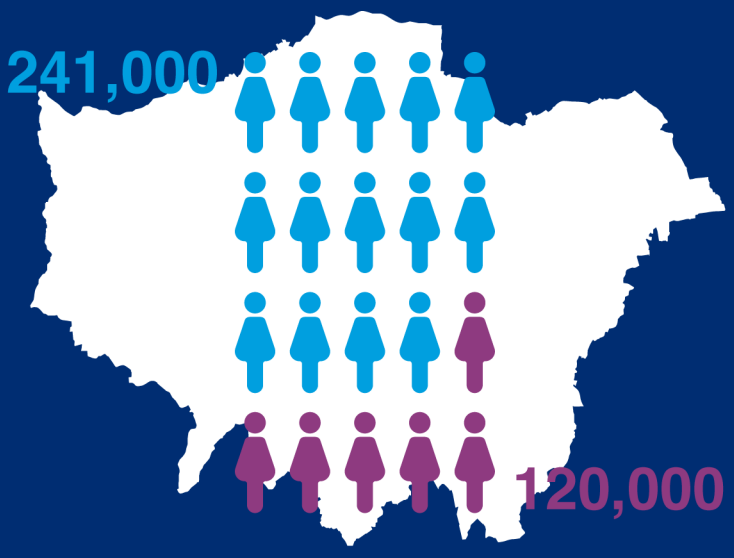
‘We only do bones here’

Why London needs a whole-health approach to domestic abuse

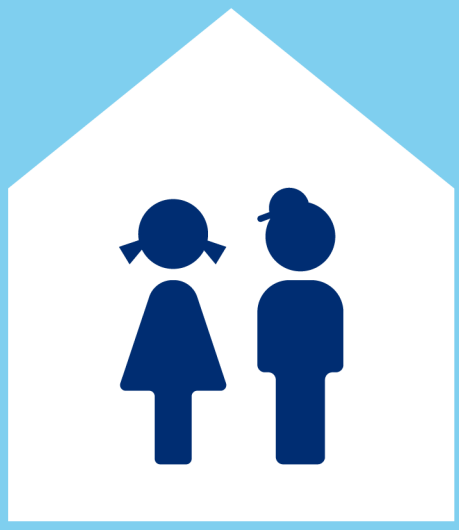
March, 2021

SafeLives

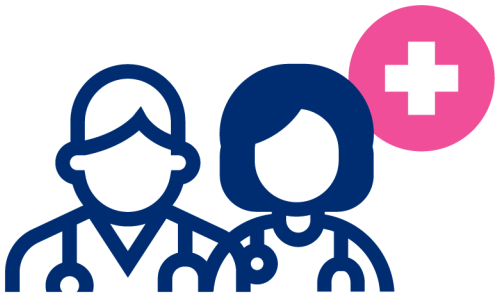
Whole Health London



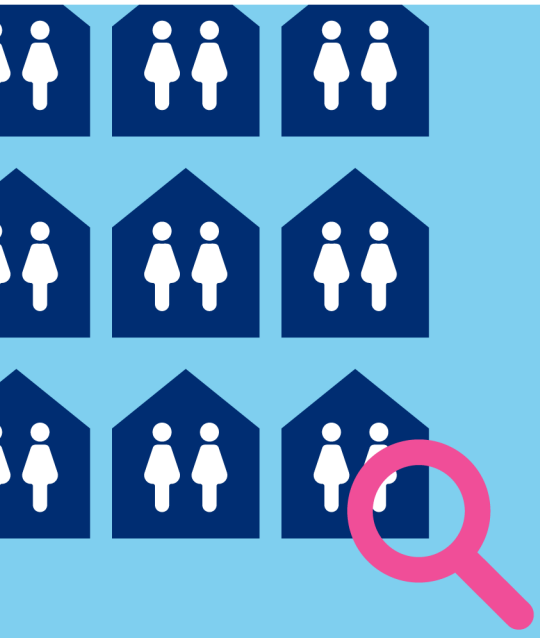
In London, we estimate that more than **241,000 women** and **120,000 men** experienced domestic abuse in the past year.



425,480
children and young people have experienced domestic abuse, or will have by the time they are an adult.



Of the 215,200 **NHS staff** working in the capital, we estimate around **13,900** experienced domestic abuse last year.



Over 13,000 cases
were heard at Marac in London in the year ending March 2020.

We estimate around
88,000 Londoners
received medical attention following partner abuse in the last 12 months.

We estimate **361,000 Londoners** experienced domestic abuse last year.

That would put health service costs alone at
£433 million.

SafeLives, Whole Health London Policy report, 2021

SafeLives

About SafeLives

We are SafeLives, the UK-wide charity dedicated to ending domestic abuse, for everyone and for good.

We work with organisations across the UK to transform the response to domestic abuse. We want what you would want for your best friend. We listen to survivors, putting their voices at the heart of our thinking. We 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 we challenge perpetrators to change, asking 'why doesn't he stop?' rather than 'why doesn't she leave?' This applies whatever the gender of the victim or perpetrator and whatever the nature of their relationship.

Last year alone, nearly 13,500 professionals received our training. Over 70,000 adults at risk of serious harm or murder and more than 85,000 children received support through dedicated multi-agency support designed by us and delivered with partners. In the last four years, over 2,000 perpetrators have been challenged and supported to change by interventions we created with partners, and that's just the start.

Together we can end domestic abuse. Forever. For everyone.

Acknowledgements

We are incredibly grateful to the members of the Whole Health London Advisory Group for their insight. We are particularly indebted to our 'by and for' specialist sector partners: Forward UK, Galop, Southall Black Sisters and Stay Safe East – we know how much pressure your services have come under in the last year and are therefore doubly grateful for the time you found to give to this project. Thank you, too, to the survivors who shared their experiences with us – we hope this report makes a difference. Finally, huge thanks to Ella Harvey, Verona Blackford and Jess Asato, who wrote this report while juggling so many other responsibilities.

Contents

“When I went to A&E the doctor told me we only do bones here, not that ‘relationship mental health stuff’. But didn’t offer to refer me to somewhere that did.”

Survivor, Southwark

Executive summary

Whole Health London is a three-year project funded by the City Bridge Trust, the funding arm of The City of London Corporation's charity, Bridge House Estates, which started in July 2020 and will conclude in June 2023. The project maps the domestic abuse response within health settings in the capital and makes recommendations for the most effective means of securing a whole-health response which truly meets the needs of all victims and survivors. London is a leader in health-based domestic abuse innovation, with significant recent investment in the capital, notably through the Violence Reduction Unit (VRU) in primary care settings and the Mayor's Office for Policing and Crime (MOPAC)'s uplift funding for Independent domestic violence advisors (Idvas) in hospital settings. However, gaps remain in provision across London and we know there is more to do improve the response to survivors of domestic abuse to get them safer sooner, as well as to reduce the costs of a crisis response at a later stage.

This report builds on the findings of the Pathfinder Project, a partnership between Standing Together, AVA, Imkaan, IRISi and SafeLives, which was a three-year fixed-term pilot funded by the Department for Health and Social Care (DHSC) which sought to embed a 'Whole Health' approach to domestic abuse in eight sites across England.[1] In this report, we focus specifically on the capital's provision of health-based domestic abuse services, combining the experience of survivors who accessed healthcare services through a dedicated survey with observations from frontline specialist services and other stakeholders who engaged in two roundtables held in December 2020 and January 2021.

We are particularly indebted to the following 'by-and-for' specialist organisations in London who helped to ensure our survey reached the survivors they work with and added vital context to this report in relation to the experiences of Black, Asian and racially minoritised, LGBT+ and disabled survivors: Forward UK, Galop, Southall Black Sisters, and Stay Safe East.

Key Findings

"I had so many medical and mental health issues because of the abuse. It was all documented but never was I asked or signposted. Only when I fled I told my GP, his reply was 'why didn't you just leave?"

Survivor, Havering

Domestic abuse in the capital continues to cause significant harm

- Domestic abuse has a devastating effect on the health and wellbeing of victims and families, and costs society £66 billion per year – of which more than £2 billion is borne by health services.[2]
- We estimate that 241,000 women and 120,000 men experienced domestic abuse in the past year in London, on the basis of Crime Survey of England and Wales estimates that 7.3 per cent of women aged 16-64 and 3.6 per cent of men in the same age bracket experienced domestic abuse between March 2019 and March 2020.[3]
- 425,480 children and young people in London will have experienced domestic abuse by the time they are an adult.[4]
- We estimate there are around 45,750 female survivors of domestic abuse working for the NHS just in London.[5]
- We estimate around 88,000 Londoners received medical attention following partner abuse in the last 12 months.[6]
- The estimated total cost to the health service of domestic abuse for victims in London who were identified in a single year equals £433 million.[7]
- One in ten offences recorded by the Metropolitan Police involves domestic abuse.[8]
- Only one in five people experiencing abuse ever calls the police but victims will be accessing every hospital, GP surgery and mental health setting every day, while children and their parents will be being supported every day in Child and Adolescent Mental Health Services (CAMHS), health visiting services and by school nurses.

Our Multi-Agency Risk Assessment Conference (Marac) data shows that 45.9 per cent of cases heard at Marac are for Black, Asian and racially minoritised victims; 11.9 per cent of victims had a disability and 2.1 per cent of cases were LGBT+ victims.[9] Our recommended levels for Black,

Asian and racially minoritised victims in London is 55.1 per cent, 19 per cent for disabled victims, and 2.5-5.8 per cent for LGBT+ victims.[10,11] London's Maracs are therefore seeing a lower rate of Black, Asian and racially minoritised victims, disabled victims and LGBT+ victims compared to what we would recommend. Recording rates for protected characteristics at Marac vary however, so it is likely that these figures do not show the whole picture.

Reported domestic abuse has increased during the Covid-19 pandemic: at the peak of the first national lockdown in April 2020, the Metropolitan Police reported arrests of nearly 100 a day for domestic abuse offences.[12] By the end of September 2020, the Met received an additional 12,107 reports of domestic abuse incidents compared to the same period in 2019, which represented an 8.5 per cent rise in cases compared to the previous year.[13] In the twelve months before the Covid-19 measures came into place, there were 144,765 domestic abuse incidents and 89,718 domestic abuse offences recorded in London. In comparison, in the rolling year to January 2021, there were 155,919 incidents and 94,251 offences recorded, representing a 7.7 per cent increase in incidents and a 5.1 per cent increase in offences.[14] Moreover, specialist domestic abuse services are consistently reporting an increase in the *severity* of abuse by perpetrators during this same period, with many pre-existing situations escalating during the Covid-19 pandemic.

There are significant gaps in the provision of health-based domestic abuse services which need sustainable funding

We undertook a mapping exercise of health-based domestic abuse provision across London asking frontline services and MOPAC how many full time equivalent practitioners were funded in specific boroughs. We found:

- 19 hospital-based Idvas working with adult survivors of domestic abuse were practicing across 13 Acute Trusts (out of 18), compared with the minimum of 36 Idvas that SafeLives would recommend for a safe service. We estimate that a minimum provision of two Idvas per acute Trust in London would cost £1.8m per year – larger Trusts with multiple sites may need to consider more than two Idvas depending on the population they serve.
- 3.4 FTE Idvas were practicing in three out of ten Mental Health Trusts, compared with the minimum of 20 across London's 10 Mental Health Trusts that SafeLives would recommend for a safe service. We estimate that a minimum provision of two Idvas per Mental Health Trust setting

would cost £1m per year, though once again, depending on the population size and number of sites, we would expect this number in practice would need to be larger.

- IRIS programmes are currently running in 16 of the 32 London Boroughs. IRISi estimates that, to provide IRIS programmes in the boroughs currently without the intervention, an initial investment of around £2.5 million would be required.

We therefore estimate that a minimum of £2.8m per year is required to fund Idvas across London's Acute Trusts and Mental Health Trusts, while IRIS requires an uplift of £2.5m, totalling £5.5m.

Survivors have experienced a lack of understanding, awareness and support from the health system, perpetuating the impact on their physical and mental health

We asked survivors of domestic abuse who had used healthcare services, for example GP, A&E or sexual health services, in the last two years to respond to a survey between 13 November 2020 - 11 January 2021 so we could better understand their experiences. The survey received 64 valid responses which we were able to analyse for key findings.

Survey respondents were more likely to identify as White than the general population of London (80 per cent of respondents in comparison with 57 per cent of Londoners) and less likely to identify as Asian (12 per cent compared with 21 per cent), Black (5 per cent compared with 12 per cent), of mixed ethnicity (5 per cent compared with 6 per cent).[15] They were also more likely to have achieved A-levels or equivalent qualifications (88 per cent compared with 63 per cent nationally).[16]

The age profile of survey respondents was older than that of the capital, with respondents less likely to be aged between 16 and 24 (3 per cent compared with 16 per cent of Londoners aged 16 to 64) and more likely to be between the ages of 35 and 44 (39 per cent compared with 24 per cent).[17]

Respondents were more likely to identify as disabled than the wider population of the capital (30 per cent compared with 19 per cent of Londoners) and less likely to identify as heterosexual or straight (83 per cent compared with 91.5 per cent of Londoners).[18]

In responding, they told us about missed opportunities to enquire about and support victims, including: survivors not being able to see a female

doctor to whom they may feel more confident in disclosing sexual abuse; doctors asking the right questions in a cold or impersonal manner; and doctors asking the right questions but only once, and not following up or engaging with the survivor on a continuing basis despite 'suspicious' circumstances. For example, one respondent in Barking and Dagenham told us:

> **"My GP told me a few months ago that he didn't know if there were services in the Borough for domestic abuse and that he would call me the next day. He didn't call for a month."**
> Survivor, Barking and Dagenham

Key issues raised included a lack of understanding and awareness of domestic abuse in the health services, insensitive responses, and victim blaming.

> **"Throughout my experience in engaging with health professionals, it seemed clear to me that there is a massive lack in training frontline NHS/mental health staff on recognising signs of abuse, responding sensitively, adjusting to survivors' needs, understanding of trauma, etc."**
> Survivor, Waltham Forest

Moreover, several survivors identified a lack of multi-agency working which left survivors feeling alone and overwhelmed:

> **"There seems to be absolutely zero join up between GP and social services, and GP and domestic abuse support services referral. Mental health referrals have to be done by patient themselves, sometimes even a small task like this can be overwhelming when you are in the middle of abuse."**
> Survivor, Barking and Dagenham

> **"When I went to A&E the doctor told me we only do bones here, not that 'relationship mental health stuff'. But didn't offer to refer me to somewhere that did."**
> Survivor, Southwark

Survivors also told us about the impact of domestic abuse:

On survivor health:

- 98 per cent of respondents to our survey said the abuse had affected their mental health while over three-quarters (76 per cent) of survivors reported having suicidal thoughts due to the abuse.
- Over three-quarters of survivors answering the survey (86 per cent) said

they suffered physical health issues as a result of the harm.
- Over half (52 per cent) used negative coping mechanisms to deal with the situation.
- 39 per cent felt they were unable to parent.

On child victims of domestic abuse and abuse during pregnancy:
- Nearly two-thirds (64 per cent) of survivors said there were children (under 18) in the household at the time of the abuse. This equalled 70 children and 2 current pregnancies living in an environment of domestic abuse. This equalled 70 children.
- The majority of children (34 per cent) were between 8 and 12 years old however, nearly half (47 per cent) of children in these households were aged 7 years or younger.
- Over a third (39 per cent) of survivors noted they had been pregnant when they experienced abuse.

On psychological, physical, economic, and sexual abuse experienced by victims in the last two years:
- Survivors had experienced many different forms of harm, mostly being manipulated psychologically (94 per cent), psychological/emotional abuse (90 per cent) and physical intimidation (82 per cent). Many of the survivors in the survey experienced multiple forms of abuse in their relationship - out of the eleven types of harm we asked survivors if they had experienced, over three- quarters (76%) had experienced 6 or more, nearly a third (32%) had experienced 8 or more in the last two years.
- Nearly three-quarters of survivors (73 per cent) also reported being physically harmed.
- Economic/financial abuse was also commonly noted with 7 in 10 (70 per cent) survivors being denied money or access to basic needs.
- Over two-thirds (68 per cent) of survivors were stopped from getting help from other people and over half (59 per cent) experienced sexual abuse.

The survivors also told us about the health services they used and their experiences. Survivors accessed a wide range of health settings in the last two years where they could have been asked about the abuse, but a majority weren't:
- In the last two years, survivors had accessed a wide range of health services with GPs (86 per cent) and mental health services (73 per cent) most frequently used by survivors. 34 per cent of survivors had accessed A&E while 22 per cent had accessed health visiting services or CAMHS (Child and Adolescent Mental Health Services).
- Over three-quarters of survivors who, at the time, were unaware or unsure if they were experiencing domestic abuse (76 per cent) said the

health professional did not ask, “is everything OK at home” or ask them if they had experienced domestic abuse.

Over a third (35 per cent) of those who left comments in the survey noted how health professionals did not appear to understand the dynamics of domestic abuse and the positions they were in.

> **“GP and surgery failed to report abuse and involve local services, including social services. Abusive partner found evidence of me trying to get help from social services to leave to protect myself and the children...I feel like I’ve left the relationship - and yet I’m still being abused and I’m not protected by anyone.”**
> Survivor, Kensington

Nearly a quarter (24 per cent) of comments mentioned how health professionals seemed uninterested, showing no professional curiosity around the reasons they were presenting, sometimes prescribing medication or diagnosing the survivor with a personality disorder after limited contacts.

> **“I didn’t get any one-to-one therapeutic support for PTSD for a long time. Indeed, it took them 18 months to acknowledge I even had PTSD. I had no previous mental health issues prior to this experience and they were all well aware of this. The treatment approach from the start was ‘what is wrong with you’ rather than what has happened to you and how can we help.”**
> Survivor, Lewisham

Some comments (18 per cent) specifically stated how survivors felt they were not believed when they described the behaviours of perpetrators and were made to feel they were ‘crazy’ by professionals responding to them.

> **“I took an overdose - following a night of drinking and drugs and an argument with my then partner. (It was a cry for help) I [went to] A&E [and] was treated like a criminal. I was told I might lose my job and my daughter may not be able to stay living with me. I was made to feel like I was crazy. I was covered in bruises on my arms and not one person asked me how I got them or if things were OK at home. If anyone had asked me I would’ve spoken but I was terrified.”**
> Survivor, Ealing

The feedback from our survey shows that many survivors are not getting the support they need. It is vital we address the gaps so that, wherever survivors present in healthcare settings, they are asked about their experiences in a trauma-informed way and given the right response for their needs.

Barriers to commissioning a whole-health approach in London

Following consultation with stakeholders including specialist local domestic abuse services, commissioners and NHS safeguarding professionals, we identified three key challenges to achieving a whole-health approach in London:

- Lack of long-term, sustainable funding
  Most health-based interventions which have proven effectiveness both in outcomes and cost are either not commissioned or, when they are, experience one-year funding rounds and the insecurity which accompanies that. Services told us in our roundtable events that the constant cycle of rebidding for funding swallows up their capacity and reduces their ability to roll-out their services further. Losing funding from a service can impact clinicians' trust in the intervention itself, as they may not understand who made the funding decision and on what basis it was withdrawn.

- A lack of integration of health and domestic abuse commissioning
  Commissioning of health-based domestic abuse provision in London is fragmented and lacks coordination. MOPAC's uplift of Idva provision in hospitals is welcome, but sits aside from local borough level commissioning of community-based specialist Idva services which means referral pathways for onward support are not as smooth as they should be. Similarly, the VRU's expansion of IRIS to 17 boroughs until 2022 represents a significant boost to primary care domestic abuse provision, but there needs to be local ownership of funding to ensure it is sustainable in the long-term. There is very little commissioning of domestic abuse provision within mental health, and little to no provision in other settings such as health visiting, CAMHS, or community midwifery. Stakeholders felt that pharmacies and dentists, as well as links into new social prescribing networks would also benefit from clear referral routes into specialist services.

- Commissioners' and health professionals' understanding of domestic abuse
  The level of knowledge and lack of understanding about domestic abuse by healthcare professionals is an issue frequently raised by survivors and domestic abuse practitioners. In the survey for this report, survivors spoke about healthcare professionals not enquiring about survivors' relationships and home lives, not investigating the reasons behind the issues they were presenting with (for example, a GP who treated only the anxiety and depression which the survivor experienced as a "symptom" of their abuse), and not responding well when survivors did disclose.

Key recommendations for London's policy-makers and commissioners

- MOPAC, alongside the VRU, NHS London including new Integrated Care Systems, and local authority commissioners, should collaborate on a five-year strategy to ensure a 'whole-health' approach is pursued in the capital as part of a public health approach to violent crime. Such a strategy should aim to increase the provision of health-based advocacy in primary, mental health and acute care settings, alongside the data collection and outcomes monitoring required to understand impact and cost-effectiveness. This should include an increased understanding of the value of collaboration with specialist community-based domestic abuse services, who will bring additional expertise in safeguarding, safety and understanding trauma and services which work for all family members including perpetrators. It should also draw on the experiences of survivors to help drive and co-create the services in their area and recognise that a well-functioning multi-agency approach is critical to ensuring we see and respond to the whole person, rather than just seeing them as a collection of disparate needs.

- We estimate the funding required to ensure full coverage of health-based provision would amount to an annual cost of £1.8 million for acute trust Idvas (our mapping exercise for example shows only 19 in post, compared to a London wide need of 36) and £1 million for mental health trusts per annum, with an initial investment of £2.5 million for IRIS programmes in general practices in boroughs which do not currently have the intervention. Investment in health-based domestic abuse practitioners should go hand-in-hand with funding for Domestic Abuse Coordinators which are integral to a Whole Health approach.

- The strategy for supporting domestic abuse victims in health settings across London should explicitly recognise the intersectional needs of victims with protected characteristics including Black, Asian and racially minoritised, LGBT+, and disabled and deaf victims, and how these will be addressed. In particular, healthcare professionals should be encouraged to recognise the specific needs of migrant victims who may be trapped with the perpetrator or facing homelessness if they leave due to lack of access to housing assistance, and that immigration status may be a significant barrier to disclosure.

