**Safeguarding: Domestic Abuse and Coercive Control**

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0:01 **Speaker**: Well, thank you so much, everyone, for coming and joining me for this webinar covering domestic violence with a sort of focus on coercive control. I think a lot of us are aware now that domestic abuse is just appalling in its toll on people and families affected. It's an abuse of human rights and it's a major public health problem because of the long-term health consequences for people who've experienced it and as well as the personal tragic impact on every family that's affected, domestic abuse is costing public services £4bn each year, with the NHS bearing almost half of that cost.

This talk is aiming to offer information and resources to support us all, to ask the right questions, to help to try to end this cycle of abuse.

0:51 **Speaker**: Over the next hour, I will talk about the definition of domestic abuse, talk very much about the importance of coercive control which is such a key sort of factor in this, talk about how we should use ‘Ask and Act’ to ask questions from possible victims. Look at just who are likely to be the victims of this. We will cover the eight stages of the homicide timeline. Look at the effect this has on children, which is profound. Recognise the importance of our role as health professionals, what we should be looking out for, why it's quite difficult sometimes to ask. And the most important message that we will come to time and again throughout the talk, is that we need to tell potential victims that we believe them when they disclose abuse.

1:37 **Speaker**: The Home Office definition is ‘any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are, or have been intimate partners or family members, regardless of gender or sexuality’.

And this can encompass but isn't limited to psychological abuse, coercive and controlling behaviour, physical abuse, sexual abuse, financial control and abuse, or emotional abuse. And there are so many different forms of this kind of behaviour.

But the bottom line that we all need to recognise all the time is that it is not OK and it's never OK.

2:27 **Speaker**: The Home Office has found after a public consultation, that coercive control is the best framework for understanding domestic abuse. Controlling patterns tend to dominate domestic abuse and this is particularly evident in high-risk abuse.

It's not always visible. Perpetrators are highly manipulative and they use subtle undermining behaviours to control their victims. They may try to isolate the victims. They can be cruel to pets or to children. They'll use constant undermining criticism like, ‘Well, that might have looked nice if you were 10 years younger or a stone lighter’. They can be jealous. They can be possessive. They can make excessive demands on their partners. And a very common one is that they'll blame previous partners for relationship failures. And that's definitely one to watch if you see that happening in friends or family members’ new relationships.

3:28 **Speaker**: Now, the Violence Against Women, Domestic Abuse and Sexual Violence Act 2015 has an overarching objective to improve the public sector response in Wales to gender based violence, to domestic abuse and to sexual violence. And the aim is to be preventative, to be protective and to be supportive. And this act includes really important things like healthy relationship education in schools. We've got a ministerial adviser that's covering this. National and local strategies have been developed. We've got national indicators to try to measure progress with annual reports and statutory guidance and directions that we're aware of in primary care, like Ask and Act.

4:16 **Speaker**: Ask and Act is a targeted enquiry. We use specific indicators as a prompt to ask potential victims whether there may be problems at home. And this is aiming to increase identification of victims. And then we're able to offer referrals, interventions, signposting. The aim is to create a culture across public service where this is an accepted issue and disclosure is then supported, accepted and facilitated. It's not something that's shameful and hidden under the carpet. We want to proactively engage with victims who are vulnerable and hidden at the earliest opportunity.

The bottom line that we need to remember all the time is that domestic abuse has a profound effect on all those who experience it. The pattern of domestic violence is one of escalation. And what that means is that no level of abuse should be viewed as acceptable or insignificant. Early intervention will save lives and considerable morbidity. This is a hidden crime and it's under-reported. But even so, it accounts for a quarter of all violent crime. Shockingly, it often starts and then intensifies in pregnancy. It can occur in all areas of society. Perpetrators can be well known with high status occupations, and this makes it quite challenging to tackle. And it's recognised that domestic abuse is historically stable and it's a persistent problem across the world.

5:59 **Speaker**: Victims say time and again that they were reassured in their relationship that he always says ‘he will never do it again, he's sorry, he just lost control. It was a momentary snap’. But we need to remember that domestic violence claims the lives of two women a week and he probably will do it again.

