

Key findings from Pathfinder Survivor Consultation (Phase 2)

CONTENTS

SECTION ONE: INTRODUCTION

SECTION TWO: METHODOLOGY

- Face to face consultation
- Online consultation
- Summary of data collected and demographic data
- Research framework, ethics and limitations

SECTION THREE: SURVIVOR CONSULTATION FINDINGS

- Summary of key themes
- Summary of
- Key findings and evidence base
- Impact on survivors

SECTION FOUR: EMBEDDING PROMISING PRACTICE

SECTION FIVE: RECOMMENDATIONS

- Recommendations for Pathfinder sites
- Recommendations for National policy makers

SECTION SIX: CONCLUSION

APPENDICES

SECTION ONE: INTRODUCTION

The Pathfinder Project seeks to develop best practice responses to domestic abuse and violence against women and girls in health settings. At the heart of the project is the core aim to ensure health systems are effectively and appropriately responding to survivors' needs.

The survivor consultations carried out capture the voices of local survivors in each site. Survivors taking part in the consultations were given the space to share their experiences of local health systems and services, and the opportunity to discuss experiences of their local primary care, acute health and mental health services.

This report presents the findings from the survivor consultation exercise, identifying key themes across the data. Sites have been anonymised and randomly assigned letters (A-E) for confidentiality purposes.

This report identifies promising practice in each site, before outlining how each area has taken steps to embed and build on good practice. Recommendations are then provided outlining a) recommendations for Pathfinder pilot sites and b) recommendations for systems change and national policy makers.

Direct quotes from survivors are presented in text boxes throughout the report.

In addition to this report, each site taking part in the consultation will be provided with a site specific briefing outlining the findings relevant to their local area.

Key learning identified by phase 2 of the Pathfinder survivor consultation should shape the final planning process for Pathfinder site work.

SECTION TWO: METHODOLOGY

In August 2018 the Pathfinder consortium carried out a survivor consultation in sites 1-3. With the expansion of the Pathfinder project to 5 new sites across England, the Pathfinder consortium set out to capture the voices of survivors in the new geographical areas taking part in the project (site 4-8).

In this second phase of the survivor consultation, the Pathfinder consultation was carried out using both face to face focus groups as well as an online consultation tool. The consultation process was led by consortium partners AVA and Imkaan.

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

A) Face to face consultation

In order to carry out face to face consultation with survivors living in the 5 Pathfinder sites, Pathfinder partners sought to deliver 2 focus groups in each area: one focus group specifically for BME survivors, and the second open to survivors from any background.

Strand one of focus group delivery :

Strand one of the delivery sought to establish one focus group per site that specifically engaged BME survivors. This was to ensure a safe space was provided for BME survivors to take part in the face to face consultations and to share their experiences.

As part of this strand of the face to face consultation Imkaan sought to communicate with specialist BME service providers, support networks and groups in each of the 5 sites. In 3 of the areas no such providers and services existed. In the 2 areas where such services or groups did exist, providers did not feel able to support with the consultation due to limited capacity. As a result strand one of the face to face consultations were not possible to deliver and the initial methodology was revised.

Strand two of focus group delivery:

The second strand of the face to face consultation sought to establish one focus group per site that was open to survivors from any background. Unfortunately one site was unable to deliver the focus group due to non attendance of women, therefore focus groups were held in 4 Pathfinder sites.

Focus groups were set up in partnership with specialist domestic abuse/ violence against women and girls service provider. Local providers were invited to submit an application outlining their capacity and ability to safely and ethically deliver a focus group with a group of 6 - 12 service users. One local specialist VAWG service in each site was then selected, based on applications received and supported through the organisation and delivery of the focus group.

Specialist services were provided with a full guidance document, on-going support and resources from AVA. This included guidance on recruitment, preparation, delivery and follow up stages, as well as all the resources needed to carry out each stage.

In the 4 sites that were able to deliver focus groups, an average of 8 women per group took part.

B) Online consultation

In addition to face to face consultation, AVA and Imkaan developed an online consultation tool. This digital survey was open to all survivors based in any of the relevant 5 Pathfinder pilot site areas. The survey was circulated to specialist services as well as key stakeholders in all 5 sites via the Pathfinder site leads.

C) Summary of participants and demographic data

A total of 43 women took part in the Pathfinder survivor consultation.

- **32 women were involved in face to face consultations across 4 of the Pathfinder areas.**
- **11 women took part in the online consultation from 3 of the Pathfinder sites.** One respondent did not provide consent for her responses to be included, therefore is not represented in this report.

The following provides an overview of the demographic data collected for all survivors taking part in either part of the consultation process (face to face or online)¹:

¹ Survivors taking place in the face to face consultations were asked to complete a pre-focus group questionnaire in order to capture demographic data as well as information relating to which health services they had accessed. Those taking part in the online consultations were similarly asked to provide similar data via the online form

100% of participants were women.²

Participants ranged from aged 22 to 68. In focus groups, the average age of the participants was 42. In the online consultation, the majority of respondents (56%) fell into the 35-44 age bracket.

14 participants (33%) identified that they were from black or minority ethnic backgrounds. Representation of BME survivors in the consultation varied greatly from site to site.

13 participants (30%) indicated they were disabled.³

No women identified that they were LGBTQ+.

Those taking part in focus groups or the online consultation indicated that they had accessed a range of health services in their local area over the last 12 months⁴. This included:

- 28 survivors had accessed a local General Practice in the last 12 months
- 18 participants⁵ had accessed mental health in the last 12 months
- 9 participants⁶ had accessed A&E in the last 12 months

The following provides an overview of participants taking part in face to face and online consultations in each Pathfinder site. For ethical reasons, sites have been anonymised.

² For face to face focus groups, Pathfinder partners worked specifically with specialist providers working with women who have experienced violence against women and girls. For online consultation, the survey did not specify that survivors must be female.

³ In focus groups, the qualitative data collected evidences that representation of those living with disability was complicated by what constituted a disability - some considered mental health to be so, whilst others who spoke of having mental health problems during the focus groups did not self-identify as disabled.

