

The Pathfinder Project

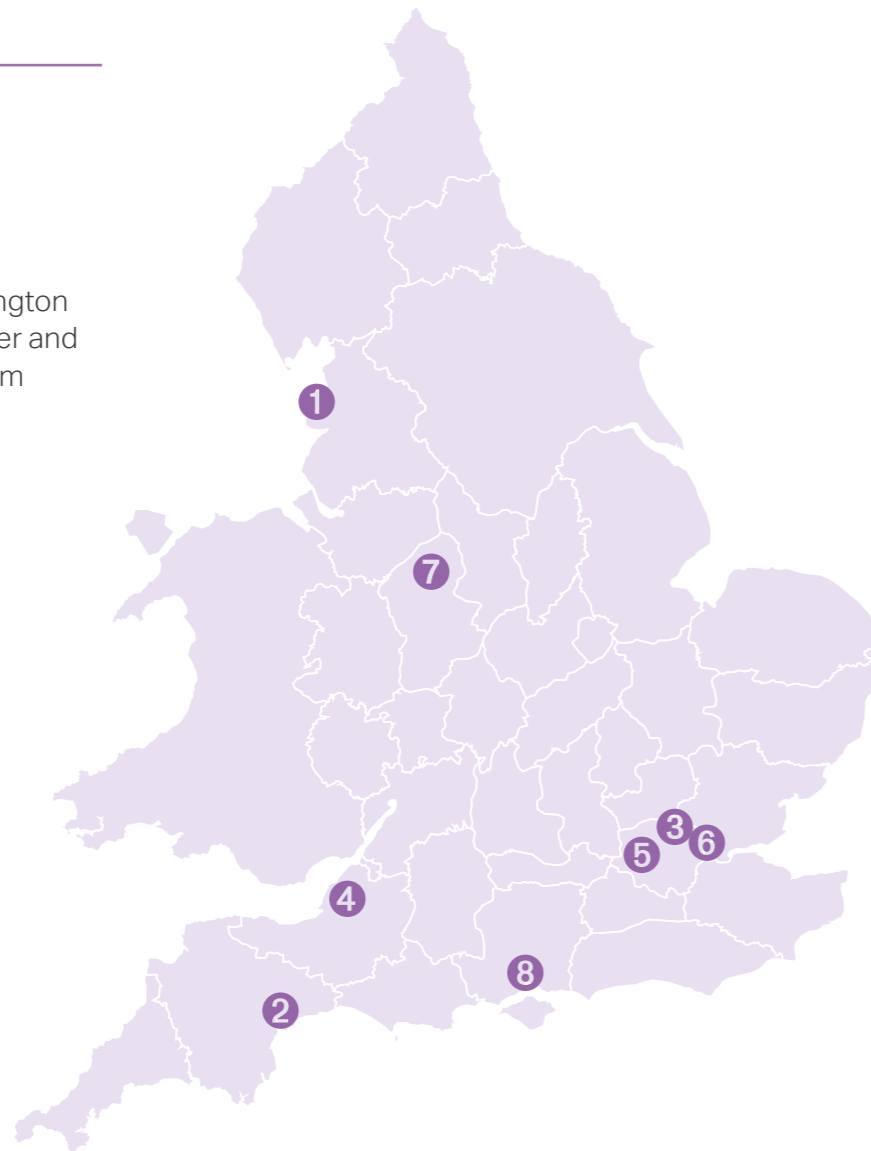
Pathfinder was a national project aimed at addressing the links between domestic abuse and health and improving the capacity of health professionals to respond to survivors effectively by establishing comprehensive health practice in relation to domestic abuse in three distinct areas; acute hospital Trusts, mental health Trusts and GP practices.

The project ran from 2017 to 2020 and was led by Standing Together as part of a consortium of expert partners including SafeLives, IRISi, Imkaan and Against Violence and Abuse (AVA).

Over the three years, the project engaged nine CCGs and 18 NHS Trusts across England to implement wide-ranging and sustainable interventions in eight local areas.

Pilot sites

- 1 Blackpool
- 2 Exeter & North Devon
- 3 Haringey & Enfield
- 4 Somerset
- 5 Three councils (Kensington & Chelsea, Westminster and Hammersmith & Fulham)
- 6 Camden & Islington
- 7 North Staffordshire
- 8 Southampton



We did this by:

- Working with health stakeholders across these eight sites to identify and share good practice
- Turning guidance into practice and providing interventions where a gap in provision was identified
- Embedding local health and domestic abuse governance structures linking the parts of each local health economy to each other and to their local specialist domestic abuse services to promote a coordinated community response to survivors and perpetrators of domestic abuse
- Sharing learning and guiding national dissemination of good practice to inform future policy work and data collection

Working in collaboration with each other and health partners at sites, the consortium made a significant impact on the capacity of NHS staff to respond to domestic abuse.

The project is being independently evaluated by Cardiff University and the findings will be released in August 2020.

The Pathfinder project was funded by:



Department for
Digital, Culture,
Media & Sport



Department
of Health &
Social Care

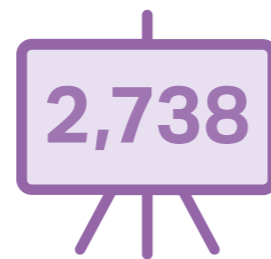
Key Achievements of the Pathfinder Project

"I... feel confident that we have significantly raised the profile of Domestic Abuse within Health's Safeguarding Agenda and I believe that our strategic partners recognise the importance and intrinsic value of health embedding a universal response to domestic abuse"

–Pathfinder Domestic Abuse Project Lead



Ten Health Based Idvas, three Domestic Abuse Coordinators and two IRIS programmes across 64 GP practices were funded



Approximately 2,738 health professionals have had domestic abuse training since the start of the Pathfinder project

15x



15 NHS Trust Domestic Abuse Policies have been reviewed

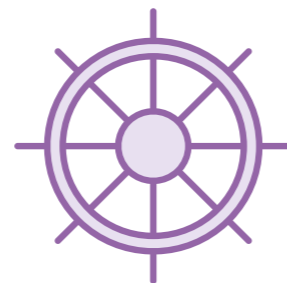


8 NHS Trust Domestic Abuse Training Packages have been reviewed

9x



9 Domestic Abuse Champion Networks in NHS Trusts have been setup and supported



Each Pathfinder site now has a steering group and an operational group to focus on the NHS Trusts response to Domestic Abuse

Pathfinder Partners

The Pathfinder Survivor consultations were led by the national Violence Against Women and Girls charity AVA with consultancy support from Imkaan, on behalf of the Pathfinder Consortium.



Standing Together was founded 20 years ago with the ambition to eradicate domestic abuse by transforming the way organisations and individuals think about, prevent, and respond to it. Operating in various operational settings including health, housing, criminal justice and community work, Standing Together works with partner agencies to ensure a Coordinated Community Response (CCR) to domestic abuse by improving their understanding and response to survivors and perpetrators. Standing Together's aim is to stop survivors falling through gaps via these improved responses within and between voluntary and statutory organisations, and ultimately eradicate domestic abuse.



AVA (Against Violence and Abuse) is a feminist charity committed to creating a world without gender-based violence and abuse. Their mission is to work with survivors to end gender-based violence by championing evidence-based change. They are an expert, independent and groundbreaking national charity particularly recognised for their specialist expertise in expert-by-experience-led approaches, multiple disadvantages and children and young people's work. Our core work includes training, policy, research and consultancy.



Imkaan is a UK-based, intersectional, black feminist organisation dedicated to addressing violence against women and girls. As a second-tier, social justice and human rights organisation with national membership, Imkaan represents the expertise and perspectives of frontline specialist black and minoritised women's services that work to prevent and respond to violence against women and girls.



IRISi is a social enterprise established to promote and improve healthcare's response to gender-based violence. Their flagship intervention is the IRIS programme (Identification and Referral to Improve Safety) which is a domestic violence and abuse training, support and referral programme for general practices. The IRIS programme is a collaboration between general practice and specialist domestic abuse services. It is commissioned and running in areas of England, Wales and Northern Ireland.



SafeLives is the UK-wide charity dedicated to ending domestic abuse, for everyone and for good. SafeLives works with organisations across the UK to transform the response to domestic abuse. They want what you would want for your best friend. They listen to survivors, putting their voices at the heart of their thinking. They look at the whole picture for each individual and family to get the right help at the right time to make families everywhere safe and well. And they challenge perpetrators to change, asking 'why doesn't he stop?' rather than 'why doesn't she leave?' SafeLives is the originator of the Independent Domestic Violence Advocate (Idva) role, and of Multi-Agency Risk Assessment Conferences (Maracs).

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Glossary

- **Child to Parent Violence (CPV):** CPV entails the abuse of a parent by their child. Paterson et al. (2002) define it as, 'any act perpetrated by a child/adolescent that causes a parent to feel threatened, intimidated or controlled – can include physical, psychological, emotional and financial abuse'¹.

There is currently no legal definition of child to parent violence and abuse. However, it is increasingly recognised as a form of domestic violence and abuse and, if the child is over 16 it may fall under the government's official definition of domestic violence and abuse.
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There is currently no legal definition of child to parent violence and abuse. However, it is increasingly recognised as a form of domestic violence and abuse and, if the child is over 16 it may fall under the government's official definition of domestic violence and abuse.
- **Holistic approach:** A holistic approach is one that understands and responds to individuals as a whole, considering their physical, mental, emotional and spiritual needs, and is able to understand the whole picture of an individuals' experience.
- **Intersectional approach:** An intersectional approach is one that understands and responds to individual's intersecting identities and experiences; for example, considering interacting experiences of 'race', ethnicity, sexuality, gender identity, disability, age, class, immigration status, caste, nationality, indigeneity, and faith. An intersectional approach recognises that historic and ongoing experiences of discrimination will impact individuals and is at the heart of anti-discriminatory practice.²
- **Person centered approach:** A person centered approach is one that centers the individual in all decisions made and processes carried out. The individuals are seen as "*equal partners in planning, developing and monitoring care to make sure it meets their needs*" (Health innovation network).³
- **Trauma informed approach:** A trauma informed approach is one that takes a "*strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment*" (Hopper et al 2010)⁴.

1 Paterson, R., Luntz, H., Perlesz, A., Cotton, S. (2002). 'Adolescent violence towards parents: Maintaining family connections when the going gets tough', Australian and New Zealand Journal of Family Therapy, 232, pp. 90-100.

2 Collins, Hill Patricia (2000) Black Feminist Thought: Knowledge, Consciousness and the Politics of Empowerment. New York and London: Routledge

3 Health innovation network, What is health centered care and why is it important? Accessed: https://healthinnovationnetwork.com/system/ckeditor_assets/attachments/41/what_is_person-centred_care_and_why_is_it_important.pdf

4 Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the storm: Trauma-informed care in homeless service settings. The Open Health Services and Policy Journal, 3, 80-100

1

Section one: Introduction

The Pathfinder Project was a three year project funded by the Department of Health and Social Care and the Department of Media, Culture and Sport.

The project consortium partners⁵ worked with health services in eight key sites in England to support the development of good practice responses to domestic abuse and violence against women and girls. At the heart of the project is the core aim to ensure health systems are effectively and appropriately responding to survivors' needs.

As part of the Pathfinder project, AVA led a series of survivor consultations to capture the voices of survivors in England, including in the specific sites where Pathfinder was based. The consultation took three phases as follows:

- **Phase one:** Consultation in Pathfinder sites 1–3 (August 2018)
- **Phase two:** Consultation in Pathfinder sites 4–8 (September 2019)
- **Phase three:** Consultation across England with a specific focus on capturing the voices of BME women, older women, LGBTQ women, women living with disability and survivors of child to parent violence (January 2020)

Survivors taking part in the consultation were given the space to share their experiences of local health systems and services, and the opportunity to discuss experiences of their local primary care, acute health and mental health services.