- A culture-change training approach delivered by specialist domestic abuse organisations, including 'by-and-for' services, should be integrated into existing health training to address the lack of awareness, understanding and gendered nature of domestic abuse across the health system. This should include training on providing

trauma-informed responses to survivors. In particular, any training for healthcare professionals should recognise the specific barriers to accessing both healthcare and domestic abuse services in minoritised groups including Black, Asian and racially minoritised, LGBT+, and disabled and deaf victims, alongside the nature of discrimination those individuals might face when they do access services.

All healthcare providers in London – NHS Trusts, GP surgeries, community health and so forth – should develop domestic abuse policies for staff and patients in line with best practice such as the Pathfinder DA Policy developed as part of its Toolkits. Alongside this, wider equality, diversity and inclusion policies need to intersect with domestic abuse policies to ensure the needs of and barriers to minoritised groups are fully understood, including the specific restrictions facing patients with no recourse to public funds (NRPF) status.

- General practices and primary-care settings should adhere to NHS England and NHS Improvement (NHSEI) guidance regarding allowing patients to register and access free-of-charge care even when they cannot supply identity documentation. They should not charge for the provision of letters which survivors need when applying for Leave to Remain or when accessing the Family Courts, and these letters should be provided electronically without the survivor needing to risk their safety and mental health by travelling to areas which may be near the perpetrator's home or workplace. We commend the Government for accepting a recent amendment to ensure that GPs do not charge for Legal Aid evidence, and would suggest this extends to any request for information which will help survivors to get safe.

Key recommendations for Westminster policy-makers and commissioners

- The UK Government should ensure that the commitment made in 2019 by NHS England to give access to Idvas across the health service is honoured, alongside the sustainable, multi-year funding required.

- Survivors of domestic abuse are likely to require swift access to mental health support. We recommend that the Government commit to shorter waiting times for victims of trauma, recognising that accessing mental health interventions will help with their recovery. The NHS' Five Year Forward View does not mention domestic abuse or the need for trauma-informed services. The Government should consider developing a new strategy for improving the health of victims of trauma, including domestic abuse survivors.

- The UK Government's new Serious Violence Bill, due at some point in 2021, should recognise the links between domestic abuse and violence outside the home and ensure that domestic abuse is considered to be part of a serious violence reduction duty.

- The Domestic Violence Rule and the Destitution and Domestic Violence Concession, should be extended to all migrant survivors, regardless of their immigration history, so NRPF conditions do not prevent them from accessing the support they need. Migrant survivors should be exceptions to the current NHS charging regime which sees those with outstanding medical debts of more than £500 automatically prevented from gaining Indefinite Leave to Remain.

- Implementing a new statutory duty on Police and Crime Commissioners (PCCs), Local authorities and Clinical Commissioning Groups (CCGs) - and their replacement Integrated Care Systems (ICSs) - to commission specialist community-based domestic abuse services will help to ensure provision for the whole family – all adult, teen and child victims of domestic abuse alongside perpetrators – to keep families safe sooner.

Introduction

Whole Health London is a three-year project funded by the City Bridge Trust, the funding arm of The City of London Corporation's charity, Bridge House Estates, which started in July 2020 and will conclude in June 2023. The project maps the domestic abuse response within health settings in the capital and makes recommendations for the most effective means of securing a whole-health response which truly meets the needs of all victims and survivors. It builds on the findings of the Pathfinder Project, a partnership between Standing Together, AVA, Imkaan, IRISi and SafeLives, a three-year fixed-term pilot funded by the DHSC that brought together expertise and funding for specialist domestic abuse interventions to embed a 'Whole Health' approach to domestic abuse in eight sites across England. This project focuses specifically on the capital's provision of health-based domestic abuse services, combining the experience of survivors who accessed healthcare services through a dedicated survey with observations from frontline specialist services and other stakeholders who engaged in two roundtables held in December 2020 and January 2021.

Domestic abuse has a profound impact on our physical and mental health. SafeLives' data shows that in the year before they got effective help, nearly a quarter of victims at the highest risk of serious harm or murder (23 per cent) and one in ten victims assessed at medium-risk of harm went to an accident and emergency department because of their injuries. In the most extreme case, one victim reported that they attended A&E 15 times during that year, demonstrating the missed opportunity to identify risk and intervene earlier.[19]

Moreover, it is vital that health services are an active part of the solution to give victims the help they so urgently need because this is often the first and only place people are likely to present. In our Cry for Health report (2016), we recommended that all hospital settings, particularly those with A&E, maternity and sexual health departments, should host an Independent domestic abuse advisor (Idva) service. A number of trusts across the UK have now adopted this approach and located specialist domestic abuse services in departments including A&E and maternity units. Since then, we have conducted an evaluation of an Idva service based in a mental health

setting which found that the project was successful in meeting its aims, while the evidence base for primary care continues to be led by IRISi.[20] The mapping on Page 32 highlights the provision of these services in hospitals, and in wider health settings, across London.

Creating a 'whole-health' approach to tackling domestic abuse could help transform the response to victims and perpetrators of domestic abuse across the capital, recognising that domestic abuse is a public health priority. A 'whole-health' approach is one where professionals in all healthcare settings recognise that domestic violence and abuse is a public health issue and is part of their core business. They all share a responsibility to provide an appropriate and effective response to domestic abuse. In particular, this report focuses on the roles of general practice, mental health and acute services in recognising domestic abuse and responding to survivors.

By drawing on learning from evidence-based interventions, survivor experience of healthcare services' response to them and input from healthcare and domestic abuse professionals, we hope this project will achieve the following:

- Increase knowledge of the effectiveness and evidence base for health-based domestic abuse interventions, particularly health-based Idvas (Independent Domestic Violence Advisors) and IRIS (Identification and Referral to Improve Safety).
- Identify the gaps in provision across London and the barriers to effective commissioning of health-based domestic abuse services with a particular focus on the needs of survivors with protected characteristics.
- Bring together policy makers and commissioners from health and social care with those working in domestic abuse and policing, as well as other multi-agency partners, to show how better partnership working can achieve a 'whole-health' approach.
- Campaign for the extra resources required to fund the suite of interventions required to create a 'whole-health' approach, in a strategic and sustainable way.
- Ensure policy makers, commissioners and frontline workers in health and social care, and domestic abuse, understand the toolkits, materials and best practice which exists so that they can pursue a 'whole-health' approach across London's boroughs.

The project has been brilliantly supported so far by an Advisory Group (see Appendix) the members of which have helped to inform the design of our survivor survey and this policy report. We are extremely grateful to our advisory group members for taking the time to mould this project and to

advise us on its direction, though of course any conclusions (or errors) are ours alone. We are particularly indebted to the following ‘by and for’ specialist organisations in London who supported us with dissemination of our survivor survey and the framing of the impact of domestic abuse in a health context: Forward UK, Galop, Southall Black Sisters, and Stay Safe East.

Understanding domestic abuse as a public health issue

Domestic abuse has long been classified a public health issue which has a devastating impact on morbidity and mortality of victims. When the cumulative impacts on mortality and morbidity are assessed, the health burden is often higher than for other, more commonly accepted, public health priorities. Each year, more than 2.3 million people aged 16-74 experience some form of domestic abuse in England and Wales. It is endemic in the United Kingdom and should be approached with the same seriousness and resource accorded to other public health harms, such as obesity and smoking.

In our *Psychological Violence* report (2019), survivors told us about having reached out to a GP or other healthcare professional before they realised they were experiencing[21] abuse. Many told the healthcare professional about feelings of unhappiness, and/or physical symptoms including migraines or weight loss, which they did not recognise as negative effects of the psychological violence they were experiencing.

> **"The deeper the abuse went, and it was very psychological – I didn't have scars as such, you know…so, for me, I started losing rapidly weight…just from the stress of it, just being ill. And it was through the GP that she said to me…you're living in domestic violence'. I couldn't even fathom that, you know? 'No, no-no… and then, she put the seed into my mind, and I was thinking 'Ok, if I go with… if I accept what she says, then things make sense' because I was very confused"**
> Survivor

As we highlighted in *Psychological Violence*, many studies have shown that psychological violence is associated with poorer physical health. A nationwide German survey with 10,264 women showed that among those aged 16-65, psychological Intimate Partner Violence (IPV) was strongly associated with allergies; problems maintaining weight; gastrointestinal syndromes (e.g. nausea, and eating disorders); psychosomatic symptoms (e.g., numbness and thrombosis, shaking and nervous twitching, cramps and paralysis, heart and circulation illness, dizziness, low blood pressure, breathlessness, and chronic throat problems); and pelvic problems (e.g.,

abdominal pain, pain or infections in intimate areas, menstrual cramps, and heavy, weak, or irregular menstruation). All are known symptoms of psychological stress. Women aged 65+ also experienced gastrointestinal syndromes and problems maintaining weight. Controlling behaviour, measured separately from psychological violence, was moreover associated with weight problems among women aged 16-65 and allergies among women aged 50-65.[22] In a Slovenian study with 470 men and women, psychological IPV victims were more likely to suffer muscle inflammations; and gynaecological disorders and inflammations.[23]

Moreover, studies conducted in the USA have shown that psychological violence is associated with a range of physical health conditions, including: hypertension; chronic prostatitis and chronic pelvic pain syndrome; urinary frequency and urgency; type 2 diabetes; disability preventing work; arthritis; migraine and other frequent headaches; stammering; sexually transmitted infections; irritable bowel syndrome; and stomach ulcers.[24,25,26,27,28]

Domestic abuse and suicide (Aitken & Munro 2018) found that almost a quarter (24 per cent) of Refuge's clients had felt suicidal and almost a fifth (18 per cent) had made plans to end their life. 3.1 per cent had made at least one suicide attempt. 83 per cent of clients had felt despair or hopeless, which are key determinants for suicidality.[29]

Thus, healthcare professionals must be equipped with the knowledge to recognise when symptoms may be linked to domestic abuse, the ability to enquire sensitively, and the pathways to ensure the survivor can access holistic support.

Healthcare professionals can play an essential role in responding to and preventing domestic abuse. They have the opportunity to recognise risk and share necessary information, identify abuse, intervene early, provide treatment, and signpost and refer patients to specialist services. This is one of the reasons for which, in guidance on domestic violence and abuse published in 2016, NICE included a quality statement to ensure "people presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion".[30]

Though domestic abuse is a crime, the criminal justice route should not be the only one available to victims when seeking help. Only one in five people experiencing abuse ever calls the police but victims will be accessing every hospital, GP surgery and mental health setting every day, while children and their parents will be being supported every day in CAMHS, health visiting services and school nurses.

For many victims, the criminal justice system is not an obvious site for

disclosure. As highlighted by the Mayor's Office for Policing And Crime (MOPAC), "prevalence estimates using London-level CSEW (Crime Survey for England and Wales) data indicates that the number of recorded crimes is well below the potential number of victims per year."[31] In particular, "younger adult victims appear under-represented in the police data when compared to CSEW estimates."

Moreover, a report commissioned by the Violence Reduction Unit, *Violence in London*, highlighted that "it is difficult to assess the extent of domestic abuse and understand trends using police recorded data for two reasons. Firstly, domestic abuse is frequently under-reported as victims are often not willing to come forward, which means many instances of domestic abuse cannot be captured by the police. Secondly, there is not a specific offence of domestic abuse; instead, offences are 'flagged' as domestic when recorded. Inconsistencies in how this is done mean it is not possible to identify the proportion of violence in London that is domestic abuse related."[32] These inconsistencies can present a greater challenge when attempting to understand trends in data for minoritised groups. For example, there is currently no systematised approach across the capital on recording domestic abuse for LGBT+ people.[33] Greater Manchester police are the only force in the country with a specific code for recording and publishing data on LGBT+ domestic violence; prior to the introduction of code D66, the force only recorded sexuality when a hate crime was reported.[34]

Some groups are particularly reticent to involve the criminal justice system. Four in five lesbian, gay and bisexual victims of domestic abuse have never reported these incidents to the police and, of those who did report, more than half were unhappy with how the police dealt with the situation.[35] Furthermore, Black, Asian and racially minoritised survivors may not report abuse to the police for a range of reasons, including concerns about the impact of stigma on their wider family or community, and feelings of distrust of the police due to past negative experiences and ongoing discriminatory practices. This can include concerns around the rates of injury and death of Black, Asian and racially minoritised people in police custody, resulting in victims of domestic abuse fearing that reporting a perpetrator is, in reality, handing them a death sentence. Migrant survivors may experience language difficulties, and the 'hostile environment' policies related to immigration (and the risk of deportation) have also contributed to the reason why these victims of domestic abuse may not come forward.[36] Survivor testimonies have highlighted that perpetrators will often use their insecure immigration status as a way of controlling and threatening the victim.[37] According to MOPAC's *Beneath the Numbers* report, "reasons for not reporting are complex and often linked to the seriousness of the offence or the relationship with the offender."[38]

Criminal justice responses are often only initiated at crisis point, and while the response to domestic abuse has improved in recent years through better training of frontline personnel, multi-agency safety planning and strengthened legislation, there is still a greater need for a public health approach to violence intervention which prioritises early intervention and prevention. The World Health Organisation (WHO) defines a public health approach to violence reduction as one which:

> **"seeks to improve the health and safety of all individuals by addressing underlying risk factors that increase the likelihood that an individual will become a victim or a perpetrator of violence. […] By definition, public health aims to provide the maximum benefit for the largest number of people. Programmes for the primary prevention of violence based on the public health approach are designed to expose a broad segment of a population to prevention measures and to reduce and prevent violence at a population-level."[39]**

We know that women are disproportionately affected by domestic abuse: of the total figure, 1.6 million women aged 16-74 (7.3 per cent of the population) experienced domestic abuse between March 2019 and March 2020, in comparison with 757,000 men in the same age bracket (3.6 per cent of the population). An estimated 5.9 million women or more than one in four women have experienced domestic abuse in their lifetime.[40] 94.7 per cent of cases discussed at Marac (Multi-Agency Risk Assessment Conferences) include female victims and research shows that "coercive controlling abuse is highly gendered, with women overwhelmingly the victims."[41,42]

In addition, women are at an increased risk of domestic homicide. Two women a week are murdered by a partner or ex-partner in England and Wales. Between April 2016 and March 2019, 40.9 per cent of all murders of women aged 16 or over in England and Wales were committed by the victim's partner or ex-partner. In comparison, 2.9 per cent of men over the age of 16 who were murdered in that time frame were killed by a partner or ex-partner.[43]

Not only is domestic abuse highly gendered, some other characteristics and identities can lead to an increased risk. Both those who experience and those who perpetrate domestic abuse are more likely to have underlying vulnerabilities than those who do not. This can include poverty, experiences of intergenerational trauma, or a range of identities that can lead to marginalisation and exploitation. For example:

- Young people are disproportionately affected by domestic abuse, both through being directly subject to abuse in their intimate relationships, and through experiencing abuse in their household. According to the Crime Survey for England and Wales, 14 per cent of women aged 16 to 19 reported experiencing some form of domestic abuse in the last year, as did 5.3 per cent of men in the same age group. For women, this is 40 per cent higher than the next age group (20-24).[44] In *Psychological Violence* (2019), domestic abuse practitioners highlighted "the normalisation of psychological violence in young people's relationships, […] with acts of controlling behaviour misconstrued as loving or caring."
- Research by Age UK has found that older people are as likely to be killed by a partner or spouse (46 per cent) as by their adult children or grandchildren (44 per cent).[45] Our Spotlights on older people found that on average, older victims experience abuse for twice as long before seeking help as those aged under 61, and nearly half (48 per cent) have a disability.[46]
- Disabled people experience higher rates of domestic abuse than non-disabled people. In the year to March 2020, the Crime Survey for England and Wales reported that women and men with a long standing illness or disability were more than twice as likely to experience some form of domestic abuse than women and men with no long-standing illness or disability (11.8 per cent in compared with 4.6 per cent).[47]
- LGBT+ victims are more likely to be abused by multiple perpetrators (15 per cent compared with 9 per cent) than non-LGBT+ victims, and more than twice as likely to have experienced non-recent abuse by a family member (6 per cent compared with 3 per cent).[48] Lesbian and gay women are more likely than heterosexual women to report partner abuse (8 per cent compared with 6 per cent). For bisexual women, that figure rises to 11 per cent, making them nearly twice as likely to report partner abuse than heterosexual women.[49] National data on transgender survivors of domestic abuse is lacking, but some evidence suggests "prevalence rates of domestic abuse may be higher for transgender people than any other section of the population."[50]
- Intersecting identities can increase the risk of domestic abuse. For example, there is an intersection between disability, LGBT+ identities, and so-called 'honour'-based forms of domestic abuse.[51] 10 per cent of the victims to whom the Forced Marriage Unit gave advice or support in 2019 had a learning disability; of these survivors, half were men.[52]

Having an identity which falls under a protected characteristic can also increase the barriers to disclosure and support faced by victims and survivors. Health practitioners may, for example, assume that a woman attending an appointment with another woman is being accompanied by a friend, rather than considering that it might be her partner; disabled survivors have often told us that health professionals have assumed they

will not be in sexual relationships, or cannot be subjected to sexual abuse. Therefore, it is vital we reduce the prevalence of such assumptions which block survivors' ability to get the help they need. Effective responses will recognise that one person's identity can relate to a range of protected characteristics, and their experience of domestic abuse cannot be separated out on the basis of different elements of their identity. The intersections of different protected characteristics can further compound barriers to disclosure and access to care and support.

Furthermore, when a perpetrator of abuse's identity relates to any these characteristics, elements of their identity may affect how effective a range of responses are, and can present a further barrier to victims' help-seeking. For example, a victim or survivor may not want to damage the reputation of a certain community, or fear the perpetrator will be treated unfairly in certain systems due to their belonging to that community. Ultimately, abuse is abuse, regardless of a person's age, race or ethnicity, religion, sexual orientation, gender identity or whether or not they are deaf or disabled.

Violence reduction strategies in the capital are already moving in direction of taking a public health approach. In a 2018 paper, *Progressing a Public Health Approach to Violence Prevention and Reduction, Appendix A: Proposed Public Health Approach,* the Greater London Authority stated: "a public health approach is rooted in good multiagency working and close working with communities, focuses on prevention, and is informed by the systematic use of evidence. It looks at who is affected by violence, how they are affected, and the relationship between violence and health inequalities. It uses data and evidence to understand and tackle the root causes of violence and to prevent or mitigate its impacts in defined populations."[53] As highlighted by MOPAC, "wards which are more vulnerable to community stability issues experience higher levels of recorded domestic abuse offending."[54] Moreover, six in ten of the London wards with the highest volume of domestic abuse offences are also 'most vulnerable' wards according to the Vulnerable Localities Profile.[55]

Health and domestic abuse in London: the impact

London's population of 8.9 million is younger than the UK average with high levels of internal and external migration.[56] Office for National Statistics (ONS) data shows that by mid-2019, London had a median age nearly five years lower (35.6 years compared with 40.3) than the UK as a whole and only 12.1 per cent of the population was aged 65 years or older. High levels of migration mean that there is a high proportion of the population aged 16 to 44 years compared with the rest of the UK, resulting in a relatively high number of births and the second-highest proportion of children in the UK.[57] While international migration is slowing, the two fastest-growing local authorities in the UK in the year to mid-2019 were the City of London (11.7 per cent) and Camden (3 per cent).

In London, we estimate that more than 241,000 women and 120,000 men experienced domestic abuse in the past year, while one in ten offences recorded by the Metropolitan Police involves domestic abuse.[58,59] A report by the Police and Crime Committee in the London Assembly found that since 2011 there was a rise from 46,000 domestic abuse offences recorded by the Metropolitan Police to just over 85,000 in 2018.[60] Alongside this there has also been an increase in recorded domestic abuse crimes that involve injury.

In the 2011 Census, 40.2 per cent of residents identified with either the Asian, Black, Mixed or Other ethnic groups while around 37 per cent of people living in London were born outside the UK, compared with 14 per cent for the UK as a whole.[61] London also has the highest proportion of people who identify as lesbian, gay and bisexual in the UK at 3.5 per cent in 2018.[62] The number of people in London who have a disability as defined by the Disability Discrimination Act is slightly lower than the rest of the UK at 21 per cent for all adults over 16, compared with 27 per cent in the rest of the UK.[63]

We haven't been able to find a breakdown of domestic abuse data in London by protected characteristics; however, our Marac data shows that 45.9 per cent of cases heard at Marac are for Black, Asian and racially minoritised victims; 11.9 per cent of victims had a disability and 2.1 per cent of cases were LGBT+ victims.[64] Our recommended levels for Black, Asian and racially minoritised victims in London is 55.1 per cent, 19 per

cent for disabled victims, and 2.5-5.8 per cent for LGBT+ victims.[65,66] London's Maracs are therefore seeing a lower rate of Black, Asian and racially minoritised victims, disabled victims and LGBT+ victims compared to what we would recommend. Recording rates for protected characteristics at Marac vary, however, so it is likely that these figures do not show the whole picture.

Reported domestic abuse has increased during the Covid-19 pandemic: at the peak of the first national lockdown in April 2020, the Metropolitan Police reported arrests of nearly 100 a day for domestic abuse offences.[67] By the end of September 2020, the Met received an additional 12,107 reports of domestic abuse incidents compared to the same period in 2019, which represented an 8.5 per cent rise in cases compared to this year already compared to the previous year.[68] In the twelve months before the Covid-19 measures came into place, there were 144,765 domestic abuse incidents and 89,718 domestic abuse offences recorded in London. In comparison, in the rolling year to January 2021, there were 155,919 incidents and 94,251 offences recorded, representing a 7.7 per cent increase in incidents and a 5.1 per cent increase in offences.[69] Moreover, specialist domestic abuse services are consistently reporting an increase in the *severity* of abuse by perpetrators during this same period, with many pre-existing situations escalating during the Covid-19 pandemic.

