Home Office

STANDING TOGETHER against domestic abuse

CROSSING PATHWAYS
INTEGRATING BEST PRACTICE WITHIN HEALTH AND DOMESTIC ABUSE

CENTRING THE SURVIVOR VOICE HIGHLIGHTS: FOCUS GROUP FINDINGS 2023

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THE PROJECT OVERVIEW

WHO ARE STANDING TOGETHER?

Standing Together is a national charity bringing communities together to end domestic abuse. We exist to keep survivors and their families safe, hold abusers to account, and end domestic abuse by transforming the way organisations and individuals think about, prevent, and respond to it. We do this through an approach that we pioneered 20 years ago, for which we are known across the UK and internationally, called the Coordinated Community Response (CCR). The CCR brings services together to ensure local systems truly keep survivors safe, hold abusers to account and prevent domestic abuse for more information on CCR see: https://www.standingtogether.org.uk/what-is-ccr

WHAT IS CROSSING PATHWAYS?

Using the CCR philosophy we pioneered the Whole Health approach to domestic abuse, which recognises the need for a systemic approach to responding to domestic abuse across the health economy. Standing Together has worked locally and nationally to coordinate health partners' response to domestic abuse over the last two decades and this knowledge and experience informed our recent national project, Pathfinder, the recommendations from which are included in the Domestic Abuse Act 2021 Statutory Guidance. For more information on our health work see: https://www.standingtogether.org.uk/health

Standing Together has been commissioned by the Home Office to help drive the national transformation of the health response to domestic abuse – Crossing Pathways. Our overall aim is to instil sustainable change and ensure a consistent and coordinated whole health system approach. The first phase of our project was to map the existing domestic abuse provision within health, analyse referral pathways, identify gaps and best practice. We have worked with partners such as Local Authorities, VAWG Forums, Police and Crime Commissioners, Specialist Domestic Abuse Services along with Health services to gather data about the interconnected nature of these systems and their approach to health and domestic abuse. We include a wide range of partners who can provide information about domestic abuse and health ensuring the landscape in scope is as diverse and inclusive as possible.

The central mechanism for this systems analysis are eight Crossing Pathways Network Groups, established across England to discuss the intersections of Health and Domestic Abuse in those region. The Survivor Voice Network runs alongside the network groups ensuring the voices of lived experience are central to informing this system analysis and proposed change.

To achieve this, Standing Together understands that it is imperative that we work within a intersectional lens when hearing the voices of survivors of domestic abuse. This report is a beginning towards that aim and informs our engagement strategy going forward for the work of the forums.

CENTRING THE SURVIVOR

This consultation has been undertaken by Arlene Mensah, Standing Together's Survivor Voice Lead as the first part of the Survivor Voices collaboration, whereby we have conducted focus groups and one - to - one interviews between June and August 2023 with fifty-five adult survivors. All of the participants had accessed healthcare services in relation to domestic abuse, historically or recently. This paper provides an overview of that initial work with the aim of centring domestic abuse survivor voices throughout this programme of work - hearing their lived experiences as they access healthcare services, the barriers they faced, and the gaps identified in provision.

We would like to thank all the survivors for sharing their experiences with us, for their courage and willingness to help in this journey to improving the landscape. We would also like to thank all organisations that supported us in our efforts to speak to as many survivors as possible.

This consultation represents a temperature check of the situation faced by some survivors today, 3 years since the end of the Pathfinder project. Pathfinder enabled the Whole Health approach to be developed and the Crossing Pathways project is an extension of that work. In this instance, the consultation will be used to inform and develop the ongoing engagement of survivors through survivor voices forums, and an action research method of working with them in conjunction with the Crossing Pathways groups and commissioned services to inform the overall analysis of best practice today.

METHODOLOGY

Invitation letters were sent to 80 organisations across England requesting support with the survivor voice project, including a range of by and for services, maternity, probation, prison, drug & alcohol services to ensure inclusivity.

Design and distribution of a toolkit for use in the consultation including an information booklet, expense policy, confidentiality policy and agreement, information sharing policy, wellbeing guidance, consent and referral forms.

