ATTACHMENT SF 3

This is the attachment marked "**SF 3**" referred to in the witness statement of Angelina Sabin Fernbacher dated 21st July 2015.

Women's Stories of Collaboration Between Domestic Violence and Mental Health Services

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ABSTRACT

The connection between domestic violence and mental ill health has been well-established yet domestic violence and mental health services often experience difficulty in working effectively together. Tension between these service sectors can contribute to poor outcomes for women who live with both domestic violence and a mental illness. This has implications for children's wellbeing and development because children's resilience to exposure to domestic violence is linked to their mother's mental health. Based on a qualitative analysis of in-depth interviews with 33 women who experienced both domestic violence and mental health concerns/ illness, this article outlines women's experiences of their contacts with domestic violence and mental health services. It identifies barriers to service collaboration and pinpoints changes that could lead to much more comprehensive responses to women.

KEYWORDS

Domestic violence, abuse, mental health, women, collaboration, children

INTRODUCTION

Domestic violence is a serious and prevalent social issue in Australia. Thirty four per cent of women who have ever had an intimate partner have experienced at least one form of partner violence during their lifetime (Mousos & Makkai, 2004). Although the links between domestic violence and mental ill health have been well-established (Bonomi, et al., 2009; Golding, 1999; Jordan, Campbell & Follingstad, 2010), domestic violence and mental health services often struggle to work effectively together (Gondolf, 1998; Humphreys & Thiara, 2003). When mental health issues such as depression are not recognised as what Humphreys and Thiara (2003) call "symptoms of abuse" in women affected by domestic violence, women's safety and recovery can be jeopardised. This has important implications for children's wellbeing and development, because research has identified that the mother's mental health is a source of children's resilience in the face of exposure to domestic violence (Hughes, Graham-

Bermann & Gruber, 2001; Humphreys, 2007).

This article focuses on women's stories of their experiences of contact with domestic violence and mental health services. The women's stories were collected as one of four interrelated but independent studies from a larger research project, Towards Better Practice (TBP), undertaken in New South Wales (NSW), which aimed to enhance collaboration between mental health and domestic violence services. The other three studies were a self-completion practitioner survey exploring the responses of domestic violence and mental health practitioners to the coexistence of domestic violence and mental ill health; focus group interviews exploring barriers to, and opportunities for, cross-sector collaboration; and an action research project where domestic violence and mental health services developed and trialled collaborative initiatives aimed to improve outcomes for women experiencing both domestic violence and mental health concerns (Irwin, Laing, Napier & Toivonen, 2008; Laing, 2009). To provide a context for the women's stories, we begin with an overview of the literature on the connection between domestic violence and mental ill health.

WHAT DOES THE RESEARCH SAY?

Links Between Mental Health and Domestic Violence

Many studies over the past two decades have identified the severe impacts that domestic violence has on women's physical and mental health (Bonomi et al., 2009; Carlson, McNutt, Choi & Rose, 2002; Krug, Dahlberg, Mercy, Zwi & Loano, 2002; Roberts, Lawrence & Williams, 1998). In particular, abused women experience higher rates of depression, anxiety, posttraumatic stress disorder (PTSD), suicidality and substance misuse than nonabused women (Bonomi et al., 2009; Golding, 1999; World Health Organisation, 2005). In addition, women with a serious mental illness, such as schizophrenia and bipolar disorder, are at much greater risk than women in the general population of experiencing sexual and physical violence, including from intimate partners (Goodman et al., 2001; Howard et al., 2010).

Other studies have shown that a longer exposure to domestic violence is associated with more severe mental health impacts (Coker et al., 2002) and that the effects of domestic violence on mental health diminish when a woman is no longer exposed to the violence (Taft, 2003). In Australia, one of the first studies to estimate the health impact of domestic violence on women using burden of disease methodology found that domestic violence is: "… responsible for more ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking." (Victorian Health Promotion Foundation, 2004, p. 8). Mental health impacts have been found to contribute 73% of this disease burden (Vos et al., 2006).