In addition, research suggests as many as one in five children and young people are exposed to domestic abuse during their childhood.[70] Therefore, of the approximately 2,127,400 children and young people who live in the capital, we estimate that 425,480 have experienced domestic abuse, or will have by the time they are reach adulthood.[71]

According to *Connecting up the care*, between April 2017 and March 2018, there were 23,097 children recorded as experiencing domestic abuse in London, accounting for 1.15 per cent of children in the capital. Of these, 3,097 – or 0.15 per cent of children – simultaneously experienced the so-called "toxic trio" of domestic violence and abuse, parental mental ill-health, and parental alcohol and drug misuse.[72] Our research suggests that this is very much an underestimate, partly because many children experiencing domestic abuse are not identified by statutory services. For example in 2017, only 57 per cent of the children involved in Insights cases were known to have been referred to children's services before the victim sought help.[73] Additionally, a substantial proportion of these referrals (31 per cent) had resulted in no action or had not proceeded beyond initial assessment or enquiries.

In the year ending March 2020, over 13,000 cases were heard at Marac in London with 13,700 associated children.[74] Of these, 2.2 per cent of

referrals came from Primary Care Services, 3.6 per cent from Secondary and Acute Trust Services, and 1.8 per cent from Mental Health Services, totalling 6.6 per cent of referrals from health partners. In contrast, Idvas were responsible for almost a third of all referrals (30.5 per cent) and the police were responsible for over a quarter (27.4 per cent). Across England and Wales, Primary Care Services accounted for 2.5 per cent of referrals, representing an increase on the London figure, whereas the national averages for referrals from Secondary Care and Acute Trust Services and Mental Health Services are lower than the rates in London, at 2.4 per cent and 1.1 per cent, respectively.

There is no 'us and them' when it comes to survivors of domestic abuse and healthcare professionals. Of the 215,200 NHS staff working in the capital, we estimate around 13,900 experienced domestic abuse last year.[75] On the basis that one in four women (27.6 per cent) have experienced domestic abuse in their lifetime, there are an estimated 45,750 female survivors of domestic abuse working for the NHS just in London. The true numbers may well be much higher, given findings from the Cavell Nurses' Trust which suggest nursing professionals are three times as likely to have experienced domestic abuse in the last year than the average person in the UK.[76] One of the survivors who responded to our survey for this report (see *Survivor experience of the health-professional response to domestic abuse in London* on page 45) told us: "this process needs a lot of work. I was completely let down by all of the health professionals I came into contact with, and I am a Nurse myself."

Regarding the impact of domestic abuse on health services in London, we estimate around 88,000 Londoners received medical attention following partner abuse in the last 12 months.[77] According to Home Office estimates, domestic abuse costs health services £2.3 billion per annum, with an average cost of £1,200 per victim (with a total cost per victim of £34,015)[78]. On the basis of our estimates that 361,000 Londoners experienced domestic abuse last year, that would put the total health services costs alone at more than £433 million for the victims in London identified in a single year.

If domestic abuse were to be responded to before the point of crisis, the higher costs which typically occur later on could be minimised. In the current climate of cuts to budgets, the value of researching not only safer but smarter, more cost-effective interventions for domestic abuse is obvious. Our *Cry For Health* report estimated that hospital-based Idva services saved on average £2,050 per victim, while research into cost benefits from the IRIS intervention in primary care has found £14 of savings per woman aged 16 years or older registered in general practice.[79,80]

London: a leader in health-based domestic abuse innovation

The context

London is a leader in its provision of health-based specialist domestic abuse services. For example, MOPAC uplifted funding for Idvas by locating them in hospitals across the capital and, in 2018, Barnet, Enfield, Haringey (BEH) Mental Health Trust piloted locating an Idva in a mental health team.[81] MOPAC's 2019 Violence Against Women and Girls (VAWG) Strategy noted the success of health-based co-location of Idvas: "the co-location of IDVAs in hospital is an extremely effective model for reaching service users who may have not previously engaged with support services, or reported to the police".[82]

IRISi, whose flagship programme is the IRIS intervention, has recently benefited from just over £1m funding from London's Violence Reduction Unit (VRU) to commission and support implementation and delivery of IRIS in seven boroughs across two years (2019/20 – 2021/22).[83] This takes the total number of boroughs with IRIS programmes running today in London to 16 (of 32). In launching the new funding, Lib Peck, Director of London's Violence Reduction Unit (VRU) said: "The public-health approach we are leading in London is firmly rooted in investing in early interventions that can break the cycle of violence and give Londoners the support they need."

VRUs are based on Scotland's model initiative which launched in 2005 and subsequently led to a 39 per cent decrease in homicides over a decade by using a public health approach which "treats violence as a disease".[84] The UK Government's Serious Violence Strategy, however, specifically excludes domestic abuse as a cause of violent crime: "we know that a significant proportion of violence is linked to either domestic abuse or alcohol, but these two important elements are not driving the increases we are seeing in violent crime".[85] This is short-sighted and represents a failure to see the whole picture. As Rosanna O'Connor wrote in a blog post for Public Health England, "violence is an outcome of interactions of a range of risk factors at the individual, relationship, community and the societal level […] To successfully prevent violence against women in the future it is essential to tackle the root causes of violence, which includes challenging societal and cultural norms that can lead to violence."[86]

Therefore, it's important to look at the life-course of a survivor of domestic abuse, including their histories of trauma, as well as at the structural factors which affect survivors' likelihood and ability to access and receive meaningful, effective services. As G.J. Melendez-Torres, a professor of epidemiology at the University of Exeter, told us for this report: "someone doesn't just wake up as a victim of abuse one day, just as someone doesn't just turn up to A&E with a heart attack. You need to look at their life-course and the multilevel factors – as individuals, in their families and relationships, in their communities and contexts – that impact their health and wellbeing. This needs to be understood through a public health lens." As O'Connor states: "to successfully prevent violence against women in the future it is essential to tackle the root causes of violence, which includes challenging societal and cultural norms that can lead to violence."

While it is true that there is a need for more holistic and long-term research which looks at domestic abuse and young people affected by violence and crime together, what has been published to date finds evidence for clear links between the experience of abuse and violence in familial settings and on street or public violence. For example, the Local Government Association found emerging evidence for a link between youth offending and specific sub-types of family violence, such as physical abuse and sibling violence.[87] Analysis undertaken by Waltham Forest Council which studied 992 young people who went through the youth offending service between 2015 and early 2019, found that the most common feature across both victims and perpetrators was domestic abuse in the family home.[88] Additionally, a report from the Children's Commissioner focused on children involved in gang violence and criminal exploitation.[89] Their analysis showed that children in gangs that were in the criminal justice system were 37 per cent more likely to have witnessed domestic violence compared to other young offenders. The report concluded that family violence and abuse was a risk factor for gang and youth violence.

Our Young People's Programme saw caseworkers supporting nearly 500 young people, a fifth (20 per cent) of whom were under 16, in 2014-15.[90] The vast majority (79 per cent) were referred due to their own intimate partner violence (IPV), and the abuse recorded was of a similar severity to that seen in adult domestic abuse services. Other risks were identified, such as child sexual exploitation (CSE) (27 per cent) and gang violence (12 per cent). Almost half of the young people supported had been exposed to domestic abuse in their family home and 17 per cent were harming other people.

Of those who were identified as either at risk or experiencing CSE, the majority were referred primarily as a result of IPV.[91] The most frequently recorded perpetrator of CSE was an adult other than the young person's

partner or family (29 per cent), followed by (ex)boyfriend (24 per cent) and (ex)boyfriend and other (23 per cent). Non-recent abuse was prevalent amongst those at risk of CSE, which included neglect during childhood (34 per cent), non-recent physical abuse (31 per cent), and sexual abuse as a child (24 per cent).

Girls as the victims of gang violence are routinely overlooked by policy makers and commissioners. As Samantha Jury-Dada points out in her research: "Rarely a day goes by in the UK without the news cycle featuring at least one heart-breaking story of a young person suffering the consequence of gang violence in our major cities. Often, the victims are young boys and the weapon of choice is nearly always a knife. Lost in the debate is the fact that most the strategies put forward are gendered and targeted at young males. The consideration of young women and girls associated with these men is often secondary for decision makers. By ignoring them, they remain invisible to authorities and in turn services are not being commissioned to support them. This makes it easier for those who are exploiting them."[92]

In a Greater London Authority (GLA) report, "sixty-eight per cent of victims of SYV [Serious Youth Violence] domestic violence and abuse were female, of whom 25 per cent were repeat victims in the previous 12 months. 13 per cent of victims of domestic violence and abuse offences were categorised as being vulnerable".[93]

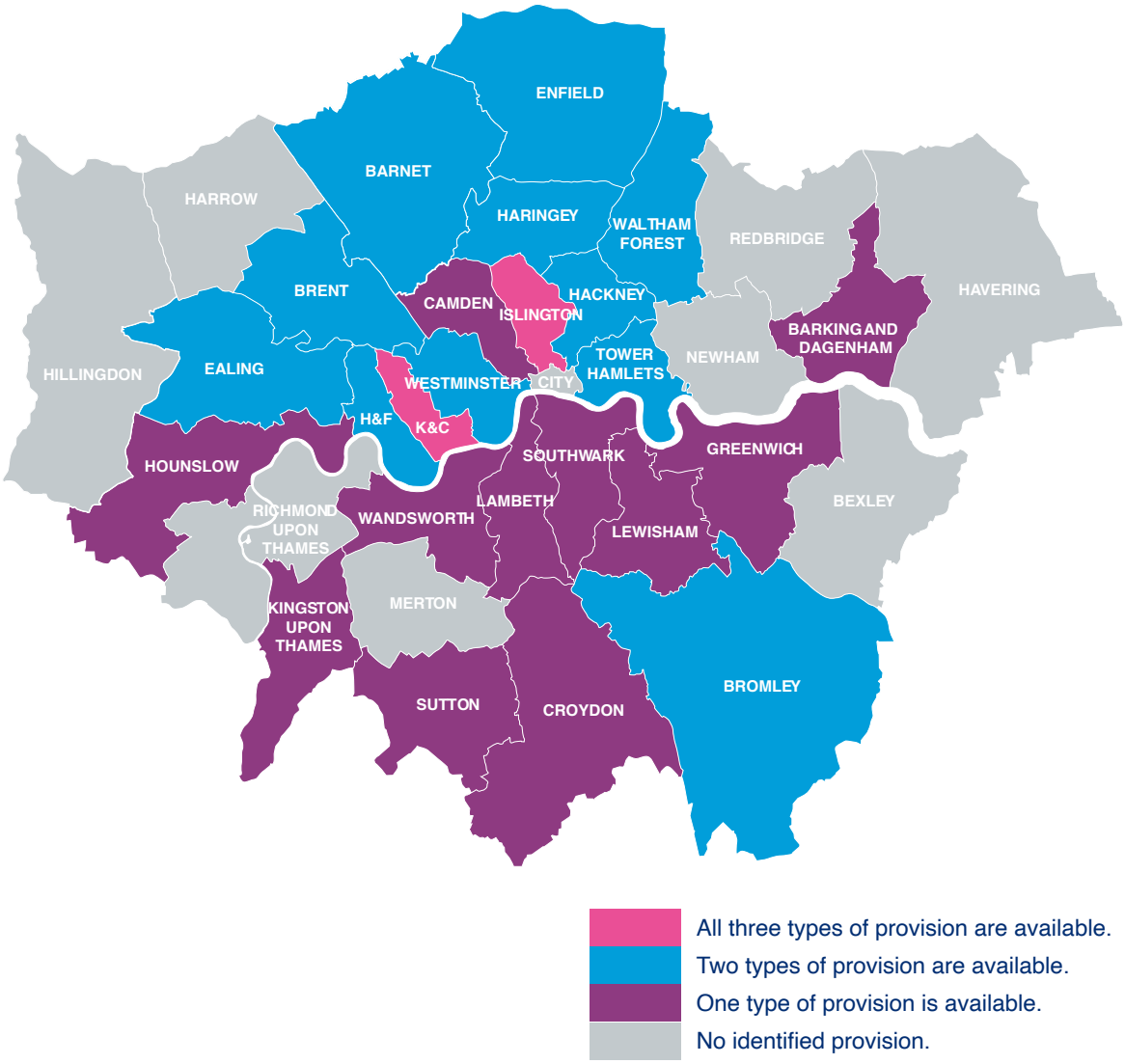
Despite the Government's lack of focus on domestic abuse initially in its Serious Violence Strategy, VRUs such as London's have recognised these links and are starting to build interventions which prioritise early intervention in domestic abuse. Indeed, a number of Public Health England's case studies for serious violence prevention are those which tackle Violence Against Women and Girls.[94] It is important that the new Serious Violence Bill, due at some point in 2021, recognises these links and ensures that domestic abuse is considered to be part of a serious violence reduction duty.

Mapping the gaps in London's health-based domestic abuse provision

Despite the really welcome recent investment in health-based domestic abuse interventions, the provision of health-based domestic abuse services remains patchy across the capital. Victims of domestic abuse should be able to expect a high quality, confident response to them wherever they present in the healthcare system.

We undertook a mapping exercise to explore the areas which are well-

served under current levels of provision, and those which need extra provision to ensure that survivors can access a whole-health, whole-person approach. While we have tried to ensure that this map reflects all domestic abuse health-based provision, local services have been stretched over the Covid period and not all were able to respond to our request for information.



Currently, there are spots in the capital where there is simply no health-based provision at all, and other areas where provision may require expanding to meet the needs of victims accessing different healthcare settings. For example, we have been unable to identify specific provision serving boroughs including Bexley, Harrow, Havering, Hillingdon, Merton, Newham, Redbridge and Richmond. Of course victims of abuse will access acute care particularly outside of their borough, with Chelsea and Westminster's Idva service receiving referrals for victims resident in 26 of the 32 London boroughs and the City of London. However, we need to avoid a postcode lottery of health-based services and aspire to a vision where all victims no matter where they present can access health-based services via empathetic, trauma-informed healthcare professionals.

Provision in London's acute care settings

According to our mapping, there are 19 FTE hospital-based Idvas working with adult survivors of domestic abuse across 13 Acute Trusts (out of 18).

We do not recommend single Idva services in acute-based settings for a number of reasons. First, when an Idva takes holiday or is on sick or any other form of leave, it means there is not a service. Second, Idvas work in a high-trauma environment and in a hospital they are far more exposed to the very visible effects of abuse compared with community-based Idvas who may see clients after they have received medical care. Being able to share their experiences with Idva colleagues can help with peer support. Ensuring there is the full complement of Idvas required to cover weekends can also help with continuity of service. Therefore, we recommend that there ought to be a minimum of 36 Idvas (two per 18 Acute Trusts) to enable a safe service. In practice, given the number of acute hospital sites in London, we expect this figure to be higher than 36.[95]

Our mapping also found that there are four Idvas funded to specifically engage with young people in St Mary's, St George's, Royal London and King's College Hospitals.

We estimate that a minimum provision of two Idvas per acute Trust in London would cost £1.8m per year.[96] If a minimum of two Idvas were commissioned for the 33 hospitals with Emergency Departments in the capital, the cost would be £3.3m for 66 Idvas.

Hospital-based Idva services

Our research has found that across the UK nearly a quarter of victims at high risk of harm and one in ten victims at medium risk went to A&E because of their injuries in the year before they got effective help. At the most extreme end of this, victims reported that they attended A&E 15 times during those 12 months.[97]

According to the Office for National Statistics: "around a third (33.1%) of partner abuse victims who had experienced any physical injury or other effects received some sort of medical attention. Victims who had received medical attention were also asked where they received it; with the majority (83.1%) doing so at a GP or doctor's surgery, 36.4% at a specialist mental health or psychiatric service and 12.2% had gone to a hospital's Accident and Emergency department."[98]

Hospital-based Idvas are a key method to ensure these survivors do not

fall through the cracks and must be integrated as part of a whole-system, whole-health approach. They also act as a consistent space for repeat disclosures: vital given many victims and survivors will present several times before feeling ready to engage fully with domestic abuse services. This is especially true for high-risk victims and those with protected characteristics and intersecting identities who may have concerns about encountering racism, ableism, homo-, bi- or transphobia or other prejudiced attitudes.

Our evaluation of five co-located hospital Idva services in *Cry for Health* revealed:

- Hospital-based Idvas were more likely to engage victims who disclosed high levels of complex or multiple needs related to mental health, drugs and alcohol, compared with community-based domestic abuse services.
- Nearly twice as many victims in hospital had self-harmed, or planned or attempted suicide than victims in a community setting (43 per cent compared with 23 per cent).
- Victims in hospital had experienced abuse for an average of 30 months, compared to an average of 36 months for victims presenting at a community-based service, highlighting the opportunity health settings have to intervene earlier on.
- 29 per cent of victims accessing community-based Idvas had been to A&E in the six months before accessing the Idva service. The vast majority of their visits (86 per cent) were related to the abuse they were experiencing: nearly two thirds (64 per cent) of visits were due to injuries directly caused by the perpetrator.[99]

After the introduction of a hospital-based Idva service, referrals significantly increased. In one of the hospitals in the *Cry for Health* evaluation, there were 11 Marac referrals in the 11 months before the introduction of the Idva service; this increased to 70 in referrals in the following 11 months.

Idvas can help victims to understand, often for the first time, that what they are experiencing is domestic abuse. While victims may not accept support initially, they leave hospital with knowledge of the support they could receive, should they choose to engage later on.[100] As stated in the MOPAC VAWG Strategy 2018-21, "the co-location of IDVAs in hospital is an extremely effective model for reaching service users who may have not previously engaged with support."[101]

Idvas in hospitals will often help with staff disclosures of domestic abuse, and staff are often an Idva's first referrals when a new service is established. This is why it is important for hospitals to have domestic abuse policies in place which meet the needs of both staff and patients.

There is also an opportunity to increase the number of specialist domestic abuse practitioners for those with protected characteristics co-located in healthcare settings. For example, Galop told us they recommend an additional Idva with specialist LGBT+ knowledge be co-located in healthcare settings which see high numbers of LGBT+ survivors presenting, such as HIV/AIDS services, Trans+ health services, and sexual health services. This works particularly well in the Angelou Partnership which has an LGBT+ Case Worker provided by Galop and funded by three London boroughs – Hammersmith and Fulham, Kensington and Chelsea and Westminster.

Our *Cry for Health* analysis identified that there could be a net positive impact on health services' budgets once victims have accessed the hospital Idva service. Before accessing the Idva service, hospital victims cost on average £4,500 each year in their use of hospital, community and mental health services, whereas community Idva victims cost £1,066 per year for the same services. The net positive impact of Idva services was, on average, £2,050 per victim, per annum, consisting of:

- Reduction of hospital service use (i.e. inpatient, outpatient, A&E): £2,184 per patient, per annum.
- Reduction of ambulance use: £200 per patient, per annum;
- Increase in local surgery use (i.e. GP, practice nurse, nurse practitioner, health visitor): £64 per patient, per annum.
- Increase in mental health service use of £196 per patient, per annum;
- Increase in substance misuse service use of £74 per patient, per annum.

There is also an increase in social services use (social worker and child and family support worker), costing £282 per patient, per annum.

The higher use of mental health and substance misuse support services post-Idva may be because victims are in a better position to prioritise their own health, rather than needing to focus solely on survival in an abusive relationship. The rise in social services costs may be due to this agency often only getting involved with a family once a victim with children starts to receive Idva help.

In a separate pilot of the Idva service at Saint Mary's Hospital, Manchester, the evaluation team calculated that the 28 cases referred to Maracs as part of the pilot saved the public sector £170,800, compared with the costs of £50,591 to the health service of employing one full-time Idva.

It is important that the co-location of Idvas in hospitals is accompanied by training delivered by the Idva service and genuine integration into the

hospital with honorary contracts, space made available and NHS email addresses. One member of our Training and Development team spoke of having only an hour with emergency department staff at one training session, during which time staff arrived late and left early as they were attending during a break time. Hospital-based Idvas can work on a longer-term basis to challenge processes and ingrained views which present barriers to survivors presenting. We recommend that training encompasses both clinical and non-clinical staff. We know that attitudes of reception staff can impact on a survivors' sense of whether they are safe and believed (see R's Case Study), while hospital cleaners and porters might oversee abusive behaviour by a perpetrator.

A key finding in Sandi Dheensa et al. (2020) highlighted that the success of hospital-based Idva services depend on a range of structural factors. The findings "illustrated the importance of ongoing domestic violence and abuse training for staff, the Idva having private and dedicated space, and the service being embedded in hospital infrastructure (e.g. featuring it in hospital-wide policies and enabling Idvas access to medical records)."[102]

Major Trauma Centres

Major Trauma Centres (MTCs) are an important avenue to offer support to younger victims of domestic abuse in London who may have experienced grievous harm. The four major trauma centres in London are located at King's College Hospital in Lambeth, St Mary's in the City of Westminster, St George's in Wandsworth and the Royal London in Tower Hamlets. Since 2015, each of these MTCs have had a youth Idva service, funded by MOPAC and delivered by Solace Women's Aid and Redthread. The current service agreement had been due to end in September 2020 but, due to the impact of the Covid-19 pandemic, has now been extended until March 2022.

According to Solace Women's Aid, the Idvas engage with young people of any gender between the ages of 11 and 25 who are "victims/survivors or at risk of domestic abuse, sexual violence, CSE, forced prostitution, FGM, forced marriage, HBV, and trafficking and modern slavery that present in the Emergency Department."[103] The service is integrated with clinically embedded youth workers engaging with victims of serious youth violence. Often these victims present at A&E with assault-related injuries, including gunshot wounds and stabbings. Research has shown the immediate aftermath of an incident is a unique 'teachable moment' in which the Idvas can effectively engage with violence-affected young people. As the MOPAC decision paper states, "the principle of youth workers embedded in hospital Major Trauma wards and A&Es aligns well with the public health approach that is at the heart of the VRU."[104]

Provision in London's primary care settings

Primary care provides a wealth of opportunities to identify victims of abuse who need help, even when the symptoms the patient seeks to address are not directly related to the abuse. We know that primary care provides a critical, consistent support for all of the community – not just people who experience abuse. This consistency means that often survivors feel able to disclose in a primary care environment.

