Written evidence submitted by Imkaan (MHB26)

About Imkaan

Imkaan is a national feminist organisation, dedicated to addressing violence against Black and minoritised women and girls. We are proud to support 38 'by and for' member organisations, representing the expertise and perspectives of frontline, specialist and dedicated Black and minoritised women's organisations, that work to prevent and respond to violence against women and girls (VAWG) every day. Our members provide vital, dedicated specialist services including advice, advocacy, safe housing, and mental health support. We provide capacity building and sustainability support to our member organisations and undertake research, strategic advocacy and policy work from a Black and minoritised feminist intersectional perspective.

Imkaan has been at the forefront of addressing the mental health challenges faced by Black and minoritised women and girls, particularly in the context of violence and abuse. Last year, we launched our report "Why Should Our Rage Be Tidy?" created in collaboration with Women and Girls Network, and the University of Warwick at a parliamentary event hosted by Dawn Butler MP (Imkaan, 2024). In the report, we reviewed published and grey literature, undertook a survey with Black and minoritised 'by and for' specialist VAWG organisations, interviewed experts, and conducted focus group discussions with 12 practitioners, and in-depth interviews with 19 victim-survivors from Black and minoritised backgrounds. The research was advised by seven experts with lived experience and presented important findings. Previously, after conducting online surveys and qualitative interviews, Imkaan had published a position paper which highlighted the impact of VAWG on Black and minoritised women's mental health needs in the context of COVID-19 (Imkaan, 2020). We have also published two guiding papers on women and mental health, "Taking a Forward View on Women and Mental Health: Key Messages for Government" (Women's Health and Equality Consortium, 2017) and "I Am More Than One Thing" (Imkaan, Positively UK and Rape Crisis, 2014) in partnership with Positively UK and Rape Crisis England and Wales. Our research is grounded in the lived realities of Black and minoritised women and girls and supports their voice and needs. We centre anti-racism and intersectionality as key components to tackling violence against women and girls.

We have regularly submitted evidence to parliamentary inquiries, including the Joint Committee on Human Rights' Inquiry on the Mental Health Bill (2025) and the Health and Social Care Select Committee's inquiry into Mental Health Community Services (2025), to highlight the systemic barriers faced by Black and minoritised women. We have supported the Women's Aid Deserve to be Heard Mental Health Campaign. As an advocate for the Black and minoritised women led 'by and for' sector, we promote the value and importance of holistic provision and access to trauma-informed VAWG support that promotes healing and recovery from violence and abuse. Given our research, policy work, and frontline engagement with specialist 'by and for' VAWG services, Imkaan is well-placed to provide evidence on Mental Health Bill to the House of Commons Public Bill Committee.

Introduction

Imkaan believes that the Mental Health Bill (the Bill) presents a unique opportunity to address the longstanding inequalities faced by Black and minoritised victim-survivors of VAWG while accessing mental health support. The main recommendations include:

1. The Bill should explicitly mention its aims to address racial disparities. This can be done by adding a fifth guiding principle – "equity" to the Clause 1 of the Bill.
2. The Bill should establish an independent Mental Health Commissioner to provide additional scrutiny over the implementation of the Act, monitor gendered racial inequalities, oversee collection of data on detention and suicide of Black and minoritised women and advocate for victim-survivors of VAWG facing mental ill-health.
3. Integrated Care Systems (ICSs) and Integrated Care Boards (ICBs) should collaborate and fund Black and minoritised led 'by and for' VAWG organisations to recruit dedicated mental health staff and deliver VAWG trauma-informed and holistic mental health support. They should fund Black and minoritised 'by and for' VAWG organisations to train mental healthcare staff in VAWG-related trauma, anti-racist practices and intersectionality. They should address the lack of diversity in the NHS therapeutic workforce.

4. There should be investment in community-based mental health services that are culturally relevant and VAWG informed for Black and minoritised victim-survivors.