6:18 **Speaker**: Now, who are the victims? The first thing to recognise is that more than 90% of victims are female. And I put this very wholesome picture of me with my friends, with our lovely new babies out in the woods just before Christmas, gathering holly to make Christmas decorations. You know, you can get a lovelier image, but I put it in there to show up that one in four women in England and Wales will experience domestic violence in their lifetime. So as health care professionals, we should be looking behind the smiles behind the sort of rosy exterior because a lot of victims have to put on a sort of smiley face or they're going to get into trouble when they get home. Domestic violence occurs at a similar prevalence in all income levels, all backgrounds. Half of victims are living with children who are less than sixteen years old. So that's a huge, huge impact on the children as well. And all evidence we have indicates that domestic violence is widespread. You will have victims in your practice population that you don't know about. On average, high risk victims live with domestic abuse for over two and a half years before they seek help. On average, a woman will be assaulted 35 times before she reports her partner to the police. 8% of women will suffer domestic violence in any given year. The likelihood of violence decreases with age. Younger women are more vulnerable and situations that put relationships under strain will increase the risk.

7:53 **Speaker**: Victims of abuse often behave differently to so-called normal people in that they'll often frustrate us by refusing help time and again. But we shouldn't assume they've got a choice to just get up and leave. Most people will act in the way that they believe is in their own best interests. So rather than being frustrated with a victim who's clearly in desperate need of medical attention, don't be frustrated that she refuses help. Instead, ask - why on earth won't she get in the ambulance? Victims know there are no crimes more difficult to prosecute than rape or domestic abuse. The secrecy and the inflexibility of family courts can lead to victims, time and again, withdrawing complaints and going back to managing their own safety. There's still a strong belief in our society that domestic abuse is a couples’ problem are not the dangerous behaviour of an individual. Challenging a controlling perpetrator is incredibly risky because convictions for domestic abuse are very low. Perpetrators are really good at manipulating how their victims are perceived in society. So, we need to be looking out for this.

9:09 **Speaker**: Coercive control is now criminalised, now well recognised as very dangerous behaviour. It was first described by the forensic social worker, Professor Evan Stark. Coercive control is often invisible, hidden, elusive. Perpetrators follow patterns of coercive control. They're more likely to have narcissistic personality disorders, but actually can control can come from a very broad range of complex reasons. Controlling patterns are perpetually active in relationships. They are systems that enforce and monitor the control that the perpetrator has over their victim. So, when violence breaks out, it's a system to monitor and control the victim. It's not a sudden loss of loss of control as it may be described. Our justice system, unfortunately, is designed to deal with incidents rather than patterns. And courts are not set up to take full account of the power differential between the parties in these relationships.

10:22 **Speaker**: Fear. Usually in normal life this is a useful survival mechanism. We all have intuition that alerts us to threats to our safety. Fear is a complex physical response regulated by the amygdala in the brain. Fight or flight response when activated sort of takes over our conscious thoughts. You know, we pull away or, you know, if a child runs out in front of the car, we swooped to grab them. There's nothing sort of thoughtful going on in that. It's an instinctive reaction. So that immediate fear response is easy to recognise, but chronic fear is incrementally built through experience. It's all about trying to predict and avoid harm. Controlling people instil in the minds of their victims the price of their resistance. Victims know only too well the consequences of challenging their abuser. So, for this reason, statements from victims are not always a reflection of the truth. Compliance might well look like consent rather than the fear that it actually is. Now we need to support our victims, help them to manage these consequences rather than judge them for the way they're behaving.

11:39 **Speaker**: In effect, we shouldn't be asking why a victim stays in a relationship, why doesn't she leave? It's got to be her fault. Oh, she's damaged. You know, she's just self-destructive. Look, she's gone from one terrible relationship to another. This could actually happen to any one of us. What we need to be asking instead is why the perpetrator is abusing them?

12:08 **Speaker**: I'm going to move on to talking about the eight stages of the homicide timeline. Now, this comes from a fantastic book by Jane Monckton-Smith, who's a criminology expert and a former police officer. The book's called ‘In Control’. It's a really good read, quite an easy read, but it gives you a lot of depth of understanding about this this problem. Jane Monckton-Smith has been researching domestic violence, coercive control and stalking for the past 30 years. And this book is the culmination of that work. It lays out a sort of identifiable set of stages which allows us to understand these patterns of behaviour and recognise problems earlier. And that means we can hopefully protect victims.

