STANDING TOGETHER
against domestic abuse

CROSSING PATHWAYS
Integrating Best Practice within Health & Domestic Abuse

CENTRING THE SURVIVOR VOICE

PHASE TWO

2024

Funded by The Home Office

TABLE OF CONTENTS

The Project Overview	3
Methodology	5
Who Spoke to us?	6
Trauma-informed Practice	10
The Brief Findings	11
Theme 1: Best Practice	12
Theme 2: Barriers	15
Theme 3: Impacts	20
Young People's Experiences	25
Theme 4: Opportunities	27
Recommendations & Action Plan	28
Next Steps & Bibliography	31

THE PROJECT
OVERVIEW

WHO ARE STANDING TOGETHER?

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

WHAT IS CROSSING PATHWAYS?

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

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

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

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

CENTRING THE SURVIVOR

This consultation has been conducted as part of a broader programme to amplify the voices of survivors with lived experience of domestic abuse and those who have supported friends, family members and colleagues who faced abuse. Between February and November 2024, we engaged with survivors and young people through a series of consultations, co-design sessions, and recommendation workshops.

The work builds on the first phase of consultations carried out in 2023 (Centring the Survivor Highlights: Report) and this second phase continues the commitment to a trauma-informed and participatory approach, ensuring inclusivity and accessibility for all 135 participants.
We would like to thank all of the survivors who contributed to this work. Their courage, insights, and creativity are invaluable in shaping recommendations that truly reflect their lived experiences. We also extend our gratitude to the organisations and individuals who supported us in facilitating these sessions.

This consultation forms part of a wider process to develop recommendations collaboratively with survivors, ensuring that their voices remain central to the work. The outcomes of these consultations will directly inform best practice guidelines and organisational responses in the coming years.

METHODOLOGY

This consultation adopted a trauma-informed and participatory approach, ensuring sensitivity to the diverse needs of participants. The work consisted of several strands, each with a distinct focus and contribution to the overall recommendations:

1. Second Phase of Consultations (February – June 2024)
This phase involved engaging with both young people and adults to explore their lived experiences and gather initial insights. Participants contributed to this consultation through one-to-one sessions, focus groups, and creative activities. The consultation was designed to allow participants to share their experiences in formats that felt most comfortable to them.

2. Co-Design Sessions (August 2024)
The co-design phase empowered a young person from the second phase of consultations to shape the recommendation workshops. One young person collaborated closely with facilitators to design the workshops.

3. CYP Recommendation Workshops (October – November 2024)
The co-designed workshops were delivered to a broader group of young people, enabling a participatory process to finalise the recommendations. 15 young people took part in the workshops. Sessions used creative and participatory methods to encourage open dialogue and collaboration. Key insights were incorporated into the final recommendations.

4. Survivor Network (October 2023 – November 2024)
In parallel to these activities, the Survivor Network provided continuous input to co-produce recommendations. Survivors who participated in the first phase of consultations engaged with the network throughout the year. The network used an action research approach to collaboratively refine the recommendations.

The recommendations resulting from these strands of work integrate insights from the Survivor Network and Children and Young People's Recommendation Workshops. By centering the voices of those with lived experience, this work aims to ensure that the recommendations are both authentic and impactful, addressing the gaps and barriers identified through this collaborative process.

WHO SPOKE TO US?

Participants were invited to join the consultation through referrals from partner organisations, local services, and community networks as well as being able to self-refer. Survivors were provided with a detailed overview of the project, including its objectives and how their contributions would shape systemic change. This approach empowered participants to make informed decisions about their involvement.

Data Collection Methods:

1. One-to-One Interviews:

- A total of 20 individual interviews were conducted, providing survivors with a safe, private space to discuss their experiences.
- These interviews allowed for deeper exploration of unique challenges and tailored recommendations for improving healthcare systems.

2. Focus Groups:

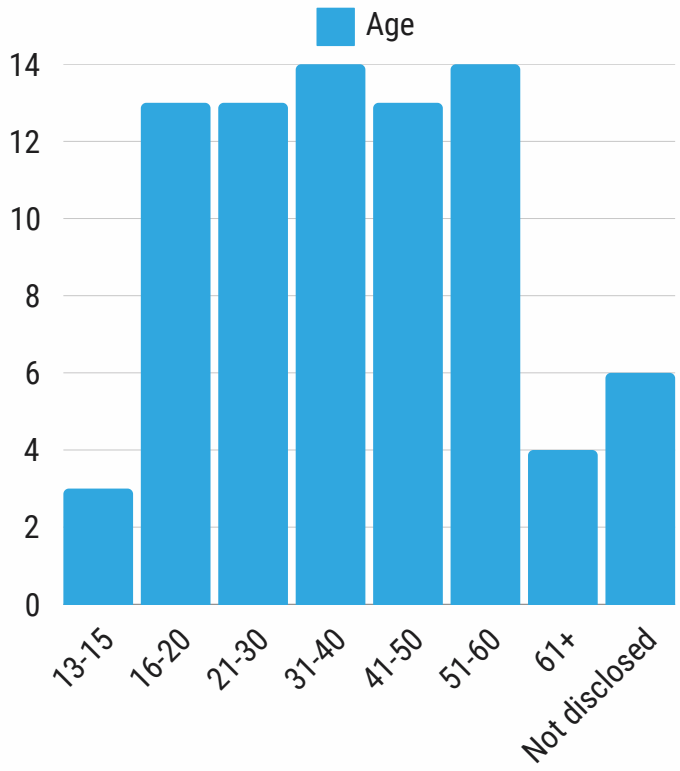
- Eight focus groups engaged survivors in collective discussions about positive experiences, shared barriers, systemic gaps, and potential solutions.
- Group discussions were structured to promote collaboration and peer support while ensuring individual voices were heard.

3. Creative Workshops:

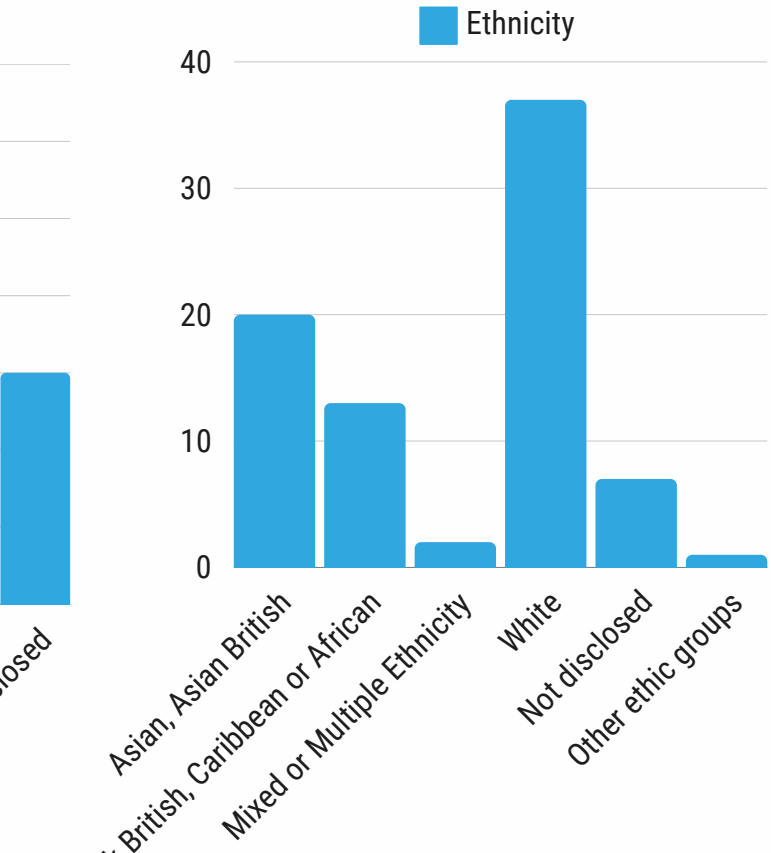
- Survivors shared their experiences through creative outlets, including poetry and visual art, reflecting themes of trauma, resilience, and healing.
- For example, one participant created a poem exploring the emotional impact of sexual violence.