⁴ The majority of online survey respondents did not provide data relating to what services they had accessed in the last 12 months

⁵ No data relating to MH service access in last 12 months was provided by those taking part in the online survey

⁶ No data relating to Acute health service access in last 12 months was provided by those taking part in the online survey

Site	Focus group	Online survey
A	<p>#Participants: 11</p> <p>Health accessed: GP, A&E, Mental Health Services, Alcohol and/or Substance Abuse Services, Dentist</p>	<p>#Participants: 0</p> <p>Health accessed: /</p>
B	<p>#Participants: 0</p> <p>Health accessed: /</p>	<p>#Participants: 3</p> <p>Health accessed: GP, mental health services</p>
C	<p>#Participants: 8</p> <p>Health accessed: GP, A&E, Mental Health Services, Health Visitors</p>	<p>#Participants: 0</p> <p>Health accessed: /</p>
D	<p>#Participants: 5</p> <p>Health accessed: GP, A&E, Mental Health Services, Urgent Care Centre, Sexual Health Clinic</p>	<p>#Participants: 2</p> <p>Health accessed: GP, mental health services</p>
E	<p>#Participants: 8</p> <p>Health accessed: GP, A&E, Mental Health Services</p>	<p>#Participants: 4</p> <p>Health accessed: Not indicated</p>

D) Research framework, ethics and limitations

Research framework

AVA and Imkaan developed the consultation framework and research questions to be used in focus groups (see Appendix A), as well as designing an online survivor consultation tool (see Appendix B).

The research framework used for both data collection methods built on learning from phase one of the survivor consultation, held with sites 1 – 3.

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

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

Data analysis

Data was thematically analysed using Nvivo software and SurveyMonkey.

Ethical considerations

- Survivor consultations were developed and delivered in accordance with thorough ethical standards and considerations. Appropriate ethical considerations were made and adapted in line with the Data Protection Acts of 1998 and 2018. This included ensuring informed consent, safeguarding participant well-being, and securely handling all data.
- All survivors taking part in face to face consultations were given a £15 Love2Shop voucher to thank them for their time.
- Focus group facilitators safely and ethically shared the data collected with AVA.

Research limitations

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

- There were a number of gaps in the data provided. For example, 2 Pathfinder areas did not provide any data for the online survey; 1 Pathfinder area did not provide any data from face to face consultations. Pathfinder sites are therefore not equally represented in the dataset and in this report.
- Furthermore, no BME specific focus groups were held. While 14 BME women were able to take part in the survivor consultation via focus groups or the online survey, BME-only spaces might have brought about different perspectives. Voices that we would have liked to have captured are therefore missing from the data set.
- The number responding to online survey was low. It was hoped that the online tool would provide a resource for survivors who did not have the opportunity to take part in a focus group to participate in the consultation process. Despite the circulating the survey many times with local specialist services and key stakeholders in Pathfinder areas, take up of the survey was poor.

- No participants indicated that they identified as LGBTQ+. This may need us to consider other ways we can engage and make the process more participatory.
- Further gaps in the data provided are evident. For example, there were many gaps in the data captured via the online survey, with respondents providing unclear information or leaving questions blank.

SECTION THREE: SURVIVOR CONSULTATION FINDINGS

The consultations provided survivors with the opportunity to share their experiences and highlight what they would like to see in local health services.

In all 4 focus groups, survivors had accessed services in all three key areas of health - primary (General Practices), acute, and mental health. Those responding to the online consultation had accessed GP and/or mental health services.

Across all focus groups as well as the survey responses, survivors' spoke most frequently and in most detail about their experiences of General Practitioners (GPs). This reflects the fact that the General Practice was the most commonly accessed health service.

Additional health professionals and services discussed by survivors include :

- Sexual health services
- Dentists
- Health visitors
- Alcohol and/or substance abuse services
- Urgent care centres

SUMMARY OF KEY THEMES

WHAT DO SURVIVORS WANT TO SEE?

The following outlines the key themes identified across the focus groups, identifying what survivors want to see in their local health services.

Expressions of what they wanted to see in place for effective responses to survivors fell into three key categories:

- A. health systems and processes
- B. service availability and accessibility
- C. professional responses

A. Health systems and processes:

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

B. Service availability and accessibility:

- **Survivors want to see a range of mental health/ therapeutic services being offered to them alongside medication**
- **Survivors want longer health appointments**

- **Survivors want to see shorter waiting times for mental health services and therapeutic options**
- **Survivors want a health system that is able to meet their particular needs, rather than a one size fits all approach. This includes access to BME specific and specialist support.**
- **Survivors want accessible systems for booking appointments**
- **Survivors want the option to see female health professionals**
- **Survivors want to see a consistent health professional whom they are able to trust**

C. Professional response:

- **Survivors want to feel heard and listened to by all professionals in health services**
- **Survivors want to feel respected by all professionals in health services, and want professionals to respond without judgment and without stereotyping**
- **Survivors want to know they will be believed if/when they disclose abuse**
- **Survivors want health professionals to fully understand the dynamics of abuse, and their experiences of trauma**
- **Survivors want health professionals to consistently pick up on signs/ indicators of abuse, and to ask them more questions about what is going on/ demonstrate professional curiosity**
- **Survivors want health professionals to understand how perpetrators might also present in the health system/ services**

KEY MESSAGES FROM SURVIVORS

In both online and face to face consultations, participants were asked to provide any final key messages for health services in their local area.

Key messages largely mirror the key themes and 'asks' identified above.

Examples of key messages provided by survivors from across the 5 Pathfinder sites include:

- It is great to see the vast majority of professionals being helpful
- It is great to see you saving lives with fast responses, thank you
- I would like to see GPs being proactive rather than reactive
- I would like to be listened to without prejudice
- I would like to see a gender-based trauma response team or member of staff with training on gender-based trauma in mental health services
- I would like to see more consistency between services
- I would like to see psychological abuse considered just as debilitating as physical abuse
- I would like to see more ethnic/cultural diversity in counselling teams
- I would like to see drastic behaviours being acknowledged as a cry for help
- I would like to be checked up on repeatedly
- I would like to see good explanations of diagnoses, how they affect you, others and general aspects of life

All key messages submitted by participants can be found in Appendix C.