1. Stage 1 is a history of control and stalking. Now, the most significant red flag that warns of danger ahead is that a partner has been or is controlling. Past behaviour is strongly predictive of future behaviour and violence is employed in coercive control as a job to elicit a particular outcome. It is not a sort of sudden loss of control. It's all about keeping the victim where they want them to be.
2. Stage 2 is the commitment whirlwind, and we can probably all think of people who've sort of suddenly met someone fallen head over heels in love. You know, they're joined at the hip. Within months they're engaged. Not all of those relationships are worrying or sinister, but it certainly is a bit of a red flag for concern controlling. People expect that the commitment is to them rather than from them, and they expect that commitment for life. Now, society reinforces this. Separation is really difficult. Divorce is a legal process. It attracts blame. There's talk about the harm it does to children. And jealousy. It's a tricky one. It's a very unhappy emotion, but it can feel flattering, especially to the victims who've got low self-esteem. And that can be really powerful. Young people are particularly vulnerable to that. And jealousy can manoeuvre individuals into living sort of isolated lives where in fact their freedoms can be really limited. Education about relationships, education about jealousy and that it's not right, it's not a good thing, needs to start in schools. And yet that speech bubble, the perpetrators can justify jealousy. You know, I'm not jealous. I'm territorial. Territorial is protecting what's already yours. They'll have a lot of ways to sort of justify their behaviour.
3. Stage 3 is where people live with the control in their relationships. Jealousy gives power by offering a plausible explanation for control. Loyalty is often used to control the influence others have over a victim. You know – ‘Why on earth do you keep going to see your mother? You know she hates me. Well, you obviously don't care about how she makes me feel’. That kind of thing. It's common for victims to have to present a happy face to others, otherwise they get into a lot of trouble when they get home. Socially confident controllers might well keep family members themselves close to sort of increase the monitoring control over the victim e.g. flattering a victim's mother. ‘Oh, I can't believe you're a mum. You look like a sister. I love the outfit you're wearing’. It’s surprising how powerful those sorts of things can be. A lot of us now know what gaslighting is. It's a pattern of behaviour which is designed to make victims of control feel that they're unstable. And again, that's incredibly powerful. Very, very difficult to overcome. Mental health issues, which are common in victims of domestic abuse, are common as are taking drugs and alcohol. And all of those things increase the power for control. ‘You're not a fit mother. Oh, if they knew what you were doing, you know, they'd have the children taken straight away from you. You're a disgrace’. All of that kind of thing is very, very difficult to push back against.

Routines and rituals are used to control to of as an early warning system to highlight a challenge to that control. So, you know, if they expect supper on their lap in front of EastEnders every night at seven o'clock and suddenly that doesn't happen, that can be a big sort of trigger for further escalation of violence. There are multiple types of control that are kind of interweaved to form an inescapable web which keeps the victims trapped if it's not challenged. Now, the horrifying thing is this stage 3, which is hell to live with, can last a lifetime if it's not challenged. And many, many women do live in these marriages for decades.

The web of control, all the different ways that the perpetrators can control their victim. Financial control, the sort of obvious way that you think of this is that a victim is given a sort of tight housekeeping budget and no more. If she needs to buy her child school shoes, that that can be very difficult. But you can get different financial control, for example, where a perpetrator refuses to work or finds work too stressful and so stays at home and the victim ends up having two or even three jobs to try and keep the family going. And then the victim feels it's even harder to leave the perpetrator because she thinks how on earth would he cope? You know, he's got no means of supporting himself. It all sort of layers up. Honour-based violence and community control is a big issue. Threats to those who matter to the victim and that may be a dependent family member, it might be the children, it might be the cat. You know, it doesn't really matter. But those threats are often very real and serve to keep the perpetrator in their place. Sexual abuse is very, very common and important, actually, for us to recognise that there's a strong link between strangulation assaults and homicide. And that's something that might be worth talking to, particularly younger patients about. That is, you know, it is not OK.

Stage three is all about ensuring a partner is compliant and trapped in their relationship.

18:57 **Speaker**: Now, talking about children and domestic abuse. About one in five children in our society have been exposed to domestic abuse, and when a woman is abused, it's very likely the children may also experience abuse. Domestic abuse is a factor in 60% of serious case reviews. And we must recognise that witnessing or experiencing domestic abuse is a form of child abuse. Children who witness violence in their home are 15 times more likely to later become victims of physical or sexual abuse themselves. And boys who witnessed domestic violence are twice as likely to become perpetrators of domestic violence themselves. It has a profound effect on children within a family, and study has shown that children who are exposed to violence in their family show the same pattern of activity in their brains as soldiers exposed to combat. And this is why adverse childhood experiences have a lifelong impact potentially on children. It actually is changing that the brain make-up.