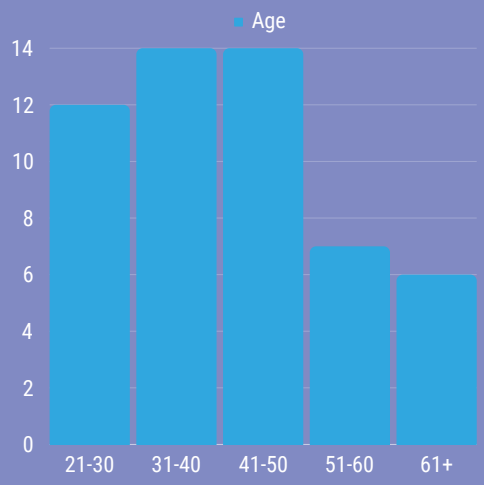
Development of an engagement plan for the 12 participating organisations including options for focus groups and one-to-one interviews. Consideration was given to settings, language and other needs which enabled a much higher level of inclusion.

PARTICIPANTS

The 55 voices in this report include those who have experienced domestic abuse and also have a breadth of additional experiences: living in rural isolation, having no recourse to public funding, being survivors of female genital mutilation, so-called honour-based abuse, human trafficking, forced marriage and/ or sexual abuse. Some survivors had learning disabilities and neurodivergence. In total there were five focus groups with 33 survivors and 22 one-to-one interviews.

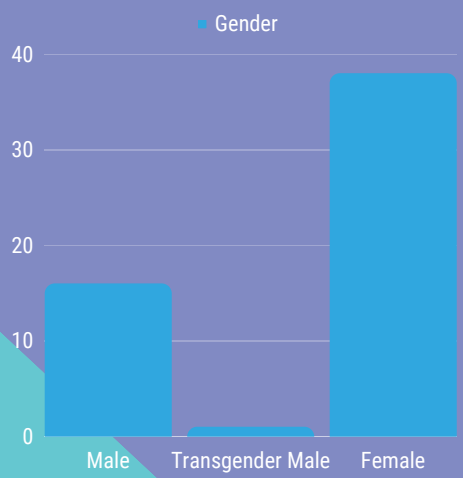
WHO SPOKE TO US?

AGE



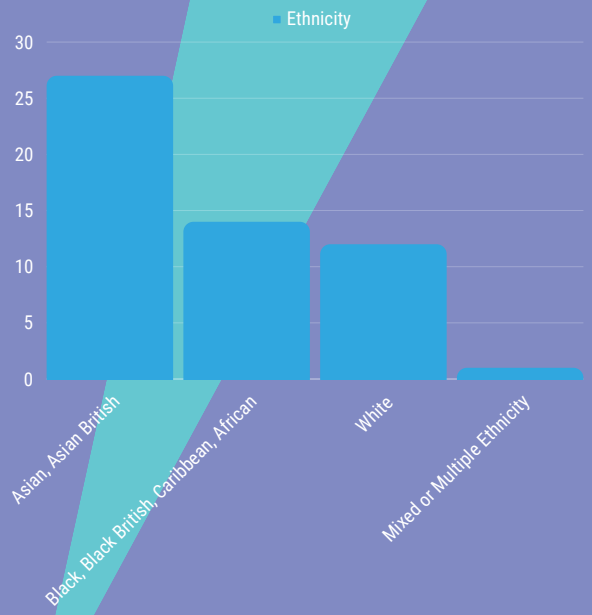
We were not able to secure first hand experiences from children and young people, however parents openly expressed challenges their children faced which is detailed in the findings.

GENDER



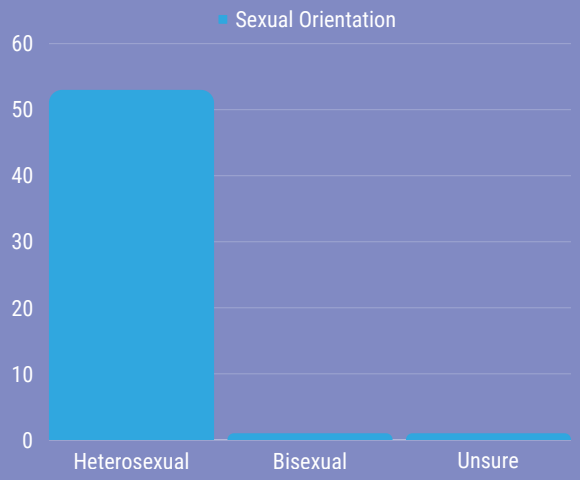
There was limited representation from the Transgender community with one transgender male survivor.

