confidentiality, safety, & their rights; to establish an initial safety plan, & to have a protocol for referral to specialist domestic abuse services.

'They (all mental health workers) could be a lot more understanding. I think they need to know not to just give tablets. They need more training. They need to be more aware what to do if a woman opens up to them.'

'GPs need a flowchart, information for women, in the bathroom where women can see it, as often they will be there with the perpetrators. GPs need to be trained to spot the signs. When the doctor is having a

conversation with you & your partner is giving the answer, that's a sign. If they are in the room with you; that is a sign.'

'They should have a big list, like a flowchart, in front of them, & say 'right, I am going to refer you there.'

In addition to information & knowledge about specialist support, women wanted specialist domestic abuse support services & victims /survivors to be involved in the development & delivery of awareness-raising training for mental health professionals, including those working in GP practices.

'It would be good if they could go on the Freedom Programme ... so they can understand what domestic abuse is.'

'They could be a lot more understanding. I think they need to know not to just give tablets. They need more training. They need to be more aware what to do if a woman opens up to them.'

'When a woman goes to a GP, if someone says they are suffering from stress or anxiety, I don't think they should just give medication. They should also have someone there who can listen, make an assessment & who can offer alternative support.'

'There needs to be more awareness of these groups (domestic abuse support) ... I didn't have a clue that there was anywhere like this. I thought I was completely on my own. And there's lots of women in this situation thinking 'I've got nowhere to go'. And you can't talk to your family, cos that's just a no go. Cos you feel so disgusted with yourself for staying in the first place, & they won't understand. But if I had been told there was a group like this when I was going through it, I would have left him a long time ago.'

Which Services (Mental Health & Other) have been the Most Helpful in Enabling Women to Share & Overcome Barriers to Seeking Support?

All 10 women who participated in the focus groups held at a specialist domestic abuse support service said that the service that had helped them the most was not

their GP, not a counsellor, not a psychiatrist, not the police, the courts or social services; but the specialist domestic abuse service from which they are receiving support. The 12 women participating in focus groups at a generic women's centre had found that centre to be the most supportive to them. Of 6 women who completed the questionnaire, 3 said the domestic abuse support service had been the most helpful; 1 woman said it was both the domestic abuse support service & her GP.

The 10 women in the focus groups based at a specialist domestic abuse support service spoke about the services having changed &, in some cases, saved their lives. For women, the key value of these services lies in their arriving at a place where they are not judged but are believed & listened to; are enabled to achieve physical & emotional safety, access a range of therapeutic support & become empowered through the Freedom Programme; where support is not time-limited & is about addressing & ending the abuse rather than just alleviating the symptoms. The 12 women who took part in the focus groups at a women's centre all spoke about the non-stigmatising aspect of it being a general women's centre, the practical support provided, & the range of therapy & therapeutic courses on offer. The overwhelming sense of relief at finding somewhere where they were helped to find a way out, heal from the damage wrought by abuse & be able to see & make a way forward was expressed by each woman in the focus groups.

'I have had about 20 counselling sessions, but I can have more. Here has helped me very much. I don't think my GP has helped me, he didn't look after me. I had abuse for 13 years. I lost the care of my son, I only see him once a week. I was in hospital [tried to take her own life] then when I came out, I had the crisis team visit me for 2 weeks. They just wanted to know I was OK & not suicidal. My workplace referred me to counselling [mainstream] & I had 5 or 6 sessions then they said no more. I was desperate, but then I came here & they offered me 20 sessions.'

'I think as well, it's because you feel like you are not judged (domestic abuse organisation). Because everywhere else you feel like you are judged ... In here, the staff & the girls in the group, they all understand. You feel you don't have to hide; it just comes out.'

'The validation part of it is very, very important. Just acknowledging what has happened to you, has actually happened to you. And that it is OK to feel like you do. You are not going crazy. Because still to this day, he would say I was making it up. He refuses to admit any of it. So I was always questioning myself. But coming here has helped me validate it & work through it.'

'They have not only saved me, they have saved the next generation as well. I am raising my children now. They have given me tools & information, there is no time frame; you don't come here for a number of days or weeks. It's not limited. I have done the Freedom Programme 3 times, & they have never once asked me to leave. Never once said you are taking up somebody else's space.'