Contact with Services

Women who experience abuse have more contact with the health system over their lifetime than non-victims (Hegarty, O'Doherty, Gunn, Pierce & Taft, 2008). For many women, the health care system is often the only place they can seek help for issues around domestic violence because health services are an acceptable surfacing point for problems that are primarily social and emotional (Warshaw & Alpert, 1999).

Women describe helpful encounters with health care providers as characterised by nonjudgmental, nondirective and respectful responses that recognise the complexity of domestic violence and do not pressure them to respond in prescribed ways (Feder, Hutson, Ramsay & Taket, 2006). Providing validation, whether or not the woman chooses to disclose, can "plant the seed" for a woman to begin her journey away from violence (Gerbert, Abercrombie, Caspers, Love & Bronstone, 1999, p. 130). Disclosure about the violence can be difficult. Gerbert et al. (1999, p. 122) describe the encounter of a woman who has experienced violence and a health care provider as a subtle "dance of disclosure". For women who also experience mental health concerns, this "dance" becomes more complicated. The responses of health professionals to disclosures are critical. Research shows that unless the listener's response to the disclosure is repeatedly supportive, disclosure itself is not associated with a significant

reduction in risk of any adverse mental health outcomes (Coker et al., 2002) .

Failure by mental health services to respond appropriately to domestic violence, either by discounting the violence or by misdiagnosis and inappropriate treatment, can place a woman at risk of ongoing and escalating violence and compromised mental health (Stark & Flitcraft, 1996a). This failure to identify domestic violence as an underlying factor in many women's presentations to mental health services is in part due to the many and complex ways in which the effects of domestic violence on women's mental health may be manifested.

Secondary Victimisation of Women and Children

When domestic violence is not recognised as a factor underlying women's complex mental health presentations, this can lead to secondary victimisation (Mulroney, 2003). Women and children may experience harms in addition to the direct effects of domestic violence if their attempts to seek help are met with inappropriate responses. This compounds their suffering and compromises their safety (Humphreys & Thiara, 2003; Stark & Flitcraft, 1996b). These harms can include blaming women for the violence they experience and for their failure to leave a relationship in which they are being abused and/or blaming women for the harm caused to children by the perpetrator's violence and abuse. Responses such as these fail to locate responsibility for the violence and its effects with the perpetrator and take no account of the dynamics of domestic violence.

Escaping domestic violence can mean that women and children are plunged into homelessness. Domestic violence is the most common cause of women's and children's homelessness (Australian Institute of Health and Welfare (AIHW), 2009). In 2007-08, 73% of a total of 76,900 "accompanying children" in crisis accommodation services were aged 9 years of age or under. Two-thirds of children accommodated in homeless assistance services have been exposed to domestic violence (Homelessness Australia, 2010).

Many of the women who access women's refuges also experience serious mental health concerns (Helfrich, Fujiura & Rutkowski-Kmitta, 2008). For example, a study undertaken in Adelaide found that 45% of women leaving refuges met the criteria for a diagnosis of posttraumatic stress disorder (Mertin & Mohr, 2000). Domestic violence services often do not have the expertise or resources to deal with chronic mental health issues. As a result, they are not always able to provide accommodation to women with a mental illness who are escaping domestic violence (Chung, Kennedy, O'Brien, Wendt & Cody, 2000). This can increase the risk of homelessness and result in a deterioration in physical and mental health for these women (Astbury & Cabral, 2000). It can also increase the risk that their children will be removed from their care (Edwards, 2004).

Collaboration

Efforts to promote interagency collaboration in domestic violence service delivery have historically been built around the criminal justice system (Clark, Burt, Schulte & Maguire, 1996; Shepard & Pence, 1999). More recently, efforts have extended to enhancing collaboration between domestic violence services and statutory child protection services (e.g. Edleson & Malik, 2008) and between child protection and adult mental health services (e.g. Darlington, Feeney & Rixon, 2005). The health sector has been a relatively late entrant into coordinated responses to domestic violence (Thurston & Eisener, 2006).