IRIS programme in general practice

IRIS (Identification and Referral to Improve Safety) is a training, referral and advocacy programme which supports general practice clinicians to recognise and better support patients experiencing and affected by domestic abuse. The programmes are a partnership between health and the specialist third sector. Developed and supported by IRISi, a social enterprise working to improve the healthcare response to gender-based violence, local IRIS programmes provide training to healthcare professionals and administration staff within GP surgeries and embed a specialist worker from a local DA service, the IRIS Advocate Educator (AE), in the practices. The AE is then the direct referral route for patients affected by domestic abuse who accept an IRIS referral.

Between November 2010 and March 2020, IRIS programmes across the UK fully trained more than 1,000 GP surgeries and received referrals for 20,544 women. In the year to March 2020, 4,943 referrals were received nationally, signalling a 34-fold increase since 2010/11. Seven new sites in London were commissioned in 2019/20, bringing the total number of ever commissioned IRIS programmes to 48 across the country, of which 32 actively referred to IRIS between April 2019 and March 2020.

There are currently 16 of the 32 boroughs in London with IRIS Programmes: Barking and Dagenham, Barnet, Brent, Bromley, Croydon, Ealing, Enfield, Greenwich, Hackney, Hammersmith and Fulham, Haringey, Islington, Southwark, Tower Hamlets, Waltham Forest, and Westminster. They are funded variously through MOPAC, local CCGs and local authorities but there is no consistency or longevity of funding or commissioning. Camden, Kensington and Chelsea, Lambeth, and Lewisham have all previously run the IRIS programme, but sustainability funding was not secured.

IRISi estimates that, to provide IRIS programmes in the boroughs currently without the intervention, an initial investment of around £2.5 million would be required.

In the IRIS randomised controlled trial, "three times more women experiencing domestic violence were identified in intervention practices than in the control practices."[105] In addition, the study "showed a high probability of the intervention being cost-saving or cost-neutral."[106]

IRIS has proven to be a highly effective model for supporting domestic abuse survivors: the trial showed that victims and survivors attending an IRIS-trained practice are six times more likely to be referred to specialist support.[107] Most recent research of IRIS programmes running outside of a trial setting, in the 'real world', shows that the programme is sustainable, and that practices with the programme are 30 times more likely to make a referral to specialist support for their patients than those without the IRIS programme.[108] Services user feedback showed: 99 per cent felt listened to and 95 per cent found the support helpful, 98 per cent were pleased to be referred to A&E, and 95 per cent were pleased to be asked about domestic abuse by their GP or practice nurse. 70 per cent of service users said they visit their GP less frequently than they did before they were referred.[109]

Sexual health services

According to IRISi, 47 percent of women attending sexual health services will have experienced domestic abuse at some point in their lives.[110] One study found that "reproductive control by others is reported by as many as one quarter of women attending sexual and reproductive healthcare services."[111] While reproductive coercion does not only occur within situations of domestic abuse, the study authors stated, "there is a strong positive association between RC [reproductive coercion] and IPV [intimate partner violence]. Women experiencing IPV are twice as likely to have a male partner who refuses to use contraception and to report unintended pregnancy and up to three times more likely to give birth as an adolescent, compared with those not experiencing such violence."

Therefore, reproductive coercion is an important, though poorly recognised, marker of abuse, and sexual health practitioners can play a key role in signposting and referring survivors to specialist support services. For that reason, IRIS ADViSE was developed as an adapted version of IRIS aimed at sexual health services in order to respond to populations who may not come into contact with GPs or other primary care services. It was piloted in two sexual health clinics in 2015, including Ambrose King Clinic in Tower Hamlets. ADViSE supports sexual health staff to recognise where patients may be affected by domestic abuse, ask them sensitively, give a validating response to disclosures, and offer and make referrals to a named worker (the AE) in a local specialist service, in line with the British Association for Sexual Health and HIV's (BASSH) guidance on

domestic abuse.

In the three months prior to the pilot, there were no domestic abuse referrals at either of the pilot sites. In Tower Hamlets, the seven-week pilot saw a 10 per cent domestic abuse enquiry rate and a 4 per cent disclosure rate, with eight patient referrals. In Bristol, the 12-week pilot saw a 61 per cent enquiry rate and 7 per cent disclosure rate, with eight patient referrals.[112] Evaluation from the sexual health clinic staff highlighted that they felt asking about domestic abuse and referring patients to specialist services was "appropriate and valuable. They responded favourably to the training and felt more confident about asking about [domestic abuse] and managing disclosures."[113]

IRISi report that women who have experience of domestic abuse are between 1.5 and 6.5 times more likely to request emergency contraception than women who do not. Moreover, "in a study of UK electronic patient records, women with experience of DVA in the past year were twice as likely to have had at least one consultation for emergency contraception than other women." Given half of all emergency contraception is supplied by UK pharmacists, IRISi have been exploring whether pharmacies might be ideally placed to implement an adapted form of the IRIS Programme.[114]

Nurse-led domestic abuse services

In 2015 in east London, a nurse-led domestic abuse service for GPs was developed as part of a collaboration between Hackney public health services, City and Hackney Clinical Commissioning Group and Homerton University Hospital NHS Foundation Trust. The service was developed in part due to concerns that "GPs were often unaware of cases of domestic abuse among their patients and existence of safety plans."[115] This led to reactive working rather than proactive practice once they have been made aware of the abuse. To aid this, the Trust integrated a "Marac liaison nurse" role to ensure that the service was not reliant on administrators sending data from the GP office to Marac coordinators.[116]

The pilot found that the Marac Liaison Nurse helped to increase the percentage of GPs sharing relevant health information with the Marac from 32 per cent to 93-95 per cent, while improved relationships with local Idva services have led to them offering joint appointments in the practice setting with the patients' consent. This has led to an improvement in "GPs' understanding and awareness of available safety plans and services."

Provision in London's mental health settings

There is a clear relationship between experiencing domestic abuse and having mental ill health symptoms. Time and time again, survivors have told us about difficulties in accessing joined-up support. Despite the high co-occurrence, the vast majority of cases go undetected in mental health services: research estimates that just 10 to 30 per cent of cases are identified.[117,118] According to Sylvia Walby the mental health costs to the NHS of domestic abuse victims equates to £176 million each year.[119]

A key element of a whole-health approach is the need to see the 'whole person' and administer to the full spectrum of their needs. We know that many survivors experience some kind of mental health impact as a result of experiencing abuse. Therefore, supporting these survivors to go on to live a life free of harm will often involve some form of mental health intervention. Our survivor survey for this report found that 94 per cent of survivors experienced some kind of psychological violence from the perpetrator, while 76 per cent of survivors reported having suicidal thoughts due to the abuse.

This reflects findings from Agenda's Hidden Harms report which was based on data from the Adult Psychiatric Morbidity Survey (APMS). It found that over half (54 per cent) of women who had experienced extensive physical and sexual violence and a third (36 per cent) of women who had experienced extensive physical violence group met the diagnostic criteria for at least one common mental disorder. Rates of phobias, for example, were ten times higher among women who experienced extensive violence compared to women who had experienced little violence.[120]

As the MOPAC and Standing Together paper, *London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process*, reports, "mental health issues were quite prevalent" across the Domestic Homicide Reviews she studied: from 84 cases analysed, 42 perpetrators and 23 victims had mental health needs.[121] 64 per cent of the perpetrators in adult family homicides had problems with their mental health, as did 44 per cent of the perpetrators of interpersonal homicide. Mental health needs were more prevalent among victims of interpersonal homicide than adult family homicide, with 33 per cent and 12 per cent, respectively.

Despite mental health issues often being symptomatic of domestic abuse for women, research has shown than less than a third of domestic violence cases are detected by psychiatric services.[122] *Domestic abuse and suicide* (2018) stated "domestic abuse has not yet been integrated fully into mental health policy as a "major risk factor for women's ill-health" and […] many health professionals still fail to identify victims or facilitate disclosures, despite the existence of national guidelines advocating routine enquiry

about domestic abuse. First responders in health and mental health settings often fail to consider domestic abuse as a precursor when treating suicidal patients, focusing instead on the immediate task of diagnosing and treating manifest psychiatric symptoms."[123]

According to Kalifeh et al. (2015), "compared to the general population, patients with SMI [severe mental illness] are at substantially increased risk of domestic and sexual violence, with a relative excess of family violence and adverse health impact following victimization. Psychiatric services, and public health and criminal justice policies, need to address domestic and sexual violence in this at-risk group." The study found that those diagnosed with SMI who were in contact with psychiatric services had two- to four-fold elevated odds of all 'subtypes' of domestic abuse (emotional, physical and sexual) compared with the general population. Over a quarter (27 per cent) of women with SMI had experienced domestic abuse in the 12 months before taking part in the study, compared with almost one in ten (9 per cent) of the control group. "These findings suggest that clinicians should routinely enquire not just about physical domestic violence, but also emotional and sexual abuse – especially given the increasing evidence that emotional abuse may have a greater health impact than physical violence."[124]

Crucially, training and better join up between health agencies can improve the likelihood that domestic abuse is recognised in mental health settings and that survivors receive the sensitive response and the support they need. According to Kalifeh et al. (2015), "there is evidence from [the Linking Abuse and Recovery through Advocacy (LARA) pilot study] that a complex intervention which includes reciprocal training of mental health and domestic violence sector professionals, and a care pathway with integrated advocacy services, can improve detection and outcomes of domestic violence among psychiatric patients."[125]

Once again, having an identity which includes protected characteristics, such as being Black, Asian or racially minoritised, Deaf or disabled, or LGBT+, can increase survivors' barriers to mental health services, and intersections of those identities can further compound those barriers. As one agency put it a decade ago in *Safe and Sane* (2010), "if you are a woman in the mental health service: it's bad, if you are a lesbian woman in the service then it's worse, if you are a black lesbian in the service, then forget all positive chances within mental health service provision."[126]

In a survey of LGBT+ people, 72 per cent of respondents who had accessed or tried to access mental health services in the 12 months prior to the survey reported that it had not been easy. Over half (51 per cent) of those who had accessed or tried to access them said the wait had been

too long, more than a quarter (27 per cent) had been worried, anxious or embarrassed about going, and almost one in six (16 per cent) said their GP had not been supportive.[127]

One specialist domestic abuse practitioner felt that, at times, mental health services seem to see their domestic abuse service as an opportunity to refer patients on without recognising the need for partnership working in survivors' care. Though able to provide some mental health support for survivors (in particular around mild instances of anxiety or depression), the service was not able to help address more complex needs, for example survivors with a diagnosis of schizophrenia. The practitioner reported that a psychiatrist had once told a survivor with complex mental health needs that they didn't need to continue seeing her as she had been referred onto the domestic abuse service who, in turn, felt they were not in a position to fully address the extent of her needs.

Several practitioners raised the Improving Access to Psychological Therapies (IAPT) programme, which was introduced in 2018 to transform the treatment of anxiety disorders and depression in adults in England. According to one, there is a lack of join up between IAPT and domestic abuse services which, ultimately, leaves survivors unable to fully address the causes of their mental health needs. Another told us that, for many survivors, six weeks of talking therapy is not enough for survivors of domestic abuse. For some, six weeks is enough time to bring up more complex issues, but not to address them, and they therefore need to be referred on to services after to continue the work, especially around adverse childhood experiences or ingrained concepts of shame and honour. This means they will need to go through the often retraumatising process of retelling their story, and frequently will experience a waiting period between services due to a lack of capacity among specialist third-sector organisations.

An Idva interviewed for *Domestic abuse and suicide* (2018) commented "'a lot of the times, you only have your GP…a lot of times you don't have a specialist service, a counselling service, to offer people, so you offer them what you can offer, but it sometimes isn't, you know, it's not what they need.'" According to the report, "many [practitioners] suggested this can lead to situations in which clients move between their GP and secondary mental health services without ever receiving appropriate specialist support."[128]

Regarding the experiences of Black, Asian and racially minoritised survivors, *Safe and Sane* (2010) found that, "mental health services, counselling or 'talking therapies' receive less resources or priority than psychiatric services, and where they do exist, there are often long waiting

lists, time-limited counselling (often limited to 6-12 weeks) and a dearth of black female counsellors and psychologists; those who do exist may not offer free services under the NHS or may lack an understanding of how race and gender intersect and impact on the mental health of BME women facing violence."[129] "However, there are pockets of good practice which provide specific counselling for BME women with mental health and domestic violence problems. These exist in both the mainstream and voluntary sectors, including mental health and social care services, although much of it depends on individuals rather than institutional response per se."[130]

Pilot mental health interventions in London

From 2009 to 2011, the LARA pilot co-located Mental Health Idvas into Community Mental Health teams and provided training. Before the presence of this pilot, mental health teams had the same level of referrals into community domestic abuse services as those reported by "nursing, social work and dentistry professionals."[131] Upon following up with clinicians they had improved knowledge, attitudes and behaviours towards domestic abuse survivors. Service users reported reductions in the frequency of violence, and an increase in diagnosis of PTSD in survivors which is a positive as it may give survivors the chance of recognising some of their coping mechanisms as a result of PTSD.[132]

The research found: "These findings indicate that interventions comprising of practical and emotional support (e.g., domestic violence education, safety planning and legal/housing support), key information (e.g., information on welfare rights, housing options and legal issues) and signposting can lead to improved outcomes for service users."[133]

Between 2013 and 2016, AVA (Against Violence and Abuse) led PRIMH (Promoting Recovery in Mental Health). The project involved working with Camden and Islington NHS Foundation Trust and Sussex Partnership NHS Foundation Trust to develop and evaluate Trust-wide responses to domestic and sexual violence. PRIMH sought to implement clear care pathways, delivered training, and used survivor voice to ensure the pilot reflected their experiences. An independent evaluation by King's College London found that staff reported increased comfort in discussing domestic and sexual violence with patients as well as increased confidence in referring survivors.[134]

Findings from a 2019 review of Idva services in Barnet led to greater join up between mental health services and Idva services, to ensure domestic abuse support was "accessible and delivered at the right place and

right time to meet local demand."[135] As a result, a number of Idvas were co-located in Barnet hospitals and mental health settings, as well as in local police stations. One key feature of the subsequent co-located Idva services was the implementation of a case worker to cover admin work in order to "relieve [Idvas] of the duty work so that they can carry more specialised work."[136]

Finally, the PATH (Psychological Advocacy Towards Healing) intervention "is based on concepts and technical strategies drawn from cognitive behavioural, experiential, dynamic, psycho-educational and feminist theories."[137] This model of care was based on evidence that survivors of domestic abuse often find that more 'traditional' forms of therapy do not support them in a way they need. Though not yet a commissionable model, the randomised controlled trial used "advocates" who already understood the victim's background and would typically support them from a domestic abuse practitioner perspective while providing additional psychological support. The trial found for those who had additional mental health support from advocates experienced improved levels of psychological distress and symptoms of depression within 12 months, compared with those who did not.

Our mapping exercise has identified 3.4 FTE Idvas working in Mental Health Trusts while we recommend that a minimum of 20 Idvas are needed in London's ten Mental Health Trusts at a cost of £1m.[138] Only Islington and Kensington and Chelsea have access to all three forms of provision for survivors, those these may be under the minimum recommended number of practitioners.

Survivor experience of the health-professional response to domestic abuse in London

"Eventually, I found a GP who took my issues seriously, including impairments caused by the assaults […] and I was referred to a specialist."

Stay Safe East Client 1

Introduction

We explored domestic abuse survivors' experiences of the response from healthcare professionals across London via an online survey. Distributed via our social media channels and partner domestic abuse services, the survey was open between 13 November 2020 and 11 January 2021 and included both open and closed questions. The inclusion criteria was narrow, stating respondents had to be survivors of domestic abuse who had accessed health services, in London, within the last two years. In choosing the last two years we wanted the responses to be representative of recent experiences of accessing health services.

Alongside other frontline domestic abuse services, 'by-and-for' organisations including Forward UK, Galop, Southall Black Sisters and Stay Safe East supported us in the distribution, sharing the survey with their service users. We are especially grateful to Stay Safe East, a specialist frontline service supporting disabled victims and survivors of domestic abuse, who were able to contribute four guided interviews to ensure the voices of some of the disabled survivors they work with were represented in this report.

In total, 127 people accessed the survey link. However, 30 respondents did

not meet the inclusion criteria and 33 either did not complete any questions or completed minimal questions; they were therefore removed from the dataset. The final sample included responses from 64 survivors. This is a small figure and we recognise the sample is not fully representative. This is due in part to the restricted inclusion criteria, and to the period of time when the survey was open which included two national lockdowns, the Christmas and New Year period, and the run up to the Second Reading of the Domestic Abuse Bill 2019-21 in the House of Lords. It was, therefore, an extremely busy time for domestic abuse organisations and frontline practitioners and many survivors with such recent experience of the healthcare system will have been unable to take the time to complete the survey. We anticipate that many survivors may have chosen not to access health services during the lockdown period and, even if they did so, the consultation was likely to have been remote, raising issues around whether they would have felt safe disclosing particularly if they were still living with the perpetrator.[139]

Only 56 per cent of the survivors responded when asked in which borough they had accessed health services: those who did respond had accessed services in a third (21) of the capital's boroughs.

Demographics

Most survivors identified as a woman or female (92 per cent), while 6 per cent identified as a man or male, and 2 per cent preferred not to say. One survivor said they were transgender. Over three-quarters (83 per cent) of survivors were heterosexual, 8 per cent were bisexual, 5 per cent were lesbian, 2 per cent gay and 3 per cent preferred to self-identify.

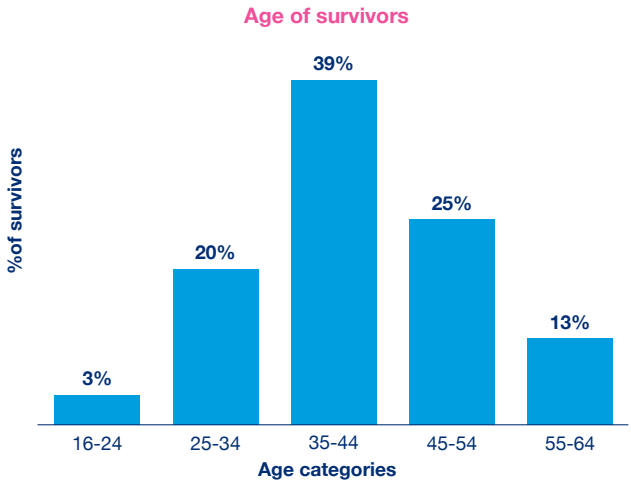
Estimates vary for the number of lesbian, gay, and bisexual (LGB) people, both nationally and in the capital. According to 2018 figures on sexuality from the ONS, 91.5 per cent of the population of London described themselves as heterosexual, 2.1 per cent as gay or lesbian, 0.7 per cent as bisexual and 0.7 per cent as 'other.'[140] The GP Patient Survey 2015 results for Greater London put the LGB population at 5.1 per cent of the wider population, while Public Health England's modelling estimates that 4.26 per cent of the population of London are LGB or 'other'.[141] The rate of LGB respondents to the survey was higher than any of these estimates.

The most populous age group for the survivors in our survey was 35- to 44-years-old, with almost four in ten (39 per cent). A quarter of respondents were aged 45 to 54 and a fifth were aged 25 to 34. 13 per cent were aged 55 to 64, and 3 per cent were aged 16 to 24 (see Figure 47).

According to the Trust for London, "London's population is comparatively

young: the average (median) age in London is 35.6, compared to 40.3 in the UK overall."[142] According to ONS estimates, 16 per cent of Londoners aged between 16 and 64 (the age range of survivors in the survey) are between 16 to 24, while over a quarter (27 per cent) are aged between 25 and 34. A quarter (24 per cent) fall within the 35 to 44 bracket, while a fifth (19 per cent) are aged between 45 and 54. Finally, 15 per cent of Londoners aged 16 to 64 are in the top bracket of 55- to 64-years-old.[143]

Therefore, people in the youngest age bracket are underrepresented in the survivor survey (3 per cent compared with 16 per cent), while the oldest age bracket was largely representative (13 per cent compared with 15 per cent). 35- to 44-year-olds were the most overrepresented group in the results (39 per cent compared with 24 per cent).



Most survivors (61 per cent) characterised themselves as White British, English, Scottish, Welsh, or Northern Irish. The remaining survivors identified as: Other White (14 per cent); Indian, Pakistani or Bangladeshi (8 per cent); White Irish (5 per cent); Chinese (2 per cent); Black/Black British - Caribbean (2 per cent); Mixed ethnicity (2 per cent); Other Black/ Black British (2 per cent); and Other Asian/Asian British (2 per cent). Three survivors (5 per cent) stated their ethnic group as: 'Black American'; 'Seychelles and Singapore'; and 'White/Black African American'. Five survivors noted English was not their first language.

In comparison, ONS 2019 population estimates for London suggest that 57 per cent of Londoners identify as White (White British, White Irish, Other White), 21 per cent as Asian (Indian, Pakistani, Bangladeshi, Chinese, other Asian), 13 per cent as Black (Black African, Black Caribbean, Other Black), 6 per cent as 'mixed' (White & Black Caribbean, White & Black African, White & Asian, Other Mixed), 2 per cent as Arab and 2 per cent as 'any other group'.[144]

This would suggest that the survey respondents were not representative of the city's population as 80 per cent of respondents identified as White,

according to the ONS data categories. 12 per cent of survey respondents identified as Asian, and only 5 per cent identified as Black.