This report presents the findings from the survivor consultation exercise, identifying key themes across the data as well as key local practice and national policy recommendations.

Direct quotes from survivors are presented throughout the report.

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Section two: Methodology

The following section outlines the two methodological approaches used, as well as the research framework, ethical considerations and research limitations of the Pathfinder survivor consultation.

A) Face to face consultations

The survivor consultation established a series of face to face consultations across England between August 2018 and January 2020. These were delivered in three key phases over the life course of the Pathfinder project.

Consultations were held either as focus groups or as 1:1 interviews. Some interviews were conducted over the phone where appropriate, as indicated below.

Across the survivor consultation phases, the following face to face consultations were carried out with survivors of violence against women and girls:

- One focus group with LGBTQ survivors. Participants were also asylum seekers.
- Three focus groups with BME survivors (two in Pathfinder sites)
- Four interviews with survivors of child to parent violence (delivered over the phone)
- Seven non-specific focus groups with survivors living in seven Pathfinder sites
- Nine interviews with Deaf survivors

In order to set up face to face consultations, Pathfinder worked in partnership with services delivering specialist services to survivors of violence and abuse.

Partners were recruited and supported with extensive guidance to deliver focus groups or interviews with survivors who had accessed health services in the last 12 months.

B) Online consultation

In addition to face to face consultation, Pathfinder used online consultation tools. These were developed by AVA, with support from Imkaan.

- Online survey for survivors living in five of the Pathfinder sites (September - October 2019)
- Online survey, for survivors living in any areas in England (January - February 2020)

C) Research framework

For phase one of the consultation process, AVA and Imkaan developed the consultation framework and research questions to be used in focus groups, as well as designing an online survivor consultation tool. For phase two and phase three of the consultation, tools were updated and revised to ensure relevance and to incorporate feedback from previous phases.

The research framework provided survivors taking part in the consultation (both face to face and online) with the opportunity to reflect on experiences of specific areas of health in their local area. This covered acute health, mental health, and primary care, as well as more general experiences of health services and systems in the local area. The research framework also provided space for participants to outline any experiences of discrimination based on their identity(ies).

Participants were also given the opportunity to put forward key 'take away messages' to health professionals and services in their area.

D) Data analysis

Data was thematically analysed using Nvivo software for qualitative data and SurveyMonkey for the online tool.

E) Ethical considerations

- The approach taken to setting up face to face consultations in partnership with specialist service ensures that participants have direct access to a known source of support when taking part in research activities.
- Survivor consultations were developed and delivered in accordance with thorough ethical standards and considerations. Appropriate ethical considerations were made and adapted in line with the Data Protection Acts of 1998 and 2018. This included ensuring informed consent, safeguarding participant well-being, and securely handling all data.
- All survivors taking part in face to face consultations were given a £15 Love2Shop voucher to thank them for their time.
- Focus group facilitators safely and ethically shared the data collected with AVA.
- Consideration was taken to accommodate different groups of survivors in formats that suited their needs. For example, it was requested that Deaf survivors taking part in the consultation wanted/preferred 1:1 interview style questioning (for various practical and personal reasons), and this was therefore accommodated in budgeting and set up.
- Appropriate interpreters were used for face to face consultations where relevant

F) Research limitations

The following identifies key limitations to the methodological approach and research outputs.

- In earlier phases of the consultation focusing on specific Pathfinder sites there are a number of gaps in the data available. Some Pathfinder sites were unable to set up consultations; most notably the majority of sites were unable to establish BME specific focus groups which was a key focus of phase one and phase two of the consultation.
- Responses to the phase two online survey were limited, with few respondents and limited/unclear answers.
- Phase three of the consultation sought to establish additional focus groups with survivors living with physical disabilities as well as older survivors (aged 60 and over). These focus groups were not set up due to a number of challenges faced at the recruitment and set up stage of the consultation phase, including practical reasons making it harder for these survivors to come together in focus groups, as well as time constraints for consultation delivery.
- Demographic data captured as part of the survivor consultation is not representative of the whole sample, due to gaps in the data available and/or provided by survivors.
- Despite efforts to ensure that the consultation was inclusive of LGBTQ survivors experiences, the number of participants identifying that they were LGBTQ is low (n=4). LGBTQ survivors are underrepresented at each phase of the consultation and are therefore underrepresented in this report.
- The approach taken by the methodology was not accessible for all survivors. While the researchers sought to be flexible where possible, the consultations were restricted by time and resource limitations. For example, one Deaf survivor noted that a BSL video survey would have been appreciated to ensure better accessibility and more comfortable participation.
- Considering the focus of the consultation on the intersection of various elements of a survivor's identity and their experience of healthcare, it is important to acknowledge that there are many survivors who are not represented here and would likely have experienced different journeys in the healthcare system. This might include (but is not limited to); women with problematic substance use issues, homeless women, socio-economically disadvantaged women, women in particular faith groups, young women⁶.

⁶ Survivors with these experiences were represented in the online survey and variously in focus groups but no distinct groups were held to hear about the experiences of these groups in particular.

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Section three: Overview of participants

A) Introduction

Survivors taking place in the face to face consultations were asked to complete a pre-focus group questionnaire in order to capture demographic data as well as information relating to which health services they had accessed. Those taking part in the online consultations were asked to provide similar data via the online form.

Below is an overview of the demographic data relating the participants across the three phases of the consultation, where data is available.⁷

B) Overview of participation

A total of 143 survivors took part in the Pathfinder survivor consultations.

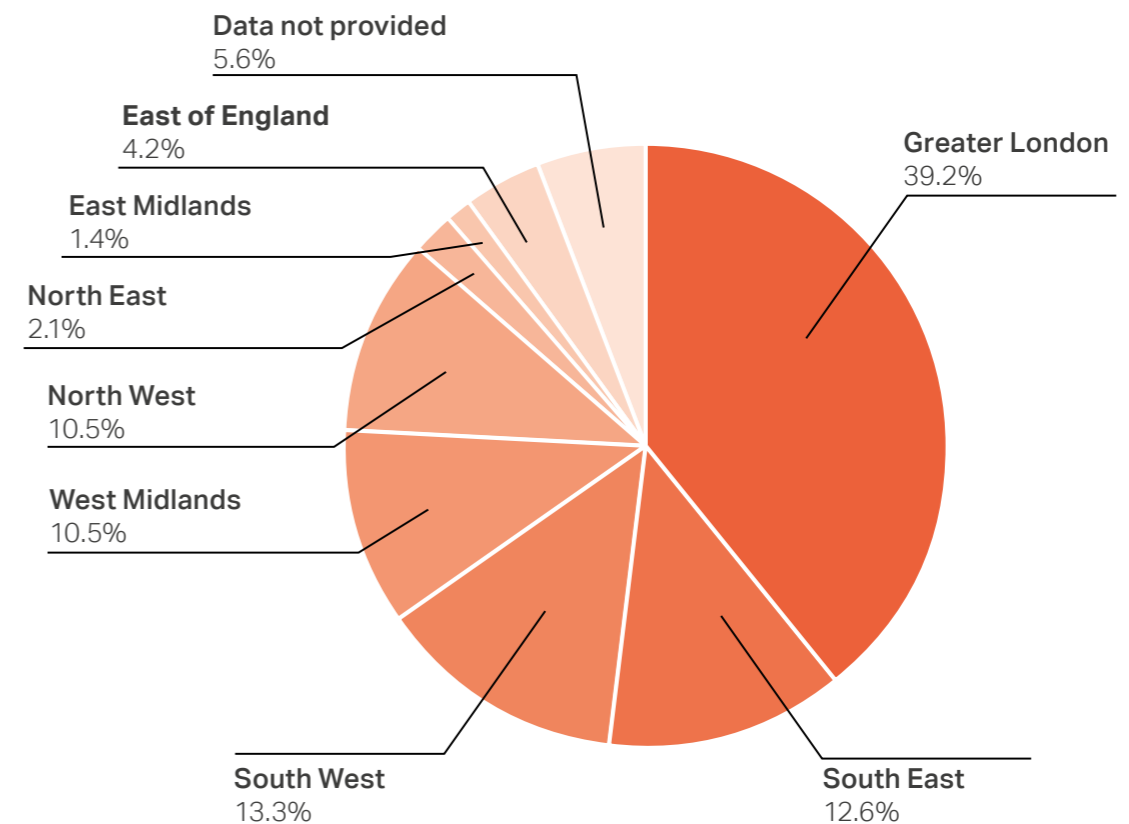
- 59% (n=84) of participants took part in face to face consultation, while the remaining 41% (n=59) took part in online consultation.
- 50% (n=72) of participants were from one of the following eight sites in which Pathfinder was operating:
 - Blackpool
 - North Devon and Exeter
 - London Boroughs of Haringey and Enfield
 - Southampton
 - London Boroughs of Westminster Chelsea, Kensington
 - Somerset
 - North Staffordshire
 - London Boroughs of Camden and Islington

⁷ Not all participants filled out these forms fully, many chose to leave questions blank or the data was not captured. As a result, all of the data below is representative of those who chose to answer these questions, not of every survivor who took part.

The remaining 50% of participants were from other areas in England, including the South East, North West and Yorkshire and the Humber.

The following graph depicts the geographical spread of the consultation.

Survivor consultation participants – Regional area of residence



⁸ For face to face consultations, Pathfinder partners worked specifically with specialist providers working with women who have experienced violence against women and girls. For online consultation, the survey did not specify that survivors must be female.

⁹ Two women in the phase Three online survey identified their age as 65-74 therefore had these ages been revealed, they may have been older than 68 (the highest age given in a focus group across all three phases).

¹⁰ Disability was not included as a question in phase One of the consultation therefore this number is likely to be considerably higher.

¹¹ It is important to note that the question of sexuality was regularly not answered/left blank by participants so the numbers might potentially be higher.

¹² This question was not asked in any focus groups/surveys outside of one focus group made up of asylum seeking women. As a result, the number is potentially higher.

C) Participant demographics

- 100% of participants were women⁸.
- Participants ranged from aged 18–68⁹. The majority of participants were aged between 35–44 years old.
- 32% (n=45) of participants were BME.
- 28% (n=40) identified they were living with disability.¹⁰
- 3% (n=4) identified as LGBTQ.¹¹
- At least three participants were asylum seekers¹².