In addition, the women enter a safe, women-only space where they gain the emotional support & friendship of other women:

'For me, it's being with other women who have been through it, the understanding, & being able to grow confidence & trust in these women. And the trust is the big thing, because after being in an abusive relationship you don't trust anyone. If not for here, I wouldn't be where I am now. I just think it's brilliant.'

'It's the camaraderie more than anything. The information they give you is worth its weight in gold, it's invaluable. But it's the network of the girls all coming together that is equally as valuable for me.'

'The friendship as well. We have become friend. Coming to these groups & meeting girls like myself, it's just amazing. And now I want to help people like myself.'

The Value of Women-Only Services

Sisters: talk to each other, be connected & informed, form women's circles, share your stories, work together, & take risks. Together we are invincible. (Isabel Allende)

All of the women in the focus groups & who responded to the questionnaire felt strongly that women-only services were crucial in helping women heal & grow strong after domestic abuse. All believed that support should be women-only, & the majority believed other services working with abused women should have women-only services.

'To be honest, I think the last thing you want to see when you walk through the door here is a man on reception.'

'It's not the time or place for a man to be here.'

'It makes you feel more secure coming here because it is a women only service.'

'I don't think I would feel as comfortable sitting in a group talking if there was a man in here.'

'I would feel more comfortable with women because they will have a better understanding of other women's situation.'

The value of organizations that help to ameliorate or challenge the impact of women's inequality is immense in terms of empowering women individually & collectively (Coy et al. 2007; Women's Resource Centre, 2011). Many of the women who took part in the focus groups had attended the Freedom Programme run by domestic abuse support services. The women believed that the Freedom Programme had significantly helped them to recognise signs of abusive behaviour, leave violent relationships, overcome the symptoms of abuse & work supportively with other women to attain confidence, self-respect, & belief in themselves & each other. This, alongside specialist counselling (delivered by domestic abuse services), appears to be the key to helping abused women recover & heal after domestic abuse.

'It [Freedom Programme] makes you understand yourself what was going on in your life. I bent over backwards to make him happy, but he was never going to be happy. I was wrong, always wrong, always going to be useless at everything. And then understanding that no, it's not me, it's him. Because I was not getting a smack every day it was hard for me to understand that I

was in an abusive relationship. But I was in a violent relationship, it was like torture.'

What do Women Want?

All of the women were clear that as well as being aware of the signs of domestic abuse and listening & believing when women disclose, the best way that mental health services can help them is through referrals to specialist domestic abuse support or women's services addressing complex needs.

'It was the Freedom Programme that helped me understand what had been happening & it was not my fault.'

'I have been to the police, & I have not been believed. I have felt totally not listened to. And I really think I would have cracked up if not for this organisation' [domestic abuse support organisation].

'Refer women to Freedom Programmes, and places like this [domestic abuse support service]. That's it in a nutshell.'

Services dedicated to supporting & empowering women to overcome gender-based violence offer the mental health sector a great deal in terms of:

- The provision of flexible & innovative approaches based in a woman-centred framework, such as the Freedom Programme, & other support that is specifically designed to aid & equip women to live safe, autonomous lives.
- Specialised provision for women who are particularly marginalised because of other forms of discrimination, ensuring that additional & culturally specific needs are met.
- Being repositories for accurate & current quantitative & qualitative data relating to the prevalence, diversity & impact of gender-based violence
- Facilitating raised awareness & providing expert training in the prevalence, impact & root causes of Violence against Women & Girls & what are the most appropriate & effective responses
- Absolute commitment to safety, security, autonomy & empowerment

- The provision of long-term support & the availability of support at whatever point in her life the woman is ready to access it

3.3 On-line Survey

In addition to the focus groups & questionnaires, a survey posing the same questions was posted online via Survey Monkey. It was acknowledged by the Task & Finish Group that this method of data collection is not best suited to eliciting nuanced experiences on a sensitive subject, but we did so in the interest of trying to involve more women who could not attend a focus group.

14 responses were received via Survey Monkey. 12 of those responding felt that their mental health had been affected by their experience of domestic abuse, with 2 people saying that their mental health was not affected. Those who identified mental health issues talked about depression, lack of self-esteem & confidence, feelings of anger, frustration & worthlessness, & self-harm. 10 out of the 14 respondents said they had contacted a service in relation to their mental health/wellbeing. 6 of these had been in touch with their GP, 4 with a counsellor, & 2 with a psychiatrist. Other services, each mentioned by 1 person, were: community psychiatric nurse, social worker, advice & support service & mental health day centre.