ETHNICITY



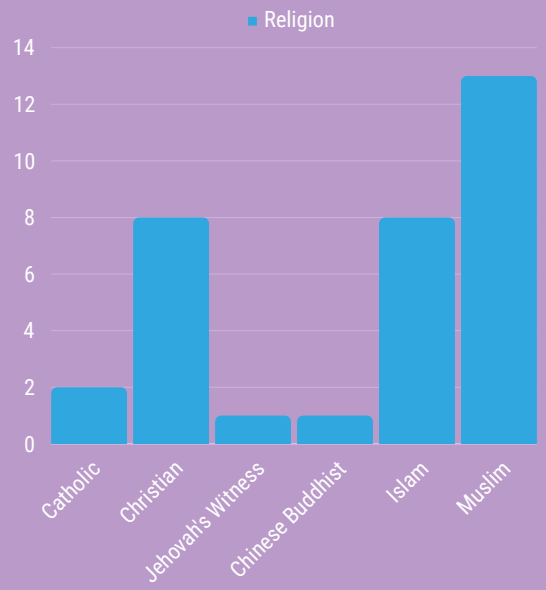
Most of survivor participants were from migrant communities, this provided insight around immigration, cultural issues amongst other subjects.

SEXUAL ORIENTATION



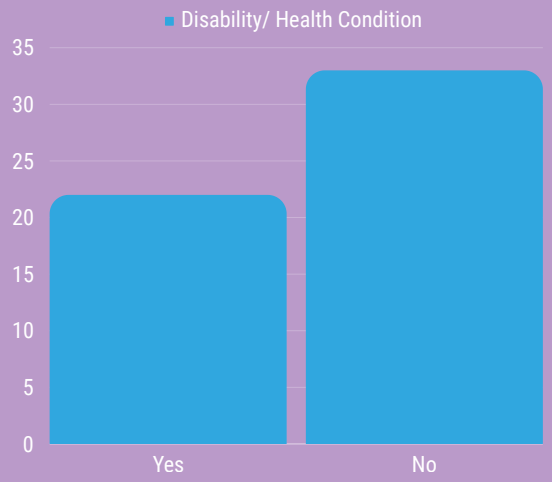
We had minimal participants from the LGBTQi+ community, we want this community to be reflected within further consultations.

RELIGION



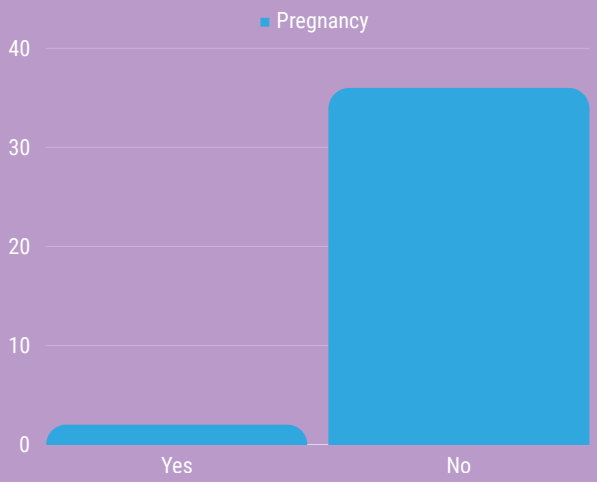
Most survivor participants were Muslim.

DISABILITY/ HEALTH CONDITION



Twenty two survivors stated they had a disability and/or health condition on their referral form. These related to physical health, mental health and neurodivergence. The research did not capture whether these conditions are linked to domestic abuse, but it is likely some of these conditions may be a direct result of domestic abuse either through injuries sustained or the impacts of stress and other factors.

PREGNANCY



Two survivors were pregnant at the time of consultation,

THE BRIEF FINDINGS

The consultations presented areas of best practice by some professionals, with some clear overarching areas for improvement. Pressures in the health system are not conducive to the best practice needed for survivors of domestic abuse and their children and this comes across clearly in the survivor voices, while simultaneously there are many developments that can be made to improve the whole health system.

