WISH CENTRE ARTICLE

HEALTHCARE AND DOMESTIC ABUSE

In this article we explore the relationship between domestic abuse, health and how the health sector can respond. The issues have a national resonance which we find repeated in our own local area in Lancashire.

The nature of abuse is itself opaque: it's hidden from view and very often goes unrecognised or unacknowledged (at first) by victims themselves. Health services are faced with difficult barriers to overcome before victims come forward, can be identified or before support can be provided from a health, or indeed any other service.

Nor are we under any illusion that this is a problem faced by a small minority of individuals on the margins: domestic abuse is the leading cause of morbidity for women aged 19-44, greater than cancer, war and road traffic accidents. And abuse doesn't stop after a certain age: older victims experience abuse for twice as long before seeking help as those aged under 61.

A Survivor's Insights

The experiences and story of Sami, one of our former service users at the WISH Centre reminds us of these realities from a survivor's perspective – a reality check for how we need to design, develop and deliver our services and support. As we can see from Sami's insights, the pattern of abuse seldom follows a neat and convenient path where abuse takes place, the victim seeks immediate help, receives support, the perpetrator leaves or stops and all is well again. If only!

Sami is a young mum with 4 children and has been able to put her abuse well into the past now, leads a fulfilling and successful life, and now maintains her contact with the WISH Centre as a very highly valued volunteer. She spoke recently about how, looking back, she had been in complete denial for a long time about the abuse she had been experiencing. She made these points about her experience:

- The violence started 6 months into her relationship, but it took her 4 years to realise it. Many victims don't recognise that abuse is actually taking place.
- As she said: "I needed help, but I just didn't realise it."
- She didn't immediately come forward for help - on average nationally a victim experiences assault 35 times before reaching out.
- The victim is not always ready to acknowledge the abuse and to seek help. In Sami's case she wouldn't have answered "yes" to the question if or when first asked by a health professional.
- No health professional Sami saw ever asked her about abuse anyway – this despite the fact that, as a mum of 4 children, she had multiple contacts with different parts of primary care during the long years she was suffering abuse at the hands of her partner.

How does a victim come to live in denial of the abuse they are experiencing? Sometimes victims are deprived of the opportunity to disclose that abuse. In Sami's case, she gradually came to realise that she had been psychologically manipulated, coerced and controlled by her partner into this state of denial which took her a long time with plenty of support to overcome. Sami's experience is very common:

- The perpetrator typically accompanies the victim when visiting a health professional or listens-in to a telephone consultation, inhibiting disclosure.
- The perpetrator progressively isolates the victim from her friends and family and other sources of help and perspectives.

- This process may come across innocently at first and the control and manipulation may begin as "love-bombing":, *"I like you in that dress, you are my world; I just want to be with you all the time; that other girl isn't really your friend you know…I don't really like you going out with them, just stay with me etc etc."*
- These are the early warning signs: control, isolation, removal of options, and manipulating the victim to remove those options – the motives behind this apparent affection are not innocent.
- Continued physical violence is often not necessary – in some cases it doesn't happen at all; in others it may only happen once – but that "once" is enough for the victim to understand the threat and to know where the boundary lies and which they must not cross.
- Perpetrators want power and control, and they think they are entitled to it.
- Financial control can also inhibit a victim leaving an abusive relationship

Healthcare Services and Responding to Domestic Abuse

In these circumstances, it is vital that every opportunity is taken to dismantle and overcome these obstacles so that victims can be reached, supported and the abuse ended.

The opportunities which healthcare services in general have to overcome these obstacles have become increasingly well researched and understood. Without being specialist DV providers, they have a crucial role to play in responding to domestic abuse which is often less visible to domestic abuse services themselves. Many health care settings are well-placed to spot the signs of domestic abuse early and to offer immediate support and pathways to specialist services.[i]

The University of Bristol (2011) *Commissioning Guidance to the IRIS project (Identification & Referral to Improve Safety),* emphasises that:

> *"We know that victims of violence and abuse trust their family doctor and practice staff… general practice has a key role to play in the health response to DVA… it is the commonest contact point for victims."*

The frustration has been that historically these opportunities have been missed and patients in GP surgeries, community clinics, health centres, maternity units, pharmacies etc and, indeed, hospital A&E departments have seldom been asked the question about possible domestic abuse. Victims frequently tell us that they have never been asked, nor in most circumstances would they offer the information unasked themselves.

As Sami's story makes clear, there is no single moment when victims are necessarily ready to come forward and ask for help. Hence, the importance of health services – who are in most frequent contact with patients on a whole range of health issues often over significant periods of time – to ask the question routinely on each contact. Health settings offer a safe space and location for survivors to disclose abuse and receive specialist support.

The paradox (University of Bristol, 2011) is that:

> *"…often practitioners are reluctant to ask because they do not know how to respond, or what referral paths are open to them. IRIS offers a solution, by providing appropriate training for primary care staff and support to their patients."*

The SafeLives (2009): *Safety in Numbers report* over 10 years ago highlighted many of these issues, showing how physical and mental health problems were found to be more frequent amongst victims of domestic violence and abuse compared to those not abused. And that the high proportion of domestic abuse victims accessing healthcare presented significant opportunities for healthcare professionals to be recognising and responding to abuse.