Recommendations

1. **Amend the Mental Health Bill to add a fifth guiding principle – "equity" to the Clause 1.**

Rationale: In 2024, the government announced a new Mental Health Bill intended to modernise the Mental Health Act 1983. The manifesto stated that the "operation of the Mental Health Act discriminates against Black people". A policy paper published by the Department of Health and Social Care accompanying the Bill noted that the Bill intends to implement the policy approaches outlined in Independent Review of the Mental Health Act 1983 led by Professor Sir Simon Wessely in 2018 (Independent Review). The Independent Review highlighted the racial disparities in mental health services. The policy paper reinforced these concerns and noted that during 2023–2024, Black people were three and a half times more likely than white people to be detained under the Mental Health Act, and seven times more likely to be placed on a Community Treatment Order (CTO). The Impact Assessment published last year stated that the Bill intends to "reduce racial disparities under the MHA and promote equality". This has been acknowledged by different Members of Parliament (MPs) in both the House of Lords and the House of Commons during reading of the Bill. In the House of Lords, members had raised concerns about Black African and Caribbean communities' facing barriers to access mental health services and being unlikely to self-refer.

However, it is disappointing to see that there is no explicit mention to tackle racial disparities in the contents of the Bill.

The proposed Bill further introduces more distinctions between Parts 2 and 3 of the Mental Health Act. This is due to the different purposes of the two parts, with the latter applying to people in the criminal justice system. However, it is our belief that this divergence will have consequences, most notably for Black and minoritised communities, who receive mental health support through the criminal justice system. One of the young, Black victim-survivors of assault in our research explained that she was unfairly placed in a mental health hospital and if not for a Black nurse's intervention she would have been institutionalised.

> "When I was 14, walking home late one night from my cousin's house, not that late about midnight, and basically got attacked by some racist white guy on the street. I saw a police car, went to stop the police car.....I saw the police car and jumped into the street. Basically, they didn't believe me, threw me in the back of a van...didn't believe me, believed the guy over me. Hysterical Black girl……they took me to a mental health hospital. Luckily, there was a Black nurse and this is when I say the Lord is with me because if it would have been a white racist nurse or a white racist doctor, I wouldn't be here standing talking to you now because they would have sectioned me, pumped me full of drugs for my whole life...".

Caribbean women gave several examples of police failure when they required help and, worse still, of being criminalised because of disbelief.

> "A Caribbean woman took an overdose, an ambulance was called and they had to break into her place because she was semi-conscious, drifting in and out of consciousness, she comes round and she's wondering who these people are in her flat. So, she's frightened and she kind of hits out and they call the police. They take her to hospital, arrest her in casualty and put handcuffs on her. That just gives you a sense of how this system criminalises, is so harsh, punitive and I don't think that is even a miss it's a hit. I don't even know how to describe that".

Our research shows that Black and minoritised women are more likely to face systemic racism resulting in poor quality mental health care and treatment outcomes. The practitioners and survivors interviewed during the research highlighted Caribbean women were more likely to be treated with prescription

medication, face detainment and exclusion from services and in some cases criminalisation. Black and minoritised survivors are less likely to be referred for psychological therapy compared to white populations.

> "I would say that the GPs are not that helpful because they do not have the time to speak to you and the services that they give are not always great like CBT or medication and all of those things. Tablets don't really help, you actually need to express yourself to get to the bottom of the problem".

In the absence of timely support, our research shows that Black and minoritised women were more likely to be placed on a psychiatric/medical pathway or be criminalised rather than accessing early VAWG trauma informed support. Black and minoritised survivors of violence-abuse experience racialised harms and inequalities, produced by daily micro-aggressions and institutional racism during their interaction with mental health systems, which exacerbate their mental distress and trauma.

During the legislative scrutiny of the Mental Health Bill, the Joint Committee on Human Rights noted the disproportionate number of Black or Black British people being detained and found "no measures directly addressing racial and ethnic inequalities in the application of the MHA". They recommended that the Bill be amended to include a fifth guiding principle— "Equity: addressing inequalities in treatment and outcomes, particularly on racial grounds".

The introduction of this principle is fully consistent with a broad set of statutory duties and strategic priorities established across key health and equality policies in the UK. For instance, the National Health Service Act 2006 sets out a duty on the Secretary of State to reduce health inequalities in health service benefits. Similarly, the Equality Act 2010 obligates public authorities to eliminate discrimination and advance equality for individuals with protected characteristics. The NHS Advancing Mental Health Equalities Strategy (2020) prioritises addressing health inequalities in mental health services. The Health and Care Act 2022 introduces a 'triple aim' duty for NHS bodies which includes reducing health inequalities. Women Health Strategy for England 2022, Guidance NHS Constitution 2023 and NHS England Patient and Carer Race Equality Framework 2024 also cites the importance of promoting equality and addressing racial disparities in mental health outcomes.