The 80 voices in this report represent a diverse range of experiences, including survivors with lived experience of domestic abuse and those who have supported friends, family members and colleagues who faced abuse. We also spoke to survivors of domestic abuse with additional challenges such as physical and mental health conditions, neurodivergence, reduced mobility, and sensory impairments. Respondents reflect a wide demographic, spanning various age groups, faiths, sexual orientations, nationalities, and ethnic backgrounds. They include individuals from regions across England, such as the West Midlands, East of England, and London, as well as those who identified as LGBTQ+ and others who chose not to disclose specific personal details, capturing a broad spectrum of lived experiences.

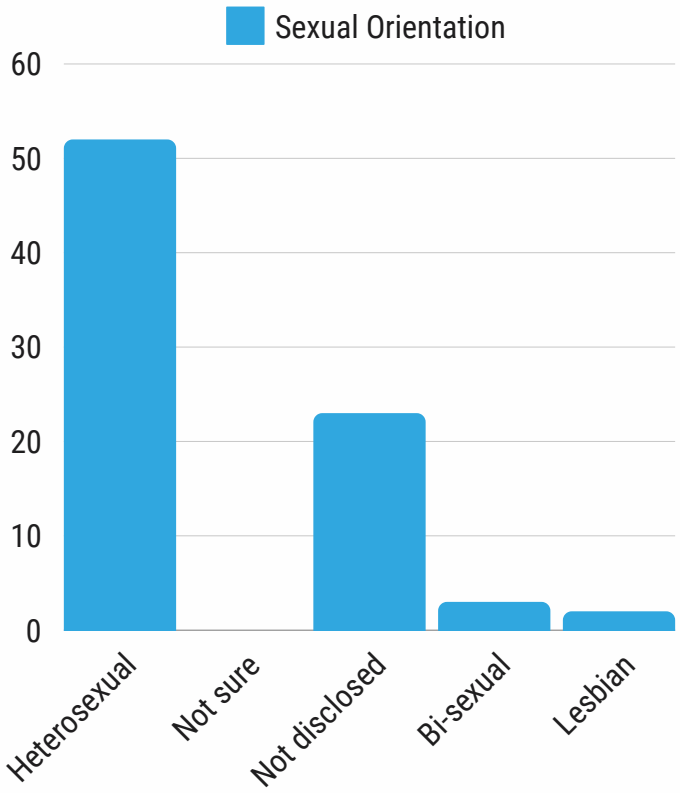
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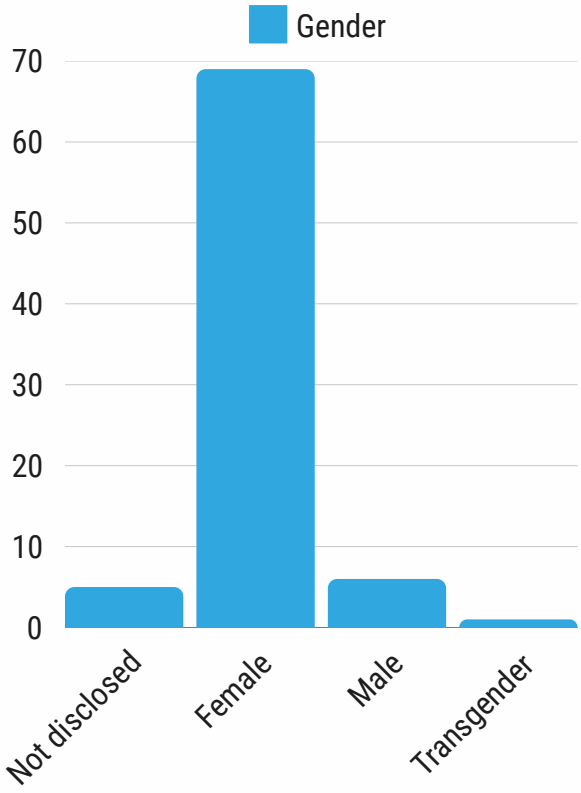
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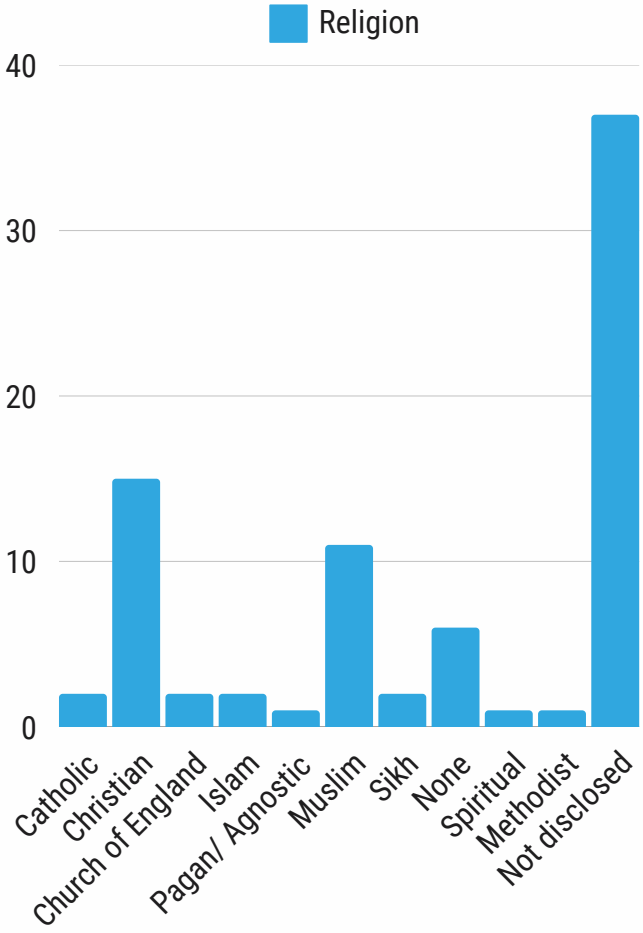
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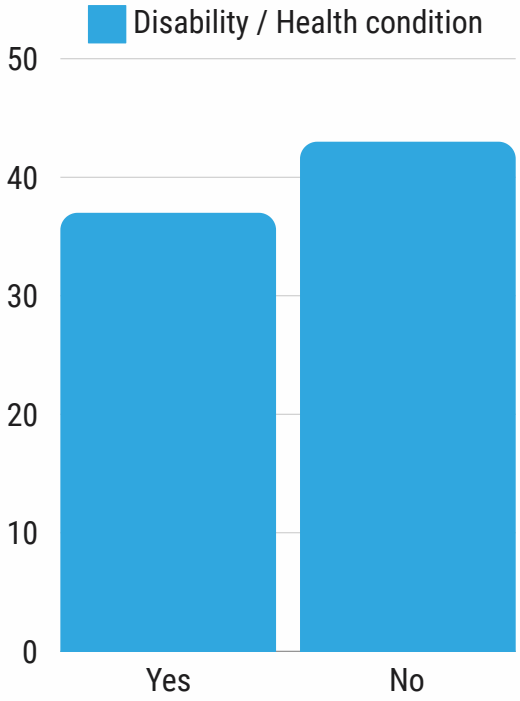
GENDER