In summary the areas for development identified by the participants can be grouped into four main areas:

- Developing the knowledge and understanding of the dynamics of domestic and sexual abuse across health settings, including specific knowledge in relation to risks, rights and the responsibilities for safeguarding held by all practitioners.
- Developing the trauma-informed care available to survivors – ensuring that practitioners are competent, have these principles embedded within them and that they extend to an understanding of survivor needs as biopsychosocial.
- Developing the cultural competency in services not only in relation to signposting to services but also to ensure that immediate support is appropriate to a diverse range of needs.
- These are the initial findings, with this work to continue through the life of the Crossing Pathways project. There are more survivors to be included as the Survivor Voice strand of the work moves into its action research phase.

TRAUMA INFORMED PRINCIPLES

The Survivor Voice Lead took a trauma informed approach throughout the research adopting the principles of safety, trustworthiness, choice, collaboration, empowerment, and cultural consideration (Office for Health and Improvement Disparities, 2022). Some examples of how these were implemented were:

- Providing survivors with the project overview so they could understand the parameters of the work and their involvement to make an informed decision to participate.
- Framing research questions to hear their experiences of healthcare related to abuse rather than asking them to share their own abuse experience.
- Sharing the research questions with survivors in advance to support with preparation towards the session and reduce anxiety of what they might be asked.
- Careful consideration of the policies, procedures and guidance in the document pack to ensure psychological safety.

- Offering survivors choice of how they participate in the research whether via focus groups or one - to - ones interviews, in person or remotely, but also accommodating their needs for participation, such as, arranging interpretation services and scheduling sessions at times of day that were convenient.
- Endeavouring to engage with a diverse range of survivors to develop a greater understanding of the intersecting experiences in different groups.
- Ensuring survivors felt listened to, explaining how the project will amplify and centre their voices.

PARTNER ORGANISATIONS

12 partner organisations engaged with the work enabling access to a range of survivor voices.

THEME 1:
BEST PRACTICE

COMMUNICATING IN SURVIVOR'S PRIMARY LANGUAGE

RESPONSE TO DISCLOSURE

BEST

SPEAKING WITH PATIENTS ALONE

PRACTICE

REFERRALS TO SUPPORT

EXPLANATION OF ABUSE

RECOGNITION OF RISK INDICATORS OF DOMESTIC ABUSE

24 survivors reported positive experiences with healthcare professionals, it should be noted that these practitioners have assisted many survivors to safety plan, flee, access specialist interventions and more. Examples of best practice were:

1. A G.P. ensuring that a survivor had appointments with a colleague who could communicate in their primary language.
2. Some survivors described G.P.s as taking them seriously and referring them on for other support following disclosure.
3. Numerous instances of health staff, in a range of settings, insisting that they spoke with participant's alone.
4. Explanations of abuse being offered to enable participants' awareness of the issue.
5. Recognition of risk indicators for domestic abuse causing changes to approach and/ or safety measures to be put in place.

"In order to obtain prescription refills for my ADHD medication, I'm required to attend the clinic regularly and complete a series of tests. The nurse who takes my blood pressure and heart rate is aware of my trauma and disabilities. She knows that I cannot attend early morning appointments, that I struggle with bright lights, and that I need to sit down for 10-15 minutes in order to prepare myself for the blood pressure machine, as I find it painful and stressful. She is incredibly kind and patient, and understands that these small adjustments can have a massive impact on outcomes for me. Without them, I arguably wouldn't be able to access this essential healthcare."

THEME 2:
BARRIERS

GENERAL PRACTICE

General practice was the area where the survivors faced the greatest number of barriers in a primary care setting with 17 instances of poor practice being described. Waiting times for appointments were problematic, this is in line with the general experience of patients at present, but is an important risk consideration for those who experience domestic abuse, given the time-pressured risks they face if they are help-seeking. Further issues with appointments were identified that could lead to a survivor of domestic abuse not feeling safe to disclose and/or escalating their risk. Key issues were:

1. Reception and appointment systems creating barriers to appointments.
2. Feeling uncomfortable trying to describe private matters at the reception desk.
3. Not having a consistent G.P. to see as well as not being able to ask to see a male/female G.P. as needed.
4. Being unable to afford to pay for supporting letters, as well as difficulty in obtaining them.
5. Being refused registration due to a lack of ID despite this being contrary to NHSE guidance.
6. Having treatment delays and the re-traumatisation of changing practices when moving.
7. Insensitivity to a disclosure of rape.
8. Treatment that minimised domestic abuse, rather than exploring the issue.
9. Advising survivors that their abuse did not qualify as domestic abuse.
10. Medicating survivors to help them to 'cope' rather than acknowledging their distress as a real outcome of abuse.