KEY FINDINGS AND SUPPORTING EVIDENCE

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

A. HEALTH SYSTEMS AND PROCESSES

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

1) Information sharing

Survivors taking part in the Pathfinder survivor consultation repeatedly highlighted the need for consistent and safe information sharing. Indeed, this theme was discussed by survivors in all but one of the Pathfinder areas.

Participants experiences of information sharing varied greatly. 2 respondents to the online survey identified that their experiences of information sharing by health services in their local area had been positive; in 2 of the focus groups, participants also discussed experiences of positive information sharing. For example, one survivor outlined how effective information sharing between her General Practitioner and the police force enabled her to be effectively safeguarded and prevented a perpetrator from entering her home.

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

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

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

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

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

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

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

One participant noted feeling discriminated against as an asylum seeker when her information was shared without her consent.

Participants also expressed concerns regarding a lack of clear record taking in health services, or health professionals failing to review any of their relevant records. Many women shared that they had been asked to retell their stories over and over again – each narration was re-traumatising, and took away valuable time from the appointment.

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

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

2) Communication and follow up

Another key theme emerging across the Pathfinder areas taking part in the survivor consultation was the need for effective communication, consistent follow up and effective routes for feeding back to health services.

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

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

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

B. SERVICE DELIVERY, AVAILABILITY AND ACCESSIBILITY

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

1) Service delivery

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

Women taking part in focus groups articulated the need for services that understood their experiences of multiple disadvantage, and were able to meet their particular needs rather than providing a one size fits all approach.

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

This was also reflected in the online consultation:

“Not everything is text book. Therefore, trying to practically understand the daily struggles of a survivor would be beneficial. This can be achieved by asking the right questions and not necessarily the clinical/tick box questions. Adapt, where necessary. Secondly, check in calls is imperative plus wrap around services, due to the complexity of needs, covers all areas and as such, allows any gaps / vital information not to be missed.”

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

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

One woman taking part in the focus group identified that she was an asylum seeker, and discussed her experience of not feeling believed or understood by health professionals as a result of her experiences.

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

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

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

Indeed, 3 women taking part in the online consultation highlighted the difference that a holistic health service offered had made to their lives – specifically in relation to one of the following: GP and an IDVA that they had had access to and a sexual health service.

“They (sexual health clinic / rape clinic within a hospital) were extremely proactive and took a holistic approach: calling to check if you were okay; offered safety advice;

signposting; follow up appointments with the SH advisors in order to discuss how you were feeling. Always asking if you are safe, which is vital.”

When discussing important key elements of health services they had accessed, those taking part in the focus group articulated the importance of having access to a consistent professional whom they trusted. As one focus group participant noted regarding her GP, this can make a huge difference.

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

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

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

Women also articulated that, when they had been able to get appointments with their GP these had often been rushed; short appointment times meant that they were unable to discuss their experiences comfortably.

(It’s) “Difficult to answer as people don’t have time to talk to you as they are so busy. (We) need specialist workers/information available.”

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

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

The need for accessible processes for booking appointments was also discussed.

2) Availability of, and access to, services

Participants articulated a number of challenges in getting health appointments – both in relation to their GP, as well as mental health services.

Participants across both face to face and online consultations wanted to see a wider range of therapeutic services and mental health support services available to them.

Participants noted a general lack of support available to them, and a lack of choice in therapy options.

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

Indeed, the majority of those responding to the online consultation who had accessed their local Acute health services identified that they had not been offered any further support following their hospital visit⁷.

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

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

“There are services but alas, the waiting times once within the services or even waiting for access to these imperative services is excruciating. Lack of funding and lack of understanding how early intervention or even consistent support for the individual is imperative.”

As one survivor responding to the online survey identifying gaps in her local area stated:

⁷ Whether they had disclosed abuse or not is not evidenced in the data

“(I would like to see...) Interim NHS support whilst waiting for sign posted niche services... Individuals are being signposted but the waiting lists are continuing to grow.”

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

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

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

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

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

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

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

Women taking part in focus groups as well as those responding to the online survey highlighted concerns around the thresholds for accessing mental health support . Women reflected how health services were being delivered, and the extent to which they were able to meet the needs of survivors. One woman, for example, had been told that her trauma wasn’t recent enough for her to get help, another hadn’t been able to access support because she was working and therefore not considered ‘bad enough’ for support.

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

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

C. PROFESSIONAL RESPONSE

- **Survivors want to be asked**
- **Survivors want to feel heard and listened to by all professionals in health services**
- **Survivors want to feel respected by all professionals in health services, and want professionals to respond without judgment and without stereotyping**
- **Survivors want to know they will be believed if/when they disclose abuse**
- **Survivors want health professionals to fully understand the dynamics of abuse, and their experiences of trauma**
- **Survivors want health professionals to consistently pick up on signs/ indicators of abuse, and to ask them more questions about what is going on/ demonstrate professional curiosity**
- **Survivors want health professionals to understand how perpetrators might also present in the health system/ services**

1) Understandings of violence against women and girls

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

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

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

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

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

Participants reflected that professionals often did not ask sufficient or adequate questions, failing to ask 'why' women were presenting with certain symptoms, and failing to identify signs of abuse. Many women shared stories of missed opportunities and lack of understanding in health services/ professionals.

“My situation should have been detected earlier, had it not been for my GP assigned to me, she did not care whatsoever. It just went on, it prolonged my agony, all the confusion and everything.”

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

“I think there is still a very big stereotype around domestic violence despite how the media still talk about it. Maybe professionals just don't want to acknowledge it, maybe they just don't like it, it's not convenient.”

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

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

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

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

A number of BME women taking part in the focus group also highlighted the need for a better understanding regarding their specific experiences; lack of representation, and limited understanding of their specific experiences presented additional barriers to women disclosing abuse and accessing support.