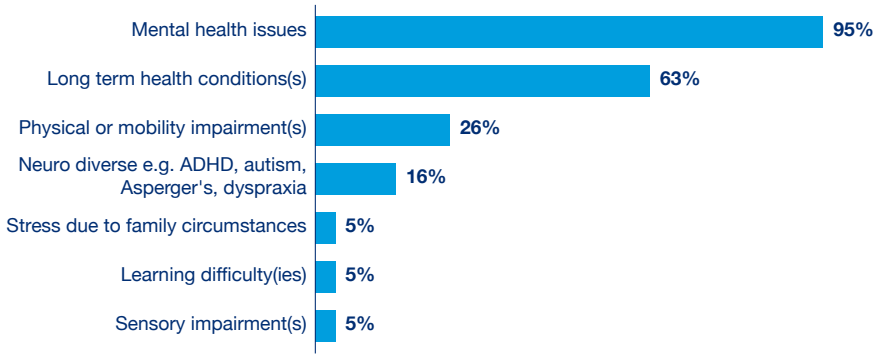
Four in ten survivors (42 per cent) had completed university undergraduate degrees as their highest-level qualification, a third (33 per cent) college (A-Levels, equivalent qualification). 13 per cent had completed secondary school (GCSEs/BTEC) and 13 per cent had achieved a postgraduate degree (Masters, PhD).

In 2017, ONS figures suggested that, nationally, 42 per cent of 21- to 64-year-olds not enrolled on an educational course had at least one undergraduate degree (this includes those with postgraduate degrees as their highest-level qualification), while 21 per cent had qualifications equivalent to an A-Level and 20 per cent had qualifications equivalent to GCSEs.[145] As such, the survey respondents were more likely than the general population to have higher levels of educational qualifications, with 88 per cent having achieved A-Level equivalents or above, compared with 63 per cent of the wider population.

Nearly a third (30 per cent) of survivors considered themselves to be a disabled person. Of these survivors, 95 per cent recorded experiencing mental health issues, nearly two-thirds (63 per cent) a long-term health condition and over a quarter (26 per cent) a physical or mobility impairment.

This suggests respondents were more likely to be disabled than the general population of London, as 2019 ONS figures estimate 19 per cent of Londoners are disabled.[146] Furthermore, in our national Idva Insights dataset, disabled survivors make up 15 per cent of survivors accessing domestic abuse services. Among these survivors, while mental health conditions were again the most common reported form of disability, the figure sits at nearly half (47 per cent) of survivors with a disability reported having a mental health impairment.[147] The fact that we worked closely with Stay Safe East may mean that the survey reached more disabled survivors, ensuring their experiences were over-represented in the responses.

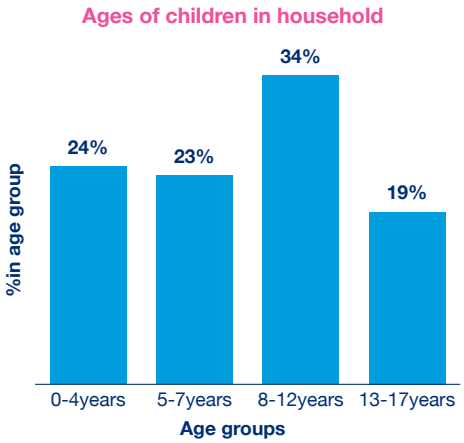
Conditions of survivors who consider themselves to be a disabled person



Relationship context

For most survivors (89 per cent), the main person harming them was an intimate partner (current or ex-partner).

However, nearly a quarter (23 per cent) of survivors had multiple abusers. Of survivors being harmed by more than one person, for nearly half (46 per cent) the second person was a parent or family member. For over a quarter (27 per cent) it was an intimate partner (current or ex-partner) and, for two survivors, their child was the additional person demonstrating harmful behaviour. Survivors who considered themselves disabled were three times more likely to have multiple perpetrators than non-disabled survivors (42 per cent compared with 14 per cent), and survivors from a Black, Asian or racially minoritised community were also slightly more likely to have multiple perpetrators than those from other backgrounds (28 per cent compared with 21 per cent).



Nearly two-thirds (64 per cent) of survivors said there were children (under 18) in the household at the time of the abuse. This was equal to 70 children experiencing domestic abuse in their home. Of these children, nearly half (47 per cent) were aged seven or younger, while a third (34 per cent) were between eight- and 12-years-old. Nearly four in ten (39 per cent) survivors told us they had experienced abuse while pregnant.

Abuse experienced

Nearly a quarter of survivors (21 per cent) had experienced domestic abuse for under two years, 30 per cent for between three and five years, and 17 per cent for between six and ten years. Nearly a third (32 per cent) of survivors had been experiencing harm from the main person abusing them for more than 10 years. These figures are much higher than in our national Insights data on survivors accessing adult Idva services: in comparison, 46 per cent of those survivors had experienced the abuse for two years or less, while 10 per cent had experienced it for 11 years or more.[148]

The difference might be explained by the fact that Idva services are mainly accessed by victims at the highest risk of serious harm or murder, while this survey was open to completion by victims experiencing risk at all levels. While Idva provision has grown significantly in London due to MOPAC and local authority investment, outreach services for those at lower risk levels remains patchy as found by the Police and Crime Committee for the London Assembly in their report in 2020: "there also needs to be more support for low-medium risk victims who are missing out on receiving support as they do not meet the threshold of being referred to a MARAC (multiagency risk assessment conference) or Idva services".[149]

In this survey, survivors who experienced non-physical forms of abuse were more likely to have experienced abuse for more than 10 years than those who had experienced both physical and nonphysical forms (40 per cent compared with 29 per cent). In our *Psychological Violence* (2019) report, practitioners and survivors told us about the difficulty victims of nonphysical abuse had in recognising the behaviour as abuse: "many survivors confirmed they did not realise what they experienced was abuse until they had left the relationship. Survivors highlighted the difficulty of identifying what was happening to them, knowing something wasn't right but constantly questioning themselves. Many described the 'frog in water' scenario due to the subtle and creeping nature of the abuse."[150] Therefore, victims of nonphysical abuse may experience longer durations of abuse before seeking help as they are less likely to recognise their situation as abusive.

Survivors had experienced many different forms of harm. The majority of survivors experienced being manipulated psychologically (94 per cent), psychological or emotional abuse (90 per cent) and physical intimidation (82 per cent). Nearly three-quarters of survivors (73 per cent) also reported being physically harmed. Economic or financial abuse was also commonly noted, with 70 per cent of survivors being denied money or access to basic needs. Over two-thirds (68 per cent) of survivors were stopped from getting help from other people and over half (59 per cent) experienced sexual abuse (See Table 2). Out of the eleven types of harm we asked survivors

if they had experienced, over three- quarters (76%) had experienced 6 or more, nearly a third (32%) had experienced 8 or more in the last 2 years.

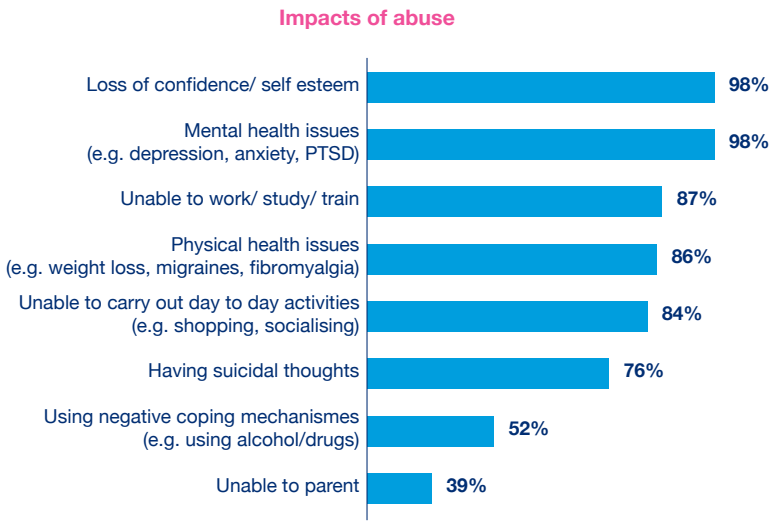
Table 2: Forms of abuse experienced by survivors

Form of abuse experienced	per cent of survivors
Manipulating you psychologically (making you doubt your own sanity or reality)	94
Psychological/Emotional (creating rules, threats, shouting, name calling, stopping you from seeing friends or family)	90
Physical intimidation (using physical size to intimidate you, destroying your surrounding environment I.e. punching walls)	82
Economic/Financial (controlling money, taking away access to basics such as water/ food/sanitary products)	70
Stopping you from getting help from other people	68
Sexual abuse (forcing you to do something of a sexual nature)	59
Controlling medication	25
Stopping care agencies from coming to see you	16
So called 'honour-based abuse' (harm as a result of protecting or defending the honour of an individual/family/community)	8
Exploiting your immigration status	7

Survivors described many ways in which the abuse affected them. Most commonly their confidence, self-esteem and emotional wellbeing were affected. **Over three-quarters (76 per cent) of survivors reported having suicidal thoughts due to the abuse.**

Many survivors (87 per cent) were also unable to work, study or train or carry out day-to-day activities (84 per cent).

Over three-quarters (86 per cent) suffered physical health issues as a result of the harm, over half (52 per cent) used negative coping mechanisms to deal with the situation and 39 per cent felt they were unable to parent.



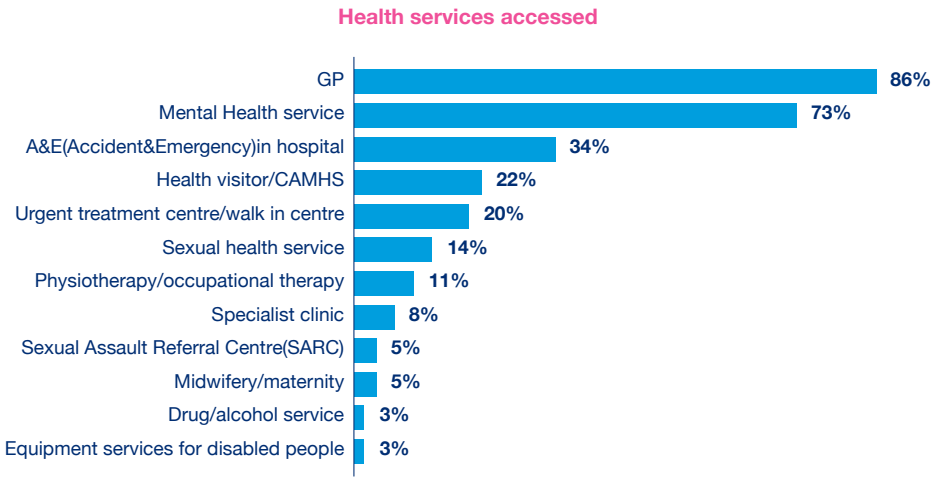
Some survivors commented on how their ability to parent well was reduced, how they were isolated, had feared for their and their children's lives and how they had been re-traumatised due to childhood abuse.

“The perpetrator is a public official who has been able to use his position to sabotage my ability to get services and retain employment.”

Survivor

Survivors' experiences of using health services

In the last two years, survivors had accessed a wide range of health services. The majority had accessed their GP (86 per cent) and mental health services (73 per cent), while one third (34 per cent) had been to A&E in a hospital.



At the point of accessing health services, half of the survivors (51 per cent) realised they were experiencing domestic abuse in their relationship. Just under half (49 per cent) either did not realise, didn't realise at first or were not sure they were experiencing domestic abuse.[151] Survivors aged between 16 and 34 years were least likely (18 per cent) to realise they were experiencing domestic abuse compared with survivors over all, with less than one in five (18 per cent) not realising at the point when they used the health services.

Of the survivors who realised they were experiencing abuse when they accessed health services, nearly two-thirds (65 per cent) attended in order to get support to cope with the effects of abuse. However, of the survivors who were aware they were experiencing abuse, 61 per cent were not asked by the health professional whether "everything is OK at home" or if they were safe.

Some survivors who did realise they were experiencing abuse spoke about the responses they received from health professionals. Many comments noted how health professionals did not appear to understand the dynamics of domestic abuse and the positions they were in.

> **"GP and surgery failed to report abuse and involve local services, including social services. Abusive partner found evidence of me trying to get help from social services to leave to protect myself and the children...I feel like I've left the relationship - and yet I'm still being abused and I'm not protected by anyone."**
> Survivor, Kensington

Other comments highlighted that health professionals seemed uninterested and survivors felt professionals showed no professional curiosity around the reasons they were presenting. Some survivors were prescribed medication or diagnosed with a personality disorder after limited contact.

> **"I didn't get any one to one therapeutic support for PTSD for a long time. Indeed, it took them 18 months to acknowledge I even had PTSD. I had no previous mental health issues prior to this experience and they were all well aware of this. The treatment approach from the start was 'what is wrong with you' rather than what has happened to you and how can we help."**
> Survivor, Lewisham

Some survivors told us they felt they were not believed when they described the behaviours of perpetrators and were made to feel they were 'crazy' by professionals responding to them.

> **"I took an overdose - following a night of drinking and drugs and an argument with my then partner. (It was a cry for help) I [went to] A&E [and] was treated like a criminal. I was told I might lose my job and my daughter may not be able to stay living with me. I was made to feel like I was crazy. I was covered in bruises on my arms and not one person asked me how I got them or if things were OK at home. If anyone had asked me I would've spoken but I was terrified."**
> Survivor, Ealing

One comment explained the impact of a poor response from health professionals when the respondent was already having to cope with the effects of domestic abuse.

> **"A survivor cannot deal with all of this and an NHS response like this whilst dealing with ongoing post separation assault on your life, home and online accounts etc. and threat to your personal safety. When the police and NHS services disbelieve you and fail to protect and support you, it just destroys you psychologically and emotionally even more in the aftermath of prolonged serious domestic abuse."**
> Survivor, Lewisham

One survivor spoke about the supportive response they received from the health professional they saw which helped them through their situation, highlighting that good practice does exist and, where it does, it has a positive effect on the lives of survivors.

Among the survivors who did not realise, didn't realise at first or were not sure that they were experiencing domestic abuse, there were a range of reasons for which they initially accessed health services. Over half (53 per cent) of these survivors attended for support with their mental health, 18 per cent for physical injuries, 12 per cent for general health reasons, 12 per cent for sexual health and 6 per cent due to pregnancy.[152]

> **"I had [GP] appointments due to stress at home during pregnancy. Requested test for STI when partner was suspected to be going to prostitutes. Needed vaccinations and smears. Finally went to GP to report the abuse when baby was 10 months old."**
> Survivor, Southwark

Over two-thirds (67 per cent) of the survivors who were unaware or unsure of their situation did not feel that the health professional investigated the reasons for their symptoms (whether or not they were related to the abuse they experienced). Over three-quarters of the survivors who were unaware or unsure (76 per cent) said the health professional did not ask, "is everything OK at home" or enquire whether they had experienced domestic abuse.

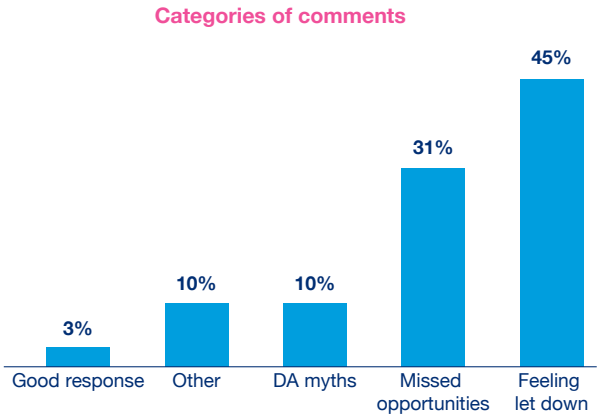
> **"I always ever only talked about my anxiety and depression making me ill, this was never questioned and I never realised these were symptoms of the abuse I was experiencing until the day I sought advice from Women's Refuge who were able to confirm immediately that it was abuse."**
> Survivor

> **"[I told the health professional] that I was afraid of my ex-husband…I had so many medical and mental health issues because of the abuse it was all documented but never was I asked or signposted only when I fled I told my GP his reply was "why didn't you just leave?'."**
> Survivor, Havering

Four survivors who were unaware that they were in an abusive relationship were asked about abuse by their health professional. Two survivors said they did not disclose the situation and two did disclose. One survivor who disclosed said, "I told the truth about my situation in hope it would make things better but it didn't really".

Finally, survivors were asked if there was anything else they wanted to tell us. 23 survivors responded to the question and their answers were separated into 29 distinct comments, with five major themes. Nearly half

of the comments (45 per cent) highlighted that survivors felt 'let down' by a lack of understanding and awareness of domestic abuse among health professionals. Survivors told us they experienced insensitive responses and victim blaming. Some survivors also noted feeling let down by a lack of multi-agency working which left them feeling alone and overwhelmed.



"There seems to be absolutely zero join up between GP and social services, and GP and domestic abuse support services referral. Mental health referrals have to be done by patient themselves, sometimes even a small task like this can be overwhelming when you are in the middle of abuse."
Survivor, Barking and Dagenham

"Throughout my experience in engaging with health professionals, it seemed clear to me that there is a massive lack in training frontline NHS/mental health staff on recognising signs of abuse, responding sensitively, adjusting to survivors' needs, understanding of trauma, etc."
Survivor, Waltham Forest

"This process needs a lot of work. I was completely let down by all of the health professionals I came into contact with and I am a Nurse myself."
Survivor, Ealing

Just under a third (31 per cent) of comments related to missed opportunities from health professionals to identify domestic abuse or, encourage a disclosure from the survivor and refer on to specialist support. Some survivors noted that opportunities can be missed as there are no openings to see female doctors if someone has experienced sexual abuse, if the doctor asks the question but in a cold, impersonal manner or if they only ask once and don't engage the survivor when there may be suspicious circumstances. In separate interviews, one disabled client of Stay Safe East said the lack of support, and of adjustments for their disabilities made them feel "like a ghost" in the system.

“When I went to A&E the doctor told me we only do bones here, not that relationship mental health stuff. But didn’t offer to refer me to somewhere that did.”
Survivor, Southwark

“My GP told me a few months ago that he didn’t know if there were services in the Borough for domestic abuse and that he would call me the next day. He didn’t call for a month.”
Survivor, Barking and Dagenham

Several survivors noted how professionals minimise the threat or don’t consider certain groups of people could be perpetrators, for example, women or people in an influential position. Other comments included how important it is for health professionals to record any abuse as they can be required as evidence.

“I must add that as my perp was a woman these services do not see the serious threat they pose. This myth must be dispelled as it also supports the perp to continue abusing unchallenged.”
Survivor, Lewisham

Again, one survivor highlighted a positive experience, telling us they felt that the health services they had attended were knowledgeable and well equipped to respond to domestic abuse.

*R's story

Following years of complex and costly immigration requirements, *R finally arrived in the UK on a spousal visa in 2017. By the end of 2018, her marriage had broken down, and she disclosed the abuse she'd experienced to her GP in the same month.

She presented with several trauma-related symptoms, including recurring nightmares, hyper vigilance in public spaces, and excessive weight loss. The first GP she saw was a locum male GP, and therefore she felt uncomfortable disclosing the details of the sexual abuse she'd experienced. As a result, R felt as though she wasn't able to tell her whole story, and was unable to receive the full breadth of the treatment she was so desperately seeking.

Furthermore, the locum GP was unhelpful, did not seem to understand or validate her experiences, and was not aware of the implications of her immigration status on the limited services she was entitled to access. In the absence of making any referrals to specialist organisations, he prescribed her sleeping tablets and ended the consultation.

In early 2019, R relocated to another borough and needed to transfer her medical records to her new practice. In addition, she required documented proof of her previous appointment and associated assessments to present to the Home Office in conjunction with her application for indefinite leave to remain as a victim of domestic abuse.

When she started this process, the GP informed her that she would need to physically return to the surgery which was dangerously close to the perpetrator's home and workplace, and pay a £15 fee in order to obtain a letter in support of her immigration application. Though R expressed concerns regarding safety and expenses, the GP did not make any concessions and instead restated his position.

It quickly became clear that the receptionist at R's original practice was not utilising a trauma-informed response and ultimately, extended no sympathy to her and/or her situation. The receptionist repeatedly attempted to cancel the appointment at the last minute while R was already en route, despite the fact that R had informed the receptionist that she had taken time off work to attend and was incurring significant additional transport costs in the process.

When she arrived at the surgery, the receptionist insisted on her paying for the letter in cash, as opposed to card payment, for the letter, which had not been communicated previously. The receptionist repeatedly suggested that R utilise a cash machine down the road which, due to its proximity to the perpetrator, would have put her safety at risk. Despite R's best efforts to articulate these risks, the receptionist was entirely unsympathetic to the trauma that R was experiencing.

As a result, R found herself crying in a very public space, while the receptionist displayed no empathy, and the other patients in the waiting room watched. Thankfully, R was able to find enough cash in her handbag to pay the letter fee but, by then, had been required to restate numerous, intimate details of her abuse in front of the other patients, while visibly upset, as the receptionist had refused to read the notes on her file or provide her with any degree of privacy, contrary to R's repeated requests.

After relocating, R was repeatedly turned down for GP registration in her new area, as a result of having to relinquish her identity documents to the Home Office for several months whilst her immigration application was in process. Although GPs are required to register all patients, regardless of ID documents, every practice in her new catchment area turned her down. As a result, R spent several months without access to any medical treatment, at a time when she needed it most, despite having paid for NHS access twice in National Insurance contributions and the Immigration Health Surcharge.

After moving house again, R was finally able to register with a surgery near her new home, and the nurse and GP there were much more helpful. They listened to her, validated her experiences, and provided her with a longer appointment. Unfortunately, this GP soon left for another practice, and she was forced to start all over again. After her first appointment with a new male GP, it was clear to R that he had not properly read through her file. As a result, she had to go through the re-traumatising process of recounting her story once again.

After nine months on various waiting lists, R was finally able to access an initial therapy session. Unfortunately, the appointment was scheduled at the wrong time, the therapist refused to acknowledge or believe the existence of R's pre-existing health conditions, and the session ended poorly. Several weeks later, R was grateful to be matched with an understanding therapist.

However, after all of the waiting, R found she was only eligible for 'pre-trial' therapy. As such, she was barred from speaking about the abuse she'd experienced until the conclusion of the ongoing criminal investigation or risk compromising the outcome.

More than two years on, R is still waiting on the outcome of the criminal investigation and has yet to receive proper treatment for the years of abuse she experienced.