It is recognised that the intersection of domestic violence and mental health services is only one of many that must be negotiated for an effective response to women and children when there are complex issues of mental health and domestic violence. Intersections with family law, child protection, alcohol and other drugs, housing and income support services are also crucial. Women's path through the fragmented system can be overwhelming, depleting their resources as mothers. The Towards Better Practice research focussed on the mental health and domestic violence sectors because of the relative invisibility of domestic violence victims/survivors within mental health services and because of the unique expertise of women's domestic violence services. The model of work developed over 30 years in the women's

community based domestic violence sector has, at its core, advocacy that requires domestic violence workers to "… reach across silos and systems, crossing organizational cultures to respond to the survivor and her needs as she frames them." (Goodman, Fels Smyth, Borges & Singer, 2009, p. 320) Through the involvement of women's domestic violence advocates, there is the potential to bridge gaps across multiple sectors (Laing & Toivonen, 2010). Nevertheless, despite the potential benefits of the coordinated expertise of both the mental health and domestic violence sectors, there are formidable challenges to the development of effective working relationships and the sharing of different bodies of expertise (Gondolf, 1998; Warshaw, Gugenheim, Moroney & Barnes, 2003).

The Towards Better Practice research project sought to work with the mental health and domestic violence service sectors to develop and trial more effective ways of working collaboratively to improve the outcomes for women experiencing domestic violence and mental health concerns/ illness. We began the project by collecting women's stories of their experiences with mental health and domestic violence services because we considered these stories to be core to this project, informing all aspects of the research.

THE WOMEN'S STORIES

Women aged 18 years or older who had experienced domestic violence from an intimate partner and who had had mental health concerns or received a mental health diagnosis, but were not currently experiencing an acute episode of mental illness were recruited through domestic violence and mental health services across NSW. As this is a vulnerable research population, women's safety and wellbeing were addressed at all stages of the research in accordance with the requirements of the University of Sydney Human Research Ethics Committee and the committees of five area health services. For example, a safety protocol was developed for any telephone contact with potential participants (Langford, 2000); a safety and wellbeing assessment was undertaken at each contact and throughout the interviews with women; and all interviews were held at a place where both the women's and the interviewers' safety could be assured. The three interviewers were all social workers with experience in mental health and domestic violence settings. The research team was guided by a reference group of service providers and consumers on safety issues and all aspects of the research process.

Through our recruitment, we aimed to include a diverse group of women. Of the 33 women interviewed, five were Aboriginal, eight were from culturally and linguistically diverse (CALD) backgrounds and two were immigrants from English speaking countries. The remainder of the women identified as Anglo-Australian. The women ranged in age from 18 to 65 years and lived in rural, regional and metropolitan NSW. Due to the nature of domestic violence, many had been forced to relocate. All the women have pseudonyms, most chosen by the women themselves.

A guided, open-ended interview schedule was developed in consultation with the collaborating partners and the TBP advisory group. The interview explored the women's experiences of using services from both sectors—domestic violence and mental health. Interpreters were used for interviews with women from the CALD backgrounds. The interviews were audiotaped and transcribed. The qualitative data analysis package NVivo was used in the thematic analysis of the interviews.

It is important to acknowledge the courage shown by the women in talking about very difficult and distressing experiences, given that few had been listened to with respect in their contacts with a range of agencies and service providers. Many commented that their motivation for participating was to help other women in their process of recovery and empowerment. For example, one respondent said:

> As I am speaking to you right now there are women out there who are copping it so hard and they are in the dark. They don't know where to go…we have got to show the men we do have power.

The women's accounts are presented in terms of the three key themes that were identified in the analysis: living with domestic violence and mental health concerns; barriers to seeking and receiving help; and

responses that worked.