RELIGION



DISABILITY / HEALTH CONDITION



Key Needs and Contexts:

- 37 out of the 80 survivors disclosed a disability or health condition including physical health conditions, mental health conditions and neurodevelopment disorders
- 12 survivors disclosed caring responsibilities with 9 caring for under 18 year-olds and 3 caring for over 18 year-olds
- No survivors were pregnant at the time of consultation

HEALTHCARE SERVICES ACCESSED

Participants reported engaging with a range of healthcare services:

General Practitioners (GPs)	
Mental Health Services	Community Support Services
Child and Adolescent Mental Health Services (CAMHS)	Sexual Health Services
Emergency Care (A&E)	Sexual Assault Referral Centre (SARC)
Maternity Services	Brain Injury Service
Specialist Services	Wellbeing Service
Dental Services	Midwife and Health Visitor Services
Optometry Services	Physiotherapist

TRAUMA INFORMED PRACTICE

The Survivor Voice Lead took a trauma-informed approach throughout the research ensuring that sessions were thoughtfully designed with trauma-informed principles at the core.

The emphasis on safety ensured that survivors understood the scope of their involvement and felt secure. By offering choice in how survivors participated, including options for remote or in-person sessions, the process respected survivors' autonomy and comfort. The inclusion of collaboration and empowerment was clear in the efforts to actively engage survivors, make them feel heard, and centre their voices throughout the research process. Lastly, the project made a concerted effort to consider cultural diversity, ensuring that diverse voices were included, and that survivors' unique needs were met through thoughtful accommodations and scheduling. (Office for Health and Improvement Disparities, 2022).

These principles demonstrate a comprehensive approach that prioritises the wellbeing of survivors, fosters trust and respect, and provides a space where they can share their experiences in a supportive, safe, and empowering manner.

Some examples of how these were implemented were:

Safety:

Providing an Overview: Survivors received a comprehensive project overview before their participation. This ensured they were fully informed about the scope of the research and their role, helping to reduce uncertainty and promote psychological safety.

Trustworthiness:

- Minimising Re-Traumatisation: Participants were provided with the questions in advance, giving them control over what they chose to share. For members of The Survivor Network, this approach also allowed them to contribute new insights or highlight issues they felt were important, rather than reiterating information they had already shared. This practice respected participants' boundaries and built trust.

Choice:

- Providing Options for Participation: Survivors could choose how to engage, whether through focus groups, one-on-one interviews or through creative workshops. Additionally, options for in-person or remote participation were offered, ensuring flexibility and comfort.

Collaboration:

- Co-Design of Recommendation Workshops: A young person from the second phase of consultations co-designed the recommendation workshops, ensuring meaningful collaboration.

Empowerment:

- Personalised Goodie Packages: Members of The Survivor Network received thoughtful goodie packages, including hand-written cards and references for future employment. These gestures showed they were valued and helped build confidence in their next steps.

Cultural Consideration:

- Engaging Diverse Survivors: Efforts were made to include survivors from diverse cultural, social, and demographic backgrounds, particularly focusing on underrepresented communities identified during the first round of research. This included outreach to communities supported by organisations specialising in CYP (children and young people), leveraging these partnerships to ensure a broader range of experiences and challenges were captured.

THE BRIEF FINDINGS

This report highlights the experiences of survivors of domestic abuse within healthcare settings, examining both best practices and barriers encountered across primary, secondary, and community care. Through the lens of survivor voices, it captures a comprehensive range of healthcare interactions, from positive experiences marked by empathy and sensitivity, to the numerous challenges survivors face when trying to access timely, trauma-informed care.

The report identifies several key areas where healthcare services demonstrate best practices. Survivors report positive experiences where healthcare professionals provide compassionate, empathetic responses, offer clear and direct communication, and engage in collaborative, multi-agency care that addresses the holistic needs of survivors. These positive practices underscore the critical importance of trauma-informed and culturally competent care, ensuring that survivors feel heard, respected, and supported in their recovery journey.

However, the report also highlights significant barriers that hinder access to effective healthcare. These barriers include administrative challenges, such as difficulties in registration, appointment scheduling, and prolonged treatment delays, as well as unsympathetic responses from healthcare providers who often fail to understand the complexities of domestic abuse. A lack of trauma-informed approaches in healthcare settings exacerbates survivors' emotional and psychological distress, preventing timely interventions and further contributing to re-traumatisation. The absence of consistent care and the failure to recognise and appropriately address the trauma survivors have experienced leave many feeling unsupported and vulnerable.

The findings in this report align closely with the Quality Standards outlined in the NICE guidance, highlighting systemic gaps in current healthcare responses to domestic abuse and reinforcing the need for trauma-informed, person-centred care that meets these established benchmarks.

This report acknowledges the dedication of colleagues within the health system and the immense pressure that individuals working under. At the same time, the findings call for systemic changes in healthcare practices. These include mandatory training for healthcare professionals, the implementation of flexible service models, and better collaboration across agencies to ensure survivor needs are met promptly and comprehensively.

The recommendations, developed through The Survivor Network and Children and Young People's Recommendation Workshops, can be grouped into 8 key areas:

TRAINING AND PROFESSIONAL DEVELOPMENT

ACCESSIBLE AND FLEXIBLE SERVICES

COMMUNICATION AND CONFIDENTIALITY

MULTI-AGENCY COLLABORATION

TRAUMA-INFORMED AND PERSON-CENTRED CARE

STREAMLINING REFERRALS AND TREATMENT

SAFETY AND CONFIDENTIALITY

ADDRESSING NEURODIVERGENCE AND DISABILITIES

THEME 1: BEST PRACTICE

Providing effective healthcare for survivors of domestic abuse requires a nuanced and sensitive approach that prioritises safety, empathy, and tailored care. Survivors often face unique challenges in accessing support, including the need for trauma-informed responses, cultural understanding, and holistic interventions. During this consultation many survivors reported positive experiences with healthcare professionals. The following examples illustrate key elements of best practice in healthcare, highlighting how compassionate, inclusive, and collaborative approaches can significantly improve outcomes for survivors. These real-life experiences demonstrate the importance of timely and thoughtful interventions, clear communication, and multi-agency collaboration in creating an environment where survivors feel seen, supported, and empowered to move forward.