Those taking part in the online consultation were asked to put forward recommendations for their local health services. Recommendations put forward included wanting professionals to ask more probing questions and for professionals to be better educated.

Women taking part in focus groups identified a need for better trauma informed responses, identifying that often professionals did not know how best to respond to those who are suffering from trauma.

2) **Responses to disclosure**

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

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

When asked about their experiences of health services in their local area, respondents to the online consultation shared positive experiences that all focused on the experience of being listened to, heard and believed by professionals.

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

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

“I do feel like I got discriminated against as a woman, that sort of over the top thing - accused of being over the top. I don't think men understand how it feels to be a woman that is scared of them. As far as they are concerned they don't think you should be scared of them. They can't comprehend it. Sometimes it takes a woman to understand the fears we as women feel being surrounded by men.”

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

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

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

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

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

IMPACT ON SURVIVORS

The survivor consultations held highlighted that when the above is not carried out, there is a direct impact on survivors and their families. For example:

- When survivors are not listened to, not believed, or when signs of abuse are not picked up by health professionals, survivors feel abandoned, further adding to their turmoil. Survivors often described a sense of isolation as a result.
- When survivors are asked/forced to retell their stories to different health practitioners they are re-traumatized and are often set back in their recovery. Survivors often felt triggered and spent days recovering from these disclosures and the impact speaking about their experiences had on their mental health.
- When health care professionals do not act on disclosures of abuse (through either advice or referrals) survivors are left feeling more alone and like their suffering has been invalidated. Survivors repeatedly spoke of how this added to feelings of abandonment and vulnerability, whilst also adding to stressful situations, as survivors spent hours scouring the internet to find support or guidance, potentially risking a perpetrator finding them looking for resources.
- When information is shared without the consent of survivors, many feel that their privacy has been infringed and their rights undermined. There were numerous instances shared during the focus groups in which survivors felt that had information been shared accurately and earlier, they would not have had to suffer as long as they had.
- When survivors are treated with a one size fits all approach they feel that they are not being listened to or treated as individuals. This, survivors explained, led to a sense of dehumanization.

“For us, when you’ve made a step and you have, because of a prescription maybe, a step back, it’s like you’re reliving certain things. You went there, opened up, and then you say i’ve closed that door and i’m moving out - but because of one thing you have to re-open that door. The next day you’re just a mess.”

SECTION FOUR: EMBEDDING PROMISING PRACTICE

In both the face to face consultation and online consultation participants shared positive experiences in health care settings. Examples of these have been presented above.

The majority of positive experiences focused on the individual professional response and the delivery of a holistic and empathetic service.

“My GP was really good. Really good. That’s why I stick with her. She knew the case from the beginning, which was good, as I didn’t have to repeat the anxiety and everything that’s happened to me. I didn’t have to repeat the trauma. She understands the case, she knew from the beginning and she does her best.”

“When the incident happened with myself I didn’t go to them I went to a sexual health clinic and the way that they did it was how it should be done. I rang, they just, they asked what happened and I just told them and they said come down immediately. It was only female allowed in there. You stayed in the room, you didn’t go in and out waiting in reception. And, um, they rang and checked up on me.”

“I was nearly sectioned twice...and they helped me come to terms (acute mental health). They didn’t call me a victim, they called me a survivor.”

Pathfinder are currently working with all pilot sites to support them to build on promising practice within their local area.

The following maps out specific examples of promising practice identified by survivors in the site, alongside a selected outline of key activities that have been undertaken in each area:

Site	Examples of good practice identified by survivors	Pathfinder activities undertaken or planned
A	<ul style="list-style-type: none"> ● Primary Care: Examples of positive experiences of GPs, including examples evidencing professional curiosity and a willingness to give referrals ● Acute: Survivors generally had positive experiences in crisis situations 	<ul style="list-style-type: none"> ● Invested in 2 health based domestic abuse workers in the specialist service who identify DA Champions in health settings for specialist training & support for addressing DVA in their service ● Reviewed strategic approach to domestic abuse in health Mental Health Trusts

	<ul style="list-style-type: none"> ● Mental Health: One example of a survivor appreciating the CBT they had been able to access 	<ul style="list-style-type: none"> ● Providing specialist train the trainer training to DA champions in MH Trust ● Providing LGBTQ+ & Disability bespoke training for professionals in MH Trust
B	<ul style="list-style-type: none"> ● Primary care: Examples of survivors having access to sympathetic and helpful General Practitioner . Survivors felt listened to and believed which was crucial to getting the help needed 	<ul style="list-style-type: none"> ● Invested in a Domestic Abuse Project Lead role (CCG) and a Complex Needs IDVA. ● Site lead supporting Domestic Abuse Project lead with developing Health DA strategy including training strategy across County ● Assessment of the Trust's policies and training ● Domestic Abuse Project Lead has created a first draft DA policy ● Provided specialist training to professionals in acute and mental health ● Monthly Trust-wide steering group established
C	<ul style="list-style-type: none"> ● Primary Care: Examples of survivors feeling supported by their GPs, and receiving non-judgemental responses. One survivor discussed how having a GP who visits her at home is incredibly beneficial to her overall health and wellbeing. Another survivor stated how her GPs non-judgemental attitude to self-harm helped her get support. 	<ul style="list-style-type: none"> ● Invested in 2 domestic & sexual abuse advisors in the specialist services who provided DSA training to mental health DV Links in the trust, and also carry a small case load of survivors who have been referred from the MH trust ● Reviewed strategic approach to domestic abuse in health Trusts