1. *Living with Domestic Violence and Mental Health Concerns*

The mental health diagnoses and mental health concerns the women experienced included anxiety and panic attacks, depression and severe depression (experienced by over half of the women), insomnia, posttraumatic stress disorder, bipolar disorder, obsessive compulsive disorder, schizophrenia and suicidal thoughts or actions. Many commented that they had been diagnosed by a health/mental health professional and prescribed medication. The forms of domestic violence experienced by the women included physical, verbal, financial, emotional and sexual violence, stalking, intimidation and threatening behaviour. Most women had endured more than one form at any given time. All of the perpetrators of this violence were men. Many of the women had children who had been exposed to the domestic violence.

Many of the women talked of how they began to see the links between their experiences of domestic violence and their mental health.

> My panic attacks, amazingly, they started, amazingly…I think it's all got to do with him and how he treated me. (Isabeau)

Some women were able to link moving away from the violence with an improvement in their mental health:

> I had a really bad depression last year and I came out of it and I felt a lot better and I suddenly realised it was because he didn't have any power over me. (Kathy)

Carla, who lived with her partner and experienced emotional and financial abuse, believes that her mental health improved dramatically after she had made the step to leave the relationship. She states that her mental health was much better:

> Because I don't live with my man anymore. I got quite depressed when I was with him.

2. *Barriers to Seeking and Receiving Help*

The women described numerous barriers to seeking and receiving help, including: attitudes of service providers; the behaviour of their abusive partners; negotiating the maze of complex service systems; and what we have referred to as exacerbating factors.

Attitudes of service providers.

Many women commented on how general practitioners, psychiatrists and other mental health practitioners rarely inquired about their current relationships, family life or other personal and social issues, thereby not addressing the underlying reason for their mental ill health (the domestic violence). As a consequence, the domestic violence remained invisible, resulting in some women continuing to stay with the abusive partner in unsafe situations as no-one presented them with other alternatives despite their contact with health professionals over many years. As Astbury and Cabral observe, silence by health care providers is not neutral, but "can be a powerfully eloquent, though destructive form of communication about the violence in women's lives." (2000, p. 88)

For example, Isabeau talked about seeing various mental health professionals over a decade, but not one of them had inquired about domestic violence as a possible cause of her mental health concern. She talked about "having her brain picked" for the myriad of different childhood traumas which could have caused her panic attacks rather than being asked about her current situation at home. In retrospect, Isabeau was angry about this as she feels she told health professionals "every secret" in her life yet none of them picked up on the abuse she was experiencing from her husband. She knows that even though she didn't have the vocabulary or knowledge to name what was happening, they certainly did. For Isabeau, it was the police who recommended that she speak with a counsellor about her emotional abuse. When she describes the counselling, she stresses that it was the first time that anyone had actually called it "domestic violence" or "emotional abuse".

> If I had gone to the first couple of therapists and if they'd picked it, well, that would have been…that would have been like 10, 11 years ago. I would have been out of there, instead of being with him. It would have been 10 years with him, not 20 years.

Similarly, when Denise was diagnosed with a mental illness at 22, her doctor did not ask her about her background or living circumstances which may have contributed to the illness. As she says:

> They never asked me about my relationships and stuff like that. They never asked me anything about that, like how my living standards were or anything. They just came and gave me my injection and my tablets and that was it.

Women were often prescribed medication for their mental health symptoms. At times, the women experienced the use of medication as a tool of control by health professionals. For example, Denise talked about being denied service if she didn't take her medication. After telling her psychiatrist that the prescribed tablets for depression were not assisting her in any way, the doctor replied:

> If you don't take these tablets, I can't help you. I won't be seeing you if you don't take the tablets.

Abusive partners.