G.P SYSTEMS, RISK & CONFIDENTIALITY

Waiting times were raised at various intervals during research sessions. Survivors tried to make appointments to see doctors but were placed in a queue. This problem is not unique to survivors of abuse but does present additional challenges and risks in this context. One survivor stated waiting a month to have an appointment with her G.P. to disclose abuse. For survivors who were still living with the abuser, it proved difficult to discreetly contact the G.P. due to the waiting times, some gave up or lost their place in the queue due to the call disconnecting.

Other survivors recognised receptionists as a physical barrier between them and their doctor. Receptionists were described as offering diagnosis and becoming agitated due to the number of people in the queue. It was felt surgeries are advocating for patients to use technology, ***'Now they try to get you on this e-consult where you do everything […]'*** Disclosing abuse is a sensitive matter and survivors described the importance of human contact and being able to trust the person receiving the disclosure.

GENDER OF DOCTORS

On two occasions, the gender of doctors was addressed concerning disclosure and examinations by general practitioners. It was observed that choice is not given when booking appointments for examinations with receptionists triaging the need for consultation, ***'You just have to see who is available.'***

Where patients must remove partial or all clothing, it was felt the gender of the doctor mattered relating to how comfortable or uncomfortable the survivor might feel. Despite the offer of a second person in the consulting room during sensitive examinations, survivors can experience re-traumatisation at these times, and the gender of the examining doctor and the second person in the room is a crucial component of trauma-informed care.

It is common for G.P. settings to have locum doctors. A female survivor was booked in with a male locum. She wanted to discuss the domestic and sexual abuse experienced, and was uncomfortable to go into the full details, due to not only the doctor being a locum doctor, but also the survivor's experience of power and control dynamics from her male perpetrator.

DOCTOR'S RESPONSE TO DISCLOSURE

A male survivor recounted his GP's response to disclosure, ***'Oh that is so sad, but sorry, I cannot help you.'*** Another survivor saw her family doctor for over 20 years. When she revealed her husband had raped her; his reaction was that rape is common in marriage. She felt ashamed, and he was the first person she had told, ***'[…] he made it seem acceptable and I accepted what he said.'***

MINIMISING SURVIVOR'S CONCERNS

Two survivors shared concerns about the abuse with their G.P. that were minimised and treated as mental health problems which has led them to question themselves or the judgment of the healthcare professional. 'Diagnostic overshadowing' appears to be common in general health care settings, meaning the misattribution of physical illness signs and symptoms to concurrent mental disorders, leading to underdiagnosis and mistreatment of the physical conditions.' (Thornicroft et al., 2009).

One survivor described this experience, when relaying his physical health concerns, he was dismissed, ***"it's your anxiety."*** The doctor even attempted to increase his medication which the survivor was not in favour of. ***'[…] in recent times you find out, "Oh, it's not your heart, it's not your dizzy spells, it's your anxiety." 'It's patronising […]'***

Another survivor spoke of disclosing to the GP over the phone, during the call she was crying, whispering and fearful. The GP missed the signs and made her feel it was all in her head. ***'[...] because we had a conversation in that phone call about how Sertraline helps slow down those kind of impulsive decisions, helps that paranoia […] So I kind of put two and two together and maybe if I was able to do that in the most darkest times in my life, then you know – But he did say it, I remember very clearly, "the medication will help with those feelings.'"*** In contrast, after the survivor fled, her new G.P. recognised the abuse and was extremely supportive.

SECONDARY CARE

Survivors accessed support from accident and emergency (A&E), maternity care, the community mental health team including peri-natal mental health and counselling services. Multiple barriers were faced by survivors in accessing secondary care services, in summary:

1. A lack of trauma-informed care, exhibited in a range of ways from low empathy to rigid systemic practices.
2. A lack of professional curiosity in exploring and raising survivors' awareness of abuse.
3. A lack of consideration of the accessibility needs of survivors.
4. A lack of help and consideration in relation to fees, childcare needs, and other financial issues.
5. Domestic abuse not seen as a contributing factor towards mental health diagnosis
6. Limited time and availability of services.