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D) Experiences of violence against women and girls

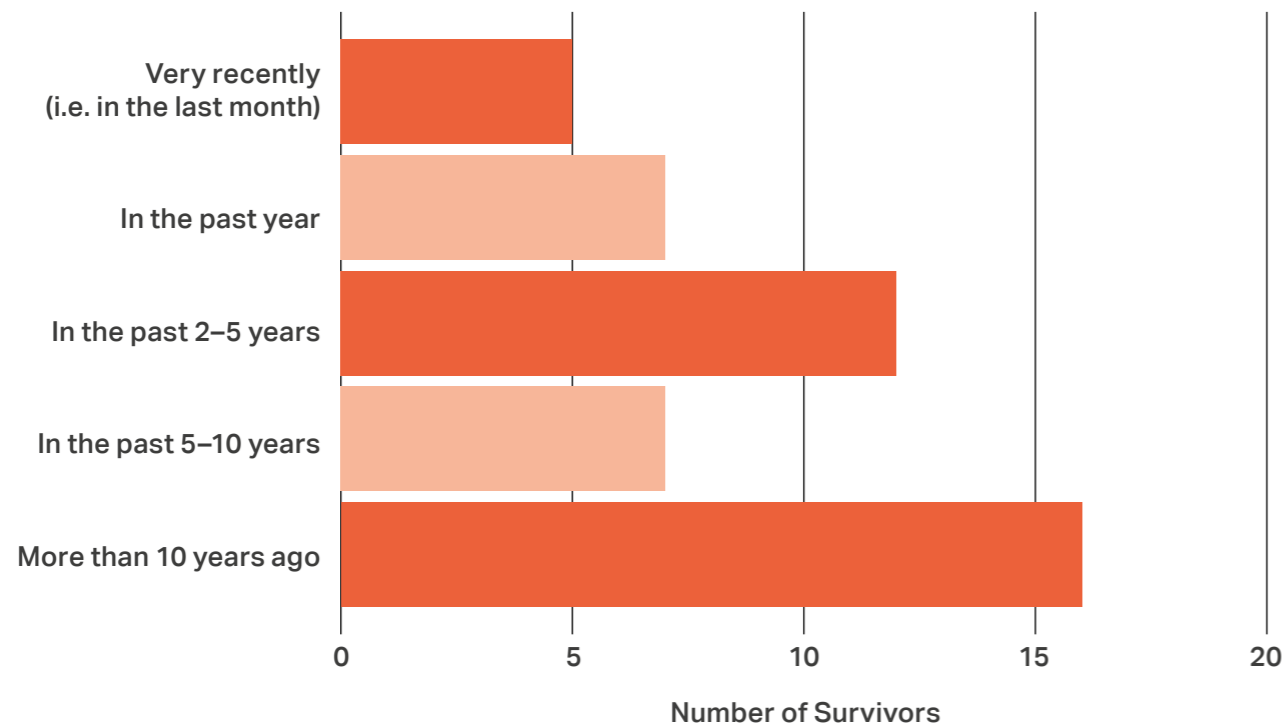
Limited data was collected to identify the specifics of the abuse that participants had experienced. However the following data is captured:

→ 100% of participants were survivors of violence against women and girls.

→ 48% of survey respondents had experienced abuse in the last 5 years and 26% had experienced violence in the last year¹³. These findings are captured in the graph below¹⁴:

→ At least 3% (n=4) of participants were survivors of child to parent violence (CPV)¹⁵.

When did you last experience abuse? (online survey responses)



¹³ Questions concerning how recently women had been victims of violence were only asked in the online surveys. These percentages are therefore representative of the women taking part in the online surveys in phases Two and Three.

¹⁴ This is a collation of phase two and phase three of the online consultation data. Some survivors skipped/did not provide an answer to this question.

¹⁵ This question was not asked in any focus groups/surveys outside of interviews with women already known to have suffered/be suffering from CPV. As a result, the number is potentially higher.

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E) Participant access to health services

Those taking part in the survivor consultation indicated that they had accessed a range of health services in their local area over the last 12 months. This indicated that survivors are regularly accessing healthcare through various avenues.

Furthermore it is apparent that survivors are accessing their GP most regularly, followed by Mental Health Services and lastly by Acute services. Where data was available¹⁶ it is evident that:

→ 71% of participants had accessed their GP in the last 12 months.

→ 49% of participants had accessed mental health services in the last 12 months.

→ 29% of participants had accessed acute services in the last 12 months.

→ The majority of survivors interviewed via face to face consultations¹⁷ have accessed at least one healthcare service in the last 12 months.

Additional health professionals and services discussed by survivors through the consultation include:

- Sexual health services
- Dentists
- Health visitors
- Alcohol and/or substance abuse services
- Urgent care centres
- Maternity services
- Alternative therapies (e.g. reiki)
- Opticians
- Specialist hospital for ear, nose and throat
- Physiotherapy

Furthermore, many survivors mentioned how they were supported by third sector/voluntary organisations in their healthcare needs (especially around their mental health). This was primarily as a result of survivors exploring options available to them, but sometimes as a result of referrals given by statutory services.

¹⁶ This data was complicated by various gaps in the pre-interview forms and across the two online surveys. As a result, the following statistics are averages taken from the data that was more readily available.

¹⁷ It is important to consider that the survivors interviewed were those more known to services or support groups. As a result, harder-to-reach survivors are not represented in this study, and they are those who are less likely to access health services.

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Section four: Overview of findings

A) Summary of findings

The consultations provided survivors with the opportunity to share their experiences of local health services and systems.

The consultation finds that survivors had mixed experiences of health services and systems in their local area.

Participants shared examples of promising practice and identified pockets of good practice in areas across England. Survivors' positive experiences of health generally focused on professionals they had encountered who had listened to their experiences and enabled them to access pivotal support.

However the survivor consultation also identified that health services and health systems are not currently delivering services that are able to meet survivors' needs. This is true in relation to:

- the services that are available
- the way in which many services are delivered
- key processes carried out by health services, such as referral processes and information sharing
- professionals' awareness and understanding of violence against women and girls
- professionals' responses to disclosures

This consultation also identifies how survivors' intersecting identities are met with additional barriers and challenges when accessing health services as a survivor.

Throughout the consultation survivors are clear about what they would like to see in place across health services and health systems, presenting recommendations for building on promising practice.

A summary of key messages from survivors is presented below.

B) Key messages from survivors

The following outlines the key themes identified across the focus groups, presenting what survivors want and need in relation to responses and support from health services.

Health systems and processes:

- Survivors want effective information sharing both between and within health services so they don't have to have to keep re-telling their stories
- Survivors want to know how their information is being shared, with clear processes in place for providing consent
- Survivors want to see accessible and effective complaints processes, and for complaints to be taken seriously
- Survivors want effective processes in place for health services to follow up with them once they have disclosed abuse

Service availability and accessibility:

- Survivors want to see a range of mental health and therapeutic services being offered to them alongside medication
- Survivors want longer health appointments
- Survivors want to see shorter waiting times for mental health services and therapeutic options
- Survivors want a health system that is able to meet their particular needs, rather than a one size fits all approach. This includes access to BME specific and disability specific specialist support.
- Survivors want health services that recognise and are responsive to trauma
- Survivors want accessible and trauma informed systems for booking appointments
- Survivors want the option to see female health professionals
- Survivors want to see a consistent health professional whom they are able to trust
- Survivors want access to appropriate interpreters readily available in all health services

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Professional response:

- Survivors want to feel heard and listened to by all professionals in health services
- Survivors want to feel respected by all professionals in health services, and want professionals to respond without judgment, stereotyping or discrimination
- Survivors want to know they will be believed if/when they disclose abuse
- Survivors want to know they will not be blamed for their experiences if/when they disclose abuse
- Survivors want health professionals to be knowledgeable about different types of abuse
- Survivors want health professionals to fully understand the dynamics of abuse and their experiences of trauma
- Survivors want health professionals to understand how equality, diversity and intersectionality factors (such as disability, sexuality, ethnicity, immigration status) intersect with experiences of abuse and access to services
- Survivors want health professionals to consistently pick up on signs/ indicators of abuse, and to ask them more questions about what is going on/ demonstrate professional curiosity
- Survivors want health professionals to understand how perpetrators might also present in the health system/ services

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Section five: Key findings and supporting evidence

This section of the report explores the key themes above in more detail, presenting the supporting evidence from the data collected as part of the survivor consultation process.

A) Health systems and processes

- Survivors want effective information sharing both between and within health services so they don't have to have to keep re-telling their stories
- Survivors want to know how their information is being shared, with clear processes for providing consent in place
- Survivors want to see accessible and effective complaints processes, and for complaints to be taken seriously
- Survivors want effective processes in place for health services to follow up with them once they have disclosed abuse

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1) Information sharing

Across the consultation, survivors repeatedly highlighted the need for consistent and safe information sharing.

Participants' experiences of information sharing varied greatly. Some survivors had had positive experiences of information sharing. For example, one survivor outlined how effective information sharing between her General Practitioner and the police force enabled her to be effectively safeguarded and prevented a perpetrator from entering her home.

Indeed, in the national online consultation, 70% of respondents agreed that they felt safe to share personal information about themselves with their General Practitioner (this is only true for 53% in relation to Acute Health).



60%

of respondents felt that their information had been appropriately shared in Acute Health settings.

That said, throughout the consultation participants also highlighted concerns regarding how information was being shared, who it was being shared with, and what was being shared, evidencing great inconsistencies both across and within health services.

Women wanted to be asked and informed regarding how information would be shared.

"If they have to ask me individually, can I pass this information on, then i'll probably say yes. But if the information is just passed just like that without me knowing, its more like simply exposing me, I can't find the right word for it, taking my dignity, taking my rights. I want the right to say yes and no."

In many instances women had not been asked whether their information could be shared, and health services across the health system (including General Practice, Acute Health services and Mental Health services) had shared information with other services or agencies without their consent.

Findings from the national survey evidence that over a third of respondents were unsure whether their information has been shared with other parties.

Participants across the board generally felt there was a lack of information regarding what would happen to the information they had disclosed, and feared the consequences of this – most notably, expressing their biggest fear that their children would be removed.

Such fears were identified as a barrier for women to speak openly about their experiences, preventing some from disclosing in the first place. Many women also felt that they were judged by professionals as incapable or bad mothers, with some feeling that inappropriate information had been shared.

"If information is shared between agencies it needs to be clear, concise, and exactly as the client said. Not opinions added into it, or assumptions being made."

Participants also expressed concerns regarding a lack of clear record keeping in health services, health professionals failing to review any of their relevant records, and/or a lack of information sharing between different sectors and services.

"I went to the GP last week and he didn't know about all the intense treatments that I have had for the last year, I thought that would be in my medical records but he hadn't a clue. If I was in crisis I wouldn't want to repeat that again to any health professional again."

One Deaf survivor shared that when her GP changed, information regarding her disability was not passed on in her notes, therefore presenting additional barriers to her.

A particular concern raised for survivors of CPV was the lack of communication and information sharing between health and schools, which was much needed for an effective response.

Many women shared that they had been asked to retell their stories over and over again – each narration was re-traumatising, and took away valuable time from the appointment.

"When you are in hospital you have to repeat your history over again then they pass you onto someone else and you have to repeat it again before you get to see the doctor, I find this embarrassing for me as I think I don't need to tell them all before I get to see the doctor."

"It has been very frustrating with the GP, I see a different GP everytime as I don't have a personal GP anymore. I have to repeat my story all the time which is really a hard thing to do all the time. There are times when I am really ill and I just can't face going to see the GP as I would need to repeat my story all over again. It's also a quick fix they just give you medication just take it, if it doesn't work just come back."

This was reflected in the key statistics captured in the national online survey; this found that, when accessing mental health services, 41% 'strongly agreed' that they had to retell their story numerous times.



41%

'strongly agreed' that they had to retell their story numerous times when accessing mental health services.

Furthermore, **participants highlighted concerns regarding the nature of the information that had been recorded**. Some women described experiences of finding information that had been recorded about themselves had been recorded with concerning conjecture.

"I looked at my medical records for evidentiary purposes and I was disgusted and appalled by some derogatory comments, inaccuracies and untruths. How can info be shared for the greater good, when one's medical notes are also poor."

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A number of patients highlighted concerns regarding what information the reception staff had access to. As one online survey respondent from a Pathfinder site stated:

“Details regarding any form of abuse pertaining to the victim, should not be accessed by the reception staff but confidentiality should be kept at the highest level. As in, only the GPs have access to this information - even at the point of it being received.”

Three women who identified that they were asylum seekers in focus groups noted that their privacy - as asylum seekers - was not respected in the same way as other peoples. One woman highlighted that she felt discriminated against when her information was shared without her consent; others found that records had not been kept as a result of their immigration status.

“The doctor asked me what medication I was on. I said I can't remember and I said that you could see on the system what medication I have got. He said he can't help me and I ended up walking out without anything. When I went the next day to get medication the doctor had the same problem and couldn't see anything on the system regarding what medication I was on. They make you wait and they call the Home Office every time which is embarrassing and that's why they are making you wait. They call the Home Office in front of you to ask about you which happens at the doctors and the hospital.”

2) Communication and follow up

Another key theme apparent across the consultation was the value in, and need for, effective communication, consistent follow up and effective routes for feeding back to health services.