Women often spoke of how their abusive partner would interfere with their contact with mental health services and subsequent treatment. They described how health professionals were often deceived by the abuser, believing his story over theirs. The consequence for women was that they were diagnosed and labelled, often as suffering borderline personality disorder. For the women from culturally and linguistically diverse backgrounds, the power of their abuser to interfere in their treatment was often magnified due to their limited knowledge of the Australian health and welfare system and, for some, their limited understanding of English.

For example, Bahar's psychiatrist used her husband as interpreter, enabling him to control both what she felt comfortable to reveal as well as what the psychiatrist understood due to her husband's limited English. Her husband used his role to block the help-seeking efforts of Bahar, who now blames herself for not getting help earlier for the abuse she and her children suffered for 25 years:

> I went to doctors. I tried to get help. I tried hard to get help, but my husband was interpreting. And I was asking, 'What do doctors say?' He has limited English, and he was [undermining] my efforts to get help to improve my situation.

Some women commented that their partners would often use the diagnosis of a mental illness/health concern to further the abuse and entrapment of the women. For example, Kim's husband used her mental illness/health concern as a way to entrap her, using stigma and fear of mental illness as a way to undermine her. He told the police and other service providers that she was crazy, paranoid, depressed and on medication.

> I did have a depressive episode but probably because I was so unhappy. He would go to the doctor and say it was me, and you go along with it…Finally, (when) I did tell people, it seemed crazy. [Later] I did go for [a protection order]… My husband went down and told the police officer that I was crazy and that I am depressed and I am on antidepressants…I dropped the order because I thought there was no point. He is still highly regarded in the community. And people still think I am crazy.

Banu's husband would emotionally abuse her by telling her that she was crazy and use her mental illness as a way to discredit her. He threatened to use the fact that she was "crazy" against her, particularly if she tried to seek help for the domestic violence. Yvonne was aware that acknowledging the effects of the abuse on her mental health could be used by her ex-partner in the Family Court:

> I talked to my GP the other day about getting antidepressants. I'm worried about talking to her about suicide, suicidal things, because at any time they could subpoena my medical records, which he has already done. And if that comes across in [Family] Court that I feel that , I don't know; I could lose custody

Complex service systems.

Lack of communication between the two service sectors has been identified in the literature as a major barrier for women seeking help for both domestic violence and mental health related concerns (Gondolf, 1998; Howard, et al., 2010).

Difficulties arose for the women interviewed when they used a number of services across the sectors. The women talked about services working separately with limited or no communication with each other. This caused confusion and complication for the women. Women talked of having to re-tell their story a number of times, which caused them further distress:

> You've got to repeat your story and that all over again. Like, you sound like a nutcase, I suppose. Oh, you just get sick of repeating it all the time (Alkira).

Generally a lack of available resources had a negative impact on service provision. This was particularly evident around access to services (waiting lists); a lack of response (particularly with police and after hours mental health services); a lack of generalist counselling for women (particularly women experiencing depression and anxiety where access to the public mental health system was limited by its focus on acute patients); limits to the amount of time women were permitted to stay in refuge accommodation; a lack of psychiatrists based in rural areas; and a lack of services to follow up with women once the "crisis" was over. Sally recalled being thankful and relieved about being offered a spot in a counselling service:

> I was lucky, but how many women are waiting six to eight months?…You know I used to want to take my life day in and day out thinking I was crazy, and I really believed I was crazy.

Other women were not so fortunate, describing the lack of availability of services as negatively affecting their mental health. The impact also carried on to children who had lived with domestic violence. When talking about her daughter, Margaret stated:

> They said they were going to book her in, but nothing was ever done. And I thought that was not right, because, being that age and hearing and seeing everything, she needed that counselling—after doing the wrist and writing the suicide book. No-one was taking any interest in what I was trying to let out—to say, 'Look, she needs help too. Not just me, she does too.'