	<ul style="list-style-type: none"> ● Acute: Examples of positive experiences of Acute mental health responses, including references to sympathetic and considerate treatment by nurses within acute MH services. One survivor detailed how being called a 'survivor' rather than a 'victim' in this context helped her to feel empowered. 	<ul style="list-style-type: none"> ● Providing specialist training on multiple disadvantage to be provided to professionals in MH Trust
D	<ul style="list-style-type: none"> ● Primary Care: Numerous survivors stated they felt supported by their GP when there was a sympathetic and caring approach taken. ● Acute: Examples of effective information sharing and effective safety planning carried out by health professionals ● Mental Health: Example of effective information sharing 	<ul style="list-style-type: none"> ● Invested in IRIS primary care intervention ● Invested in a Domestic Abuse coordinator, due to be recruited in the two mental health trusts ● Review of Domestic Abuse policies and strategies in Acute Trusts and Mental Health trusts ● Mental Health Trusts launching Domestic Abuse Ambassadors networks in November 2019 ● Development of a Domestic Abuse staff policy to be shared with all trusts
E	<ul style="list-style-type: none"> ● Primary Care: Several examples of positive experiences of empathetic and compassionate GPs. ● Mental Health: Mental health services in the area appeared to be the best received. One survivor detailed how local mental health services were brilliant at accommodating the complexity of her mental health issues; another 	<ul style="list-style-type: none"> ● Invested in 2 specialist mental health IDSVAs into mental health Trust ● Invested additional specialist DA worker into Mental Health Trust safeguarding team ● Review of Trusts strategic approach to domestic abuse in health Trusts

	<p>noted how antenatal counselling had saved her life.</p>	<ul style="list-style-type: none">• Provided specialist training to professionals in Acute and Mental Health Trust
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SECTION FIVE: RECOMMENDATIONS

B) Additional recommendations for health systems and services

Recommendations for Local Authorities/CCG:

- Invest in interventions for survivors within health services, for example the (continued) implementation of IRIS, and embedding Health Idvas in Acute Trusts and Mental Health Trusts.
- Invest in trauma informed responses to violence against women and girls across health services.

Recommendations for statutory and third sector agencies and services across sites:

- Strengthen referral pathways in the local area. This should be done by facilitating workshops between agencies (both statutory and third sector) to understand respective roles, responsibilities and capacity, helping services to understand their 'fit' with the rest of the system. Create a 'general' pathway for survivors that can be relayed to them to help them understand, visualise and navigate the support they are entitled to and the processes this entails
- Identify what BME communities are in the area and review health needs and services available to them
- Specialist services to collaborate with local BME community groups.
- BME groups included in decision making and co-production of local service development
- Set up a BME practitioners' network/ working group

Recommendations for health services:

Interventions

- (Continued) engagement with, and delivery of, IRIS intervention
- Acute Health and Mental Health Trusts should seek to embed a specialist DVA practitioner on-site with them rather than working remotely
- (Continued) engagement and roll out of IRIS model in primary care
- In instances where women must be put on a waiting list to access support (e.g. Mental Health services), interim support should be offered (directly or via referral) for the duration of the waiting period; for example, regular phone calls to check in with survivors, directing women to relevant resources, helplines or women's centers.

Training needs

- Training for all staff working in health care settings, regardless of role, on:
 - ❖ violence against women and girls, the dynamics of abuse and intersectionality

- ❖ asking the right questions and identifying domestic abuse
- ❖ managing disclosures
- ❖ referring to specialist services and referral pathways
- ❖ embedding safety planning into practice
- ❖ appropriate responses and approaches when perpetrators are present
- ❖ additional safeguarding training to ensure women are not put in unsafe situations within the health service
- ❖ trauma and women's mental ill health
- ❖ the knock on effect and impact of abuse, and health responses, on survivor's children and families
- ❖ shifting service culture to ensure women are heard, listened to and believed
- ❖ challenging discrimination against women, survivors, BME women and women with English as a second language
- Training for frontline practitioners should work on the ability to retain compassion and sensitivity in their work even when under great pressure, combating 'compassion fatigue'; and increasing their ability and motivation to explore the root cause of people's problems
- Additional training for GPs regarding submitting health reports to support survivors' legal cases against perpetrators

Information sharing and communications

- Improved information sharing and record keeping both internally and across agencies so that women do not have to keep sharing their stories. There is a need for safe, portable record of someone's experiences, reducing the need for them to keep repeating their stories with high risk of re-traumatisation
- Improve safe follow up of communications sent to survivors if survivors are not responding
- Provide interpretations and multilingual information and support for all women that need
- Increase availability and accessibility of literature and posters on domestic abuse, and embed discrete ways of disclosing abuse into health services practice
- Re-assess policies on consent and information sharing to ensure consistency within agencies. Include survivors in this process

Local accountability

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

C) RECOMMENDATIONS FOR NATIONAL HEALTH POLICY AND PRACTICE

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

- Commit to improving health services responses to domestic abuse and violence against women and girls on a national level
- Promote and support interventions to support survivors in health services, such as IRIS and hospital based IDVAs.
- Invest to increase availability of mental health support and therapeutic options for survivors. This should include the provision of longer term mental health support for survivors, and on-going support when women are discharged from mental health services or support programmes.
- Improve digitalised data collection methods and systems on a national level to enable effective and safe data collection and information sharing between health services, therefore enabling health services to a) evidence the demand for support, b) improve referral pathways for survivors and c) prevent women from having to repeat their stories.
- Invest in primary care service delivery to ensure that survivors/ women are able to access primary care services when they need and for longer appointments: all women should be able to access primary care appointments without having to first justify their reason. Primary care services should also ensure effective record keeping to ensure that when an identified survivor requests an appointment this can be prioritised.

SECTION SIX: CONCLUSION

The survivor consultation process provided a key opportunity for women who have experienced domestic abuse to feed into the Pathfinder project, and highlight their personal experiences of local health care services and professionals.

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

This report also evidences examples of good practice, and the key activities undertaken by Pathfinder sites with the support of the Pathfinder consortium in order to embed promising practice, in line with survivors 'asks'.