Throughout her experiences in engaging with health professionals, R has been forced to conduct her own research at length, and use the knowledge she's acquired to advocate for herself. It became clear that the vast majority of the health professionals she's encountered have not received adequate training in domestic abuse or in trauma-informed responses. She feels there is a lot of work still to be done.

*R's name has been changed to protect her identity

Migrant survivors' experiences of healthcare

London has the largest number of migrant inhabitants than any other region in the UK. In 2019, about 35 per cent of the population of people born abroad and living in the UK lived in London, totalling approximately 3,317,000 migrants.[153]

Migrant women are at "an increased risk of domestic violence, sexual violence, suicide, sexual and economic exploitation, domestic abuse-related homicide and harmful cultural practices", according to research by Southall Black Sisters and Women's Aid.[154] As showcased in R's experience above, migrant survivors can face a range of barriers to health which are unique to their situation. "In the context of the hostile environment for migrant women in the UK, the threat of destitution, detention and/or deportation looms large over them."[155]

Health services are an important site of disclosure for migrant survivors of domestic abuse, as highlighted by research from Latin American Women's Rights Service and the StepUp Migrant Women coalition. 22 per cent of the survivors in the survey who reported their experience of VAWG to the police then turned to health services, making it the second most popular site following specialist women's services.[156]

Despite clear guidance issued in 2015 and 2017 by NHS England which reiterated universal entitlement to care, free of charge, and emphasised that no documentation is required to register with a GP, many practices continue to insist that they cannot register individuals without ID.[157,158] A 2019 study showed that, of 100 London general practices, 75 per cent of surgeries' websites stated that prospective patients needed documentation to register, and only 12 per cent included a plan for people without documentation.[159] This can present a barrier to healthcare for a range of groups, including Traveller communities, and those experiencing homelessness. As seen in R's story, this can pose significant problems for migrants and migrant survivors as they may need to send off their documentation in order to apply for Indefinite Leave to Remain.[160]

Even when a migrant survivor is able to register at a GP, their No recourse to public funds (NRPF) status can continue to bar them from accessing support, with one report finding "women with NRPF are more vulnerable to abuse and often cannot access domestic violence services because of their NRPF condition."[161] According to End Violence Against Women, "the impact of No Recourse to Public Funds (NRPF) conditions on migrant women who have suffered domestic abuse and are financially or otherwise dependent on their spouse or partner has been devastating."[162]

Primary NHS healthcare services, including general practice and pharmacists, are available free of charge to all, regardless of immigration status. However, survivors have told us about their experiences of GPs referring them on to other services which they then cannot access due to NRPF status. When making referrals for migrant survivors, healthcare professionals must understand which services are available to patients with NRPF status. Moreover, they must recognise the unique mental health needs of migrant survivors, who are often unable to access refuges or housing assistance and therefore remain trapped with their perpetrator or face homelessness if they leave.

In written evidence submitted to the Domestic Abuse Bill Public Bill Committee, Southall Black Sisters (SBS) stated, currently, "the safety of migrant women with NRPF is essentially relegated to a parallel and highly precarious system of support, separate from the wider VAWG referral pathways and state protection."[163] In order to support these survivors and enable them to access the range of healthcare services they need, there must be an extension of the Domestic Violence Rule, and of the Destitution and Domestic Violence Concession, to all migrant survivors, regardless of their immigration history.

In interviews with frontline, by-and-for organisations, practitioners did tell us about "pockets" of good practice in London, especially regarding survivors with NRPF status. One example saw health-based Idvas contacting specialist practitioners to try to ensure a survivor did not have to return home to the perpetrator after presenting in a health setting, or face homelessness. On join up between health services and specialist domestic abuse services in the current system, one practitioner told us, "it's difficult, but you can do it."

The need for a whole-health approach

A whole-health approach can address the issues raised by survivors' experiences. Primarily, commissioners must recognise GPs and mental health services as key points of contact with survivors, as must A&E – survivors cannot continue to present at the Emergency department only to be told they can't access help for "that relationship, mental health stuff." As such, co-located Idvas in hospitals, mental health Idvas, and IRIS AEs in GP surgeries with simple referral pathways must be in place to ensure survivors are identified and can access an appropriate response to the abuse.

Routine or clinical enquiry into domestic abuse, depending on the healthcare setting, accompanied by the time and space to listen to patients' responses, must become the norm to address issues faced by survivors when they felt the healthcare professional was uninterested.

Practitioners must know the right questions to ask: as the survey showed, many survivors are not aware that the 'relationship problems' they are facing constitute domestic abuse. As such, "is everything okay at home?" or "do you feel safe?" can be more effective questions. This is especially true of younger people, who more readily use the language of "toxic", "controlling" or "manipulative" relationships rather than "abusive" or "harmful" relationships and "domestic violence."[164]

By-and-for organisations pointed out the need for healthcare professionals to avoid assumptions based on myths and stereotypes about what abusive relationships look like. For example, LGBT+ survivors have told practitioners of experiences in which healthcare professionals have written off abuse in same-sex relationships as a "catfight" or with problematic phrases including, "boys will be boys."

Furthermore, health professionals need to be sensitive to the fact that for many LGBT+ survivors, there will be a 'double disclosure' in which they not only need to tell their story about the abuse they are experiencing, but, for many, it will be the first time they have told their GP or other health professional about their sexuality or gender identity. This can potentially put them at risk of discrimination. As such, building health professionals' knowledge and confidence around LGBT+ specific issues and inclusive language, and displaying signs or symbols which convey an accepting atmosphere can help to smooth the process of the 'double disclosure' for LGBT+ survivors. Similarly, a practitioner working with Black, Asian and racially minoritised survivors highlighted that signs and posters in healthcare settings regarding charging procedures for migrants, alongside fears of information sharing with the Home Office, create an intimidating space in which migrant survivors do not feel safe, welcomed, or comfortable disclosing their abuse or their immigration status.

Once a disclosure has been made, the pathways must be in place for multi-agency responses to ensure survivors are not burdened with or overwhelmed by the need to navigate difficult systems and retell their story to myriad professionals with differing levels of knowledge around abuse. Moreover, a better understanding of the dynamics of domestic abuse, and of common myths regarding those experiencing it is clearly necessary to ensure that health professionals are equipped to respond appropriately.

The evidence from survivors chimes with MOPAC's findings in the 2018-21 VAWG Strategy, highlighting restricted time slots with GPs as a key barrier to disclosure. Survivors feel there is not enough time to ask questions sensitively, or disclose information about their experiences. Survivors also raised issues regarding a lack of training, and a lack of awareness in recognising the signs of abuse. We agree with the MOPAC VAWG Strategy

that it's important to "recognise that victims' needs can be wide ranging and intersecting and that a 'one size fits all' approach to victim care is not always sufficient."[165] The current investment in IRIS programmes by the VRU indicates their willingness to support evidence-based interventions to address some of these issues in line with a 'whole-health' approach to domestic abuse.

How to create a whole-health approach in London

Understanding current challenges for a whole-health approach

As the NHS begins to transition away from CCGs and to Integrated Care Systems (ICS), there is a key opportunity to ensure domestic abuse is addressed as part of a public health approach to violent crime. ICSs have the potential to embed a joined-up collaboration between health and social care alongside the commissioning of domestic abuse services. According to The King's Fund, this will create "better outcomes and a less fragmented experience for patients and users."[166] Commissioning domestic abuse interventions falls squarely within Domain Five of the Commissioning Outcomes Framework, "treating and caring for people in a safe environment and protecting them from avoidable harm."[167]

ICSs should invite health and social care partners to utilise "needs-based" commissioning as a key tenet of their commissioning model. For some health authorities, this will mean they will be able to proactively plan service provision in order to support the whole family – adult, teen and child victims and perpetrators - in a preventative manner, as opposed to working in a solely reactive way, solving the various issues as they arise.

In order for this to happen, ICSs need to proactively support multi-agency partners, particularly VAWG third sector specialists, to help understand the health system and identify key decision makers. This will allow both commissioners and practitioners to work in a more unified way, creating cross-agency initiatives rather than commissioning in silos. Domestic abuse professionals are experts in safeguarding, safety and understanding trauma, which could be of great value to NHS professionals if they only had the capacity and the opportunity to share it. As such, NHS Trusts should proactively reach out to their specialist community-based service delivery partners to create a system and services which work for all.

Moreover, we invite health partners to think creatively about the data they use to evidence their commissioning. If ICSs only consider data that is presented to them via criminal justice routes, they are likely to miss victims using their services without recourse to criminal justice agencies for example Black, Asian and racially minoritised victims. Instead, ICSs should be utilising the experiences of survivors to help drive and co-create the services in their area, as well as safeguarding data and that from local multi-agency partners.

Lack of long-term, sustainable funding

A primary barrier to creating a whole-health approach to domestic abuse is the lack of long-term and sustainable funding available for health-based domestic abuse interventions, and community-based services. The domestic abuse sector has been historically underfunded, and Covid-19 has created ever more pressure in terms of demand on services and complexity of cases. One frontline service manager told our roundtable that the increase during Covid in complexity of cases including survivors' mental health needs had led to a 25 per cent increase in the amount of resource required to safely support clients. In our report *A Safe Fund*, we estimate that around £1bn is needed annually across England and Wales to fund the full suite of services required by the whole family – adult, teen and child victims, and the perpetrators who harm them.[168]

Many of the interventions outlined above, such as IRIS programmes or hospital-based Idvas which have proven effectiveness both in outcomes and cost, are either not commissioned or, if they are, experience one-year funding rounds and the insecurity which accompanies that. Services told us in our roundtable event that the constant cycle of rebidding swallows up their capacity and reduces their ability to roll-out their services further. When funding ends for 'innovative' interventions and they aren't recommissioned, much of the expertise and crucial areas of learning that is developed over the course of the intervention is lost. A systematic, whole-health approach would mitigate the risk of losing time and expertise which could be better used identifying, responding to, and supporting survivors and victims of domestic abuse.

As Gwen Kennedy, Director of Nursing Leadership & Quality at NHS England & Improvement, told us in one of our roundtables on the barriers to a whole-health approach, there needs to be a recognition in the NHS that these services need to be sustainably funded, rather than commissioners taking a 'one-off', project-based approach. Only through longer-term funding will services be effectively embedded within mainstream functions. Moreover, losing funding can impact clinicians' trust in the intervention

itself, as they may not understand who made the funding decision and on what basis.

The need for greater integration of health and domestic abuse commissioning

According to the NHS Confederation, "it is clear that there is near universal support for creating a system of integrated health and care, which will be focused on population health, with greater investment and focus on community, primary care and mental health services. It is seen as the only way of creating a sustainable future for the health and the care system in the face of rising demand."[169]

Survivors in the survey raised the issue of having to navigate complex systems themselves while recovering from the trauma of their experiences, sharing their stories again and again to different professionals. Health-based advocates can help to improve this experience, acting as the victim's voice with multiple agencies.

In her presentation, Gwen Kennedy highlighted the need to avoid a narrow focus on the NHS and instead to ensure the full involvement of local government, alongside voluntary and community-sector organisations if ICSs are to realise the goal of improving population health and wellbeing.

As our *Cry for Health* analysis found, survivors who present in health settings – in this case, specifically hospitals – are more likely to have complex needs:

- Mental health difficulties: 57 per cent hospital, 35 per cent local Idva clients
- Alcohol misuse: 18 per cent hospital, 8 per cent local Idva clients
- Drug misuse: 11 per cent hospital, 5 per cent local Idva clients
- Financial difficulties: 40 per cent hospital, 30 per cent local Idva clients
- Physical disability (including hearing & sight) or learning difficulty: 12 per cent hospital, 8 per cent local Idva clients
- Any of the above complex needs: 74 per cent hospital, 58 per cent local Idva clients
- The 'toxic trio' (domestic abuse, mental health difficulties and alcohol or drug misuse): 20 per cent hospital, 7 per cent local Idva clients.

Some of these may have arisen as a consequence of their experience of domestic abuse, while others may be used as a coping mechanism.

Not only does this mean they would greatly benefit from better join up between agencies, but they are also potentially less able to navigate the

disjointed system as it is now in order to access the range of services and support they will need. A well-functioning multi-agency approach is critical to ensuring we see and respond to the whole person, rather than just seeing them as a collection of disparate needs.

Effective multi-agency working is a core principle of the transition towards ICSs as a model of commissioning, and therefore the move presents a key opportunity to overcome this barrier. Some local authorities and NHS Trusts have already embedded elements of this approach, for example in co-locating Idvas and other domestic abuse practitioners in settings which span local domestic abuse services and statutory agencies including housing or health settings.

For example, to improve Trust-wide responses to domestic abuse, both Central and North West London NHS Foundation Trust and West London NHS Trust have recruited a Domestic Abuse Coordinator who will work over both Trusts for 12 months. They led the co-ordination of the Trust's response to domestic abuse as well as a Domestic Abuse Champions Network. The champions network was put in place to help improve staff's response to domestic abuse.[170]

In addition, Chelsea and Westminster NHS Foundation Trust have also embedded a Domestic Abuse Coordinator co-located between Standing Together, their local specialist service, and the Trust.

The Pathfinder pilot project ran between 2017 and 2020, and was led by Standing Together as part of a consortium of expert partners including SafeLives, Imkaan, AVA, and IRISi. The project engaged nine CCGs and 18 NHS Trusts across England to implement sustainable interventions in eight local areas, which included: Haringey and Enfield, Camden and Islington, and the so-called "super council" of Westminster, Hammersmith and Fulham, and Kensington and Chelsea. One mental health Idsva (Independent domestic and sexual violence advocate) was quoted as saying: "through the co-locations and developing partnerships with mental health services, we identified engagement with survivors [with whom] previously we were unable to establish contact."[171]

This style of working can not only streamline the system for survivors and victims, but also improve the levels of information sharing between settings and agencies, as is so clearly necessary. In 46 per cent of the London Domestic Homicide Reviews (DHR) featuring interpersonal homicides included in a MOPAC and Standing Together report, there was a lack of information sharing between health agencies. For DHRs featuring adult family homicides, 40 per cent lacked information sharing between specifically health agencies, and 48 per cent included missed

opportunities to share information across the board.[172]

Commissioners' and health professionals' understanding of domestic abuse

The level of knowledge and lack of understanding about domestic abuse by healthcare professionals is an issue frequently raised by survivors and domestic abuse practitioners. In the survey for this report, survivors spoke about healthcare professionals not enquiring about survivors' relationships and home lives, not investigating the reasons behind the issues they were presenting with (for example, a GP who treated only the anxiety and depression which the survivor experienced as a "symptom" of their abuse), and not responding well when survivors did disclose.

Comments raised issues including the perpetuation of domestic abuse myths, and survivors not feeling like they were being believed.

This was found in Sandi Dheesa's paper, *Recording and sharing information about domestic violence/abuse in the health service*, in which she states: "several research studies have shown that healthcare professionals use the term 'alleged' and other terms to imply doubt (e.g., 'patient claims'; e.g., Olive, 2017), which, according to victims/survivors, has led to records being seen as less reliable evidence of domestic violence/abuse in court (e.g., Bacchus et al., 2010). Victims/survivors who request their records report feeling disbelieved, which compounds a sense of trauma."[173]

As highlighted above, over one third of survivors' comments noted that health professionals did not appear to understand the dynamics of domestic abuse. Preconceptions around what constitutes domestic abuse, and how survivors 'ought' to behave and react to their experience abound. Though criminalised in 2015, coercive and controlling behaviour is still too often ignored or downplayed, even when the survey results showed that those who survivors who experienced non-physical abuse experienced it for longer than those who experienced both physical and non-physical abuse.

The survivor who told us their GP asked them why they didn't "just leave" the perpetrator is not alone in their experience: there is an enduring lack of understanding that cuts across society which suggests a 'real' victim of abuse will leave the perpetrator along with their home, belongings and even their workplace or children's school. This lack of understanding can be further compounded by attitudes around what a "typical" survivor looks like. Common myths include a perceived absence of abuse within relationships of two women, the rarity of older victims, or the lack of sexual

abuse of disabled women; any such myths only serve to raise further barriers to people disclosing abuse and receiving the support they need.

Health professionals have a great capacity to improve a survivor's experience by just listening and believing them: when asked what made the biggest difference to their safety and wellbeing, one survivor in the Pathfinder project answered, "talking to my GP and IRIS. They listened and understood and supported me emotionally, offered me advice and let me make my own decisions."[174]

Recommendations

Key recommendations for London's policy-makers and commissioners

- MOPAC, alongside the VRU, NHS London including new Integrated Care Systems, and local authority commissioners, should collaborate on a five-year strategy to ensure a 'whole-health' approach is pursued in the capital as part of a public health approach to violent crime. Such a strategy should aim to increase the provision of health-based advocacy in primary, mental health and acute care settings, alongside the data collection and outcomes monitoring required to understand impact and cost-effectiveness. This should include an increased understanding of the value of collaboration with specialist community-based domestic abuse services, who will bring additional expertise in safeguarding, safety and understanding trauma and services which work for all family members including perpetrators. It should also draw on the experiences of survivors to help drive and co-create the services in their area and recognise that a well-functioning multi-agency approach is critical to ensuring we see and respond to the whole person, rather than just seeing them as a collection of disparate needs.

- We estimate the funding required to ensure full coverage of health-based provision would amount to an annual cost of £1.8 million for acute trust Idvas (our mapping exercise for example shows only 19 in post, compared to a London wide need of 36) and £1 million for mental health trusts per annum, with an initial investment of £2.5 for IRIS programmes in general practices in boroughs which do not currently have the intervention. Investment in health-based domestic abuse practitioners should go hand-in-hand with funding for Domestic Abuse Coordinators which are integral to a 'whole-health' approach.

- The strategy for supporting domestic abuse victims in health settings across London should explicitly recognise the intersectional needs of victims with protected characteristics including Black, Asian and racially minoritised, LGBT+, and disabled and deaf victims, and how these

will be addressed. In particular, healthcare professionals should be encouraged to recognise the specific needs of migrant victims who may be trapped with the perpetrator or facing homelessness if they leave due to lack of access to housing assistance, and that immigration status may be a significant barrier to disclosure.

- A culture-change training approach delivered by specialist domestic abuse organisations, including 'by-and-for' services, should be integrated into existing health training to address the lack of awareness, understanding and gendered nature of domestic abuse across the health system. This should include training on providing trauma-informed responses to survivors. In particular, any training for healthcare professionals should recognise the specific barriers to accessing both healthcare and domestic abuse services in minoritised groups including Black, Asian and racially minoritised, LGBT+, and disabled and deaf victims, alongside the nature of discrimination those individuals might face when they do access services.

  All healthcare providers in London – NHS Trusts, GP surgeries, community health and so forth – should develop domestic abuse policies for staff and patients in line with best practice such as the Pathfinder DA Policy developed as part of its Toolkits. Alongside this, wider equality, diversity and inclusion policies need to intersect with domestic abuse policies to ensure the needs of and barriers to minoritised groups are fully understood, including the specific restrictions facing patients with NRPF status.

- General practices and primary-care settings should adhere to NHSEI guidance regarding allowing patients to register and access free-of-charge care even when they cannot supply identity documentation. They should not charge for the provision of letters which survivors need when applying for Leave to Remain or when accessing the Family Courts, and these letters should be provided electronically without the survivor needing to risk their safety and mental health by travelling to areas which may be near the perpetrator's home or workplace. We commend the Government for accepting a recent amendment to ensure that GPs do not charge for Legal Aid evidence, and would suggest this extends to any request for information which will help survivors to get safe.

Key recommendations for Westminster policy-makers and commissioners

- The UK Government should ensure that the commitment made in 2019 by NHS England to give access to Idvas across the health service is honoured, alongside the sustainable, multi-year funding required.

- Survivors of domestic abuse are likely to require swift access to mental health support. We recommend that the Government commit to shorter waiting times for victims of trauma, recognising that accessing mental health interventions will help with their recovery. The NHS' Five Year Forward View does not mention domestic abuse or the need for trauma-informed services. The Government should consider developing a new strategy for improving the health of victims of trauma, including domestic abuse survivors.

- The UK Government's new Serious Violence Bill, due at some point in 2021, should recognise the links between domestic abuse and violence outside the home and ensure that domestic abuse is considered to be part of a serious violence reduction duty.

- The Domestic Violence Rule and the Destitution and Domestic Violence Concession, should be extended to all migrant survivors, regardless of their immigration history, so NRPF conditions do not prevent them from accessing the support they need. Migrant survivors should be exceptions to the current NHS charging regime which sees those with outstanding medical debts of more than £500 automatically prevented from gaining Indefinite Leave to Remain.

Implementing a new statutory duty on PCCs, Local authorities and CCGs (and their replacement ICSs) to commission specialist community-based domestic abuse services will help to ensure provision for the whole family – all adult, teen and child victims of domestic abuse alongside perpetrators – to keep families safe sooner

Conclusion

This report has sought to provide a spotlight on the current experiences of survivors of domestic abuse accessing healthcare services as well as levels of provision of health-based services who could support them to get safe and well. It is clear that London is a leader in the provision of health-based services, but that gaps remain across a number of boroughs and the funding which underpins the recent expansion of services is time-limited and needs greater coordination and ownership across commissioners in the capital.

Survivors told us that they wanted healthcare professionals who had a better understanding of domestic abuse and the trauma they had lived through, being sensitive to the risks of their situation and the needs they had, particularly for ongoing support. They also told us that repeating their experiences to many professionals both within and without healthcare was re-traumatising, and in the case of migrants survivors, lack of access to healthcare added on extra layers to the trauma they had already faced.

Frontline specialist domestic abuse practitioners told us that the funding cycles for health-based commissioning were short-term and precarious, and that they worked hard to build trust in their intervention only to have funding removed, taking them back to square one.

Commissioners told us that there needed to be greater join up between them so that the benefits of health-based domestic abuse provision accrued in the right places - particularly within the NHS itself which is likely to see a decrease in repeat usage of high cost services such as A&E.