Our recommendation: Clause 1 of the Bill lays down 4 principles to inform decisions under the Bill—choice and autonomy, least restriction, therapeutic benefit and the person as an individual. We believe a fifth guiding principle—equity should be included in the Bill to clearly signal the Bill's intent to acknowledge and address racial disparities in mental health outcomes and access to care.

2. **Establish an independent Mental Health Commissioner to provide additional scrutiny over the implementation of the Mental Health Act and to advocate for mental health of Black and minoritised victim-survivors of VAWG, their families and caregivers.**

Rationale: Our research showed that Black and minoritised victim-survivors faced mental ill-health as a result of violence and abuse and experienced loss of self, loss of security-safety, loss of family and community social support. The most common symptoms amongst survivors accessing support recorded by specialist Black and minoritised led 'by and for' organisations in the period April 2019 - March 2020 included depression, anxiety, complex PTSD, panic attacks, suicide ideation and attempts and self-harm. The multiple forms of silencing about violence-abuse, including stigma and shame that women encountered within their social and cultural contexts were widely noted.

> "I had to drag myself kicking and screaming to therapy. And I think that's what people don't understand. The stigma behind it that's drilled into us from day one as black people or people that come from immigrant communities that don't access those services. You don't tell. You don't ask for help".

When women finally looked for help, they felt betrayed by a hostile and unhelpful system response. Professionals often failed to make the connection between their mental ill-health and their experience of violence-abuse, which worsened their mental health. Women accessed multiple services during

lengthy and complex routes to positive support, frequently marked by unhelpful, discriminatory and re-traumatising responses. They reported between 10-40 different contacts, over several years, before receiving a response they regarded as helpful; it had taken 15 years and over 40 encounters with services for one woman to find answers. They were readily mis/diagnosed and faced a lack of appropriate support. Some women were clear that GPs only dealt with surface level issues rather than taking the time to talk to them and identify the underlying issues connected to their child and adult experiences violence and abuse. Overall, encounters with GPs were frequently unhelpful and negatively experienced.

> "When I moved to the refuge I got a new GP surgery. The person I was assigned to was extremely unhelpful and she didn't see the trauma, even though I told her. I explained I was in a refuge, it almost felt like she was adding to my trauma and it was like she was the bully and had replaced my abuser".

Specialist practitioners described a system that has a dehumanising and re-traumatising impact on women frequently leaving them feeling unsafe, voiceless and powerless.

> "It was not only in the NHS, but particularly in the NHS, they spoke about their experiences of the assessment process as dehumanising, that they were minimising and not relational, and it was distressing and disturbing for them…..".

Our research found that unless minoritised women had access to trauma-informed, VAWG-sensitive and holistic support from Black and minoritised 'by and for' organisations their mental health became worse and more chronic. Added to this, Black and minoritised women are more likely to have their experiences of VAWG dismissed or minimised and face more barriers to access because of systemic racial bias and wider socio-economic inequalities and consequently suffer more prolonged and unequal access to mental health support and care. Racial stereotyping, discrimination, criminalisation, misdiagnosis/over-diagnosis, biases contribute to the systemic pathologisation of minoritised women's mental wellbeing which has led to the disproportionate use of punitive measures, coercive care and over-medicalisation of minoritised communities over several decades within the health system. Women with insecure immigration status were frequently turned away by mainstream organisations and told to contact police or social services which made them feel hopeless. Despite such overwhelming evidence, there is an ongoing failure to tackle the differential treatment and outcomes for racialised minority communities.

The Mental Health Commissioner should be established to monitor racial inequalities in mental health services across the protected characteristics. The Commissioner should assess the availability of VAWG sensitive mental health community-based provision to Black and minoritised victim-survivors of VAWG. They should ensure that holistic, therapeutic and VAWG trauma informed support is available.

The Commissioner should oversee the collection, analysis, and publication of disaggregated data to identify and address disparities. There is well-established evidence of significant disparities in the use of the Mental Health Act with Black people more likely to be detained or placed under CTO. While NHS publish annual statistics on detentions and CTOs by ethnicity and gender separately, we cannot see how many Black and minoritised women are detained. We also do not know the number of Black and minoritised women who die by suicide in the context of domestic abuse. Existing research indicates that more women take their life due to domestic abuse as compared to their death by domestic homicides, but the true figure is impossible to establish from the available data. This data is required to inform policy and understand the experience of Black and minoritised women, particularly survivors of VAWG and develop targeted interventions that address structural inequalities in the system.