APPENDIX

Appendix A: Focus group research framework

Time	Questions	Resources
10 mins	<p><u>Introduction</u></p> <ul style="list-style-type: none"> • Thank everyone for taking the time to attend the meeting. • Check everyone understands the meeting will last up to two hours but there will be a break in the middle and they are also welcome to take a short break at any time if they need to. • Confirm everyone understands the aim of the meeting is to discuss their views on how services can be run more effectively to meet the needs of women who experience multiple problems in their lives. • Ask if everyone has their copy of the participant information sheet. (<i>Hand out copy to anyone that does not have one</i>). Allow people to ask any questions about the consultation. • Ask everyone to hand in their completed consent form and pre-focus group questionnaire, or to complete them now. • Check that consent is given - reiterate that the meeting will be recorded and the recording along with notes from the meeting will be anonymised and sent to a researcher at AVA for analysis. • Set any groups rules with the group (<i>depending on the group you may want to make this into a short activity to write up group rules onto flip chart paper</i>) 	<p>Spare consent forms</p> <p>Spare questionnaires</p> <p>Flip chart paper</p> <p>Pens</p>
10 mins	<p><u>Activity: Ice breaker</u></p> <ul style="list-style-type: none"> • Everyone to introduce self (first name) and share something they are looking forward to (this could be today/ this week/ in the future) • Start recording after this activity. This is vital for confidentiality of participants. 	
	<p><u>1. Discussion topic: whole health responses</u></p>	

20 mins	<p>Question A) From your experience, how do you think health professionals in your area are responding to survivors and their needs? (GP, nurse)</p> <p>Question B) From your experience, what are the barriers for survivors navigating the health system?</p> <p><i>Discussion prompts:</i></p> <ul style="list-style-type: none"> • Are survivors being listened to and heard? • Explore health system strengths and weaknesses • What is the quality of support? • What has been the response to complex needs (drugs and alcohol, self harm, suicide)? • Are there barriers to getting support and accessing services, eg waiting lists and thresholds? Other barriers may include getting appointments, not being asked or believed, language barriers. 	
25 mins	<p><u>2. Discussion topic: experiences in different health settings</u></p> <p>Question C) What is your experience of your GP ?</p> <p>Question D) What is your experience of A&E?</p> <p>Question E) (ONLY ASK IF APPROPRIATE) What is your experience of the mental health service ?</p> <p><i>Discussion prompts for each of the above:</i></p> <ul style="list-style-type: none"> • What was good about the health service/ professionals response? • What could be improved? • What would a best response look like? 	
15 min	Refreshment break	
20 mins	<p><u>3. Discussion topic: experience of any form of discrimination within in health</u></p> <p>Question F)_Do you think you have been treated differently or discriminated in health services, based on who you are / your identity?</p> <p><i>Discussion prompts:</i></p> <ul style="list-style-type: none"> • In what ways have you been treated differently? / can you say what this was? • Did you make a complaint? if not, why not? 	

<p>10 mins</p>	<p><u>4. Discussion topic: Information sharing</u></p> <p>Question G) What has your experience been of how information has been shared between health services and other support services that you have accessed?</p> <p><i>Discussion prompts:</i></p> <ul style="list-style-type: none"> • Was this experience positive or negative? • Is there anything you think could be done differently (in terms of information sharing)? • Would it be beneficial to you/ others who have had similar experiences to you for information to be shared between health services and other support services? 	
<p>15 mins</p>	<p><u>3. Activity: Post-it messages</u></p> <p><i>Prepare for the activity by sticking three sheet of flip chart paper on the wall – each with the different title ‘GPs’ ‘Mental health services’ and ‘Acute/ emergency services’</i></p> <ul style="list-style-type: none"> • For each area of health/ flip chart sheet, get participants to write on a post-it note a take away message for health professionals • The take away message should be what health support they would like to see, or a change they would like to happen. It could also be a something that health professionals are doing really well. <p><i>Participants to stick post-it on wall - can share at the end if they want or facilitators does, with group discussion</i></p>	<p>Post-it notes/ pens</p> <p>Flip chart paper</p>
<p>10 mins</p>	<p><u>4. Discussion theme: Final comments and reflections</u></p> <p>Question H) Is there anything else you want to share about your experiences of health services and professionals in the local area?</p> <p><i>Discussion prompt:</i></p> <ul style="list-style-type: none"> • Leave open to wider discussion and any final points that participants want to raise 	
<p>5 mins</p>	<p><u>Closing</u></p> <ul style="list-style-type: none"> • Acknowledge the groups sharing • Thank participants for their time • Stop recording • Give out vouchers 	

Appendix B: Online consultation research framework

SECTION ONE - Consent to take part

- Please tick the boxes below to confirm you consent to being part of this consultation: *I am over 18 years old; I consent to the information I provide being stored and analysed by AVA. The information collected will be used solely to as part of the Pathfinder project survivor consultation write up and project report; I confirm I understand that the information I provide is confidential and will be anonymised in any reports arising from the consultation.*

SECTION TWO – Demographics

- Please identify which area you are from: *Pathfinder site areas*
- Gender: *female, male, trans woman, trans man, non-binary, other*
- Age: *16-24, 25-34, 35-44, 45-54, 55-59, 60-64, 65-74, 75+, prefer not to say*
- Ethnicity: *Arab, Asian or Asian British, Asian or Asian British Indian, Asian or Asian British Pakistani, Asian or Asian British other, Black or Black British African, Black or Black British Caribbean, Black or Black British other, Chinese, Mixed White and Asian, Mixed White and Black African, Mixed White and Black Caribbean, Mixed other, White British, White Gypsy/Roma, White Irish, White Irish Traveller, White other, Other ethnic group, Prefer not to say*
- Sexuality: *what is your sexual orientation? (please leave blank if you would prefer not to say)*
- Living with disability: *Do you consider yourself to have a disability? (yes, no, prefer not to say, other - please specify)*
- If you feel comfortable to do so, please indicate when you last experienced abuse: *very recently (i.e. in the last month), in the past year, in the past 2-5 years, in the past 5-10 years, more than 10 years ago*

SECTION THREE – experiences of health in your area

- What is your general impression of how health services are responding to victims / survivors of domestic abuse in your local area? *open text*
- How confident are you that health services in your area are adequately responding to victims / survivors of abuse? *(Not at all confident, a little bit confident, fairly confident, very confident, i don't know)*
- Which do you think is providing the best respond to victims / survivors in your local area? *(GPs, mental health services, hospitals, other, don't know)*
- Can you explain why? *open text*
- Which do you think is providing the weakest response to victims / survivors in your local area? *(GPs, mental health services, hospitals, other, don't know)*