While these best practices illustrate the positive strides being made in healthcare settings to support survivors of domestic abuse, it is important to acknowledge that not all survivors have had similar experiences. Despite the efforts of some healthcare professionals and systems to provide trauma-informed, compassionate care, many survivors still face significant barriers when trying to access the support they need. These challenges—ranging from administrative obstacles to a lack of understanding of trauma—continue to hinder the ability of healthcare services to offer timely, effective interventions. The following section outlines these barriers, which highlight the urgent need for broader systemic change.

COMPASSIONATE AND KIND RESPONSES

FEELING SAFE AND SUPPORTED

CLEAR AND DIRECT RESPONSES

TIMELY RESPONSES

CULTURALLY COMPETENT AND INDIVIDUALISED CARE

ACCESSIBLE AND INCLUSIVE SERVICES

COLLABORATION AND ENGAGEMENT

MULTI-AGENCY COLLABORATION

TRAUMA-INFORMED CARE

WOMEN-CENTRED AND SENSITIVE CARE

HOLISTIC AND COMPREHENSIVE SUPPORT

APPROPRIATE REFERRALS AND FOLLOW-THROUGH

COMPASSIONATE AND KIND RESPONSES

Healthcare professionals showed empathy and kindness, making a significant difference even when they were unsure how to respond.

- "She came and took me to a room and made me a cup of tea and just sat with me. I don't know how long for but it felt like forever. She just sat with me and listened to me, and was just very comforting and lovely."
- "Somebody was really listening to me and I felt most cared for in my life."

FEELING SAFE AND SUPPORTED

Healthcare providers created a non-judgmental environment, helping patients feel safe and reassured during challenging times.

- "I felt so supported when I was in there. Also then [The local drug and alcohol service] visited me again regularly...I've got no one else, which is wrong because I don't need them for substance abuse...but they're there for me for someone to talk to because I don't have anyone."
- "I had the crisis team out and they were involved with me for 3 weeks. They were incredibly supportive."

CLEAR AND DIRECT RESPONSES

Healthcare professionals explained procedures and diagnoses clearly and thoroughly, helping patients feel informed and included in their care.

- "I think I respond well, like really well to decisiveness and so if I come to the GP as mentioned...if they've responded to me with a clear action plan or pathway out of domestic abuse that I can like really visualise, like step one is to do this and do that, like things I can actually do that makes me hopeful."

TIMELY RESPONSES

Survivors appreciated prompt interventions and urgent appointments, especially during crises.

- "When I got here, when I landed in and spoke to [the support workers], I was like this is completely different...Within minutes I got results, I started to get help instantaneously."

CULTURALLY COMPETENT AND INDIVIDUALISED CARE

Healthcare professionals understood and respected patients' cultural backgrounds, nurturing trust and meaningful connections in their care.

- "When there were problems in understanding your cultural background, they [health services] understand really nicely."

ACCESSIBLE AND INCLUSIVE SERVICES

Services accommodated specific needs, such as language barriers or disabilities, ensuring all patients received equitable care.

- "For somebody to name it is massive, or you know just to ask questions about me. How are you? What are you – what do you want? What do you need? You're important too, not just the children, or not just your husband, or not just what this medical form says."

COLLABORATION AND ENGAGEMENT

Healthcare providers used collaborative approaches, involving families and allowing for patient input to deliver personalised and effective care.

- "The GP went above and beyond and they also included my other children and my partner, even though my partner wasn't at that surgery they asked as well and said would it help if, with consent, they contacted his GP just to let them know."

- "They make the call for you too because I can't get through to solicitors but when they call immediately the solicitor responds to it."

MULTI-AGENCY COLLABORATION

Healthcare professionals worked effectively with external agencies (e.g., Women's Aid, trauma counsellors), ensuring survivors received comprehensive care.

- "The mental health person I saw in hospital referred me to [A domestic abuse service], and they also referred me to social services, wrote to my GP told them I needed to be referred to the community mental health team psychologist."

TRAUMA-INFORMED CARE

Healthcare providers acknowledged and addressed trauma, helping survivors feel seen, heard, and supported.

- "The doctors have been very understanding. I've had to have a lot of gynaecological exams recently, which is a massive trauma because I've had sexual abuse as a child. After I've dealt with the physical examination, I can be extremely emotional."

WOMEN-CENTRED AND SENSITIVE CARE

Healthcare teams tailored their care to women's preferences, such as providing female staff, to create a more comfortable and respectful experience.

- "I had a situation last year when I had breast cancer, I was having an examination...and I was wearing a dress...They changed everything and they were amazing. They said from now on you'll just have one lady in. She said if that's what makes you feel comfortable...that's fine. And they were amazing."

HOLISTIC AND COMPREHENSIVE SUPPORT

Healthcare professionals addressed the wider needs of patients and their families, providing comprehensive support and practical solutions.

- "Some professionals are better at that than others. Focusing on all of me, not just the individual issues, reading between the lines of what I'm saying or not saying."

APPROPRIATE REFERRALS AND FOLLOW-THROUGH

Healthcare teams made timely and thoughtful referrals, ensuring patients received the specialist care they needed.

- "The GP was incredible and she made lots of calls out of hours to check that I was safe, they made so many safeguarding referrals."

THEME 2: BARRIERS

Survivors faced a range of barriers when accessing health services (primary, secondary and community care), which significantly impacted their ability to receive timely and appropriate care. Many of these barriers were rooted in systemic issues, professional attitudes, and a lack of appropriate support. These barriers often left survivors feeling unsupported, misunderstood, and re-traumatised. From dismissive attitudes and inadequate training among healthcare professionals to logistical challenges such as difficulty securing appointments and lack of continuity in care, survivors were frequently forced to navigate a fragmented system that failed to meet their needs. Cultural and social barriers, such as discrimination and stigma, further exacerbated these challenges, particularly for survivors from minority backgrounds. Additionally, historical misunderstandings of domestic abuse meant that many survivors were left isolated and unsupported, as domestic abuse was not always recognised or adequately addressed by the healthcare system. The examples in the report demonstrate that it is commonplace for the Quality Standards set out in the NICE guidance to be unmet in practice. The following section highlights examples from survivors to illustrate their experiences.

The barriers described by survivors can be grouped into these 7 key themes:

PROFESSIONAL ATTITUDES AND AWARENESS

LACK OF TRAUMA-INFORMED RESPONSES

PRACTICAL BARRIERS TO ACCESS

IMPACT OF HISTORICAL MISUNDERSTANDINGS

FEAR OF RETALIATION AND PRIVACY CONCERNS

INCONSISTENT AND FRAGMENTED CARE

CULTURAL AND SOCIAL BARRIERS

PROFESSIONAL ATTITUDES AND AWARENESS

Survivors faced numerous barriers and poor practices when accessing health services, often feeling dismissed and unheard. Their concerns were minimised, with routine enquiry questions failing to address the complexities of their experiences. Health professionals frequently overlooked key indicators of abuse, sometimes blaming mental health issues for trauma-related physical symptoms. Systemic misogyny was evident, with dismissive GPs neglecting holistic care—for example, one frustrated GP asked a survivor, "What do you want me to write down?" Follow-up care was often absent, with inadequate responses such as advising family members to administer medication without further support. A lack of training on issues like child-to-parent abuse and the mislabelling of survivors as "difficult" due to unrelated conditions left survivors feeling unsupported, their abuse unacknowledged and unrecorded.