In a number of focus groups, women described experiences of being promised referrals to services, but then nothing ever happened. Similarly, when women had presented at hospital after visits resulting from abuse, they felt there was a lack of follow up.

One survivor shared an extremely traumatic experience of losing her new born baby due to the lack of follow up in a health service.

“I missed the health visitor appointment on many occasions then she should ensure she physically sees me within 2-3 days. This might have prevented my baby dying. While at the hospital after giving birth if a social worker/ mental health professional spent time with me they might have noticed that I was in an abusive marriage”

Women who were survivors of child to parent violence felt that a lack of understanding of their experiences meant they were frequently left without any follow up support.

One survivor of CPV went to see her GP after her son had broken her rib. Despite this, no referral(s) were made. As a result the survivor stopped going to her GP.

As one survivor shared:

“I thought (my GP) was going to disappear under his desk, he was so embarrassed and didn't know what to do or where to signpost.”

Survivors want to see accessible and effective complaints processes, and for complaints to be taken seriously. In one focus group, women spoke extensively of complaints being dismissed, not being followed through or being lost.

“I put in a complaint about a doctor in one of my previous surgeries and it was from then that I noticed changes in the way people were talking to me. It was like literally sometimes you put in a complaint about the wrong doctor, all they have to do is put something saying you're a hypochondriac down. Once that is written down about you, you can't go to a doctor and have an honest conversation. I remember at one point I was vomiting blood and they still wouldn't take me seriously.”

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3) Booking appointments

The need for accessible processes for booking appointments was discussed by a number of survivors taking part in face to face consultation. Women expressed concerns around clunky digital systems for booking appointments, and how they presented barriers to women hoping to access health services.

“The tendency towards online interaction is definitely not a good thing, if you are in crisis you need to hear a voice that is soothing, reassuring and calm because if you have high levels of anxiety you can work yourself up into a tizz. If you have someone that is calm you can respond and re-centre yourself, also they can hear that something is...amiss”.

Survivors were also concerned that receptionists often asked them to justify the reason for wanting an appointment.

“I've lost all faith in my GP... I don't feel like I can phone and get an appointment with my GP to talk about things. When I do phone, the receptionist asks me what it's concerning, but I don't want to tell a total stranger. I get told that it's going to be telephone conversation (with the GP). I can't do it over the phone, I struggle to find my words at the best of times. You are just not supported, there's just no follow up.”

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B) Service delivery, availability and accessibility

- Survivors want to see a range of mental health and therapeutic services being offered to them alongside medication
- Survivors want longer health appointments
- Survivors want to see shorter waiting times for mental health services and therapeutic options
- Survivors want a health system that is able to meet their particular needs, rather than a one size fits all approach. This includes access to BME specific and disability specific specialist support.
- Survivors want health services that recognise and are responsive to trauma
- Survivors want accessible and trauma informed systems for booking appointments
- Survivors want the option to see female health professionals
- Survivors want to see a consistent health professional whom they are able to trust
- Survivors want access to appropriate interpreters in all health services

1) Service delivery

Participants provided reflections on how health services were currently being delivered, and the extent to which they were able to meet the needs of survivors.

Women taking part in the consultation articulated the need for services that understood their experiences as survivors and that were able to meet their particular needs rather than providing a one size fits all approach.

"I don't feel that health understands and responds appropriately to what survivors may have gone through or how to handle or deal with what some of the things survivors are telling them that they are going through. It's more of a generic kind of a treatment, so you have depression or anxiety this is what you need. There isn't that understanding of what an individual survivor is going through."

"Everyone gets thrown into the same bucket...You're then categorised. You are looked at differently, spoken to differently, you are dealt with differently...That subtlety of understanding cases on their own merit is not something that I've seen so far."

More specifically, **participants called for services that were delivered in a more holistic, trauma informed and person centered way.** That is – services that understand and respond to individuals as a whole, considering all aspects of their life including their experiences of trauma. For definitions of these approaches to service delivery see the report Glossary (p4).

"Domestic abuse is an insidious, terrifying premeditated crime. See the impact and signs, not the symptoms. Medication isn't the answer to trauma. Trauma informed services are."

Those who *had* had access to timely and appropriate support highlighted the difference this had made to their lives as well as the lives of their children. For example:

"The experience I had with the doctor at the beginning when I was pregnant, it was amazing on the NHS. I had a very very stressful situation with the father of my child and without the antenatal counselling I had I would not have been able to be here to be honest."

"They (sexual health clinic / rape clinic within a hospital) were extremely proactive and took a holistic approach: calling to check if you were okay; offered safety advice; signposting; follow up appointments with the SH advisors in order to discuss how you were feeling. Always asking if you are safe, which is vital."

The majority of positive experiences of health services shared by survivors was in relation to their General Practitioner. This may reflect the fact that primary care was the health service accessed the most by consultation participants.

A key part of survivor's positive experiences of health services (in general) was having access to a consistent professional whom they trusted.

"I'm very lucky that I have a GP that actually does listen to me, and soothes me when I'm having like crisis moments."

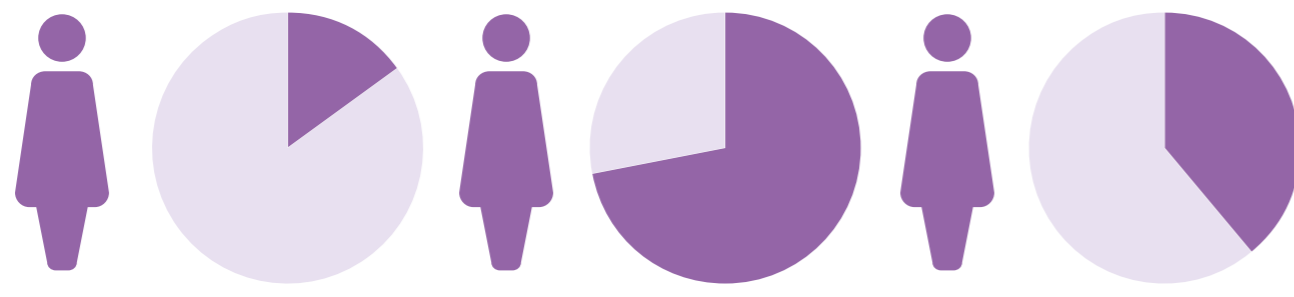
Survivors also identified the importance of having the option to choose a service delivered by a female professional, and for this request to be taken seriously. Women taking part in the focus groups had often been seen by male members of staff, despite their records stating their preference for working with a female professional.

"I found that men, they don't understand. It's like, oh well I pose no threat but she's acting like this, she must be a hypochondriac. But they have no idea how it feels to have a colposcopy, a surgery that intimate, done by a man two weeks after you've been raped"

While there is evidence of pockets of promising practice in this area, many survivors identified that the health services they had accessed had not been trauma informed, holistic or person-centered.

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Indeed, in the national online consultation (phase three):



Only 15%

of participants felt confident that their local health services are providing adequate level of support for survivors of domestic abuse.

72%

of respondents indicated that they do not think health services have an adequate understanding of the trauma impact of domestic abuse.

Only 39%

felt safe accessing mental health services; this was true for 66% of respondents in relation to General Practices, and 67% in relation to Acute health settings

This is reflected in the stories shared by women taking part in face to face consultations.

Women described feeling rushed and pressured in appointments that were too short to discuss their experiences comfortably.

"The doctors didn't help me with anything. They just don't have the time. You go there with blood pressure, you stick to the blood pressure. You don't divert to something else. It's like they give you five minutes, three minutes, your minutes are up, you go. That's how it is."

"Mental health issues aren't really a ten minute conversation, especially depending on where you are with any issues of abuse or responses to trauma they can manifest in so many weird ways that it's hard to explain to someone. Especially as you may come in one day and seem ok, it's hard to explain why actually this is how I've been acting over the past week and have them know what to do in ten minutes."

Across the consultation, many women felt that services were not appropriate for, and responsive to, their individual experiences.

For example:

→ Deaf women taking part in face to face interviews highlighted that services they had accessed had generally shown very little understanding around the Deaf community. Particular concerns were flagged around lack of understanding around BSL and other languages and lack of appropriate interpreters.

A number of Deaf women taking part in the consultation had not been offered an interpreter. In place of an interpreter, some women had been asked to write things down. One survivor was told to bring a friend to interpret.

→ Participants who were survivors of CPV also found that services generally were not set up to respond to the specifics of their experiences. Here survivors shared that the focus of services was on child protection rather than taking a broader more holistic health-centered approach.

→ One woman discussed her experience of not feeling believed or understood by health professionals as a result of her being an asylum seeker.

"I am an asylum seeker, and I have some other trauma, and this woman is not able to understand that. When I tell her things, she goes 'oh really'. So her response, i felt like she doesn't believe me... like she doesn't understand me."

→ A number of BME survivors taking part in consultation also highlighted the importance of access to BME specific and specialist services and to diverse professionals, as well as the importance of ensuring that health professionals are equipped to understand their specific experiences as BME women.

"I personally feel just as an African if I go somewhere else, this is so much personal to me, I fail to find something I can identify with. I shut down and fail to express myself, you know, why I'm there in the first place. Personally, I know probably this is impossible, but it would be amazing in all of these services to have some diversity in it you know...It lifts up a lot of weight... Somehow we are always left behind"

2) Availability of, and access to, services

Access to health services was repeatedly raised by survivors taking part in the consultation.

Survivors highlighted the importance and difference it made to them when timely support was available and accessible to them.

"I was suffering from anxiety/depression living in an abusive controlling relationship. Visited my GP who supported me by offering counselling and medication at the time I was at my worst. They also wrote letters to help me get housed as my abusive partner at the time was threatening to throw me out and make me homeless."

"The counselling service at the surgery was the best thing which I needed at the time post-abuse. more recently my I have also felt supported by my female GP who was very empathetic, supportive and provided follow-up support."

That said, participants articulated a number of challenges in accessing health appointments.

Indeed when those responding to the national online survey were asked whether there were barriers for survivors in accessing support via health services in their local area, 79% said 'yes'.



79%

Of those responding to the national online survey were asked whether there were barriers for survivors in accessing support via health services in their local area, 79% said 'yes'.

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Participants across the board wanted to see a wider range of therapeutic services and mental health support services available to them.

Participants noted a general lack of support available, and a lack of choice in therapy options. This was in reference to both the support for themselves as well as - for a number of survivors who were mothers - support for their children.

65% of respondents to the national online survey indicated that there had not been a range of good options available to them to support their mental health.

For some participants, availability was put down to the "post-code lottery".

"Postcode lottery meant I couldn't access any and also wasn't informed of any, I got my support from the... voluntary sector."

Of those responding to the national online consultation only 30% said they had been offered further support as a result of going to their General Practice; only 33% had been offered further support as a result of visiting the hospital.

"You really need the support. You rang because you need help. You really need someone to tell you something to make you feel better. To be told simply we don't deal with that, we deal with recent ones, it makes you feel lost."

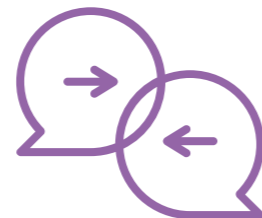
For some, the lack of support available to them was connected to their identities. Survivors taking part who identified they were asylum seekers discussed that the lack of further support offered to them was partly down to a lack of understanding by health professionals regarding what health care support is available for asylum seekers and refugees.

A number of survivors had been offered treatment, but had found this to be inappropriate or inadequate for their circumstances. One woman, for example, described being offered a 'text bot'; several others had been offered Cognitive Behaviour Therapy which they had found to be ineffective, and for at least one woman had made things worse.

"I have accessed CBT but I didn't get the help from CBT.. (I'm) not sure if that was the right treatment for me as it didn't help. The therapist didn't understand my situation and what I was going through. I attended all 6 sessions. It wasn't for me. I felt worse when I came back from CBT, they haven't offered anything else to me."