The Independent Review has also recommended "improving the quality and consistency of data and research on ethnicity" in the context of mental health. As mentioned before, the UK government has existing obligations under laws like the National health Services Act 2006, Equality Act 2010, the Health and Care Act 2022, and the NHS Constitution 2023, which mandate the reduction of health inequalities. The Mental Health Commissioner would act as a key mechanism for delivering these duties, especially

for Black and minoritised women, disproportionately affected by poor mental health outcomes. It aligns with commitments made in Women Health Strategy for England 2022 and NHS England Patient and Carer Race Equality Framework 2024. It further aligns with international obligations under the Istanbul Convention (Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence) 2011 and UN Convention on the Rights of Persons with Disabilities which require the State parties to take necessary measures to ensure that victim-survivors have access to appropriate healthcare services. It would be consistent with the UK's approach to protect rights of marginalised groups through independent oversight bodies such as Domestic Abuse Commissioner, Children's Commissioner and Victims' Commissioner. The Joint Committee on the Draft Mental Health Bill has also recommended establishment of Mental Health Commissioner.

Our recommendation: The Bill should establish an independent Mental Health Commissioner to provide additional scrutiny over the implementation of the Act, monitor gendered racial inequalities, oversee collection of data on detention and suicide of Black and minoritised women and advocate for survivors of VAWG facing mental ill-health.

3. **Integrated Care Systems (ICSs) and Integrated Care Boards (ICBs) must identify and collaborate with Black and minoritised 'by and for' trauma-informed VAWG organisations.**

Rationale: Many women who do not report domestic abuse to police and other statutory agencies do access GPs, mental health and other health practitioners (Centre for Women's Justice and Imkaan, 2023). Multiple case studies in our report highlighted how healthcare professionals failed to probe for domestic abuse.

> Nadira had taken an overdose and was taken to hospital by ambulance, where she was seen by a psychiatrist and referred to the community mental health team. She received a home visit the next day by a male nurse without an interpreter and was seen with her husband present. They discussed an "argument" which triggered the overdose, but there was no consideration of the possibility of domestic abuse, and the need to facilitate her seeing a member of the mental health team in private with an interpreter.

The experts, specialist VAWG practitioners and victim-survivors of VAWG interviewed during our recent research highlighted that NHS therapists and mainstream agency professionals failed to make the link between violence-abuse and trauma and mental ill-health of survivors (Imkaan, 2024). The generic nature of NHS counselling and a limited understanding of violence-abuse related trauma led to the signs of trauma being missed and/or minimised by professionals outside of VAWG trauma-informed specialists.

Many of the available NHS interventions were found to address generalised anxiety and/or depression rather than trauma linked to violence- abuse and especially the lived experiences of minoritised women. Women mentioned about the tendency of mainstream professionals to focus only on its secondary manifestations – self-harm or disordered eating, which disconnected these from their root causes in violence-abuse. The approach of NHS therapists and mainstream agencies was widely regarded by women as lacking a VAWG and trauma-informed perspective, where women were required to constantly repeat their stories. An intersectional understanding of these issues in relation to racialised minorities was marked by discriminatory and stereotypical responses. Without training in identifying VAWG and delivering trauma-informed care, mental health professionals were unable to provide effective support to victim-survivors.

> "Some of the mental health services have developed services for anxiety and trauma but they don't provide the right type of support, they're still insensitive in terms of understanding women's experiences of VAWG. It's difficult to access services for Black and minoritised women, the majority of people who access trauma therapies are disproportionately white (in London)".

Women and practitioners in our study emphasised the importance of GPs referring survivors only to trauma-informed therapists with an understanding of VAWG and intersectional experiences to avoid them being re-traumatised.

> "If you just have trauma-informed and you are not survivor-led, which is a really important component of being trauma-informed, and you don't have insight into somebody's cultural and ancestral contexts, their ethnicity or social positioning, you do that individual a mis-service. You miss them in a way that's really important and you don't really connect. In this work you really need to connect to somebody ... what I hear repeatedly from Black and minoritised survivors when they are working with practitioners is that they don't feel trusted, they don't feel they are seen and they don't feel validated in those spaces".