When asked if the service they were in touch with had asked the question about any experiences of domestic abuse, the majority, 8 people, said the question had not been asked, with 5 saying they had been asked. One person commented:

'Not something you tend to bring up without the question being asked'

Even though 5 people reported having been asked the question, only 2 people had been given information about specialist domestic abuse support services, with a majority of 11 people not given any further information.

12 people answered the question about whether they felt listened to or understood, with 6 people saying they had & 6 saying they hadn't. One person commented that they had only received support to be re-housed, but had not been offered the counselling or further support they felt they needed. Another commented that

although the abuse itself is long-term, they felt they were expected to 'get over it' very quickly. Another commented:

'The counsellor was out of her depth & didn't understand at all'

A variety of reasons were cited for not wanting to use mental health services. These included stigma, fear of losing children, not being aware of the services, not wanting details recorded on health files, not feeling the need for those services & feeling undeserving.

When asked if having women-only services was important to them, the majority of 9 people said that yes, this was important to them:

'Women supporting women is the only way I would feel safe'

'It's pretty obvious that if you've been abused by a man, you don't want one anywhere near'

5 women said women-only services were not important to them, with 2 of these giving reasons:

'I don't see all men as a threat, in fact I find mixed centres really helpful at getting perspective about men'

'I understand that most women experience abuse at the hands of men, but mine was from another woman'

In response to the question on what their key messages for services would be, the majority of people talked about the need to be listened to & understood, for professionals to have a through awareness of the issues & support available, & for support to be built around the needs of the individual rather than a service model:

'Many women are abandoned by statutory services if they go back to the abuser, but consistent & reliable support needs to be in place for a successful break'

'Give women as much time as they need. Don't expect them to deal with everything in 6 sessions & then discharge them.'

Section 4: Discussion & Conclusions

Over the course of the Task & Finish Group, 22 women participated in focus groups, 6 women filled in questionnaires or gave an individual response, & 14 women responded to the on-line survey. Despite the differing methods of engagement used & detail explored, the experiences of women were powerfully similar. Women spoke of various forms of psychological, emotional, financial, sexual & physical control that male partners had used in order to subordinate, threaten & isolate them & the significant effects of that abuse on their mental health in terms of loss of identity, confidence & self-esteem, anxiety, self-doubt, depression, social isolation, eating problems, harmful use of alcohol & drugs, self-harm & suicidal ideation. A clear theme that emerged from the focus groups is that professionals may understand domestic abuse if a woman presents with a black eye or broken bones; but they do not, in the main, recognise or understand the symptoms of psychological abuse or coercive control. It is this systematic, insidious abuse that has the most profound & long-lasting impact on women's mental health.

Despite guidelines on domestic violence & abuse existing within professional bodies, we found very few examples of health professionals in either primary or secondary care services asking women about domestic abuse. It is widely accepted that the health service is one service that almost all survivors of domestic abuse will come into contact with at some point in their lives, & as few victims will openly disclose domestic abuse, screening in a health care setting provides a safe place & opportunity for them to seek help, advice & support (Standing Together, 2004). The women we spoke to highlight the fact that inappropriate responses by health professionals are a significant barrier to disclosure. The recent NICE Guidance (2014) recommends training for all health & social care professionals, including pre-qualification & continuing professional development courses, on the issues surrounding domestic abuse & how to respond. Only 2 out of the 42 women we engaged with had been given information about or directly referred to a specialist domestic abuse support service by a health professional. There is a clear need for health services to have access to information on local organisations & referral pathways in place.

For most of the women, their GP was the first port of call. The findings from the focus groups support the guidance for general practitioners developed by CAADA & IRIS (2012). This guidance sets out the importance of GP surgeries having information about domestic violence support, engaging with local domestic abuse services, commissioning training for the practice team, establishing a simple care pathway, & adhering to information-sharing protocols. All of these recommendations echo the views of the women who took part in the focus groups, who speak from personal experience of what has worked & what has not worked for them.