ACCESS TO MATERNITY TREATMENT AND HOSPITAL FEES

The Royal College of Midwives have been advocating for the end of migrant women maternity charging. In an article they warn that, *'the fear of having to pay for their care is stopping many women engaging with maternity services and puts the safety of their pregnancy at risk' (RCM 2022.)*

When accessing maternity services three survivors with an asylum or overstayer status were confronted with hospital fees.

G* was asked for paperwork relating to her immigration status when presenting to the hospital. Treatment was denied without paperwork. G* said this scared her and led her to approach a hospital outside of her catchment area. The fear of hospital fees was a constant concern. When contractions began, she delayed going to hospital, the panic regarding the fees caused her to give birth in the ambulance. G* was surprised when she received yet another bill. ***'Despite the fact that I gave birth to her in the vehicle they are still requesting for [big] money… it's not good.'***

R* is an asylum seeker who needed evacuation surgery following a miscarriage. When she came around from surgery, the hospital billing department called asking for payment. R* was so upset, ***'I told them see – I am not in the mood to talk to anybody right now. I have just undergone a surgery – I lost a baby and [the] only thing you can tell me is to come and clear the bill. What bill are you talking about? I am an asylum seeker, so I am entitled to the healthcare.'*** The midwife supported in resolving the matter by taking the asylum paperwork to the billing department who cancelled the charge.

Other maternity experiences centred around how healthcare professionals ask about domestic abuse, effective support during and after pregnancy and staff conduct.

HOW HEALTH PROFESSIONALS ASK ABOUT DOMESTIC ABUSE

I's* midwife asked I* if she was experiencing abuse on hearing about her in-laws controlling behaviour. I's* response was, ***'No'*** because she did not yet recognise her experience as abuse. She believes healthcare professionals should review how they ask the question, and the follow-ups to it. In this case, they could have supported her awareness by naming psychological abuse, helping her to reframe the way she viewed her experience.

'[..] I don't like talking to health professionals about my abuse […]'

Nine survivors experienced insensitive or inappropriate behaviour from healthcare professionals, which impacted their emotional wellbeing, or the support they received, some examples were feeling bullied, comments about how nice their abuser seemed, judgments about children and a derogatory movie quote about people from a particular ethnicity.

'[…] if you lack any understanding of the seriousness of [domestic abuse] then you will come out with these glib comments. It's not even maybe necessary, I think the language [surrounding domestic abuse] is almost closed off – when they get bedded in of the seriousness [of domestic abuse], I think the language will come naturally. I don't think you'd say that kind of thing if you grasp what you're dealing with [domestic abuse].'

Language was highlighted by the survivor above in terms of the way people are spoken to and the impact it can have on them.

Others spoke of the ways in which clearer explanations or improvements to the way situations were approached, could have led to more positive outcomes.

LACK OF CONSIDERATION IN RELATION TO CHILDCARE NEEDS

Three single parents discussed difficulties with taking their children to hospital. When attending hospital, they were not able to leave their children with friends or family members.

X* attended hospital for a scan, hospital staff were hostile towards her bringing her daughter with her.

W* has two children, when her son became unwell the whole family went to A&E. They were still there by the early hours of the morning, a doctor told W* that her daughter could not stay.

E* is a mother of two. One of her son's has special needs which affects his behaviour, and he is unable to communicate which adds further complexities when he is unwell. E* has experienced long wait times in A&E, sometimes she gives up waiting and goes home. Trying to keep her son calm for up to 4 hours or preventing him from disrupting others becomes problematic.

The above examples showcase limiting survivors and their children's access to healthcare settings, alongside missed opportunities for healthcare settings to support survivors of domestic abuse or have an intersectional approach for accessible services for single mothers.