Similarly, the AVA (2013) *Complicated Matters* toolkit[ii] is an innovative resource to help improve responses to survivors and perpetrators of domestic and sexual violence, substance misuse and mental ill-health. This is the culmination of the Stella Project Mental health Initiative, funded by DH - a multi-practice and partnership project

across Bristol, Nottingham and Hounslow. It comments on the relative neglect of these issues in medical education, noting that:

> *"…domestic or sexual abuse may well be hidden if the GP does not ask about it, undermining efforts to address the mental health or substance abuse problem, ignorant of the trauma that drives them."*

Unfortunately, as the SafeLives' policy report (2015) *Getting it Right First Time* commented, considerable opportunities for victims to access support continued to be missed across the NHS and other health and public services. Reasons cited included a patient's fear of not being believed or validated, shame or embarrassment among victims, a fear of social services involvement, lack of interest from health professionals in wellbeing, lack of time for health professionals to deal with their disclosure, as well as a lack of domestic abuse awareness amongst healthcare professionals

Since then better practice is now being forged in this area. For example, the national *Pathfinder Project* (2017-2020), led by Standing Together (as part of a consortium of expert partners including SafeLives, IRISi, Imkaan and Against Violence and Abuse (AVA). The *Project* has built a case for a "whole health approach" by embedding local health and domestic abuse in governance structures, linking different parts of the health economy and promoting a co-ordinated community response to survivors and perpetrators of domestic abuse, IDVAs placed in healthcare settings, and updated healthcare staff training..

The new *Whole Health London* project led by SafeLives has been informed by the *Pathfinder Project* and has recently (November 2020) launched a new survey to explore the experiences of survivors over the age of 16 when accessing health services across London. The project anticipates a series of roundtables with health and domestic abuse stakeholders across the capital to drive change.

The same issues have been reinforced by Women's Aid in their *Change That Lasts* Impact Briefing 4 (2020) through the *Trusted Programme and Expert Voices initiatives*; and also in the recommendations from the *All-Party Parliamentary Group on DVA* Annual Report (2019) with recommendations on VAWG training for all frontline healthcare staff, including GPs and midwives.

The Wish Centre's Experience

What is our experience in Lancashire?

The picture is mixed. Our staff report at least some good practice with local healthcare providers who clearly recognise the value and need for referrals into specialist DVA provision and contact details. Midwifery and health visitors feature fairly frequently as examples of good practice. Some GP practices are good at enabling IDVAs to see victims at the surgery and GPs occasionally advise clients to contact us. Pharmacies can also be good routes for getting messages safely and privately to a victim.

Wish Centre staff made a concerted effort during the Covid-19 Lockdown to raise awareness in local pharmacies who have been very helpful and co-operative. This summer one of our IDVAs herself presented at her chemist with a foot injury and the pharmacy assistant did actually ask if "things were OK at home", passing over police and Wish Centre contact details; our IDVA reassured her that her injury was a genuine accident but was impressed by the service and the informed response from the pharmacy.

Also, the Wish Centre has long supported the concept of a hospital IDVA and in recent years we have collaborated with the East Lancashire Hospital Trust, providing supervision for this role across the whole of its subregional footprint in Blackburn with Darwen, Burnley, Accrington and Gisburn Park hospitals. It has been effective with consistently good outcomes, both supporting patient admissions who have disclosed abuse in the safe space of hospital and also in supporting hospital staff coming forward to disclose domestic abuse themselves. The links with the hospital IDVA are highly valued in our team.

But overall, the picture is variable and a bit hit-and-miss. Our IDVA staff have commented:

"We rarely get direct referrals from local GPs."

"I haven't had any referrals from the GP themselves."

"I have had three clients who had been to their GPs but they were not asked about DV as mother-in-law, sister-in-law or husband had attended with them."

This is an area where improvements in training and promoting knowledge of pathways to specialist DV services are necessary. This is also true of other local services, including opticians, pharmacies and hairdressers where awareness and protocols are patchy. Opportunities for referrals are being missed, opportunities for victims to disclose are being restricted and necessary support is delayed at best.

As Shigufta Khan, Wish Centre Chief Executive commented:

"There's excellent practice out there nationally now on this issue and the IRIS project is a model which can be applied more widely. I am really pleased to see the positive impact that the hospital IDVA has had on victim referrals in the hospital trust. In addition, there is a commitment on domestic abuse training to improve practice by Lancashire Care Foundation Trust (LCFT) staff to ask service users about domestic abuse."

The cost of DVA to the health service as a whole is £1.7 billion per year with the major costs being to GPs and hospitals. This does not include mental health costs, estimated at an additional £176 million.[iii] It makes sense that specialist DV support is provided as soon as possible for victims presenting in healthcare locations. Given the long-term impact of violence on women's health, women who have suffered abuse are more likely to be long-term users of health services, thereby increasing health care costs.

Despite some local moves in the right direction, better informed and practical relationships and links between healthcare providers and specialist DV services here in Lancashire are needed. This will take resources to build the capacity across healthcare on DVA and to establish clear and well-understood pathways to specialist support for victims, their children and others at risk. From our experience this investment is proving hard to land, despite a template for its effectiveness already being out there.

Bob McDonald, WISH Centre
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[i] DVA is linked to a host of different health outcomes and is a risk factor for a wide range of both immediate and long-term conditions . The health impacts may show as physical symptoms, injuries, chronic pain, neurological symptoms, gastrointestinal disorders, gynaecological problems and increased cardiovascular risk . The patient may be depressed, self-harm, have post-traumatic stress disorder (PTSD), anxiety, insomnia, increased substance use and have thoughts about suicide . Cessation of abuse does not necessarily mean that mental health problems cease as well . The influence of abuse can persist long after the abuse itself has stopped and the more severe the abuse, the greater its impact on physical and mental health. DVA can start or escalate in pregnancy with the most serious outcome being the death of the mother or the foetus. It is also associated with low birth weight and premature birth, both of which have subsequent long term health effects.

[ii] AVA – Against Violence and Abuse (2013) *Complicated Matters: A toolkit addressing domestic and sexual violence, substance misuse and mental ill-health.*

[iii] *Walby S . The cost of domestic violence: Update 2009. Lancaster: Lancaster University; 2009*