Many women also commented on negative experiences with other agencies, such as police and statutory child protection services. Some talked more about issues with specific staff at a range of services. Both groups described occasions of cruel, disrespectful and non-trusting treatment by staff which mirrored the way they were treated by the abuser. Women who expressed unhappiness with the services that they had received commonly described feelings that either the service providers did not believe them about their experiences of domestic violence, depression or other mental health concerns/illness or that they were unable to trust the service providers (have faith in their ability to provide assistance). For some women, this resulted in feeling like they were alone in their struggle:

> I had no help at all. I was on my own. It was like a war, a battle. I had to end it and see how I can get out of it. I didn't have help (Dani).

These issues of trust seemed to exacerbate mental health issues for some women. The lack of trust in services meant to help them was the end of the line for some women and led to anxiety and depression. Katya talked about the blame she felt from workers in a refuge:

> Every time when I go and push them to help me, they make me feel like I am a criminal, it is my fault.

Some women described feeling like they were a burden to the service providers. This sense of burdening the workers appeared to be caused, in part, by the attitudes of some of the workers, who were described by some women as "not helpful","judgmental" and "rude". Kim talked about staff at some domestic violence and mental health services believing that domestic violence only happens in lower socioeconomic environments. She felt "patronised" by staff:

> Like you are poor and hard done by—'Ah… you poor thing.'

EXACERBATING FACTORS.

Drugs and alcohol

Many of the women identified complex factors in

their lives that worked to limit their ability to seek support. Half of the women interviewed described using drugs and alcohol as a way of coping with the violence as well as a way of medicating themselves to alleviate the symptoms of their mental illness/ health concerns. However, the use of drugs and alcohol sometimes compounded the mental illness/ health concern as well as had a negative impact on the women's overall health and wellbeing. For four of the women, using drugs and alcohol as an effect of the domestic violence led to the removal of their children, in some cases, to the care of abusive ex-partners.

Carla and Sally both used alcohol to deal with their depression and the tremendous grief and loss they had experienced. Iona, Lea and Ilke all used drugs and alcohol to deal with the long lasting effects of domestic violence as well as when the actual physical and sexual assaults occurred. Lea stated:

> I think you drink to block it out. I'm going to get drunk. This is my saying anyhow. I'm going to get drunk so I won't be able to feel it later.

Under-resourced rural communities

Women also described the difficulty accessing services in small rural and remote communities. Some women lived great distances from town which made it difficult to attend counselling and groups that were located in town. Lack of transportation was a major obstacle in getting to support services. In some areas, psychiatrists would only fly into town every week, which often meant waiting for weeks to see a psychiatrist. Women who had lived in the city and moved to the country made particular mention of the limited access to services in rural areas.

An additional compounding factor which proved to be a barrier for women seeking help was the lack of anonymity—everyone knowing everyone else's business. Margaret lived in a small country town and talked about how her abusive partner used her mental illness to turn the community against her, increasing the isolation she felt and undermining her self-esteem and confidence:

> He is a well-known person in [town] and the name [calling], the spitting [at me]. In a country town they believe him over me. And it got that way that [my family support worker] had to come…shopping or whatever because it was that bad. The ladies behind the checkout would not give you the change, just throw it at you.

The prejudice against Margaret spilled over into the criminal justice system, with a local magistrate denying Margaret an apprehended violence order (AVO), she believed, due to his friendship with the abuser. Eventually she went to another town, court and magistrate to get the AVO.

Immigration status

Newly arrived migrant women in the study faced additional barriers when seeking help. One of the major obstacles for women who had little or no understanding of English was the inconsistency in the use of interpreters by service providers. Often the partner acted as the interpreter. This left the woman completely isolated and without access to services.

As well as language barriers, women from CALD backgrounds referred to cultural pressures that stopping them from leaving. Some women described family members who were not supportive of their decision to leave the abusers for "old-fashioned" or "traditional" reasons. For example, Duyen's relatives in Australia preferred she stayed with her abusive partner no matter what the circumstances. She received no support from her family after she left the relationship and had to move interstate.