Evidence from evaluations of hospital-based and mental health-based Idva services, as well as the IRIS programme have shown the impact on survivor safety as well as on budgets. Health-based interventions help to identify survivors sooner, particularly those who may not typically present at community-based services or in the criminal justice system. Moreover, healthcare professionals are better prepared to recognise domestic abuse,

ask about it, record it and share that information, and respond sensitively to it when there is greater join up between settings and agencies.

We urge commissioners to be brave and agree a joint Whole Health London strategy for domestic abuse. No one agency or service can achieve these outcomes and it is time for newly formed ICSs to join ranks with MOPAC, the VRU, local authority commissioners, NHS London and the specialist domestic abuse sector to help end to domestic abuse for everyone and for good.

Appendices

Case studies from our survivor survey

Case Study 1

Tara is between 35 and 44 years old. She is from an Asian/Asian British community and identifies as heterosexual. She considers herself to be a disabled person and has a long-term physical/mobility health condition and experiences mental health issues.

She has been experiencing domestic abuse from her intimate partner and from her own, and her partner's, parents. Tara's child, aged 12, was too demonstrating harmful behaviour towards her. Tara's three children were living in the household at the time of the abuse and she was pregnant with her fourth child.

In the last 2 years Tara has experienced both physical and non-physical abuse, has been stopped from accessing help from other people, having care agencies coming to see her and has experienced so called 'honour-based'' abuse. She has been experiencing abuse from her intimate/ex-partner for more than 10 years.

The abuse has impacted on her confidence and self-esteem, left her unable to work, train or study, unable to parent, caused her physical and mental health issues and she has had suicidal thoughts. She lost custody of children to her abuser, then her family. Her children were put into foster care and put up for potential adoption.

In the last 2 years, Tara has accessed her GP, a health visitor, mental health professionals and physiotherapy/occupational therapy. When she accessed these services she realised she was experiencing domestic abuse and wanted to get help from the health services to get support to cope with the effects of abuse. She was asked by a health professional "is everything OK at home' or "if she was safe". However, Tara didn't feel

the professionals Case studies from our survivor survey fully understood her situation. She was being monitored by her ex and continually watched by both families. Her ex also constantly threatened her - even from prison. The health professional didn't offer to refer her directly to a domestic abuse service.

Tara doesn't feel the London borough where she lives has enough cultural awareness and people hold discriminatory attitudes towards individuals from Black, Asian and racially minoritised communities. She felt she was blamed as a victim and professionals sided with her abuser and family members causing further abuse postseparation that had detrimental effects on both Tara and the children.

All Tara's children returned to her care following her successful application to high court appeal.

Case Study 2

Jane is between 25 and 34 years old. She is from a White British community and identifies as heterosexual. She considers herself to be a disabled person and experiences mental health issues.

The main person harming her was an intimate/ex-partner. Jane's five children, ranging from 1 to 9 years old, were living in the household at the time of the abuse.

In the last 2 years Jane has experienced both physical and non-physical abuse, has been stopped from accessing help from other people and having care agencies coming to see her. She has been experiencing abuse for between 3 and 5 years.

The abuse has impacted Jane's confidence and self-esteem, left her unable to work, train or study, unable to parent, caused her physical and mental health issues and she has had suicidal thoughts. She used negative coping measures (e.g. using alcohol/drugs) to deal with the abuse.

Over the last 2 years, Jane has accessed her GP and mental health professionals. When she accessed these services she did not realise she was experiencing domestic abuse. Jane was never asked 'is everything OK at home' or asked if she had experienced domestic abuse; and she did not feel the health professionals investigated the reason for her symptoms.

Jane completed a course which made her aware what she was experiencing was domestic abuse. This resulted in Jane desperately needing some form of therapy. Jane's GP told her that he didn't know if

there were services in the Borough for domestic abuse and that he would call her the next day. Her GP didn't call for a month. When he did, he told Jane she would need to call 'Talking Therapies' who she had dealt with before and had told her the domestic abuse, PTSD, anxiety and depression was too complex.

Case Study 3

Hanna is between 25 and 34 years old. She describes herself as from a White 'Other' community and identifies as bisexual. She considers herself to be a disabled person and has a Neurodiverse condition (e.g. ADHD, autism, Asperger's, dyspraxia). The main person harming Hanna was an intimate/ex-partner.

In the last 2 years, Hanna has experienced both physical and non-physical abuse. She has been stopped from accessing help from other people, having care agencies coming to see her and has been exploited over her immigration status. Hanna has been experiencing abuse for between 3 and 5 years.

The abuse has impacted on Hanna's confidence and self-esteem, left her unable to work, train or study, unable to carry out day to day activities, caused her physical and mental health issues and she has had suicidal thoughts. She has used negative coping measures (e.g. using alcohol/ drugs) to deal with the abuse. Hanna was isolated from friends and family and unable to access state support due to no recourse to public funds.

Over the last 2 years, Hanna has accessed her GP, mental health professionals, and physiotherapy/occupational therapy. When she accessed these services she realised she was experiencing domestic abuse and went to the health services to get support to cope with the effects of abuse. Hanna was asked 'is everything OK at home' or asked if she had experienced domestic abuse. A health professional did offer to refer her directly to a domestic abuse service. Hanna noted an initial positive response from her GP, but later she considered her response insensitive. She was charged fora letter needed for her immigration application, and was later refused GP registration in her new area as she had to relinquish her ID documentation to the Home Office while her indefinite leave to remain application was in process.

Throughout Hanna's experience of engaging with health professionals, it seemed clear to her there is a massive lack of training in frontline NHS/ mental health staff on recognising signs of abuse, responding sensitively, adjusting to survivors' needs, and understanding of trauma. Hanna had to wait over 9 months for therapy. She felt her initial therapist was insensitive to her other health issues (specifically sleep disorder) but a later therapist was amazing.

Case Study 4

Meena is between 45 and 54 years old. She is from an Asian/Asian British community and identifies as heterosexual. The main person harming Meena was a family member. She was also being abused by a partner/ex-partner. Meena's 15 year old child was living in the household at the time of the abuse.

Meena has experienced physical and non-physical forms of abuse and has been stopped from getting help from other people. She has been experiencing abuse for more than 10 years. The abuse has impacted on Meena's ability to carry out day-to-day activities (e.g. shopping, socialising). In the last 2 years, Meena has been to her GP and realised she was experiencing domestic abuse when she accessed the service. The GP asked Meena, "is everything OK at home" or if she was safe. Meena told the GP about the domestic abuse and how her abuser suffered with Alzheimer's disease. She felt the response was appalling, doing nothing to treat the very unwell abuser, and simply told her to move out, which no one wanted. Meena noted health professionals have only started treating the abuser when she said she would make a duty of care complaint.

The GP did not offer to refer Meena to a domestic abuse service.

List of advisory group members

- **Jess Asato**
  Head of Public Affairs and Policy, SafeLives
- **Medina Johnson**
  CEO, IRISi
- **Donna Covey CBE**
  Director, AVA
- **Guddy Burnet**
  CEO, Standing Together
- **Miranda Pio**
  Programme Manager for Pathfinder, Standing Together
- **Nicola Douglas**
  Children and Health Team Leader, Standing Together
- **Fiona Dwyer**
  CEO, Solace
- **Niki Scordi**
  CEO, Advance
- **Rachel Nicholas**
  Head of Service, Victim Support
- **Prof. Gene Feder**
  Professor of Primary Care, Bristol Medical School, University of Bristol
- **Prof Louise Howard**
  Professor of Women's Mental Health, KCL
- **Jessica Southgate**
  CEO, Agenda
- **Laurelle Brown**
  Programme Manager, London Violence Reduction Unit
- **Karolina Bober**
  VAWG Strategy and Commissioning Manager, Islington Council
- **Jain Lemom**
  Senior Policy and Commissioning Manager for VAWG, MOPAC
- **Dr Liz Henderson**
  GP and Deputy Medical Director, IRISi Clinical Lead in Southwark, NHSEI
- **Aiswarya Kurup**
  Project Manager, NHSEI London Region Safeguarding Team
- **Leni Morris**
  CEO, Galop
- **Dr Jasna Magić**
  National LGBT+ Domestic Abuse Project Manager, Galop
- **Peter Kelley**
  Service Lead, Galop
- **Michele Lawrence**
  Head of Safeguarding, Public Health England
- **Ruth Bashall**
  CEO, Stay Safe East

Glossary

CAMHS = Child and Adolescent Mental Health Services
CCG = Clinical commissioning group
DA = Domestic abuse
DHR = Domestic homicide review
DHSC = Department for Health and Social Care
GLA = Greater London Authority
ICS = Integrated care system
Idva = Independent domestic violence advisor
IPV = Intimate Partner Violence
IRIS = Identification and Referral to Improve Safety programme
Marac = Multi agency risk assessment conference
MOPAC = The Mayor's Office for Policing and Crime
MTC = Major trauma centre
NHSEI = NHS England and NHS Improvement
NRPF = No recourse to public funds
PCC = Police and Crime Commissioner
STP = Sustainability and transformation partnership
VAWG = Violence Against Women and Girls
VLP = Vulnerable Localities Profile
VR/VRU = violence reduction/unit

Footnotes

1. More information: https://www.standingtogether.org.uk/pathfinder
2. Home Office (2017), The economic and social costs of domestic abuse. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/918897/horr107.pdf
3. Mid-year population estimates multiplied by CSEW prevalence rates.
   3,301,509 women aged 16-74 in London, 7.3 per cent = 241,010
   3,321,856 men aged 16-74 in London, 3.6 per cent = 119,587
   Office for National Statistics (2020), Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland – Mid-2019: April 2020 local authority district codes. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland
4. Office for National Statistics (2020), Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland – Mid-2019: April 2020 local authority district codes. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland
5. In October 2020, there were 215,200 NHS staff in London (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/october-2020). The gender split is approximately 77 per cent women and 23 per cent men, resulting in approximately 165,700 female employees and 49,500 male employees (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2020). Given the prevalence statistics highlighted by the CSEW, this suggests 12,100 female NHS employees and 1,800 male NHS employees experienced DA in the last year. (https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020).
6. The CSEW estimates 33.1 per cent of those who experience partner abuse went on to receive medical attention following the abuse. On the basis of the CSEW prevalence figures (year ending March 2020) and mid-year population estimates, we estimate 266,000 Londoners experienced partner abuse in the last year, resulting in around 88,000 who received medical attention.
   https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/partnerabuseindetailappendixtables
7. According to Home Office estimates, domestic abuse costs health services on average £1,200 per victim. On the basis of our estimates that 361,000 Londoners experienced domestic abuse last year, that would put the total health service costs alone at more than £433 million for the victims in London identified in a single year.
8. London Assembly Police and Crime Committee (2020), Domestic Abuse. Available at: https://www.london.gov.uk/sites/default/files/pcc_domestic_abuse_report_april_2020.pdf
9. http://www.safelives.org.uk/sites/default/files/resources/Marac%20data%202019-2020%20England%20and%20Wales.xls
10. This figure is based on the Family Resources Survey 2018-19 which identifies that almost 1 in 5 of the working age population (16-64 years) is disabled. SafeLives' definition of disability is consistent with the core definition of disability under the Equality Act 2010
11. There is variation in estimates about the size of LGB populations, and even less data on transgender populations, but Public Health England's current estimate for the national LGB population is between 2.5 per cent and 5.8 per cent. The results of research conducted in Scotland and Wales suggest that similar estimates could be made for these areas.
    PHE (2017), Producing modelled estimates of the size of the lesbian, gay and bisexual (LGB) population of England. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585349/PHE_Final_report_FINAL_DRAFT_14.12.2016NB230117v2.pdf
12. BBC (2020), Coronavirus: Met Police making 100 domestic violence arrests a day. Available: https://www.bbc.co.uk/news/uk-england-london-52418650
13. London Assembly (2020), COVID-19 and domestic abuse: the rise of cases during lockdown. Available at: https://www.london.gov.uk/press-releases/assembly/covid-19-and-domestic-abuse
14. London Assembly (Undated), Domestic and Sexual Violence Dashboard. Available at: https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-statistics/

domestic-and-sexual-violence-dashboard
15. GLA (2019), London's diverse population. Available at: https://data.london.gov.uk/dataset/london-s-diverse-population- [Accessed 15/03/21]
16. Office for National Statistics (2017), Graduates in the UK labour market: 2017. Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/graduatesintheuklabourmarket/2017
17. Office for National Statistics (2020), Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland – Mid-2019: April 2020 local authority district codes. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland
18. GLA (2019), London's diverse population. Available at: https://data.london.gov.uk/dataset/london-s-diverse-population- [Accessed 15/03/21]
19. SafeLives (2015), Getting it right first time. Available at: https://safelives.org.uk/sites/default/files/resources/Getting%20it%20right%20first%20time%20-%20complete%20report.pdf
20. SafeLives (2018), Barnet, Enfield and Haringey Mental Health NHS Trust: Mental Health Idva pilot evaluation 2018 (LINKS). Available at: https://safelives.org.uk/sites/default/files/resources/BEH-MHT%20LINKS%20pilot%20evaluation.pdf
21. SafeLives (2019), Psychological Violence. Available at: https://www.safelivesresearch.org.uk/Comms/Psychological%20Violence%20-%20Full%20Report.pdf
22. Stöckl, H., & Penhale, B. (2015). Intimate partner violence and its association with physical and mental health symptoms among older women in Germany. Journal of interpersonal violence, 30(17), 3089-3111.
23. Selic, P., Svab, I., & Gucek, N. K. (2014). A cross-sectional study identifying the pattern of factors related to psychological intimate partner violence exposure in Slovenian family practice attendees: what hurt them the most. BMC public health, 14(1), 223.
24. Mason, S., Wright, R., Hibert, E., D, S., Forman, J., & Rich-Edwards, J. (2012). Intimate partner violence and incidence of hypertension in women. Annals of Epidemiology, 22(8), 562–567. http://doi.org/10.1016/j.annepidem.2012.05.003
25. Coker, A. L., Smith, P. H., Bethea, L., King, M. R., & McKeown, R. E. (2000). Physical health consequences of physical and psychological intimate partner violence. Archives of family medicine, 9(5), 451.
26. Link, C. L., Lutfey, K. E., Steers, W. D., & McKinlay, J. B. (2007). Is Abuse Causally Related to Urologic Symptoms? Results from the Boston Area Community Heath (BACH) Survey. European Urology, 52(2), 397–406. http://doi.org/10.1016,j. eururo.2007.03.024
27. Mason, S., Wright, R., Hibert, E., D, S., Forman, J., & Rich-Edwards, J. (2012). Intimate partner violence and incidence of hypertension in women. Annals of Epidemiology, 22(8), 562–567. http://doi.org/10.1016/j.annepidem.2012.05.003
28. Coker, A. L., Smith, P. H., Bethea, L., King, M. R., & McKeown, R. E. (2000). Physical health consequences of physical and psychological intimate partner violence. Archives of family medicine, 9(5), 451.
29. Aitken, R., Munro, V.E. (2018), Domestic abuse and suicide. Available at: https://www.refuge.org.uk/wp-content/uploads/2020/08/NEW-Suicide-Report-HIGH.pdf
30. https://www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse
31. MOPAC (2018), Beneath the Numbers: An exploration of the increases of recorded Domestic Abuse and Sexual Offences. Available at: https://www.london.gov.uk/sites/default/files/201902_beneath_the_numbers_-_an_exploration_of_the_increases_of_recorded_domestic_abuse_and_sexual_offences_v1.pdf
32. The Behavioural Insights Team (2020), Violence in London: what we know and how to respond. Available at: https://www.bi.team/wp-content/uploads/2020/02/BIT-London-Violence-Reduction.pdf
33. Metropolitan Police (2019), Support for LGBT domestic violence: 01.FOI.19.002956. Available at: https://www.met.police.uk/foi-ai/metropolitan-police/disclosure-2019/june/support-lgbt-domestic-violence/
34. Milliken, A. (2017), Manchester Police is first in the UK to officially record LGBT domestic abuse. Pink News. Available at: https://www.pinknews.co.uk/2017/04/10/manchester-police-is-first-in-the-uk-to-officially-record-lgbt-domestic-abuse/
35. Stonewall (Undated), Protecting lesbian, gay and bisexual people: A practical guide for police forces. Available at: https://www.stonewall.org.uk/sites/default/files/police_guide_web_final.pdf
36. EVAW & Imkaan (2020), Access to Justice for Women and Girls during Covid-19 Pandemic.

Available at: https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/Access-to-Justice-for-Women-Girls-during-Covid-19-Pandemic.pdf
37. LAWRS (2019), The right to be believed: Migrant women facing Violence Against Women and Girls (VAWG) in the 'hostile immigration environment' in London. Available at: https://stepupmigrantwomen.org/research-righttobebelieved/
38. MOPAC (2018), Beneath the Numbers: An exploration of the increases of recorded Domestic Abuse and Sexual Offences. Available at: https://www.london.gov.uk/sites/default/files/201902_beneath_the_numbers_-_an_exploration_of_the_increases_of_recorded_domestic_abuse_and_sexual_offences_v1.pdf
39. World Health Organization, 2017. Violence Prevention Alliance: The public health approach. Available at: http://www.who.int/violenceprevention/approach/public_health/en/ [Accessed 23/02/21].
40. Office for National Statistics (2020), Domestic abuse in England and Wales overview: November 2020. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020
41. SafeLives (2020), Marac National Dataset 2019/20. Available at: https://safelives.org.uk/practice-support/resources-marac-meetings/latest-marac-data
42. Myhill, A (2015), Measuring Coercive Control: What Can We Learn From National Population Surveys? Available at: https://journals.sagepub.com/doi/10.1177/1077801214568032?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed
43. Office for National Statistics (2020), Domestic abuse in England and Wales overview: November 2020. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020
44. Office for National Statistics (2020), Domestic abuse in England and Wales overview: November 2020. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020
45. Age UK (2020), No Age Limit: the blind spot of older victims and survivors in the Domestic Abuse Bill. Available at: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/age_uk_no_age_limit_sept2020.pdf
46. SafeLives (2016). Safe Later Lives: Older people and domestic abuse. Available at: https://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse
47. Office for National Statistics (2020), Domestic abuse in England and Wales overview: November 2020. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020
48. SafeLives (2018), Free to be safe. Available at: https://safelives.org.uk/knowledge-hub/spotlights/spotlight-6-lgbt-people-and-domestic-abuse
49. Office for National Statistics (2017), Women most at risk of experiencing partner abuse in England and Wales: years ending March 2015 to 2017. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/womenmostatriskofexperiencingpartnerabuseinenglandandwales/yearsendingmarch2015to2017
50. Magić, J. & Kelley, P. (October 2019). Recognise & Respond: Strengthening advocacy for LGBT+ survivors of domestic abuse. Galop, the LGBT+ anti-violence charity. London, UK. October 2019
51. SafeLives (2017), Your choice: 'honour'-based violence, forced marriage and domestic abuse. Available at: https://safelives.org.uk/sites/default/files/resources/Spotlight%20on%20HBV%20and%20forced%20marriage-web.pdf
52. Home Office (2020), Forced Marriage Unit Statistics 2019. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/894428/Forced_Marriage_Unit_statistics_2019.pdf
53. GLA (2018), Progressing a Public Health Approach to Violence Prevention and Reduction, Appendix A: Proposed Public Health Approach. Available at: https://www.london.gov.uk/moderngovmb/documents/s62485/04b%20SYV%20PH%20Appendix%20A%20-%20Report.docx?CT=2
54. MOPAC (2018), Beneath the Numbers: An exploration of the increases of recorded Domestic Abuse and Sexual Offences. Available at: https://www.london.gov.uk/sites/default/files/201902_beneath_the_numbers_-_an_exploration_of_the_increases_of_recorded_domestic_abuse_and_sexual_offences_v1.pdf
55. The Behavioural Insights Team (2020), Violence in London: what we know and how to respond. Available at: https://www.bi.team/wp-content/uploads/2020/02/BIT-London-Violence-Reduction.pdf
56. Office for National Statistics (2020), Population estimates for the UK, England and

Wales, Scotland and Northern Ireland: mid-2019. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2019estimates
57. Office for National Statistics (2020), Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2019. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2019estimates
58. Mid-year population estimates multiplied by CSEW prevalence rates.
3,301,509 women aged 16-74 in London, 7.3 per cent = 241,010
3,321,856 men aged 16-74 in London, 3.6 per cent = 119,587
Office for National Statistics (2020), Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland – Mid-2019: April 2020 local authority district codes. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland
59. London Assembly Police and Crime Committee (2020), Domestic Abuse. Available at: https://www.london.gov.uk/sites/default/files/pcc_domestic_abuse_report_april_2020.pdf
60. London Assembly Police and Crime Committee (2020), Domestic Abuse. Available at: https://www.london.gov.uk/sites/default/files/pcc_domestic_abuse_report_april_2020.pdf
61. House of commons Library (2020), Migration Statistics. Available: https://commonslibrary.parliament.uk/research-briefings/sn06077/
62. Office for National Statistics (2020), Sexual orientation, UK. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/datasets/sexualidentityuk
63. Office for Disability Issues (2014), Disability and Mobility, London. Available at: https://data.london.gov.uk/dataset/disability-and-mobility-london
64. SafeLives (2019), SafeLives Marac data England and Wales April 2019 - March 2020 . Available at: http://www.safelives.org.uk/sites/default/files/resources/Marac%20data%202019-2020%20England%20and%20Wales.xls
65. This figure is based on the Family Resources Survey 2018-19 which identifies that almost 1 in 5 of the working age population (16-64 years) is disabled. SafeLives' definition of disability is consistent with the core definition of disability under the Equality Act 2010.
66. There is variation in estimates about the size of LGB populations, and even less data on transgender populations, but Public Health England's current estimate for the national LGB population is between 2.5% and 5.8% . The results of research conducted in Scotland and Wales suggest that similar estimates could be made for these areas.
67. BBC (2020), Coronavirus: Met Police making 100 domestic violence arrests a day. Available: https://www.bbc.co.uk/news/uk-england-london-52418650
68. London Assembly (2020), COVID-19 and domestic abuse: the rise of cases during lockdown. Available at: https://www.london.gov.uk/press-releases/assembly/covid-19-and-domestic-abuse
69. London Assembly (Undated), Domestic and Sexual Violence Dashboard. Available at: https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-statistics/domestic-and-sexual-violence-dashboard
70. Radford, L. et al (2011), Child abuse and neglect in the UK today. Available at: https://learning.nspcc.org.uk/media/1042/child-abuse-neglect-uk-today-research-report.pdf
71. Office for National Statistics (2020), Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland – Mid-2019: April 2020 local authority district codes. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland
72. London Assembly (2020), Connecting up the care. Available at: https://www.london.gov.uk/sites/default/files/connecting_up_the_care.pdf
73. SafeLives (2017), SafeLives Insights national briefing on children living with domestic abuse. Available at: https://safelives.org.uk/insights-national-briefing-children
74. SafeLives (2020), Marac National Dataset 2019/20. Available at: https://safelives.org.uk/practice-support/resources-marac-meetings/latest-marac-data
75. In October 2020, there were 215,200 NHS staff in London (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/october-2020). The gender split is approximately 77 per cent women and 23 per cent men, resulting in approximately 165,700 female employees and 49,500 male employees (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/september-2020). Given the prevalence statistics highlighted by the CSEW, this suggests 12,100 female