One survivor of CPV had been offered therapy which she said to be "useless and sent (her) son into shame about his behaviour occasionally making it worse."

Furthermore, less than 30% of respondents to the national online consultation felt their experience of domestic abuse was sufficiently addressed in their mental health treatment plan.



Less than 30%

of respondents to the national online consultation felt their experience of domestic abuse was sufficiently addressed in their mental health treatment plan.

Three women responding to the online consultation stated that they had had to pay for private health care due to the lack of availability of services.

"I am actually paying for my own therapy now six years later because it take me that long to save up for it"

A number of survivors had been offered medication but not mental health support or services to go alongside this; they felt that the medication was used to 'palm off' survivors, leaving women without support to address deep rooted trauma they had suffered.

"My GP is quick to write out a prescription but not listen to what I am saying when I have spoken about the abuse and not offer any counselling just medication."

"I feel like they don't tackle the actual problems, they just throw pills at the situation. You go in and your just like, I feel depressed, and then rather than ask you why, they just say 'here are the pills' without asking you why or telling you about the services available."

Where mental health services were available, survivors across all sites had been made to jump 'through hoops' to get support, and many had been placed on long waiting lists. Furthermore, virtually no support was offered to survivors on waiting lists.

"CAMHS (for my child) only want to see you if you do 10 star jumps backwards whilst drinking a cup of tea".

"Once you start helping yourself, then they are more likely to help. But getting there it's so hard. It's like you're jumping through hoops to get there. You'll get on one rung of the ladder but then there's always inconsistency...When you feel desperate, it feels like you're hitting a brick wall."

Where survivors had been offered mental health support, this had often been for short periods of time with an insufficient number of appointments allotted to them.

"I have never been seen for my trauma and was denied secondary mental health care and offered 6 cbt sessions which wouldn't even start to unravel years of abuse sexual and physical" - national consultation

"I find with the counselling, it takes a long time to access it. Then you get X amount of sessions, and you've only just got started. You are just scratching the surface."

Some women also felt that the services available to them were not sufficiently specialist, or able to understand their specific experiences. For example, women stated:

"There is so little counselling for ethnic minorities. I am speaking out of experience here. Culturally, when I come to somebody who doesn't understand our cultural background. They might console me, but they don't understand my people. People from where I'm from they understand me."

"I am an asylum seeker, and I have some other trauma, and this woman is not able to understand that. When I tell her things, she goes 'oh really'. So her response, I felt like she doesn't believe me... like she doesn't understand me."

One survivor was not given access to a specialist Deaf Counsellor, and instead was made to have counselling through an interpreter - an experience that was extremely negative.

Another Deaf survivor was referred to a helpline which demanded a phone call which made it physically impossible for her to access this help.

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A number of participants also highlighted concerns around the thresholds for accessing mental health support.

Women reflected how health services were being delivered, and the extent to which they were able to meet the needs of survivors. One woman, for example, had been told that her trauma wasn't recent enough for her to get help, another hadn't been able to access support because she was working and therefore not considered 'bad enough' for support.

"Sometimes I felt like the fact that I had a job and a certain level of education and all these things ...I was told basically that i'm fine because I couldn't be not fine because I was doing the things I was doing."

For many participants, access to services was made harder by the barriers they faced in accordance with their ethnicity and/or immigration status and/or disability.

For example:

- Women who were Deaf described how their access to services was entirely determined by their access to interpreters - often appropriate interpreters were not available in health settings.
- Women who were survivors of CPV faced barriers in both accessing support for themselves and for their children.
- Women who were asylum seekers felt discriminated against and experienced being spoken down to due to their immigration status. They also found that ID issued by the Home Office was frequently not accepted by health services, leaving them without access.
- Women who were BME also faced discrimination and were not taken seriously as a result of their ethnicity

"When I was homeless on the street my friend had to get me a room as they wouldn't accept my Home Office letter as ID. I struggle a lot to get health care as I need ID to prove who I am, I get depressed a lot. If I have to access health care I need to show them some ID which is difficult as they don't always accept my Home Office letter as ID."

C) Professional knowledge and response

- Survivors want to feel respected by all professionals in health services, and want professionals to respond without judgment, stereotyping or discrimination
- Survivors want to know they will be believed if/when they disclose abuse
- Survivors want to know they will not be blamed for their experiences if/when they disclose abuse
- Survivors want health professionals to be knowledgeable about different types of abuse
- Survivors want health professionals to fully understand the dynamics of abuse and their experiences of trauma
- Survivors want health professionals to understand how equality, diversity and intersectionality factors (such as disability, sexuality, ethnicity, immigration status) intersect with experiences of abuse and access to services
- Survivors want health professionals to consistently pick up on signs/ indicators of abuse, and to ask them more questions about what is going on/ demonstrate professional curiosity
- Survivors want health professionals to understand how perpetrators might also present in the health system/ services

1) Understandings of violence against women and girls

Survivors taking part in the consultation highlighted the need for all health professionals to understand different forms of abuse, the dynamics of abuse, how to identify when someone is experiencing it, and also to understand how perpetrators might present.

Women repeatedly identified the need for additional training and better understanding around violence and abuse, trauma, the dynamics of abuse, how to identify abuse, and how it impacts/ interacts with mental health as well as other forms of multiple disadvantage. Survivors felt there was a particular need for this in relation to understanding coercive control and 'less physical' forms of abuse.

"People haven't been informed. They haven't been trained about it. There is no knowledge. So, domestic violence is the black eye, you haven't got a black eye, must just be an argument in the family and what's wrong with that. Part of life isn't it. You call the police, you think they will listen, they look at you and say, oh why are you making such a big fuss."

"Whether its coercive, physical, mental or whatever the abuse is, no one really understands it who hasn't been through it themselves, I mean why should they, and that's fair enough. But, there are services we approach, if they put up barriers, then you feel like you're being abused by everybody."

"I would like for staff to be trained around behaviours and other issues that might be related to abuse such as substance use, homelessness and mental health."

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Indeed, the majority of those responding to the online consultation felt that neither General Practitioner nor staff working at their local hospital were equipped and able to identify signs of abuse.

“They often treat the pain or symptoms but don't ask about the cause or pick up the signs of DA. When links are made such as the IRIS project, then it can be effective.”

Survivors responding to the national online survey were asked the extent to which they felt confident in professionals' abilities to identify signs of violence and abuse. This exercise found that:



Less than 20%
of respondents felt that General Practitioners could identify signs of violence and abuse

Less than 50%
of respondents felt confident that professionals in Acute health settings are aware of and/or able to identify signs of violence and abuse

Only 23%
of respondents were confident professionals in this are aware of and/or able to identify signs of violence and abuse when asked the same question in relation to mental health settings,

Participants reflected that professionals often did not ask sufficient or adequate questions, failing to ask 'why' women were presenting with certain symptoms, and failing to identify signs of abuse.

Many women shared stories of missed opportunities and lack of understanding in health services/ professionals.

“I went to A and E for a broken nose and they um they didn't do anything. They identified it and I said that it was my partner but nothing from A and E. They just left it.”

“My ex partner was abusive towards me in front of a midwife and nothing was done or said”

“I found that when I went to go the doctors... there were so many hints and bits of pieces, but nobody ever asked me I was alright, was there anything underlying? Nobody triggered a question or something that even got me thinking about it, right down to the fact that when I was aged 32 and had a hysterectomy my ex husband forced me to say i wanted... they never asked... I pushed and I pushed, and nobody ever asked me. I just felt that people thought that I was neurotic. Nobody asked me why I was going in so often.”

Survivors also felt it important that health professionals had better understandings of how perpetrators might present in health services and health systems, and how the perpetrator might act to prevent them from accessing appointments. For example, one woman taking part in the focus group described being prevented from leaving the house to attend the GP; two women described their perpetrators attending mental health appointments with them and the health professional listening to the perpetrator over the survivor – resulting in one of the women being sectioned.

Survivors in both face to face and online consultations articulated **the importance of health professionals directly asking questions about experiences of abuse and providing space for women to safely disclose their experiences.**

“Sometimes I find if you have one situation going on, but you also have another issue, it can't be dealt with alongside.”

“If they ask you more than once is everything ok, is everything ok at home and you feel that compassion, that oh they really care about me, you are prompted to open up. For someone that is a survivor, you just need that little window and everything comes crashing down.”

Survivors also shared that health services lacked an understanding around how different aspects of their identities interacted with, and intersected with, their experiences of violence and abuse and their access to support.

For example:

→ For women who were survivors of CPV, it is evident that there was a particular lack of understanding around this form of abuse, survivors' experiences, and how best to respond to a disclosure. Many found that professionals were quick to blame CPV on children's hormones rather than identifying coercion and control. One woman described her therapist walking out half way through an appointment saying she couldn't cope with the violence from the child. Furthermore, three of the four women were talking about children who had been adopted and were clear that the abuse was linked to early childhood trauma, however it seemed that health and social care did not understand this link and were blaming the adoptive families.

“Maybe if I said I was experiencing violence, they would help but I have been asking for help around behaviours. You worry that children will be taken away – the finger pointing, you are vulnerable asking for help. Without the back story, it may look like something else”.

“I feel blamed for my child's behaviour that stems from the abuse I didn't cause. We get lumped in with a stereotypical family that we are not.”

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→ Numerous BME women taking part in the focus group also highlighted the need for a better understanding regarding their specific experiences; lack of representation, and limited understanding of their specific experiences presented additional barriers to women disclosing abuse and accessing support. Some women had faced cultural stereotyping that meant professionals normalised the abuse they were suffering.

"Assumption (were) made that DA is just part of my 'culture' and that unless there are physical signs of abuse, it is not that bad or even abuse"

→ Deaf women taking part in the consultation repeatedly highlighted the lack of understanding around the Deaf community. Some women reported professionals being very visibly uncomfortable around them as a Deaf person. There is also a notable lack of understanding around Deaf people with mental ill health.



Deaf women taking part in the consultation repeatedly highlighted the lack of understanding around the Deaf community.

2) Responses to disclosure

Survivors wanted to feel heard, listened to and believed by all professionals in all health services.

"We need things to be taken seriously. We want as many generations that have passed through it to make it easier for the next generation and educate the abusers and the victim to know that if you've been a victim, it's a long process."

When asked about their experiences of health services in their local area, respondents to the online consultations shared some positive experiences - these largely focused on the experience of being listened to, heard and believed by professionals.

"All I can say is that it took me 16 years to tell someone in a therapy session at (mental health service) I spoke the unspeakable about my sex abuse from my ex husband she was gentle kind and made me feel safe and listened got me help and support more than the mental health trust did she educated me so I could get away from my abuse other while I would have been dead I will never forget her she saved my life and I was free at last"

It was important to all survivors that they and other survivors were treated with respect and dignity, and that professionals did not judge them or apply stereotypes to them if or when they did disclose their experiences.

Many of the women taking part in the survivor consultation shared stories of professionals asking insensitive or loaded questions, questioning them in public areas, making assumptions about their lifestyles, victim blaming, discriminating against them, or being dismissed. One woman had been laughed at when she disclosed her abuse to her General Practitioner.

Some women felt that, once they had disclosed, they were treated as victims rather than as human beings.

Many women described feeling dismissed and/or trivialized by professionals when they disclosed abuse, with some professionals providing a deeply unsympathetic response.

"My GP before trivialised my abuse that I experienced, demean it, how I was feeling as if it wasn't a big deal. I didn't feel I could complain they would bring my mental health into question and say that I was out of my mind."

"When I had a medication review with a nurse she was incredibly unsympathetic. She wanted to know why I was on medication and so I told her a bit about my experiences of domestic abuse and sexual assault, and before I could go deeper into the story she interrupted me and stuck a hand in my face and said "Ok, ok, I don't need to know the ins and outs"."