It was clear from many of the women we spoke to that there are significant fears about & examples of women having 'mental health' issues used against them by the perpetrator of domestic abuse, their community & particularly the courts. Campaigners have recently called for psychological abuse to be made a crime in England & Wales. The groups, including Women's Aid, say current legislation focuses too much on specific incidents & fails to take into account the issues of power & control which are the essence of domestic abuse. Women's Aid is urging every criminal justice agency & government department to sign up to the joint Survivor's Charter (Women's Aid/All Party Parliamentary Group on Domestic & Sexual Violence 2014).

Section 5: Recommendations

1. Develop systems for the data collected by specialist domestic abuse services to contribute to Liverpool City Council's analysis of domestic abuse.

Relevant to: Domestic Abuse Services, Liverpool City Council

2. Domestic abuse training for GPs, social care & mental health professionals, including psychiatrists, should be commissioned from specialist domestic abuse support organizations, & cover:
 - Prevalence, impact & root causes of domestic abuse
 - Knowing why women do not disclose; what are the barriers to disclosure
 - Being able to spot the signs of abuse & coercive control
 - Being able to ask the question sensitively & in a way which does not further endanger the woman (& children)
 - Being able to respond appropriately when a woman discloses

Relevant to: Liverpool CCG, Liverpool City Council, Merseyside Police

Training on domestic abuse should also be part of the curriculum for nursing, social work, & other front-line professional courses

Relevant to: University curriculum leads, Local Medical Committee, Mersey Deanery, professional bodies

3. Effective partnerships between statutory health care providers & specialist domestic abuse services in the voluntary sector should be developed, including the development of referral pathways to specialist services

Relevant to: GPs, Inclusion Matters, Mersey Care Trust, domestic abuse services

4. A financial commitment from commissioners is needed in order to meet the increased demand for specialist domestic abuse services & to effectively use the expertise within the women's sector

Relevant to: Liverpool CCG, Liverpool City Council

5. Professionals should have knowledge of local Domestic Abuse support organizations and the services they offer & use a local protocol on identifying and responding to Domestic Abuse

Relevant to: GPs, Inclusion Matters, Mersey Care, & Liverpool Community Care

6. Information, in a range of formats & languages, about local specialist domestic abuse support services should be available within primary & secondary health care settings

Relevant to: GPs, Inclusion Matters, Mersey Care, & Liverpool Community Care

7. The issue of women experiencing stigma & prejudice, associated with mental health needs, in the family courts should be addressed

Relevant to: Merseyside Criminal Justice Board, Courts Sub-Group

8. Women from BAMER communities should be trained, & employed within specialist domestic abuse services as interpreters

9. Recommendations from this report should be:

- included within Liverpool Domestic Abuse Strategy & Action Plan
- revisited & reviewed to evaluate progress

Section 6: References

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Appendix 1: Task & Finish Group Members

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Andy Kerr	Liverpool Clinical Commissioning Group
Angela Clarke	South Liverpool Domestic Abuse Service (SLDAS)
Claire Stevens	Liverpool Mental Health Consortium (LMHC)
Collette Graham	Inclusion Matters Liverpool
Debbie Knott	Liverpool John Moores University
Diane Foulston	Barnardo's Volunteer
Gill Moglione	Savera
Jackie Patiniotis	Liverpool Women's Network
Jess Thalrose	WHISC
Jill Summers	Liverpool City Council
Julia Walimbwa	MRANG
Julie Anderson	Healthwatch
Kathy Devlin	Beacon Counselling
Louise Wardale	Barnardo's
Lynne Jones	Independent
Maire Gollock	Centre 56
Margaret Brown	Mersey Care NHS Trust
Meryl Cuzak	Mersey Care NHS Trust
Mimi Gashi	Sahir House
Paula Nolan	Liverpool Domestic Abuse Service (LDAS)
Pippa Georgeson	Mersey Care NHS Trust
Rachel Shipley	Student Social Worker, Liverpool Hope University
Sarah Butler-Boycott	Liverpool Mental Health Consortium (LMHC)
Sharon Cooper	Women's Turnaround, PSS
Stephanie Wright	Women in Business
Sue Neely	Public Health, Liverpool City Council
Tammy Nyamuranga	MRANG
Val Walsh	Liverpool Women's Network

Appendix 2: Local Organisations providing Domestic Abuse &/or Mental Health Support