NHS employees and 1,800 male NHS employees experienced DA in the last year. (https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020).
76. Cavell Nurses' Trust (2019), Skint, shaken yet still caring. Available at: https://www.cavellnursestrust.org/wp-content/uploads/2019/06/Skint-shaken-yet-still-caring-Key-Findings-Cavell-Nurses-Trust-Final.pdf
77. The CSEW estimates 33.1 per cent of those who experience partner abuse went on to receive medical attention following the abuse. On the basis of the CSEW prevalence figures (year ending March 2020) and mid-year population estimates, we estimate 266,000 Londoners experienced partner abuse in the last year, resulting in around 88,000 who received medical attention.https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/partnerabuseindetailappendixtables
78. Home Office estimates, domestic abuse costs health services £2.3 billion per annum, with an average cost of £1,200 per victim (with a total cost per victim of £34,015)
79. SafeLives (2016), A Cry for Health: Why we must invest in domestic abuse services in hospitals. Available at: https://safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf
80. Barbosa, E.C. et al. (2018), Cost-effectiveness of a domestic violence and abuse training and support programme in primary care in the real world. Available at: https://bmjopen.bmj.com/content/8/8/e021256
81. SafeLives (2018), Barnet, Enfield and Haringey Mental Health NHS Trust: Mental Health Idva pilot evaluation 2018 (LINKS). Available at: https://safelives.org.uk/sites/default/files/resources/BEH-MHT%20LINKS%20pilot%20evaluation.pdf
82. https://www.london.gov.uk/sites/default/files/vawg_strategy_2018-21.pdf
83. IRISi (2020), London's Violence Reduction Unit invests £1m in boosting doctors' skills in identifying and supporting victims of domestic abuse through the IRIS programme. Available at: https://irisi.org/londons-violence-reduction-unit-invests-1m-in-boosting-doctors-skills-in-identifying-and-supporting-victims-of-domestic-violence-through-the-iris-programme/
84. Scottish Violence Reduction Unit (Undated), About us. Available at: http://www.svru.co.uk/about-us/
85. HM Government (2018), Serious Violence Strategy. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/698009/serious-violence-strategy.pdf
86. O'Connor, Rosanna (2021), Tackling Violence Against Women and Girls, Public Health England. Available at: https://publichealthmatters.blog.gov.uk/2021/03/16/tackling-violence-against-women-and-girls
87. Local Government Association (2018), The relationship between family violence and youth offending. Available at: https://www.local.gov.uk/sites/default/files/documents/15%2034%20-%20The%20relationship%20between%20family%20violence%20and%20youth%20offending-V4_1.pdf
88. Waltham Forest (2019) Triggers to violence https://walthamforest.gov.uk/sites/default/files/%27Triggers%20to%20violence%27%20FINAL.docx
89. Children's Commissioner (2019) Keeping kids safe: Improving safeguarding responses to gang violence and criminal exploitation: https://dera.ioe.ac.uk/32954/1/CCO-Gangs.pdf
90. SafeLives (2015) Young people and interpersonal violence: final data report from the young people's programme: http://www.safelives.org.uk/sites/default/files/resources/Young%20people%20and%20interpersonal%20violence-%20final%20data%20report%20from%20the%20young%20people%27s%20programme.pdf
91. SafeLives (2015) Young people at risk of child sexual exploitation Research briefing for professionals working with young people: http://www.safelives.org.uk/sites/default/files/resources/SafeLives%20research%20briefing%20-%20young%20people%20at%20risk%20of%20CSE.pdf
92. Jury-Dada, S. (2018), #GirlsAndGangs: Girls, gangs and their abusive relationships. Available at: https://www.wcmt.org.uk/sites/default/files/report-documents/Jury-Dada%20S%202018%20Final.pdf
93. GLA (2018), Progressing a Public Health Approach to Violence Prevention and Reduction, Appendix A: Proposed Public Health Approach. Available at: https://www.london.gov.uk/moderngovmb/documents/s62485/04b%20SYV%20PH%20Appendix%20A%20-%20Report.docx?CT=2
94. HM Government (2019), A whole-system multi-agency approach to serious violence prevention: A resource for local system leaders in England. Available at: https://assets.publishing.service.

gov.uk/government/uploads/system/uploads/attachment_data/file/862794/multi-agency_approach_to_serious_violence_prevention.pdf
95. There are 18 Acute Trusts in London, which run 38 hospitals. 33 of these have Emergency Departments (EDs), Urgent Care Centres (UCCs) or Urgent Treatment Centres (UTCs).
96. We recommend a minimum of two Idvas per acute hospital trust, totalling 36 Idvas, costing £50,000 pa each.
97. SafeLives (2015), Getting it right first time. Available at: https://safelives.org.uk/sites/default/files/resources/Getting%20it%20right%20first%20time%20-%20complete%20report.pdf
98. Office for National Statistics (2018), Domestic abuse: findings from the Crime Survey for England and Wales: year ending March 2018. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusefindingsfromthecrimesurveyforenglandandwales/yearendingmarch2018#effects-of-partner-abuse-and-medical-support
99. SafeLives (2016), A Cry for Health: Why we must invest in domestic abuse services in hospitals. Available at: https://safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf
100. SafeLives (2016), A Cry for Health: Why we must invest in domestic abuse services in hospitals. Available at: https://safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf
101. GLA (2018), A Safer City for Women and Girls: The London Tackling Violence Against Women and Girls Strategy 2018-2021. Available at: https://www.london.gov.uk/sites/default/files/vawg_strategy_2018-21.pdf
102. Dheensa, S., Halliwell, G., Daw, J., Jones, S.K., Feder, G. (2020), "From taboo to routine": a qualitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse. BMC Health Serv Res 20, 129 (2020). https://doi.org/10.1186/s12913-020-4924-1
103. Solace (Undated), Major Trauma Centres. Available at: https://www.solacewomensaid.org/get-help/other-support-services/major-trauma-centres
104. MOPAC (2020), Youth Independent Domestic Violence Advocates. Available at: https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/governance-and-decision-making/mopac-decisions-0/youth-independent-domestic-violence-advocates
105. Feder, G. et al. (2011), Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised control trial. Available at: https://doi.org/10.1016/S0140-6736(11)61179-3
106. Feder, G. et al. (2011), Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised control trial. Available at: https://doi.org/10.1016/S0140-6736(11)61179-3
107. Feder, G. et al. (2011), Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised control trial. Available at: https://doi.org/10.1016/S0140-6736(11)61179-3
108. Panovska-Griffiths et al, 2020. Available at: https://irisi.org/wp-content/uploads/2020/08/ARC-BITE-IRIS-FINAL.pdf
109. IRISi (2020), Improving The General Practice Response To Domestic Violence And Abuse. Available at: https://irisi.org/wp-content/uploads/2020/10/IRIS-National-Report-2020.pdf
110. IRISi (Undated), Our Projects. Available at: https://irisi.org/about-irisi/our-projects
111. Rowlands S, Walker S., (2019). Reproductive control by others: means, perpetrators and effects, BMJ Sex Reprod Health 2019;45:61–67. Available at: https://srh.bmj.com/content/familyplanning/45/1/61.full.pdf
112. IRISi (Undated), IrIS ADViSE. Available at: https://pdfhost.io/v/IoQKR5.Pk_Copy_of_Blue_Simple_University_General_Newsletter.pdf
113. IRISi (Undated), Our Projects. Available at: https://irisi.org/about-irisi/our-projects
114. IRISi (Undated), Our Projects. Available at: https://irisi.org/about-irisi/our-projects
115. https://cdn.ps.emap.com/wp-content/uploads/sites/3/2020/02/200212-Development-of-a-nurse-led-domestic-abuse-service-for-general-practice.pdf
116. Smikle M et al (2020), Development of a nurse-led domestic abuse service for general practice. Nursing Times [online]; 116: 3, 20-23. Available at: https://cdn.ps.emap.com/wp-content/uploads/sites/3/2020/02/200212-Development-of-a-nurse-led-domestic-abuse-service-for-general-practice.pdf
117. Howard, L.M., Trevillion, K., & Agnew-Davies, R. (2010). Domestic violence and mental health. International Review of Psychiatry; 22(5): 525-34. DOI: 10.3109/09540261.2010.512283.
118. Trevillion, K., Corker, E., Capron, L.E. & Oram S. (2016). Improving mental health service responses to domestic violence and abuse. International Review of Psychiatry, 28 (5): 423-432.

DOI: 10.1080/09540261.2016.1201053.
119. Walby, S. (2004), The Cost of Domestic Violence. Available at: https://eprints.lancs.ac.uk/id/eprint/55255/1/cost_of_dv_report_sept04.pdf
120. Agenda (2016), Hidden Hurt: Violence, abuse and disadvantage in the lives of women. Available at: https://weareagenda.org/wp-content/uploads/2015/11/Hidden-Hurt-full-report1.pdf
121. MOPAC (2019), London Domestic Homicide Review (DHR): Case Analysis and Review of Local Authorities DHR Process. Available at: https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5f633ee1e0e0be6ec5b858a1/1600339696014/Standing+Together+London+DHR+Review+Report.pdf
122. Howard, L.M., Trevillion, K., & Agnew-Davies, R. (2010). Domestic violence and mental health. International Review of Psychiatry; 22(5): 525-34. DOI: 10.3109/09540261.2010.512283.
123. Aitken, R., Munro, V.E. (2018), Domestic abuse and suicide. Available at: https://www.refuge.org.uk/wp-content/uploads/2020/08/NEW-Suicide-Report-HIGH.pdf
124. Khalifeh H, Moran P, Borschmann R, Dean K, Hart C, Hogg J, Osborn D, Johnson S, Howard LM. Domestic and sexual violence against patients with severe mental illness. Psychol Med. 2015 Mar;45(4):875-86. doi: 10.1017/S0033291714001962. Available at: https://pubmed.ncbi.nlm.nih.gov/25180908/
125. Khalifeh H, Moran P, Borschmann R, Dean K, Hart C, Hogg J, Osborn D, Johnson S, Howard LM. Domestic and sexual violence against patients with severe mental illness. Psychol Med. 2015 Mar;45(4):875-86. doi: 10.1017/S0033291714001962. Available at: https://pubmed.ncbi.nlm.nih.gov/25180908/
126. Siddiqui, H., Patel, M. (2010), Safe and Sane: A Model of Intervention on Domestic Violence and Mental Health, Suicide and Self-harm Amongst Black and Minority Ethnic Women. Available at: https://southallblacksisters.org.uk/news/download-safe-and-sane-report/
127. Government Equalities Office (2018), National LGBT Survey: Research report. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721704/LGBT-survey-research-report.pdf
128. Aitken, R., Munro, V.E. (2018), Domestic abuse and suicide. Available at: https://www.refuge.org.uk/wp-content/uploads/2020/08/NEW-Suicide-Report-HIGH.pdf
129. Siddiqui, H., Patel, M. (2010), Safe and Sane: A Model of Intervention on Domestic Violence and Mental Health, Suicide and Self-harm Amongst Black and Minority Ethnic Women. Available at: https://southallblacksisters.org.uk/news/download-safe-and-sane-report/
130. Siddiqui, H., Patel, M. (2010), Safe and Sane: A Model of Intervention on Domestic Violence and Mental Health, Suicide and Self-harm Amongst Black and Minority Ethnic Women. Available at: https://southallblacksisters.org.uk/news/download-safe-and-sane-report/
131. Trevillion, K.; Byford, S.; Cary, M.; Rose, D.; Oram, S.; Feder, G.; Agnew-Davies, R.; Howard, L. M., (2013). Linking abuse and recovery through advocacy: an observational study. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6998308/
132. Trevillion, K.; Byford, S.; Cary, M.; Rose, D.; Oram, S.; Feder, G.; Agnew-Davies, R.; Howard, L. M., (2013). Linking abuse and recovery through advocacy: an observational study. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6998308/
133. Trevillion, K.; Byford, S.; Cary, M.; Rose, D.; Oram, S.; Feder, G.; Agnew-Davies, R.; Howard, L. M., (2013). Linking abuse and recovery through advocacy: an observational study. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6998308/
134. https://avaproject.org.uk/wp/wp-content/uploads/2016/11/AVA-Promoting-recovery-in-mental-health-1-1.pdf
135. Barnet Safer Communities Partnership Board (2021), Preventing and Responding to Violence against Women and Girls & Domestic Abuse (VAWG & DA) - Annual Report (Jan 2021). Available at: https://barnet.moderngov.co.uk/documents/s62866/VAWG%20Annual%20Report_SCPB.pdf
136. Barnet Safer Communities Partnership Board (2021), Preventing and Responding to Violence against Women and Girls & Domestic Abuse (VAWG & DA) - Annual Report (Jan 2021). Available at: https://barnet.moderngov.co.uk/documents/s62866/VAWG%20Annual%20Report_SCPB.pdf
137. “PATH trial for domestic violence survivors”, PLOS One (2018), Ferrari G et al.
138. There are ten Mental Health Trusts in London (below) and we recommend a minimum of two Idvas per trust, at a cost of £50,000 pa each.
    - Barnet, Enfield and Haringey Mental Health NHS Trust
    - Camden and Islington NHS Foundation Trust
    - Central and North West London NHS Foundation Trust
    - East London NHS Foundation Trust

- North East London NHS Foundation Trust
- Oxleas NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust
- South West London and St George's Mental Health NHS Trust
- Tavistock and Portman NHS Foundation Trust
- West London NHS Trust

139. The Health Foundation (2020), How has COVID-19 affected service delivery in GP practices that offered remote consultations before the pandemic? Available at: https://www.health.org.uk/news-and-comment/charts-and-infographics/how-has-covid-19-affected-service-delivery-in-gp-practices
140. Office for National Statistics (2020), Sexual orientation, UK. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/datasets/sexualidentityuk
141. PHE (2017), Producing modelled estimates of the size of the lesbian, gay and bisexual (LGB) population of England. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585349/PHE_Final_report_FINAL_DRAFT_14.12.2016NB230117v2.pdf
142. Trust for London (Undated), The age distribution of the population. Available at: https://www.trustforlondon.oons rg.uk/data/population-age-groups/#:~:text=Population%20by%20age-groups%20(2019),-Data%20source&text=London's%20population%20is%20comparatively%20young,40.3%20in%20the%20UK%20overall.&text=The%20largest%20five-year%20age,in%20the%20rest%20of%20England. [Accessed 19/03/21]
143. Office for National Statistics (2020), Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland – Mid-2019: April 2020 local authority district codes. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland
144. GLA (2019), London's diverse population. Available at: https://data.london.gov.uk/dataset/london-s-diverse-population- [Accessed 15/03/21]
145. Office for National Statistics (2017), Graduates in the UK labour market: 2017. Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/articles/graduatesintheuklabourmarket/2017
146. GLA (2019), London's diverse population. Available at: https://data.london.gov.uk/dataset/london-s-diverse-population- [Accessed 15/03/21]
147. Office for National Statistics (2020), Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland – Mid-2019: April 2020 local authority district codes. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland
148. SafeLives (2021), Insights IDVA dataset 2019-20: Adult Independent domestic violence advisor (Idva) services. Available at: https://safelives.org.uk/sites/default/files/resources/Idva%20Insights%20Dataset%20201920.pdf
149. London Assembly Police and Crime Committee (2020), Domestic Abuse. Available at: https://www.london.gov.uk/sites/default/files/pcc_domestic_abuse_report_april_2020.pdf
150. SafeLives (2019), Psychological Violence. Available at: https://www.safelivesresearch.org.uk/Comms/Psychological%20Violence%20-%20Full%20Report.pdf
151. n=47 survivors responded to this question
152. n=17 survivors who did not realise/didn't realise at first/were not sure responded to the question
153. The Migration Observatory (2020), Migrants in the UK: an overview. Available at: https://migrationobservatory.ox.ac.uk/resources/briefings/migrants-in-the-uk-an-overview/
154. Quoted in Savera (2020), No Recourse to Public Funds leaves migrant victims in the lurch. Available at: https://www.saverauk.co.uk/2020/08/10/no-recourse-to-public-funds-migrants/
155. LAWRS (2019), The right to be believed: Migrant women facing Violence Against Women and Girls (VAWG) in the 'hostile immigration environment' in London. Available at: https://stepupmigrantwomen.org/research-righttobebelieved/
156. LAWRS (2019), The right to be believed: Migrant women facing Violence Against Women and Girls (VAWG) in the 'hostile immigration environment' in London. Available at: https://stepupmigrantwomen.org/research-righttobebelieved/
157. NHS England (2015), Patient registration standard operating principles for primary medical care (general practice). Available at: https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2019/04/patient-registration-standard-operating-principles-nov-2015.pdf
158. NHS England (2017), Primary Medical Care Policy and Guidance Manual (PGM). Available at:

https://www.england.nhs.uk/publication/primary-medical-care-policy-and-guidance-manual-pgm/
159. Hodson, N., Ford, E., Cooper, M., (2019), Adherence to guidelines on documentation required for registration to London GP practice websites: a mixed-methods cross-sectional study. British Journal of General Practice 2019; 69 (687): e731-e739. DOI: 10.3399/bjgp19X705581
160. Gov.uk (2019), Indefinite leave to remain in the UK: your rights and status. Available at: https://www.gov.uk/guidance/indefinite-leave-to-remain-in-the-uk
161. Wooley, A. (2019), Access denied: The cost of the 'no recourse to public funds' policy. Available at: https://static1.squarespace.com/static/590060b0893fc01f949b1c8a/t/5d021ada54e8ee00013fe5b9/1560419116745/Access+Denied+-+V12+%281%29.pdf
162. EVAW (Undated), Women living in a hostile environment. Available at: https://www.endviolenceagainstwomen.org.uk/wp-content/uploads/FINAL-living-in-a-hostile-environment-for-Web-and-sharing-.pdf
163. Southall Black Sisters (2020), Written evidence submitted by South Black Sisters. Available at: https://publications.parliament.uk/pa/cm5801/cmpublic/DomesticAbuse/memo/DAB18.htm
164. SafeLives (2020), My Story Matters: #TalkAboutToxic, Survey results. Available at: https://safelives.org.uk/sites/default/files/resources/Talk%20about%20toxic%20survey%20results%20Report.pdf
165. GLA (2018), A Safer City for Women and Girls: The London Tackling Violence Against Women and Girls Strategy 2018-2021. Available at: https://www.london.gov.uk/sites/default/files/vawg_strategy_2018-21.pdf
166. The King's Fund (2020), Integrated care systems explained: making sense of systems, places and neighbourhoods. Available at: https://www.kingsfund.org.uk/publications/integrated-care-systems-explained
167. NHS Digital (2020), About the NHS Outcomes Framework (NHS OF). Available at: https://digital.nhs.uk/data-and-information/publications/ci-hub/nhs-outcomes-framework [Accessed 04/03/21]
168. SafeLives (2020), A Safe Fund: costing domestic abuse provision for the whole family, Available at: https://safelives.org.uk/sites/default/files/A%20Safe%20Fund%20costing%20domestic%20abuse%20provision%20for%20the%20whole%20family%20in%20England%20and%20Wales_0.pdf
169. NHS Confederation (2019), Unfinished business: the need to invest in the whole health and care system. Available at: https://www.nhsconfed.org/resources/2019/06/unfinished-business-the-need-to-invest-in-the-whole-health-and-care-system
170. Pathfinder (2020), Pathfinder Toolkit. Available at: https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5ef35f557271034cdc0b261f/1593007968965/Pathfinder+Toolkit_Final.pdf
171. Pathfinder (2020), Pathfinder Key Findings Report. Available at: https://safelives.org.uk/sites/default/files/resources/Pathfinder%20Key%20Findings%20Report_Final.pdf
172. MOPAC (2019), London Domestic Homicide Review (DHR): Case Analysis and Review of Local Authorities DHR Process. Available at: https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5f633ee1e0e0be6ec5b858a1/1600339696014/Standing+Together+London+DHR+Review+Report.pdf
173. Dheensa, S. (2020). Recording and sharing information about domestic violence/abuse in the health services: Research report and good practice recommendations for healthcare. Available at: https://research-information.bris.ac.uk/ws/portalfiles/portal/248068597/FINAL_REPORT_Recording_and_sharing_DVA_information_in_healthcare.pdf
174. Pathfinder (2020), Pathfinder Key Findings Report. Available at: https://safelives.org.uk/sites/default/files/resources/Pathfinder%20Key%20Findings%20Report_Final.pdf

SafeLives
Office 5.04, Floor 5, HubHub,
20 Farringdon Street,
London, EC4A 4EN

Suite 2a, White Friars
Lewins Mead
Bristol, BS1 2NT

0117 403 3220
info@safelives.org.uk
safelives.org.uk

Charity no: 1106864
Company: no: 5203237
Scottish Charity reference number SCO48291