For many women, they felt they were dismissed and overlooked as a result of who they were as individuals, and assumptions that had been made about them.

Survivors also shared many stories regarding instances where they had faced stereotyping and discrimination in health settings - experiences which were re-traumatising and compounded suffering.

For example:

→ Some survivors described experiences of gender stereotyping, with professionals dismissing and minimising survivors' experiences on the assumption that women were 'overreacting' or being 'too sensitive'. One woman was told by a health professional that her experiences of domestic abuse were just 'a family fight, what is there to worry about'.

"I went to the doctor and I said I am in hiding currently and the doctor's response was we all are having it hard and are experiencing something, so immediately I have shut off because they have shut me off."

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- LGBTQ survivors frequently faced assumptions regarding their sexuality, with professionals assuming that they were heterosexual.
- BME women who were part of the LGBTQ community highlighted that their sexual identity was often not seen, due to assumptions that BME women are heterosexual.

"I went to A&E because I was in so much pain, I had an examination and the doctor went on to say having that you are having a lot of sex. ... She was assuming that I am heterosexual without asking me first. I still have a cyst which hasn't been treated."

- Numerous BME women had faced racism and discrimination in health setting, leaving them without support.

"Recently I feel that there has been quite a bit of prejudice because I am black regarding the domestic violence I have experienced. I was left feeling an supported and looked down upon and that it's not that serious and not bad as I am making it out to be and I was told to move on with my life without it being addressed properly. The impact of some of the health professionals has made me feel worse in myself and making me feel is this racism that I am experiencing. There is a lack of understanding regarding BME communities needs when it comes to domestic violence and how they are impacted."

- Women also shared stories of assumptions being made based on their class.

"I feel that I am judged based on my accent, upbringing, the way I dress, and the fact that I'm white, middle class and went to a good school. Society has the idea that a domestic abuse victim is lower class or perhaps comes from a culture where women aren't respected and shows visible bruises"

Across the board, women with children felt particularly judged in regards to their parenting, and felt they were deemed to be 'bad mothers'. Others felt that they had been judged not to be 'bad enough' to warrant support or access to help.

"I get told that I'm articulate, so when I go along I think that maybe they judge me the other way and they think that I don't need the help."

Survivors wanted health professionals to be able to refer them on to specialist services and to support them to access further support. Many felt that health professionals did not have the relevant information or training in order for them to do this.

6

Section six: Impact on survivors

The Pathfinder survivor consultation highlighted the direct impact on survivors and their families when health services and systems did not listen to and effectively respond to their lived experiences.

Survivors facing multiple barriers to access and/or who have faced discrimination face additional and compounding impacts, such as further traumatisation and stigmatisation.

Examples of the impact of health service responses on survivors include the following:

- When survivors are not listened to, not believed, or when signs of abuse are not picked up by health professionals, survivors feel abandoned, further adding to their turmoil. Survivors often described a sense of isolation as a result, and for some make it less likely for them to seek help later, delaying or denying access to safety and support.

"Some GPs and mental health professionals just didn't believe me. Words like 'alleged domestic abuse' and 'persecutory delusions' are actually on my medical records now. The whole experience traumatised more than I already was."

Sometimes it's so exhausting. You have so many memories of how you've been told that you're worthless that you are still taking on board those things. So when somebody in authority tells you or doesn't believe you or doesn't ask the questions, you go away feeling worse than when you went in.

6

→ A lack of understanding of abuse and trauma can leave survivors with misdiagnosis and inaccurate assessments. Survivors in this consultation highlighted how this further stigmatises and traumatises.

"I had been wrongly assessed as delusional and was absolutely shocked when I read the first psychologist's assessment report. Was, very distressing for me, fighting to be believed. Through my informal complaint, I was assigned to the Head Psychologist. A gay doctor. This helped and he reassessed me and identified Complex CPTD. If I, had had the right trauma informed support from when this all started, I believe I, wouldn't, have gone from anxiety to PTSD to C-PTSD. There is no doubt for me that the delay in not receiving the right support early on, incorrect assessments of me and the health system traumatised me further."

"My abuser was drugging and poisoning me. I lived a hitchcock film...I should have been signposted to the police and had hair and nail samples taken to gather evidence of the drugging and poisoning. Instead I was just labeled mentally unwell...They should never refer a DV victim to voluntarily self-admit into a mental hospital, which is what happened in London. It was the most distressing experience on top of what I had already gone through. I was not suddenly mentally unwell, I was simply highly traumatised and petrified of what would happen next after the abuse...They shouldn't think what is wrong with this person, but ask/think what has happened to you. Someone with no previous history of mental ill health."

- When information is shared without the consent of survivors, many feel that their privacy has been infringed and their rights undermined. There were numerous instances shared during the focus groups in which survivors felt that had information been shared accurately and earlier, they would not have had to suffer as long as they had.
- When survivors are asked/forced to retell their stories to different health practitioners they are re-traumatized and are often set back in their recovery. Survivors often felt triggered and spent days recovering from these disclosures and the impact speaking about their experiences had on their mental health.

"You have to explain yourself time after time which can be sole destroying. And brings up old wounds and you can't just turn it off so you end up go through a bad stage of depression."

- When health care professionals dismiss and/or do not act on disclosures of abuse (through either advice or referrals) survivors are left feeling more alone and like their suffering has been invalidated. Survivors repeatedly spoke of how this added to feelings of abandonment and vulnerability, whilst also adding to stressful situations, as survivors spent hours scouring the internet to find support or guidance, potentially risking a perpetrator finding them looking for resources.

"My GP is rubbish... I went to see him just after I'd been to refuge last year, his response was 'what do you want me to do?'. I just wanted him to listen to me but I came out of there feeling more broken than ever."

- When survivors are treated with a one size fits all approach they feel that they are not being listened to or treated as individuals. This, survivors explained, led to a sense of dehumanization.

7

Section seven: Examples of key messages from survivors

In both online and face to face consultations, participants were asked to provide any final key messages for health services in their local area. Key messages largely mirror the key themes and 'asks' identified above.

Examples of key messages provided by survivors include¹⁸:

Positive experiences and promising practice:

- I really appreciate that you have made a tremendous difference to me
- It is great to see you saving lives with fast responses, thank you

Service delivery:

- I would like to see more consistency between services
- I would like to be checked up on repeatedly
- I would like to see more ethnic/cultural diversity in counselling teams
- I would like to see good explanations of diagnoses, how they affect you, others and general aspects of life
- I would like to see BSL workers in all services rather than Community Support Workers.

¹⁸ The below are adapted from direct quotes given by survivors across all three phases of the consultation.

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- I would like to see improvements in sharing people's information with consent
- I would like to be treated by a female practitioner
- I would like to be referred to groups that can understand my religion and culture

Professionals responses:

- I would like to be treated without an assumption being made about my sexuality.
- I would like to see GPs being proactive rather than reactive
- I would like to see psychological abuse considered just as debilitating as physical abuse
- I would like to see drastic behaviours being acknowledged as a cry for help
- I would like to see greater awareness around abuse in LGBTQ+ relationships.
- I would like to see professionals listening actively and understanding the individual's perspective
- I would like to be listened to without prejudice
- I would like to see professionals not making assumptions or minimising survivor's experiences

Training and development:

- I would like to see a gender-based trauma response team or member of staff with training on gender-based trauma in mental health services
- I would like to see more professional awareness around the Deaf community and their needs
- I would like to see professionals recognising CPV, listening, starting to offer meaningful help, and stopping blaming parents. Realise that the idea that any violence from children must be learned behaviour is incorrectly applied to all cases.
- I would like to see more awareness of trauma
- I would like to see more awareness around cultural stereotypes and the barriers to support they create
- I would like to see professionals unpacking the low disclosure rates of BME women and meeting the needs of BME communities without discriminating against us

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Section eight: Recommendations

Recommendations for health systems and services

Recommendations for Local Authorities/CCG:

- Invest in interventions for survivors within health services, for example the (continued) implementation of IRIS, and embedding Health based Idvas in Acute Trusts and Mental Health Trusts.
- Invest in trauma informed responses to violence against women and girls across health services.
- Invest in specialist BME, LGBTQ and disability services. Audit what services are currently available to different groups in local areas.
- Involve experts by experience in planning for future responses, ensuring this is done ethically and provides opportunities for experience and potential employment.
- Create standards on identification needed for asylum seekers using health services

Recommendations for statutory and third sector agencies and services:

- Strengthen referral pathways in the local area. This should be done by facilitating workshops between agencies (both statutory and third sector) to understand respective roles, responsibilities and capacity, helping services to understand their 'fit' with the rest of the system. Create a 'general' pathway for survivors that can be relayed to them to help them understand, visualise and navigate the support they are entitled to and the processes this entails
- Include community groups - BME, LGBTQ and disability - groups in decision making and co-production of local service development.
- Set up a practitioners' network and working groups focusing on BME, LGBTQ and disability.
- Ensure effective and meaningful collaboration with local BME groups and communities, LGBTQ groups and disability groups.

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Recommendations for health services:**Accessibility**

- Ensure services are accessible to those with physical disabilities of various kinds and disabilities considered in safety planning with survivors who disclose.
- Provide accessible systems for booking appointments that do not require access to a mobile phone
- Ensure patients are not asked to justify the reason for requesting an appointment with their GP
- All health services should have accessible interpretation services with short wait times and a shift rota in acute services to ensure women are not treated without access communication.
- Book interpreters or provide VRS for every appointment with Deaf patients
- Embed effective and appropriate referral pathways and referral systems in to specialist services

Interventions

- Embed the primary care IRIS intervention in every Local Authority area
- Acute Health and Mental Health Trusts should seek to embed a specialist DA practitioner on-site with them rather than working remotely
- In instances where women must be put on a waiting list to access support (e.g. Mental Health services), interim support should be offered (directly or via referral) for the duration of the waiting period; for example, regular phone calls to check in with survivors, directing women to relevant resources, helplines or women's centers.
- Developing clear referral pathways for support between health, criminal justice, social care and DA services to support effective responses to Child to Parent Violence (CPV)

Training needs

- Training for all staff working in health care settings, regardless of role, on:
 - violence against women and girls, the dynamics of abuse and intersectionality in particular
 - different forms of abuse, including child to parent violence
 - challenging myths and assumptions around domestic abuse
 - asking the right questions and identifying domestic abuse
 - managing disclosures
 - referring to specialist services and referral pathways
 - embedding safety planning into practice
 - appropriate responses and approaches when perpetrators are present
 - additional safeguarding training to ensure women are not put in unsafe situations within the health service
 - trauma and women's mental ill health
 - the knock on effect and impact of abuse, and health responses, on survivor's children and families
 - shifting service culture to ensure women are heard, listened to and believed
 - challenging discrimination against women, survivors, BME women, women with English as a second language, women with mental ill health, disabled women, LGBTQ+ survivors, survivors of CPV, asylum seeking women and Deaf women.

- Training and support for frontline practitioners should work on the ability to retain compassion and sensitivity in their work even when under great pressure, combating 'compassion fatigue'; and increasing their ability and motivation to explore the root cause of people's problems
- Additional training for GPs regarding submitting health reports to support survivors' legal cases against perpetrators
- Training for reception staff in all practices around appropriate questioning, trauma-awareness and equality and diversity.

Information sharing and communications

- Improved information sharing and record keeping both internally and across agencies so that women do not have to keep sharing their stories. There is a need for safe, portable record of someone's experiences, reducing the need for them to keep repeating their stories with high risk of re-traumatisation
- Improve safe follow up of communications sent to survivors if survivors are not responding
- Provide interpretations and multilingual information and support for all women that need. Interpreters should be available at all times in acute services to minimise the risk of treatment without communication.
- Increase availability and accessibility of literature and posters on domestic abuse, and embed discrete ways of disclosing abuse into health services practice
- Re-assess policies on consent and information sharing to ensure consistency within agencies. Include survivors in this process.