- Can you explain why? *open text*
- Are there barriers for victims / survivors accessing support via health services in your local area? If yes, please outline what these are. *open text*
- Do you think you have been treated differently or discriminated against in health services, based on who you are / your identity? *yes/no*
- If yes, please outline
- What has your experience been of how information has been shared between health services and other support services that you have accessed? *open text*

SECTION FOUR – Primary care in your area

- How many times do you think you have visited a GP in the last 12 months?
(*never, once or twice, several times, at least once a month, at least once a week - if non the skip section*)
- To what extent do you agree with the following statements:
 - “I am happy with the overall service that my GP has offered me in the last 12 months”
 - “I felt safe to share personal information about myself with GP”
 - “ I have felt listened to by my GP “
 - “ My GP has believed my story and what I have shared”
 - “ I have had to re-tell my story to my GP many times”
 - “I feel safe visiting my GP”
 - “I am happy with the quality of support I have been offered”
 - “ I am confident that my GP will respond adequately to other women who have had similar life experiences to me”
 - “I am confident that my GP would be able to identify signs of violence and abuse that women may be experiencing”
 - “ I have been offered further support as a result of visiting my GP”
 - “I trust health professionals in the advice or support they provide”
- What was good about how your GP responded to your experiences? *open text*
- Is there anything you would like to see done differently at your GP to ensure that those who have had similar life experiences to you are supported? *open text*
- How well do you think your GP is able to respond to the needs of women who have had similar life experiences to you? (*Not at all well , slightly well, well, very well, I don't know*)

SECTION FIVE – Acute health in your area

- How many times do you think you have visited the hospital in the last 12 months?

(never, once or twice, several times, at least once a month, at least once a week - if non the skip section)

- To what extent do you agree with the following statements:
 - “I am happy with the overall service that the hospital has offered me in the last 12 months”
 - “I felt safe to share personal information about my self with staff at the hospital”
 - “ I felt listened to by professionals at the hospital”
 - “I was believed by professionals at the hospital”
 - “ I have had to re-tell my story many times”
 - “My personal information has been shared appropriately by the hospital”
 - “I am happy with the quality of support I have been offered”
 - “ I am confident that health professionals at the hospital will respond adequately to other women who have had similar life experiences to me”
 - “I am confident that health professionals at the hospital would be able to identify signs of violence and abuse that women may be experiencing”
 - “ I have been offered further support as a result of visiting the hospital”
 - “I feel safe visiting the hospital ”
 - “I trust health professionals in the advice or support they provide”

- Is there anything you would like to see done differently to ensure that those who have had similar life experiences to you are supported? *open text*

- Is there anything you would like to share about your experience of the local hospital? *open text*

SECTION SIX - experiences of Mental Health services

- Have you accessed/used mental health services in your local area? *yes/ no*

- If yes, how recently did you access these services? (*In the last month, In the last 6 months, in the last 12 months, in the last 3 years, in the last 10 years*)

- To what extent do you agree with the following statements:
 - “I am happy with the overall service that mental health services have offered me”
 - “I have felt safe accessing the service”
 - “There have been a range of good options available to me to support my mental health”
 - “I am happy with the length of support that has been offered to me”
 - “I am happy with the quality of support I have been offered”
 - “I felt safe to share personal information with staff”
 - “ I felt listened to by professionals at the service”
 - “I have felt believed by professionals at the service”
 - “My personal information has been shared appropriately by mental health services”

- “ I have had to re-tell my story many times”
 - “ I am confident that health professionals at the hospital will respond adequately to other women who have had similar life experiences to me”
 - “I am confident that health professionals at the service would be able to identify signs of violence and abuse that women may be experiencing”
 - “ I have been offered further support since accessing mental health services”
 - “I trust health professionals in the advice or support they provide”
- Is there anything else you would like to see in terms of mental health provision or approaches taken by mental health services in order to support survivors in your local area?

SECTION SECTION - Final messages

- What more do you think health professionals can do to support survivors, secure their safety and meet their needs? (*open text*)
- Are there any key steps or actions you would like to see in your local area in order to improve health services responses to abuse? (*open text*)
- Are there any further comments you would like to add regarding your experience of health services and the support they provide survivors? (*open text*)

Appendix C: Collated final messages for health services

Primary care:

Site	Final messages shared – primary care
<u>A</u>	<p><u>Thank you for...</u></p> <ul style="list-style-type: none"> ● Referring me to Healthy Minds <p><u>I would like to see...</u></p> <ul style="list-style-type: none"> ● More GPs available for appointments. In my area there are not enough GP's to be able to address the issue of DVA properly, e.g. one GP worked half days and covered 10 villages ● One person from each GP practice fully trained in DVA so that they could do the sign-posting, provide initial support, safety advice etc. ● Survivors trained as volunteers in GP surgeries ● The same GP repeatedly ● Better communication between services ● More education on self-harm and where people can access support ● A DVA trained staff member at every surgery ● GPs looking for root causes of problems ● Group sessions offered once a month if signs of DV are identified ● A big conference on DV where GPs can learn more ● GPs going that extra mile ● Shorter waiting lists ● More leaflets on DV around surgeries ● Barriers to support being broken down <p><u>I would like to be</u></p> <ul style="list-style-type: none"> ● Understood and believed ● Checked up on repeatedly when problems have been identified (specifically mental health) ● Listened to ● Followed up if I miss an appointment <p><u>Please don't ...</u></p> <ul style="list-style-type: none"> ● Prescribe medication too quickly and without additional support
<u>B</u>	No final messages collected