Women also did not feel understood by the mostly white, and sometimes male, therapists they were assigned, some of whom had tried to offer support as best as they could. A pronounced shortage of therapists from minoritised communities had serious implications for survivors seeking mental health support. Women felt negatively judged about their ethnicity in such encounters; for them, both the approach and background of the therapist mattered.

The Independent Review had recommended increasing "representation of people from ethnic minority backgrounds, especially those of black African and Caribbean heritage in key health and care professions". However, NHS WRES data mentions that only 24.2% of their staff comes from Black and minority ethnic background (NHS WRES, 2022). One of the practitioners mentioned that:

> "We've got 4% of therapists that come from Black and minoritised communities...how are we supporting with bursaries?... in our sector it is predominantly white, what does that mean, how are we supporting our communities to get those skills? That's really important in being able to see ourselves reflected in different places, not just as caseworkers".

When women accessed specialist 'by and for' Black and minoritised services, they were able to draw on emotional and therapeutic support at an earlier stage. When women were informed about specialist services by first responders or referred to specialist 'by and for' services early in the help-seeking process, even with complex cases, they reported more positive experiences. Notably, younger women in abusive relationships, given information about 'by and for' services by a friend or someone in their network, were able to leave and gain access to specialist support more quickly. Once they were safe, supported and held by professionals who understood, women's symptoms reduced, became manageable or disappeared. With support, care and a sense of safety, most often afforded by 'by and for' specialist VAWG services, women moved from hopelessness to being hopeful, feeling they had control over their lives and wanting to build a future for themselves.

> "If I had had the support that I've got from [specialist organisation] earlier on that may have helped me with the past trauma that I had, that was still there in the background. It would creep in and sort of continue to cause my mood to be down. So I feel like if I could've had the support earlier on then these issues wouldn't have affected me".

Black and minoritised women led 'by and for' organisations play a crucial role in early intervention and prevent women and girls from developing chronic mental health issues. Black and minoritised 'by and for' specialist therapeutic support counters potentially damaging and re- traumatising support to survivors resulting from the failure of agencies-professionals to centre the lived experiences of minoritised women. 'By and for' specialist organisations combine an intersectional approach with VAWG and trauma-informed expertise. In identifying what they would have found helpful or how the system response can be improved, women suggested that more information about 'by and for' support organisations should be available in more places and given to women by more agencies-professionals.

Despite playing a vital role in the care pathway for survivors, 'by and for' organisations described feeling dismissed and/or marginalised by statutory services.

Last month, we conducted a survey to understand the challenges faced by Black and minoritised led 'by and for' organisations in providing mental health support to their service users (Mental Health Snapshot Survey, May 2025). They confirmed what we already knew – that there is little to no engagement of ICBs with the Black and minoritised 'by and for' VAWG organisations. Only 40% of organisations responding to the survey reported being aware of or invited to participate in discussions with their local ICBs to shape mental health strategies. Among those engaged, most felt that their local VAWG strategy includes considerations for the mental health and wellbeing of Black and minoritised women and girls, but these considerations were considered surface-level or tokenistic rather than meaningfully embedded. One-third of participants expressed concerns that mental health remains an afterthought, and local strategies often fail to incorporate VAWG sensitive and culturally competent care for Black and minoritised communities. Over 70% emphasised the need for trained professionals who understand racial trauma, domestic abuse, and other intersecting forms of VAWG from an intersectional lens. One of the respondents stated that:

> "The Integrated Care Board feels very elitist in relation to who represents on the boards. We have no communication directly with them in Newham, and it is difficult to ascertain who to contact to initiate a conversation. This lack of engagement with our organisation gives me a clear indication of how we are seen—Invisible, hard to reach, like our users."

Over 90% of Black and minoritised 'by and for' organisations responding to the survey cited funding limitations as the biggest challenge preventing them from providing extended support, including counselling, therapeutic services, and long-term mental health interventions. Very few Imkaan members are funded to deliver VAWG sensitive therapeutic support through the NHS Improving Access to Psychological Therapies (IAPT) pathway. Due to short-term nature of funding or lack of funding, within a context of high demand and organisational constraints, 'by and for' organisations are unable to offer the longer-term support required to respond to the many layers of complex trauma rooted in Black and minoritised women's experiences of violence-abuse.