Local accountability

- Ensure accessible routes for complaints and accountability
- Keep survivors in the loop regarding their complaints and whether they have been heard or passed on

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Recommendations for national health policy and practice

Across the data collected as part of the survivor consultation a number of systems and process challenges were highlighted. The following recommendations address the systems challenges that are directly impacting survivors experiences of local health services.

- Commit to improving health services' responses to domestic abuse and violence against women and girls on a national level
- Embed an intersectional approach to domestic abuse in future training programmes, safety planning and risk assessment formulation and planning of referral pathways.
- Promote and support interventions to support survivors in health services, such as IRIS and health based Idvas.
- Invest to increase availability of mental health support and therapeutic options for survivors. This should include the provision of longer term mental health support for survivors, a broader range of therapeutic and talking therapies available), and on-going support when women are discharged from mental health services or support programmes.
- Improve digitalised data collection methods and systems on a national level to enable effective and safe data collection and information sharing between health services, therefore enabling health services to a) evidence the demand for support, b) improve referral pathways for survivors and c) prevent women from having to repeat their stories.
- Invest in primary care service delivery to ensure that survivors/ women are able to access primary care services when they need and for longer appointments: all women should be able to access primary care appointments without having to first justify their reason. Primary care services should also ensure effective record keeping so that when an identified survivor requests an appointment this can be prioritised.
- Encourage the creation of BME, LGBTQ+ and Disabled practitioners' network/ working groups and the involvement of these groups and those with lived experience in future work around improvement of services.

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Section nine: Conclusion

The Pathfinder survivor consultation process provided a key opportunity for survivors across England to share their personal experiences of local health care services and professionals.

This report captures the key themes from across the three phases of consultation, highlighting what survivors want to see in their local health services.

The report finds pockets of promising practice whereby women have been effectively listened to and supported through health services and systems, providing vital lifelines to them.

Generally, however, this consultation evidences the need for health services and systems across England to improve responses to domestic abuse

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Appendices

Appendix 1 - BME Survivor Journey Map

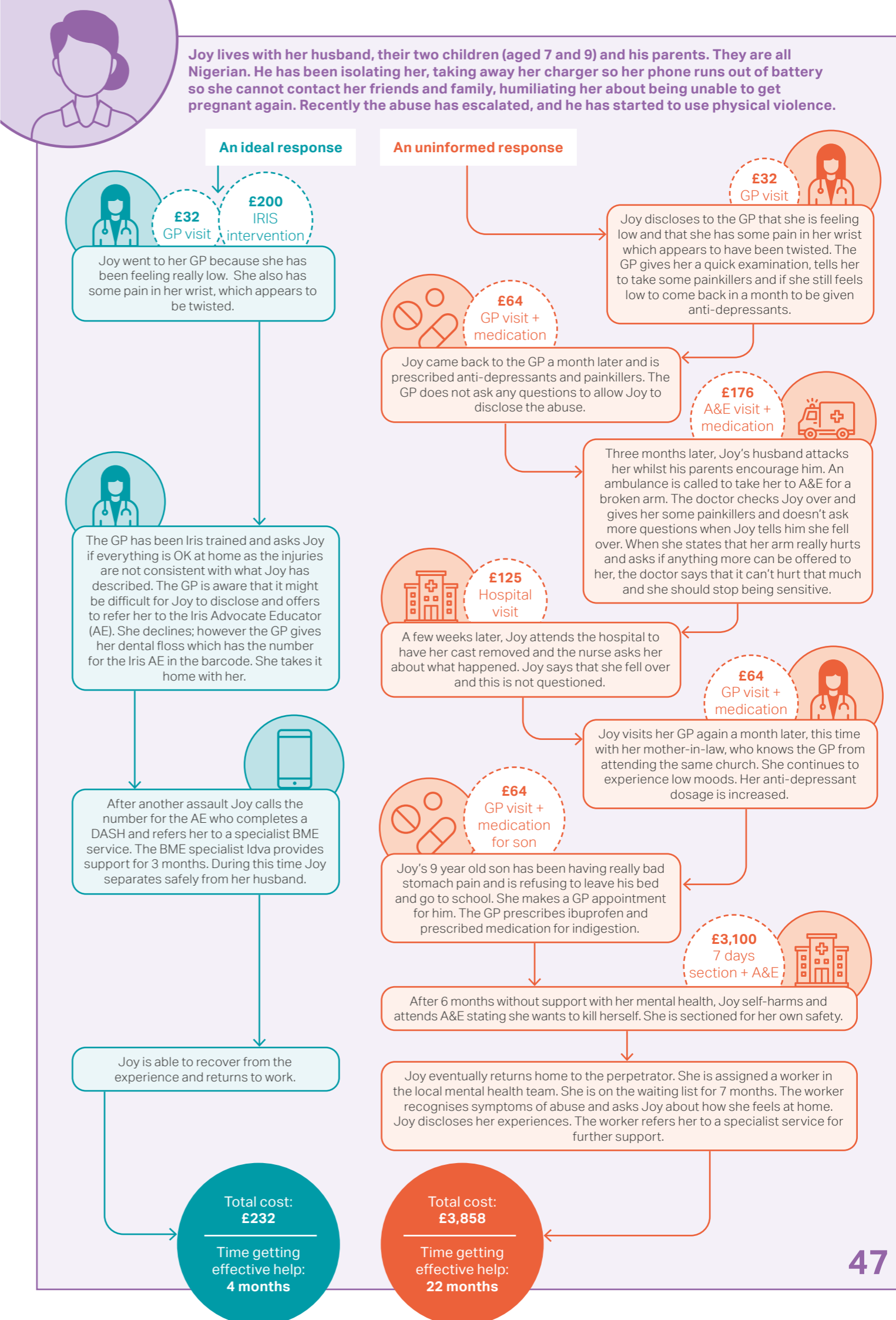
Appendix 2 - Older Survivor Journey Map

Appendix 3 - Child to Parent Violence Survivor Journey Map

Appendix 4 - Deaf Survivor Journey Map

Appendix 5 - LGBT+ Survivor Journey Map

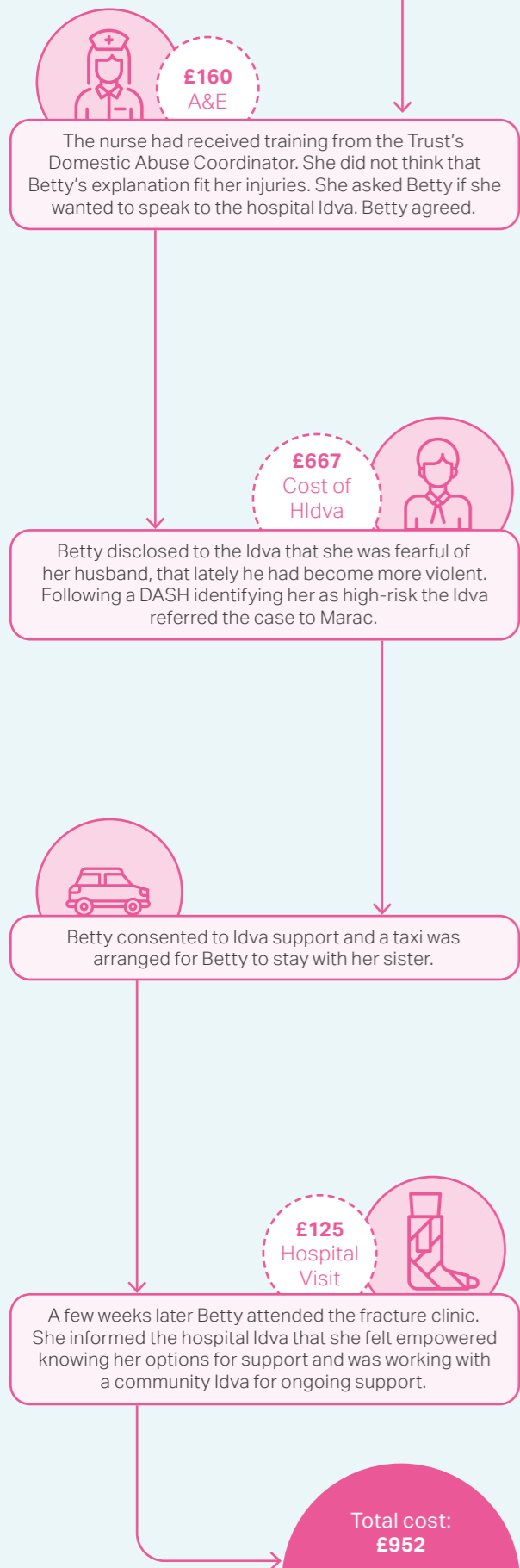
These Survivor Journey Maps depict a typical journey through the health system for a survivor of domestic abuse. The journeys are based on the experiences of real women who shared their stories as part of the Pathfinder survivor consultation process. They are presented next to an example ideal response and highlight how survivors could be identified and responded to quicker and more effectively to save unnecessary risk and trauma to the survivor and cost to the NHS.



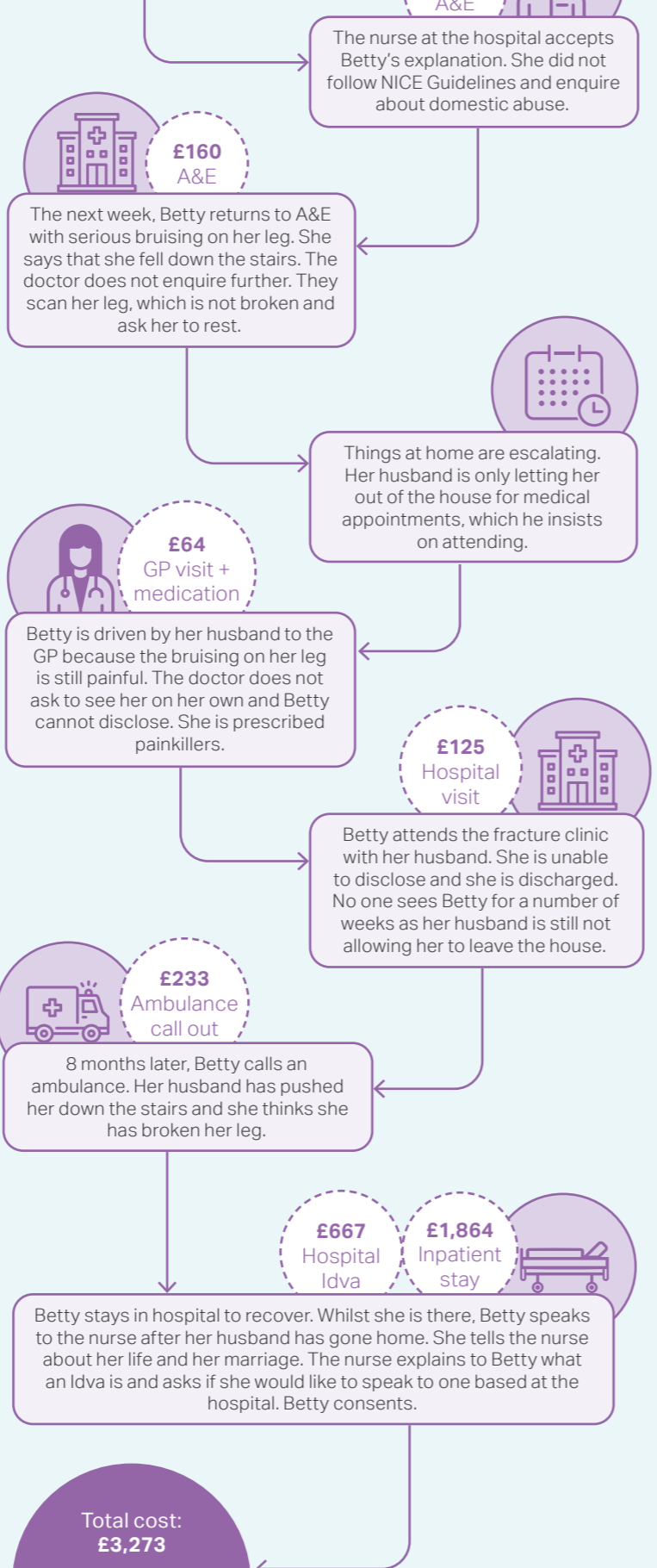


Betty (aged 78) has been with her husband for over 50 years and has experienced verbal, emotional and physical abuse throughout their marriage. She attended A&E with a fractured arm following a physical attack. She stated that she had slipped and fallen.