THEME 3:
IMPACTS

CHILDREN LIVING WITH IMPACTS OF DOMESTIC ABUSE WITHOUT EARLY INTERVENTION

INCREASED PAIN/ POOR PAIN MANAGEMENT

DETERIORATING MENTAL HEALTH

INCREASED RISK

IMPACTS

ISOLATED IN ABUSE

MISTRUST OF SERVICE PROVIDERS/ PRACTITIONERS

INCONSISTENT/ UNHELPFUL CARE

EXPLANATION OF ABUSE

DECREASED LIKELIHOOD OF DISCLOSURE

ECONOMICALLY SANCTIONED

Survivors were asked about the impact that the barriers which they faced had on them, consistently describing impacts that created further need for them to seek support and/ or isolation from support services:

1. Deteriorating mental health
2. Increased pain/ poor pain management
3. Mistrust of service providers/ practitioners
4. Inconsistent/ unhelpful care
5. Isolated in abuse
6. Economically sanctioned
7. Decreased likelihood of disclosure
8. Increased risk
9. Children living with impacts of domestic abuse without early intervention.

Overall impacts were far reaching and at their worst resulted in self-harm and attempts at suicide.

INTERSECTIONALITY

Although the impact on survivors were cross cutting it must be noted that those from racialised and migrant communities suffered significant levels of isolation as a result of the systemic issues that they faced. Experiencing isolation based on migrant status these survivors were further isolated through language, cultural and empathy barriers in the care and support that they received. Many described the impacts on both their physical and mental health as a result of their experiences in health settings, as well as reduced trust in the availability of support. All of these impacts serve to further entrap them in abusive dynamics.

THEME 4:
OPPORTUNITIES

TRAINING/ AWARENESS

PRACTITIONER SKILLS

OPPORTUNITIES

SUPPORT & SERVICES

POLICY DEVELOPMENT

After exploring the experiences and impacts of contact with health settings survivors were asked what could have made their experience more positive. Feedback was wide ranging and obtained from both poor practice experiences as well as ideas given by participants. Opportunities will be developed over the life of the project and are framed under these headings:

1. Training/ Awareness
2. Practitioner Skills
3. Support and Services
4. Policy Development.

TRAINING & AWARENESS

Survivors identified training needs as well as skills development in a range of areas:

- **Domestic Abuse** - survivors who accessed both primary and secondary care believed domestic abuse training is important. The training should ***'give professionals the right tools to know someone is being abused,'*** including spotlights in the following areas:
- Highlighting how male perpetrators behaviour can impact women's health, and the issues for women's mental health generally in the context of domestic and sexual abuse.
- To ensure an understanding of the prevalence and impacts of domestic abuse during pregnancy.
- Developing an understanding of the importance of offering single sex appointments.
- To raise awareness of male experiences of domestic abuse and how they might present to services.
- To develop understanding of the challenges in life following domestic abuse including post-separation abuse.

- **Trauma Informed Care** - survivors who accessed primary care, secondary and community care advocated for trauma informed care training addressing how trauma might manifest in survivors of interpersonal and family violence and abuse. Based on some of the issues with diagnostic approaches a model of training that explores the barriers to trauma-informed assessment presented by the medical model of diagnosis was felt to be important.

- **Relationship-based practice** – In line with the above the participants spoke extensively about the need for empathy, trust and concern from healthcare staff with a focus on building relationships that enable safe disclosure and ongoing recovery. Consequently, developing relational skills in practitioners was identified.

- **An understanding of the needs of diverse community groups:**
- Increased knowledge about the issues faced by, and awareness of the rights of, migrant survivors.
- Training regarding the experience of those with disabilities.
- Cultural competence – developing understandings of the diverse needs of Black and Brown members of British society.

POLICY DEVELOPMENT

IMMIGRATION & ACCESS TO HEALTHCARE

All three survivors from West Africa with no recourse to public funds agreed healthcare fees should be scrapped. Emphasis was made on their rights, R* knew her rights as an asylum seeker and was able to say she was ***'entitled,'*** to free healthcare. She shared most do not carried out their own research, but rather are afraid to challenge professionals. As overstayers, the other two survivors felt they have a lack of rights, G* felt more recognition should be given to overstayers contributing to the U.K.'s economy.

NEXT STEPS

This research will inform the structure and approach of the second phase of the Survivor Voice work as well as the Crossing Pathways Networks. The Survivor Network will develop the recommendations concerning primary, secondary and community care from October 2023 to November 2024. These will be published in the overarching project report in 2025 and directly feed into the Crossing Pathways Networks.

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