Themes:

- Not being listened to
- Indicators not picked up by professionals
- Not taken seriously or minimising
- Lack of relationship with professionals
- Mental health being blamed
- Systemic Misogyny
- Lack of training and awareness of child to parent abuse

I think the GP was kind of annoyed because they only have like 10 minutes, so she sort of was a bit annoyed that I was disclosing this and she actually said to me **what do you want me to write down**."

LACK OF TRAUMA-INFORMED RESPONSES

Survivors encountered significant barriers due to health agencies' lack of sensitivity and understanding of trauma. Many were retraumatised by having to repeatedly disclose their experiences to multiple professionals, causing emotional distress. One survivor highlighted the toll of repeatedly sharing their trauma. Victim-blaming was also prevalent, with trauma symptoms, such as those from acquired brain injuries, misinterpreted as signs of being "difficult." The absence of trauma-informed care led to inappropriate mental health support that overlooked the root causes of distress. In some cases, perpetrators attended antenatal appointments, preventing private disclosure and compromising survivors' safety. The practice of DARVO (Deny, Attack, Reverse Victim and Offender) further invalidated survivors, leaving them unsupported and blamed for their abuse.

Themes:

- Additional barriers around pregnancy
- Perpetrators accompanying survivors to antenatal appointments
- DARVO (Deny, Attack, Reverse Victim and Offender)
- Re-traumatisation (Having to disclose multiple times)
- Inappropriate support given especially around mental health

“I’ve had many panic attacks and breakdowns in the surgery. When I’m out walking, I’ve had panic attacks because **I’m still repeating the same story** to multiple professionals."

PRACTICAL BARRIERS TO ACCESS

Survivors faced numerous challenges that hindered their ability to access essential support. One of the most common barriers was difficulty securing appointments, with some survivors unable to make appointments due to work commitments or the rigid appointment systems in place. For instance, one survivor shared that appointments were only available by calling at 8 a.m., which was impossible for them as a single parent. Survivors also faced restrictions during appointments, such as being told they could only discuss one issue per session, even when multiple concerns were interconnected. Short appointment times and telephone consultations, often used as a substitute for face-to-face interactions, left many survivors feeling unsupported. Hospital waiting times and long periods between appointments further compounded the issue, leaving survivors without timely care. Additionally, many survivors were asked to take on the responsibility of seeking help themselves, such as self-referring to services or contacting the police, adding another layer of stress. Financial barriers were also common, with survivors needing to pay for GP letters and often not being signposted to financial services or support. Practical barriers were also observed for those living in rural areas, where travel costs added to the burden of accessing support, and some survivors found themselves unable to access specialised services, such as trauma-informed dentistry or discreet sexual health testing. These compounded barriers were made worse by the overwhelming nature of healthcare systems, especially for survivors who had fled abusive situations, as they faced a constant need to navigate various services that lacked coordination.

Themes:

- Barriers in accessing appropriate support, referral and signposting to other services
- Difficulties booking appointments
- Inflexibility of appointments e.g. phone-only appointments unless urgent
- Short appointment times and only being able to discuss one issue at a time
- Responsibility to support themselves (self-refer to services, call police etc.)
- Rural Premium' (Extra costs for travel to access support)
- Lack of access to trauma-informed dentistry
- Being told by GP to go to A&E
- Long hospital waiting times (Emergency Department and appointments)
- Being unable to register with NHS Dentist
- Extended time periods between appointment and follow ups
- Needing to pay for GP letter
- Only being offered telephone appointments
- Being unable to make appointments due to work
- Not being given access to discreet sexual health testing (outside of clinic due to children)
- Covid (limited access to healthcare services, disruption to regular appointments and challenges to accompaniment and privacy)
- Overwhelming healthcare systems after fleeing



"So you have to phone up in the morning at 8 o'clock on the day to get an appointment. If you leave it until half 8 or 9 o'clock all the appointments are gone. I'm a single parent, my children are with me at that time of the morning, so a **I would find it difficult calling at that time** of the morning anyway, and b if I did I can't really explain anything personal to them on the phone because I'm driving, or my children are there, or I'm in the playground."

FEAR OF RETALIATION AND PRIVACY CONCERNS

Survivors experienced significant anxiety about privacy and the potential repercussions of disclosing abuse. Many feared their information could be misused in legal proceedings or accessed by perpetrators. One survivor shared that their son was denied treatment because the perpetrator had access to his medical records. Others expressed concern that disclosing their sexual orientation or gender identity might lead to discrimination in court. Fear of being treated differently or labelled also deterred survivors from seeking help, with some worried their disclosures would be recorded and used against them. Survivors highlighted the lack of protection under legal provisions like Clare's Law, which could have offered greater safety and control. These fears around confidentiality and the misuse of personal information left many unable to access the support they needed, perpetuating their vulnerability.

Themes:

- Fear of prejudice affecting court cases (homophobia)
- Fear of being treated differently after being given a label (sexuality/gender)
- Fear of things being put on record
- Not being offered Clare's law by police
- Medical records accessed by perpetrators

"I took him to the GP about that and she said well his father has access to his medical records so if I write down that you've come to say this then he won't like that. So **she was putting the onus on me what she should note**. I felt that there should be some system that even if the family courts demand it, it's not released because then my son couldn't get treatment or support because – do you see what I mean."

INCONSISTENT AND FRAGMENTED CARE

Survivors faced significant challenges due to a lack of continuity in support. Many felt abandoned by social services after fleeing abuse, with no consistent care provided. Frequent changes in professionals handling their cases led to repeated disclosures and inconsistent support. One survivor described a follow-up appointment that merely repeated the initial one with a different professional, increasing their frustration. Survivors also struggled with transfers between services when fleeing to new areas, often leaving them without crucial support. Fragmented systems added to their difficulties—for example, being employed by a GP practice yet needing to visit another GP for appointments or not receiving support as an employee. Frequent changes in mental health workers and treatment plans without explanation further exacerbated instability, while missed follow-ups left survivors waiting for calls or results that never came. These disjointed experiences left survivors feeling isolated and unable to access the coordinated care they needed.

Themes:

- Lack of support from social services
- Multiple incidents that led to professionals noticing
- Inconsistent allocated worker or professional
- Inconsistent support
- No support once fled
- Follow up appointment was a repeat of the initial appointment with a different professional
- Difficulties being transferred between services in different areas (after fleeing)
- Employed by GP so had to go to different GP
- Not offered support as an employee in GP
- Lack of continuity in care
- Missed follow-ups

"Each time I go downhill, more support is requested by the hospital, by the crisis team. Now – well, who knows what – **one day I might not feel strong enough to actually make a cry for help because nobody is following me up**."