> "Most funding is project-based and often restricted to a specific number of sessions... Without sustained and flexible funding, it's difficult to meet the long-term counselling needs of survivors."

We have filed Freedom of Information (FoI) requests to Integrated Care Boards (ICBs) to understand their commissioning process. While most responses are still pending, one ICB indicated that it had provided approximately £600,000 in funding over the past three financial years to a mainstream organisation to deliver the Identification and Referral to Improve Safety (IRIS) training and advocacy programme. No funding was allocated to any 'by and for' organisations. The ICB noted that referrals through this pathway for Black and minoritised communities have remained consistently low.

ICBs must collaborate and fund Black and minoritised led 'by and for' VAWG organisations. Different policies including ICS Implementation Guidance on Partnerships with the Voluntary, Community and Social Enterprise (VCSE) Sector 2021, Health and Care Act 2022, Working in Partnership with People and Communities Statutory Guidance 2023 and Guidance on Integrated Care Board Constitutions and Governance 2024 require ICBs to involve community to address health inequalities. They have public involvement legal duties where they need to centre decision-making around voice of communities and work with voluntary and community sector. They are required to "address health inequalities by understanding communities' needs and developing solutions with them". One of the principles of working with people and communities is to "build relationships based on trust, especially with marginalised groups and those affected by health inequalities". The guidance recognises that the VCSE sector has "an excellent understanding of the health and care issues faced by those [disadvantaged] communities". Additionally, under VAWG Strategy 2021, Women Health Strategy for England 2022 and Policy Paper Suicide Prevention in England: 5-year Cross-Sector Strategy 2023, ICBs and other NHS organisations are required to provide trauma-informed and tailored support to victim-survivors of VAWG. This can be done by funding Black and minoritised led 'by and for' VAWG organisations to to recruit dedicated mental health staff.

Our recommendation: We emphasise that ICSs and ICBs should collaborate and fund Black and minoritised led 'by and for' VAWG organisations to recruit dedicated mental health staff and deliver VAWG trauma-informed and holistic mental health support. They should fund Black and minoritised 'by and for' VAWG organisations to train mental healthcare staff in VAWG-related trauma, anti-racist practices and intersectionality. They should further address the lack of diversity in the NHS therapeutic workforce.

4. **There should be investment in community-based mental health services that are culturally relevant and VAWG informed for Black and minoritised victim-survivors.**

Rationale: The community mental health framework has not been sufficient in understanding and integrating VAWG and the specific intersectional consequences for Black and minoritised women. An intersectional VAWG and trauma-informed practice, as opposed to a medicalised approach, helps to address women's unequal access to opportunities, resources and rights which add to women's distress, through institutional advocacy and building community support structures to combat women's social isolation alongside therapeutic support and resources. Intersectional VAWG support and advocacy organisations recognise and respond to the exclusion and disproportionate inequalities experienced by minoritised survivors and their communities.

Our research highlighted the need for resources that support 'by and for' organisations to strengthen and expand their work through new ideas and practice, especially non-Eurocentric models of support, to respond to the specific ways in which trauma manifests for minoritised survivors. Practitioners spoke about different models of support they had developed within their organisations which drew on more diverse knowledge and belief systems and which had positive impacts on survivor wellbeing. They emphasised the importance of a space that validates and makes visible the entirety of survivors' experiences in ways that feel culturally and socially relevant to them.

We believe that intersectional, VAWG-trauma informed models developed by specialist 'by and for' Black and minoritised women's organisations offer effective, innovative practice in supporting Black and minoritised women. An example of a VAWG specialist comprehensive multi-disciplinary model is exemplified by Women and Girls Network's 'Holistic Empowerment Recovery Model'. It is important for policymakers and NHS commissioners to recognise the role of specialist women's voluntary/community sector organisation as key collaborators in delivering and developing best practice community health services.

NHS The Community Mental Health Framework for Adults and Older Adults 2019 and NHS Long Term Plan 2019 mentions how community mental health services can address inequalities in mental health care. The Independent Review and the Joint Committee on Human Rights have recommended for provision of culturally appropriate community mental health services.

Our recommendation: There should be investment in community-based mental health services that are culturally relevant and VAWG informed for Black and minoritised victim-survivors.

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