Stigma and shame

Stigma was an issue for women with a diagnosed mental illness. Women reported not being believed about the violence and being treated disrespectfully. Lily felt like she was treated poorly as a result of her mental illness. She related how she received more sympathy for her physical illness (cancer) than she ever did when she was suffering with a mental illness.

The Indigenous women interviewed described how shame interfered with seeking help for domestic violence. Shirley described feeling "shamed and embarrassed" about the violence she had

experienced, particularly when she would have to walk around with black eyes. Lea stated:

> Shame is very important in Aboriginal culture—shame if I go and tell them, shame for saying that. And we try to teach the young ones that it's nothing to be ashamed about because it happens to a lot of people.

Some of the women from CALD backgrounds also felt ashamed to use services and have others outside of their family know intimate details of their lives. Bahar stated:

> If you go to the women's refuge or Department of Housing, everybody knows. I would like to live my life in a dignified way and confidential because I don't want other people to know my situation.

3. *Responses that Work*

Having experienced domestic violence and mental health service sectors, the women identified what worked for them. The need for a coordinated service system was high on their list.

Coordinated and flexible services.

Many women commented on the fragmented service delivery that they had received and talked about the need for coordinated services to support them. Most women saw staff and organisational flexibility as positives aspects of service delivery. This flexibility was talked about in direct contrast to the bureaucratic rigidity of some organisations, where women had to negotiate through a mountain of "red tape". For example, Ilke experienced flexibility with the staff members at the refuge where she was staying:

> You are only allowed to stay here for two months, but they had a meeting for me. I was approved to stay for as long as I needed to, which has been three months, two weeks and two days.

Responsive and respectful practitioners.

Many talked about instances of personalised, individual support and suggested that if services were looking to improve, they could work with women in this way. Examples of this type of support included accompanying women to stressful or difficult appointments (e.g., with the doctor or court appearances) and advocating for women when they were negotiating the complicated health and welfare system. Others spoke of simpler forms of this support—particular staff members being supportive listeners and treating them with dignity and respect. Many suggested that service providers be more proactive and provide increased outreach in the form of referrals or direct contact. Many respondents commented how positive it was when they worked with a specific staff member who they believed was committed to them, their mental health and their journey away from violence. This commitment helped the women feel optimistic, boosted their confidence and made them feel important and worthy of access to care. The positive messages provided by workers was in direct contrast to those of their abusive partners.

Mutual support from hearing other women's stories.

Many women commented how helpful it was for them to meet with other women who had escaped domestic violence and to learn from their experiences and successes. Some women who had not had contact with other survivors suggested this as a move forward in their journey away from violence. Women also talked about mental health support groups where women facing similar issues could come together to support each other.

Working holistically.

Another area of importance identified was health professionals working holistically and looking at all aspects of the women's health. For example, they would often use non-traditional therapies to help with the trauma associated with domestic violence and mental illness/health concerns rather than just prescribe medication.

Increasing public awareness about domestic violence and mental health.

The women believed in the importance of an increase in public awareness, through education and public campaigns, to further general understanding and identification of domestic violence, its links to mental health and its impact on children. Emotional abuse as a form of domestic violence was targeted

as an area where more public awareness is needed. Many of the women spoke of not having identified their own abuse as domestic violence, especially in incidences where they were not physically abused.

CONCLUSION

The women were asked at the end of the interview what message they would give to service providers to assist them to provide more comprehensive services. They stressed the importance of being believed and treated with respect and a nonblaming attitude; the importance of a system that is coordinated; the provision of assistance to navigate complicated service systems; staff being knowledgeable about the links between mental health and domestic violence and the impact this has on children; and staff understanding cultural and racial differences in the presentation and treatment of mental health and domestic violence difficulties. These messages and the women's stories make an important contribution to the development of knowledge about domestic violence and mental health. They indicate ways we can work with women to support them in changing their lives and pinpoint changes that could lead to more comprehensive responses to meet the needs of these and other women who have similar experiences.

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