CULTURAL AND SOCIAL BARRIERS

Survivors faced significant challenges due to discrimination, cultural stigma, and a lack of understanding or support for their specific needs. Many encountered ableism, with their conditions overlooked or misunderstood by professionals. Social stigma was especially strong for survivors from minority backgrounds, such as those in the Asian community, who feared involving social services due to shame and cultural taboos. Survivors struggling with their sexuality or gender identity often felt unsupported, further hindering access to help. The lack of culturally aware care, particularly for complex family dynamics like raising a child with additional needs or being a single parent, left many feeling isolated. The absence of language support, including interpreters for critical health discussions, worsened these barriers. These cultural and social obstacles left survivors struggling to engage with services, burdened by societal pressures and inadequate care.

Themes:

- Discrimination (ableism)
- Feeling ashamed / embarrassed
- Lack of language support
- Male allocated worker
- Confusion around sexuality/gender identity

"When I been to somewhere personal independent payment the clinical test they arrange somebody, then they come and say to me the person will be late you have to wait. Then a few minutes when I talk they say **you are speaking English you no need interpreters**."

FEAR OF RETALIATION AND PRIVACY CONCERNS

Survivors faced significant challenges due to the lack of recognition and support for domestic abuse in the past. Many reported that domestic abuse was not properly understood or acknowledged by professionals, which led to them being isolated and unsupported. For example, one survivor shared, "Health professionals treated my experience of strangulation as a mental health issue," reflecting how abuse-related symptoms were often misinterpreted or ignored. The absence of a robust policy or framework for responding to domestic abuse meant that both professionals and patients lacked the necessary resources and guidance to properly address the issue. Survivors also experienced systemic misogyny, where their experiences were minimised or dismissed, further perpetuating their trauma. Additionally, inadequate historical recognition of domestic abuse meant that survivors were often left to cope on their own, without the appropriate care or interventions. These historical misunderstandings left lasting scars, as many survivors had to navigate systems that failed to acknowledge the full extent of their experiences.

Themes:

- Lack of access to resources for professionals and patients (With regard to DA)
- Inadequate Policy and Framework in responding to DA
- Systemic misogyny and minimisation
- Inadequate historical recognition of abuse

"**My experience of strangulation & suffocation was seen as a Mental Health issue** by not 1 but 4 GP practices."

THEME 3: IMPACTS

The barriers faced by survivors in healthcare settings had profound and wide-ranging impacts on their physical, emotional, and psychological well-being. These impacts included increased trauma, re-traumatisation, and a loss of trust in the healthcare system, making it harder for survivors to seek help or disclose abuse. Delays in care, a lack of consistency in healthcare providers, and financial strain contributed to worsening physical and mental health, while fear of disclosure and the re-traumatising effects of retelling their stories created a cycle of isolation and emotional distress. Survivors also faced practical challenges, such as loss of access to critical support services, difficulties with housing and legal assistance, and the impact of family court cases. These barriers not only perpetuated the trauma survivors faced but also hindered their long-term recovery and safety. Addressing these impacts requires a comprehensive, trauma-informed approach to healthcare and support systems.

The impacts described by survivors can be grouped into these 8 key themes:

EMOTIONAL AND PSYCHOLOGICAL IMPACT

INCONSISTENT AND FRAGMENTED CARE

FINANCIAL AND ECONOMIC IMPACT

SOCIAL AND RELATIONAL IMPACT

SELF-WORTH AND IDENTITY IMPACT

CAREER AND WORK-RELATED IMPACT

TRUST AND ENGAGEMENT WITH SERVICES

FEAR AND TRAUMA-RELATED IMPACT

EMOTIONAL AND PSYCHOLOGICAL IMPACT

The barriers survivors faced when accessing healthcare often led to significant emotional and psychological consequences. The lack of appropriate support, dismissive attitudes from professionals, and the difficulty of repeatedly disclosing trauma led to feelings of re-traumatisation and re-victimisation. These experiences exacerbated survivors' mental health issues, contributing to anxiety, depression, and PTSD. Survivors frequently felt ignored or invalidated, which compounded their existing emotional scars and led to low self-esteem, isolation, and self-blame. These barriers also created a cycle of emotional distress, making it harder for survivors to engage with services and receive the necessary care, as fear of judgment and further victimisation kept them from seeking help.

Themes:

- Declining mental health
- Self-blame
- Re-traumatisation/Re-victimisation

"I became **withdrawn**, lacking in confidence and self-esteem, **depressed**, **anxious** and in **constant fear**."

INCONSISTENT AND FRAGMENTED CARE

The barriers to accessing healthcare resulted in a direct and lasting impact on survivors' physical health. Many survivors faced long delays in receiving treatment, misdiagnosis, or a lack of understanding of abuse-related injuries. For example, symptoms of strangulation or physical injuries were sometimes dismissed as mental health issues, preventing survivors from receiving the necessary medical care. The cumulative effects of these healthcare barriers led to worsened physical health, including chronic conditions that remained untreated for extended periods. Survivors often experienced long-term physical health problems, which were exacerbated by the stress of navigating a healthcare system that failed to acknowledge the full extent of their trauma.

Themes:

- Decline in physical health
- Permanent and long-term physical health issues

"I've just found out after 10 years of going to the doctors with random pains, I've got rheumatoid arthritis but **they told me it was all in my head**. And somebody like me who had mental health issues in that setting **I believed them**."

FINANCIAL AND ECONOMIC IMPACT

Barriers to healthcare not only impacted survivors' emotional and physical well-being but also had severe financial and economic consequences. The inability to access the necessary support meant that survivors faced additional costs, including travel expenses for healthcare appointments (particularly in rural areas), out-of-pocket expenses for treatments, and the financial strain of accessing private services or legal support. Survivors also experienced economic hardship due to the extended delays in receiving appropriate care, which affected their ability to return to work or pursue opportunities for financial independence. The healthcare system's failure to provide adequate support compounded the financial abuse many survivors had already experienced, leaving them further vulnerable and financially insecure.

Themes:

- Debt and financial issues
- Financial losses

"There is **no signposting** financially."

SOCIAL AND RELATIONAL IMPACT

The healthcare barriers faced by survivors also impacted their relationships with family members, including their children. The inability to access appropriate medical care or support services left many survivors struggling to manage the effects of abuse, which in turn affected their ability to care for and support their children. The lack of coordinated care and support from healthcare providers contributed to feelings of isolation, as survivors often felt unsupported in managing both their health and their family's needs. This lack of support also extended to the legal and social systems, where survivors were often left to handle challenges such as custody battles or family court cases without adequate documentation of abuse or professional advocacy, making it even harder for them to protect themselves and their families.

Themes:

- Loneliness and isolation
- Becoming withdrawn
- Family estrangement
- Impact on Family Court case(s)
- Children exposed to abuse
- Community impact for accessing support

"**I have a lot of social anxiety now**, I'm petrified around groups of people. I am very timid around men, it impacts me accessing healthcare now because **sometimes I can't stay**."