An ideal response

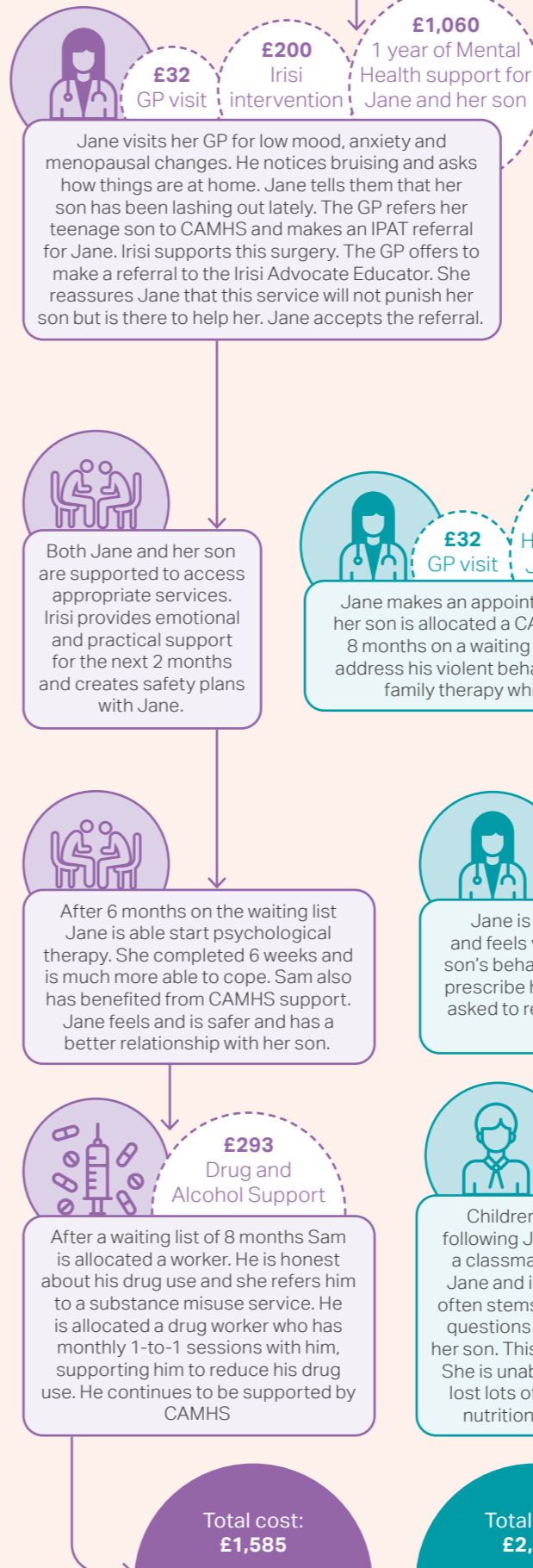


An uninformed response

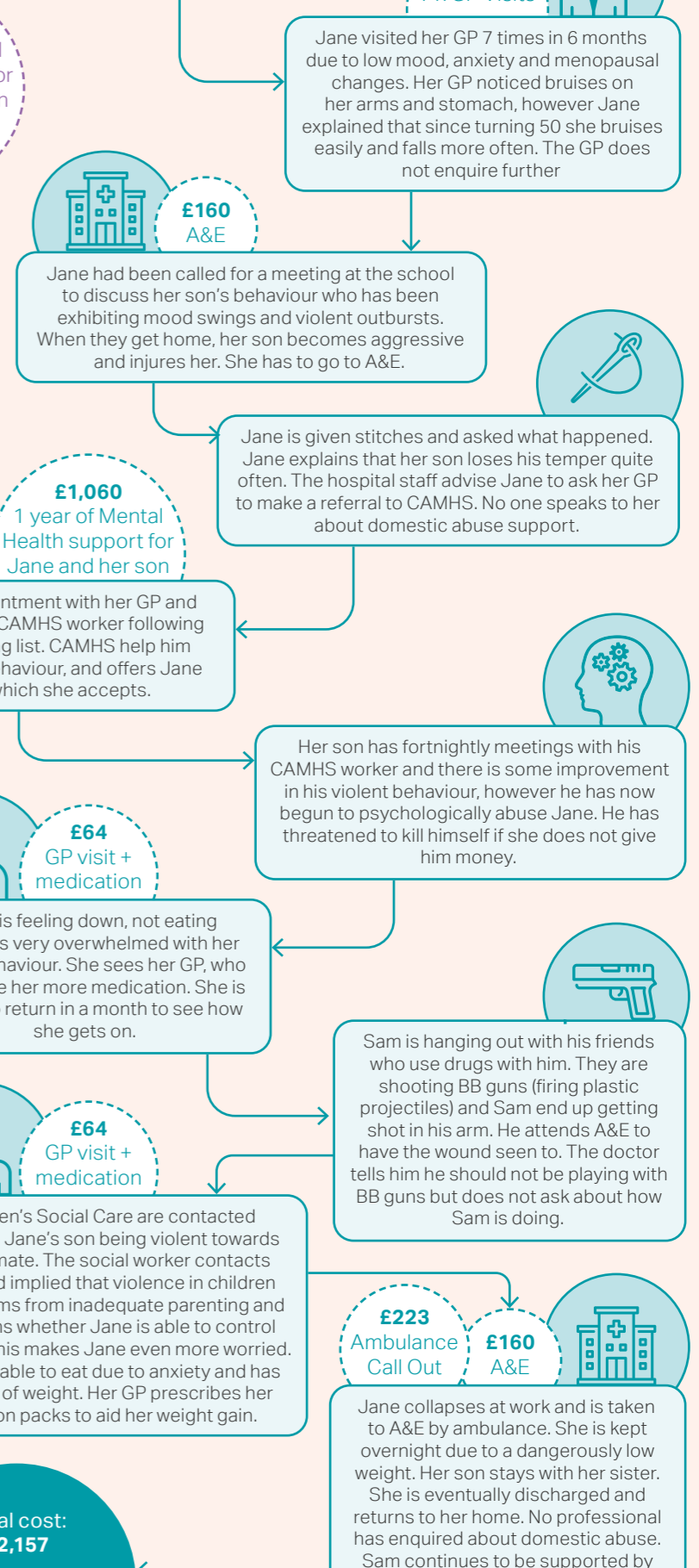


Jane lives alone with her teenage son Sam who is abusive towards her. He often has violent outbursts and damages the house. The behaviour started a year ago, around the same time Sam started taking drugs.

An ideal response



An uninformed response

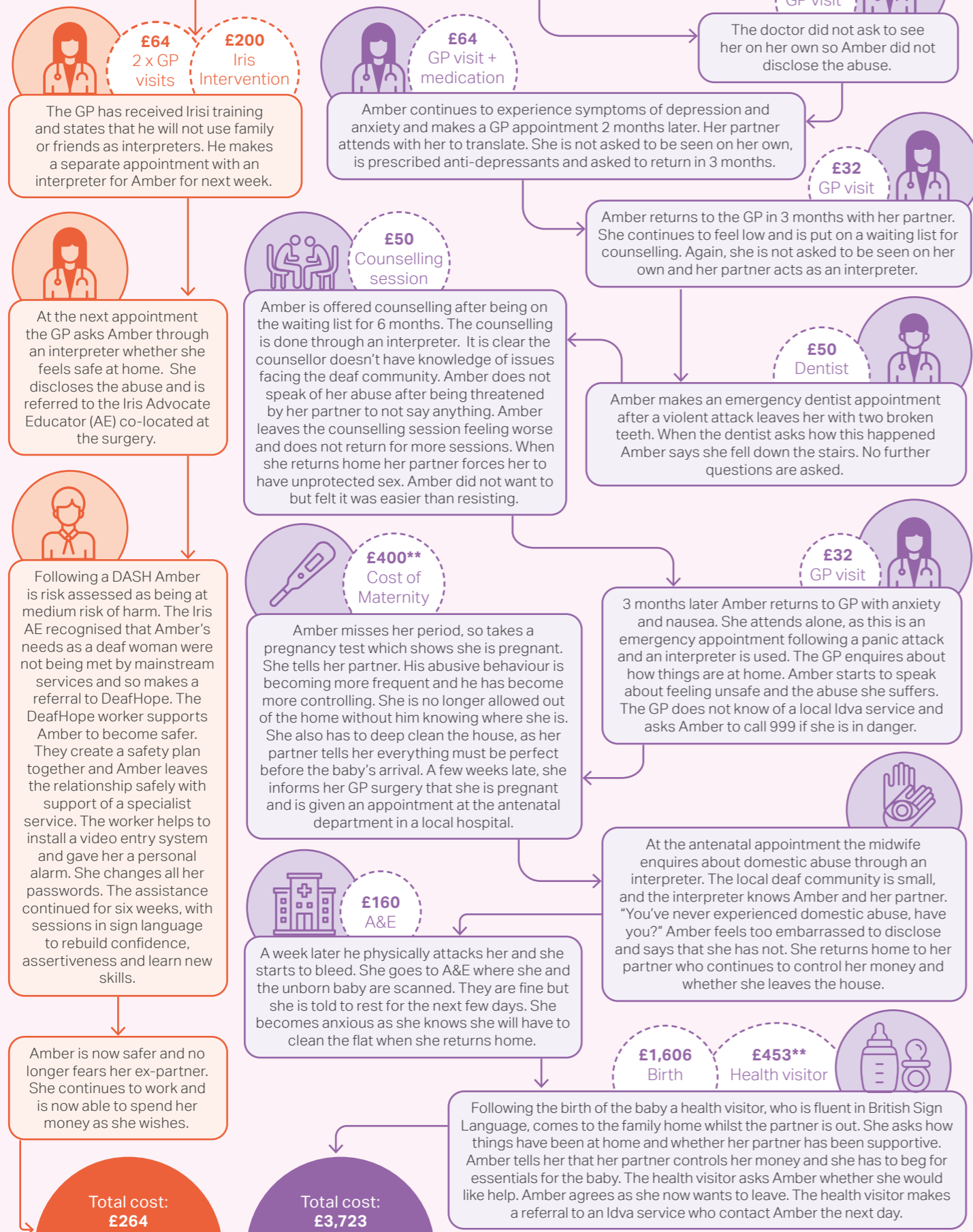




Amber, a 22 year old woman, has regular check-ups at the GP surgery for hearing loss. She presents with symptoms of depression and anxiety. Her partner does not allow her to leave the house on her own. He has been taking her wages and giving her an allowance of £10 a week. She goes to attend an appointment with her GP.

An ideal response

An uninformed response



* includes cost of 3 ante-natal appointments with a midwife, 3 GP appointments and 2 post-natal visits
 **includes the cost of antenatal review, new baby review, 6-8 weeks check, 1-year review, 2-2.5 year review



A lesbian woman, Samira, 18 years old, has no form of ID other than her birth certificate. She lives with an abusive partner, after being kicked out of her parents' home due to her sexuality. She is financially dependent on her partner, who sometimes does not allow her food and does not top up her mobile phone, so she cannot speak to her friends. Because she has no ID she cannot access benefits. She is not named on the tenancy agreement or the bills.

An ideal response

An uninformed response