Domestic Abuse Services

ABC Service	Addressing Barriers to Change outreach@localsolutions.org.uk	0151 482 2482
Amadudu	PO Box 180, L17 3WU Women's Refuge	0151 734 0083
Breathing Space	Louise.Spruce@pss.org.uk Women Survivor's Group (Childhood Abuse)	0151 708 0415
Centre 56	centre.56@btconnect.com	0151 727 1355
IDVA Service	idva@localsolutions.org.uk	0151 482 2497
ISIS Scribblers	www.isisscribblers.tumblr.com Twitter: @isisscribblers Women Survivors Writing Support Group	
LDAS	72-74 Durning Road, L7 5NG	0151 263 7474
MDVS	merseysidedvs@ymail.com	0151 709 8770
RASA Liverpool	rasa@rasamerseyside.org Helpline: 0151 666 1392	0151 707 4313
Savera Liverpool	saveraliverpool@hotmail.co.uk	07716 266484
SLDAS	Bridge Chapel Centre, L19 4XR Freephone: 0800 0837114	0151 494 1777 0151 494 2222
Worst Kept Secret	PO Box 182, Liverpool L69 2SW	0151 330 2012

Helpline: 0800 028 3398

WKS2@localsolutions.org.uk

Women's Services

MRANG	37-45 Windsor Street, L8 1XE	
WHISC	120 Bold Street, Liverpool L1 4JA whiscdropin@btconnect.com	0151 707 1826
Women's Turnaround	Isis Women's Centre, 142-5 Stanley Street, Liverpool L5 7QQ womensturnaround@pss.org.uk	07595 863133
Voice4Change	voice4change@msn.com	0151 920 2211

National Services

Broken Rainbow		0300 999 5428
Forced Marriage	Helpline	0800 5999 247
Women's Aid	24-hour Helpline	0800 2000 247

Appendix 3: Domestic Abuse & Mental Health On-Line Survey Questions

1. Has your mental health and wellbeing been affected by personal experience of domestic abuse? (For example, low self-esteem, negative feelings about body image, depression, anxiety)
2. Have you ever contacted a support service in relation to your mental health/wellbeing? (Give details if you wish)
3. If 'yes', which services did you use? (E.g. GP, counsellor, crisis support)
4. Did the service you used ask you directly whether you were experiencing, or had experienced, domestic abuse?
5. Were you given information about organisations which could offer you specialist support & how they could help you? (E.g. Liverpool Domestic Abuse Service or South Liverpool Domestic Abuse Service) Did you follow this up?
6. Did you feel listened to or understood? (Which services have been most helpful in enabling you to share & overcome barriers to seeking support?)
7. If you wanted them to, have mental health services helped by talking to other support agencies, on your behalf, about your particular needs & how they could best help you?
8. If you feel your mental health/wellbeing has been affected by domestic abuse but you have not used mental health services, is there a particular reason for this? (Please select as many answers as you wish or add other reasons you may have)
 - Stigma
 - Fear of having children taken into care
 - Not feeling the need to use a service
 - Previous negative experience of using services
9. Is having a women-only service important to you? Could you explain why?
10. Finally, if you have one key message for support services, what would it be?

Appendix 4: Focus Group Questions

1. Has your mental health been affected by the domestic abuse you experienced?
2. Are you able to say what the impact of domestic abuse has been on your mental health & wellbeing?
3. Did you seek support from mental health services because of the domestic abuse you experienced?
4. Can you tell us which mental health services you have used?
5. Did the service you used ask you if you were experiencing, or had experienced, domestic abuse?
6. If not, do you think it would have helped if you were asked?
7. If you were asked the question, how supportive were they in helping you talk about the abuse & the impact it has had on your mental health?
8. Were you given information about organisations where you could go for specialist support & how these can help you? (e.g. SLDAS/LDAS)
9. Did you feel listened to & understood?
10. If you wanted them to, have mental health services helped by talking on your behalf to other support agencies about your particular needs & how they can best help you?
11. Has using mental health services helped you in coping with domestic abuse? If yes, can you explain how? If no, why?
12. If you feel your mental health has been affected but you have not used mental health services, is there a particular reason for this?
13. Which services have been most helpful for you in enabling you to share & overcome barriers to seeking support?
14. How important is having a women-only service for you, & why?
15. If you have one key message for mental health services, what would it be?