<p><u>C</u></p>	<p><u>I would like to see</u></p> <ul style="list-style-type: none"> ● The option made available to keep the same GP ● Family doctors - one GP for the whole family ● Explicit and clear records written in case evidence is needed in courts ● GPs educated in cultural differences ● Better training in DSA ● GPs who are able to recognise signs of abuse ● An explanation of what the journey through the system for domestic abuse survivors looks like ● Specialist domestic abuse services ● Better signposting to specialist services ● More knowledge of referrals to give <p><u>Please don't</u></p> <ul style="list-style-type: none"> ● Get social services involved too quickly
<p><u>D</u></p>	<p><u>I would like to see</u></p> <ul style="list-style-type: none"> ● A more professional response to survivors ● Free medical reports/letters for survivors ● Greater vigilance and sensitivity to warning signs ● Compassion ● GPs with more knowledge so that they are able to spot the early warning signs ● GPs being proactive rather than reactive ● A female health care professional on hand for survivors ● Confidentiality respected ● A computerised, compartmentalised service which groups our problems under 'mental health', 'physical' etc. so its easier to see our history ● More time spent with patients <p><u>I would like to be</u></p> <ul style="list-style-type: none"> ● Able to get appointments with less waiting time ● Listened to without prejudice
<p><u>E</u></p>	<p><u>It is great to see....</u></p> <ul style="list-style-type: none"> ● You helping people

	<ul style="list-style-type: none"> • The vast majority of professionals being helpful <p><u>I would like to see...</u></p> <ul style="list-style-type: none"> • Longer appointments when needed • Better administration, especially relating to receptionists and appointment making • More consistency in treatment • Shorter waiting times for appointments <p><u>I would like to be</u></p> <ul style="list-style-type: none"> • Listened to • Referred to relevant services • Given more time in appointments <p><u>Please don't ...</u></p> <ul style="list-style-type: none"> • Offer anti-depressants so quickly • Allow receptionists to question survivors in public • Have preconceptions/personal opinions - you never know how bad someone is feeling • Make me explain my issues at reception where other people can listen
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Acute health services:

Site	Final messages shared – acute health services
<u>A</u>	<p><u>I would like to see...</u></p> <ul style="list-style-type: none"> • Practitioners asking the right questions • Drastic behaviours being acknowledged as a cry for help • Kindness at all stages, we could be a member of your family, it's all we need • If abuse is suspected, make up a reason to take the victim away from the perpetrator to ask them if they need help • More awareness and education • More questions being asked about how people sustained an injury • Clearer records being made of incidents that could be linked and shared with other authorities • Practitioners taking the time to listen • Help offered even if its not asked for

	<p><u>Please don't ...</u></p> <ul style="list-style-type: none"> • Accept obvious excuses • Make me feel like a fool
<u>B</u>	<p>No final messages collected</p>
<u>C</u>	<p><u>I would like to see</u></p> <ul style="list-style-type: none"> • Better signposting to specialist services • More knowledge of referrals to give
<u>D</u>	<p><u>It's great to see</u></p> <ul style="list-style-type: none"> • You doing great work <p><u>I would like to see</u></p> <ul style="list-style-type: none"> • Space created for sharing, rather than a focus on procedures exclusively • An after-service check i.e. transport, safety and wellbeing • Female members of staff on hand • A gender-based trauma response team or member of staff with... training on gender-based trauma
<u>E</u>	<p><u>It is great to see....</u></p> <ul style="list-style-type: none"> • You saving lives swiftly with fast responses, thank you <p><u>I would like to see...</u></p> <ul style="list-style-type: none"> • Shorter waiting times - perhaps giving people an estimated time so they don't have to wait but can leave and come back • Patients categorised or put into different sections so they can be seen to faster <p><u>Please don't ...</u></p> <ul style="list-style-type: none"> • Dismiss me. If I have come to you it's because I need i

Mental health services:

Site	Final messages shared – mental health services
<u>A</u>	<p><u>Thank you for....</u></p> <ul style="list-style-type: none">• the CBT <p><u>I would like to see...</u></p> <ul style="list-style-type: none">• Better information sharing• More questions being asked about DVA• More understanding when individuals are late to mental health appointments• Greater understanding from reception staff• Identification of correct services early on to save time, money and stress• Services being advertised in more GPs surgeries• Shorter waiting lists• Funding put in the right places• More follow through after being hospitalised for mental health problems• Face to face follow ups <p><u>Please don't ...</u></p> <ul style="list-style-type: none">• Keep me waiting (been waiting 5 months now)• Trust someone's partner without making some inquiries: I was taken to a mental health hospital on my partner's say so• Put a price on mental health• Prescribe medication without talking first• Disbelieve me
<u>B</u>	No final messages collected
<u>C</u>	<p><u>I would like to see</u></p> <ul style="list-style-type: none">• Better support after being discharged• A universal system of mental health support• Good explanations of diagnoses, how they affect you, others and general aspects of life• Better knowledge regarding the mental health of women of an African background

<p><u>D</u></p>	<p><u>It's great to see</u></p> <ul style="list-style-type: none"> ● You helping, your work is appreciated <p><u>I would like to see</u></p> <ul style="list-style-type: none"> ● A service between IAPT and mental health wards for those who are mildly depressed but do not need to be sectioned ● A non-judgemental, individual and open-minded approach ● Our problems taken seriously with more understanding ● You working with WGN ● A more holistic approach being adopted ● Referrals offered if services aren't given ● Professionals thinking like a victim ● More compassion <p><u>Please don't...</u></p> <ul style="list-style-type: none"> ● Treat individuals with a one size fits all approach
<p><u>E</u></p>	<p><u>I would like to see...</u></p> <ul style="list-style-type: none"> ● Psychological abuse considered just as debilitating as physical abuse - counselling needs to be offered ● More access to mental health services ● Less waiting time for counselling ● More ethnic/cultural diversity in counselling/mental health teams ● Information being shared properly, maybe through a web file where all specialties can access anytime to know your history without personal opinions added just the facts and medications and treatments ● Data handled carefully and sensitively ● Longer periods of counselling available ● Postnatal counselling being offered by midwives <p><u>Please don't...</u></p> <ul style="list-style-type: none"> ● Categorise individuals ● Discriminate or stereotype people ● Treat us under the same umbrella, treat us like human beings