SELF-WORTH AND IDENTITY IMPACT

The barriers faced by survivors of domestic abuse when accessing healthcare led to significant impacts on their sense of self-worth and personal identity. These barriers caused survivors to internalise negative experiences and perceptions, contributing to feelings of shame, guilt, and low self-esteem. Health services, at times, failed to acknowledge the trauma survivors had endured, leading to further damage to their self-confidence. Survivors struggled to trust themselves and their own instincts, often blaming themselves for the abuse they had suffered or doubting their worth. As a result, they withdrew from social connections, felt disconnected from their true selves, and experienced an ongoing battle to reclaim their personal identity. This sense of disempowerment made it harder for them to engage with services, pursue their goals, or envision a positive future.

Themes:

- Low self-esteem and self-worth
- Low confidence in personal identity
- Inability to pursue goals or dreams

"**I am lonely**, I feel dirty like I am somehow a mistake to society and **I don't have support.**"

CAREER AND WORK-RELATED IMPACT

The barriers to accessing health services also had a profound impact on survivors' careers and work-related lives. These barriers often led to prolonged absences from work, diminished productivity, and ultimately, the inability to progress in their careers. Survivors faced challenges in balancing their professional lives with the emotional and physical toll of abuse, which was often exacerbated by the lack of appropriate healthcare support. Many survivors struggled with the mental and physical effects of their trauma, which made it difficult to maintain stable employment or pursue new career opportunities. The financial strain resulting from these challenges, coupled with a lack of support from both healthcare professionals and employers, further hindered their ability to achieve career stability or advancement. This had long-term consequences on their financial independence, career growth, and overall sense of purpose.

Themes:

- Impact on career (Left work or could not progress)
- Extended period of time before being able to access appropriate support (DV, benefits, housing, safeguarding)

"**I had to leave work.** My mental health declined, I would have said because I was in trauma response constantly. I was battling services as well as trying to keep my family safe because **nobody was really doing anything**."

TRUST AND ENGAGEMENT WITH SERVICES

Barriers to accessing health services led to significant challenges in survivors' ability to trust and engage with services. Many survivors reported feeling dismissed or unsupported by healthcare professionals, which eroded their trust in services over time. This lack of trust was compounded by experiences of not being listened to, not having their concerns taken seriously, or feeling that professionals did not understand the complexities of their trauma. As a result, survivors became reluctant to seek help, fearing that their needs would not be met or that they would face further mistreatment. Some survivors even withdrew entirely from services, either due to fear of re-traumatisation or because they felt unsupported by the systems meant to assist them. This breakdown in trust and engagement often left survivors feeling isolated and vulnerable, with no recourse to the support they desperately needed.

Themes:

- Not feeling supported by services and feeling alone
- Not wanting to engage with services
- Lack of trust in GP

"I blame the services…because **had anybody written any of this down it would have been different**. If I had gone to court with a health visitor saying he's very aggressive, it would have changed everything because he wouldn't have had the right to claim full custody."

"**I had to do it all myself**, and it really annoys me when I hear all these things about domestic abuse initiatives because my feeling is very strong that **you are absolutely on your own**."

FEAR AND TRAUMA-RELATED IMPACT

The barriers survivors faced in accessing health services led to profound fear and trauma-related impacts. Many survivors described ongoing fear and anxiety, particularly in relation to medical settings, where they felt vulnerable to further abuse or re-traumatisation. The lack of trauma-informed care often left them feeling unsafe, especially when healthcare professionals were unprepared to address the complexities of their experiences. Survivors also reported heightened fear of not being believed or being blamed for their abuse, which reinforced feelings of helplessness and self-doubt. This fear extended beyond healthcare environments, influencing their ability to trust others and engage in relationships. The compounded trauma from healthcare barriers, such as being dismissed, misunderstood, or retraumatised, intensified the emotional and psychological toll on survivors, exacerbating feelings of powerlessness, isolation, and helplessness.

Themes:

- Becoming fearful (men, relationships)
- Fear of homophobia and additional abuse
- The perpetrator becoming increasingly emboldened

"I will say I need a female chaperone, a nurse or my partner with me. It doesn't even have to be an examination it could just be a conversation **I don't want to be in a confined area with a man that I don't know**."

YOUNG PEOPLE'S EXPERIENCE

The data reflects the experiences of 5 young people between the ages of 16 and 19 years who participated in the second round of consultations. Sessions used creative and participatory methods to encourage open dialogue and collaboration.

Services Accessed
Young people engaged with a range of services, reflecting the interconnected nature of healthcare, education, and legal systems. Key services include:

- Child and Adolescent Mental Health Services (CAMHS): Frequently accessed for mental health support.
- The Bridge & Sexual Assault Referral Centres (SARC): Critical for sexual health and post-assault care.
- School-Based Services: School nurses, counsellors, and other school staff often facilitated referrals to specialist support services.
- General Practitioners (GPs): Provided consistent medical and mental health care, often fostering trust through regular follow-ups.
- Social Services and Family Court: Engaged in contexts involving family interventions and legal proceedings.

Some young people accessed multiple services, highlighting the need for better coordination between sectors to ensure continuity of care.

BEST PRACTICE

Young people's positive experiences highlight the importance of trust, consistency, and trauma-informed care. Examples include:

- Supportive Interventions:
  - Sexual Health Services and SARC were noted for creating supportive and empowering environments.
  - GPs who provided consistent care and follow-ups helped young people feel valued and safe.
- School Support:
  - School nurses played a vital role by recognising distress and facilitating timely referrals to specialist services.
- Trauma-Informed Approaches:
  - Instances where young people felt listened to and were provided with clear next steps were particularly valued.

"My GP made sure I always saw the same doctor, which helped me feel like someone was on my side."

BARRIERS

Challenges faced by young people reflect systemic issues, dismissive attitudes, and logistical difficulties. Key barriers include:

- Systemic Challenges:
  - Poor coordination within CAMHS resulted in repeated explanations of issues and delayed care.
  - Lockdown restrictions amplified barriers, such as difficulty accessing emergency contraception.
- Dismissive Responses:
  - In some cases, healthcare professionals failed to acknowledge or take young people's concerns seriously, undermining trust.

"I couldn't access the morning-after pill during lockdown, and I felt very alone."

"The CAMHS team didn't communicate properly, so I had to explain my issues repeatedly."

IMPACT

Barriers and poor practice had profound emotional and psychological impacts on young people:

- Emotional Impact:
  - Feelings of being unsupported and invalidated led to increased emotional distress.
  - Art pieces created during consultations revealed themes of fragmentation, isolation, and a longing for safety.
  -

"The lack of support made me feel like I didn't matter."

"I didn't want to speak up again after the first time I was dismissed."

These findings underscore the need for a holistic, trauma-informed approach that prioritises trust, consistency, and collaboration across sectors to improve outcomes for young people accessing services.



Image: A mask with two layers symbolised the need for survivors to hide their true selves while yearning for understanding.

THEME 4: OPPERTUNITIES

The recommendations and actions developed by The Survivor Network through co-produced workshops, including CYP Recommendation Workshops, offer a comprehensive framework for enhancing support for domestic abuse survivors across healthcare settings. Grounded in trauma-informed, person-centred approaches, these recommendations aim to dismantle systemic barriers, prioritise safety and inclusivity, and guarantee equitable access to services. In line with NICE guidance, these recommendations further validate and strengthen the evidence base for addressing the systemic challenges highlighted in the report.

By nurturing multi-agency collaboration, advancing professional training, and amplifying the voices of survivors, these actions strive to empower individuals, reduce harm, and support recovery. This holistic approach highlights the essential role of healthcare systems in recognising, responding to, and alleviating the effects of domestic abuse, ensuring survivors and their families receive the care and support they need to thrive.

RECOMMENDATIONS & ACTION PLAN

Recommendation	Action	Timeline
1. Training and Professional Development	Mandatory trauma-informed training on domestic abuse, neurodiversity, mental health, and intersectionality.This is in line with NICE Quality Statement 2	6 months–1 year
	Survivor-led training with diverse voices, case studies, and real-world scenarios.	1-2 years
	Focused training on male victim-survivors, children, and neurodivergent individuals.	6 months–1 year
	Refresher training every 1-2 years to maintain competency.	1-2 years
	Young People's Snapshot Young people's input highlights the need for relatable role models or peers to contribute to this training.	
2. Accessible and Flexible Services	Offer longer, flexible, or walk-in appointments with remote consultation options.	1 year
	Implement triage systems across healthcare settings (e.g., primary care, secondary care, and community care) and through cross-departmental triage to prioritise survivors based on the urgency of their physical, mental, or emotional health needs, rather than the time of their referral.	1 year
	Offer in-person assessments.	1 year
	Strengthen regional collaboration to improve service accessibility.	1 year
	Prioritise cancelled appointments for remote areas and ensure travel support for healthcare staff.	2-3 years
	Provide childcare facilities in hospitals and clinics with bookable play centres.	2-3 years
	Young People's Snapshot Young people specifically noted challenges during lockdowns and the need for better access to emergency services like contraception.	
3. Communication and Confidentiality	Avoid using withheld/private numbers; ensure caller ID shows recognisable names like 'NHS.'	6 months
	Offer alternative secure communication methods to protect victim-survivors.	6 months
	Record and honour victim-survivor communication preferences.	6 months
	Develop a centralised system for sharing victim-survivor data across care settings.	2-3 years
	Young People's Snapshot Young people emphasised the need for proactive outreach from healthcare providers to reduce their hesitation in seeking help, which could complement adults' focus on a centralised system.	

ACTION PLAN

Category	Action	Timeline
4. Multi-Agency Collaboration	Regular multi-agency meetings to coordinate care and address urgent needs.	2-3 years
	Train staff to develop Shared Care Agreements for seamless collaboration.	1 year
	Collaborate with specialist organisations for comprehensive support.This is in line with NICE Quality Statement 4	6 months–1 year
	Enhance cross-sector dialogue between healthcare, legal, education, and transport sectors.	1 year
	Young People's Snapshot Young people specifically noted challenges during lockdowns and the need for better access to emergency services like contraception.	
5. Trauma-Informed and Person-Centred Care	Recognise victim-survivors as experts in their own experiences; provide time and space for them to share.This is in line with NICE Quality Statement 1	6 months
	Schedule regular reviews to avoid re-traumatisation through repeated disclosures.	1 year
	Adopt a trauma-informed approach addressing physical, mental, and emotional needs.	6 months–1 year
	Recognise children impacted by domestic abuse as victim-survivors. Ensure trauma-informed care and interventions focus on the unique needs of children who witness abuse, addressing both the immediate emotional impacts and the long-term effects on their understanding of healthy relationships to empower children and young people in their future intimate relationships.	6 months
	Young People's Snapshot Young people emphasise the need for more immediate mental health support in schools, reflecting their reliance on educational settings for initial intervention.	
6. Streamlining Referrals and Treatment	Ensure admin teams follow up on referrals to confirm acceptance and communicate outcomes.This is in line with NICE Quality Statement 3	6 months
	Advocate for victim-survivors when referrals are deemed inappropriate.	1 year
	Implement triage systems for urgency-based prioritisation, particularly in mental health and general health care settings to reduce delays and create multidisciplinary hubs for care.	1-2 years
	Young People's Snapshot Young people specifically mentioned the frustration of having to repeatedly disclose their trauma due to poor coordination, underscoring the need for consistent care providers.	

ACTION PLAN

Category	Action	Timeline
7. Safety and Confidentiality	Use flagging systems on victim-survivor records for prioritised care.	6 months
	Avoid compromising safety by disclosing sensitive information in public areas.This is in line with NICE Quality Statement 1	6 months
	Provide private, safe spaces for victim-survivors during consultations.	6 months
	Young People's Snapshot Young people added insights about their discomfort in disclosing abuse in non-private school or healthcare settings, suggesting additional emphasis on creating safe environments in diverse contexts.	
8. Addressing Neurodivergence and Disabilities	Increase neurodivergence assessment centres and ensure safe, accessible locations.	1 year
	Introduce disability passports for streamlined care adjustments.	2-3 years
	Recognise victim-survivors' self-awareness and avoid dismissive assumptions.	6 months
	Young People's Snapshot Young people advocated for inclusive training that specifically addresses how professionals should interact with neurodivergent young people, focusing on understanding rather than assumptions.	



Image: A pencil sketch of flowers and butterflies reflected the need for places of growth and recovery.

NEXT STEPS

The publication of this report marks an important milestone in centring the voice of survivors, but it is only the beginning of our journey. Moving forward, we will share the findings widely through our Crossing Pathways Networks and beyond, supported by a dedicated social media campaign. A Survivor Voice Webinar is planned to further amplify these insights, alongside promotion at high-profile events such as the Parliamentary event in February 2025 and the next Health event scheduled for March 2025.

To ensure the recommendations from the report drive meaningful change, additional work with the Survivor Network and children and young people (CYP) from the Recommendation workshops has been undertaken. Their suggestions include initiating a campaign, establishing pledges for healthcare providers to uphold dignity and person-centred care, and leveraging the DA and Health Leadership group's influence to advocate for systemic change, including government-mandated training in all aspects of care. Young people have also requested regular updates on healthcare improvements via social media channels. Work has already begun on these pledges, with a promotional campaign launched in December 2024.

Young people have also highlighted the need for tailored training for healthcare professionals that incorporates empathy, tact, and trauma-informed approaches, alongside creative platforms such as performances to illustrate their experiences. Additionally, young people have recommended digital innovations, such as apps and tools, to enhance accessibility and engagement, as well as improved questioning practices in schools and healthcare settings to identify and address abuse sensitively.

Furthermore, we are developing accreditation work that will integrate the survivor voice, while actively seeking sustainable funding to maintain the momentum of this project. A key focus will be taking an intersectional approach, ensuring we have the resources to reach and uplift diverse communities. Only by continuing to elevate survivors' voices can we create a lasting impact and nurture accountability within healthcare systems.

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