1. 20:08 **Speaker**: Stage 4 is where there is a trigger. It can be separation - that's probably the most common trigger. But any number of other life changes e.g. the victim becoming pregnant, running into financial difficulties with, you know, redundancy or retirement. Socialisation is a powerful and it's an insidious force in society. Boys are often socialised to expect to feel in control of their family. They feel that it's their right and you can fight for your rights. And this sets up an expectation and a pressure on them. Pregnancy can be a trigger because suddenly a woman's priorities change a little bit. You know, she's got her baby to look out for and also midwives, doctors, other people suddenly become more influential. The tipping point is not simply jealousy.

21:11 **Speaker**: Now, this is really important, the myth of the crime of passion. For millennia, we have rationalised the killing of spouses with the reassurance for us in society that this was a crime due to passion. But the reality is that intimate partner homicide is one of the more predictable forms of homicide. In 2020 in the UK, intimate partner homicide rate more than doubled after lockdown restrictions. But there are links between domestic abuse and wider crime and other forms of homicide. There are many cases when more than one partner has been killed and the victim's story is often lost. You know, they're dead and we are very good at rationalising what happened. Victim blaming is common. And I'm not sure if you've heard of Occam's Razor, which we use a lot in medicine, where the simplest explanation is probably the right one. You know, like common things are common. But this is not valid for coercive control. These are complicated people who have layer upon layer of complexity and what they're setting up. You need to look deeper.

1. 22:23 **Speaker**: Stage 5 is escalation, the most dangerous category of stalker is an ex-partner, the ‘not known to the victim’ stalkers is actually less of a risk. Stalking is a means to gather information and exert fear from a distance. And it's uniquely damaging to victims who are manipulated into a state of hyper vigilance. The instinct that something is wrong, something is very wrong, may be built on cumulative knowledge. And stalking and coercive control are twin behaviours that go hand in hand. There is now a huge array of modern technology which is available to perpetrators to track and monitor their victim. A friend was asking me because she knows I know a little bit about this, whether it's acceptable for someone to put a tracking device in someone's car. This was her friend who left her husband, and she couldn't understand how her ex-husband kept turning up and, you know, shouting at her, but she didn't understand how he knew where she was going to be. And she found a little tracking device in the glove compartment of a car, blu-tacked up to the top, that cost about £80, I think. And yes, I was able to say to my friend who knew her, no, that is absolutely not legal and not acceptable. And it's very, very worrying. But the ability for people to do this fairly cheaply and easily is escalating these problems. Not all perpetrators will progress from this escalation. And many controlling relationships just circle from stage 3 to stage 4 to stage 5 and then back again as the victim just gives up and goes back to the sort of controlling state of stage three.
2. 24:15 **Speaker**: Stage 6 is where there's a change in thinking and the perpetrator's strategy changes from attempting to keep a partner in a relationship to try and destroy them for leaving it. Now, this picture of all of these sets of shoes, unfortunately, comes from the Counting Dead Women Project, where women have died in suspicious circumstances, which, when the project looks into it in more detail, suggests that there may have been much more to it because many cases of women's deaths have the most ridiculous, appalling explanations. You know, the defence that's put forward and is believed just when you look at the more closely seem ridiculously unlikely. The reality is that lawyers are well versed in what arguments are likely to succeed. We need to take the threat of suicide and the threat to kill very, very seriously. Many of these cases are not a snap loss of control. When you review them, they were carefully planned, logically well-organised and determined.
3. 25:30 **Speaker**: Stage 7 is the planning stage. Now, I think most of us know that the most vulnerable time for a victim leaving their victim is when they leave their partner. But I kind of always imagine that was when it happened, you know, or for the next few days afterwards. But in actual fact, the average time between separation and homicide is just over a month. So that risk goes on for some time. And again, as I say that the evidence is that many homicides are carefully planned and preceded by a trigger event. An example is a man called Robert Trigg, who was a former chef from Worthing. He killed two of his partners by staging their deaths. But the second victim's family had to fight for five years to get the police to recognise that their daughter had been killed by Trigg and hadn't just died in her sleep. There's a really long history of professionals being reluctant to consider a sinister cause for these deaths. And now, thank goodness we've got a greater willingness for professionals to be curious and to look deeper.

These statistics are just awful. In the first three weeks of the first lockdown in 2020, 16 people were killed, which was the highest number for 11 years. There was a 49% rise in calls to the abuse helpline compared with average, and a 35% rise in calls to men's advice line in the first week of lockdown. This has really been escalated with the Covid pandemic.

1. 27:04 **Speaker**: The final stage of the timeline is homicide and/or suicide. Intimate partner homicides are so disturbing because choice is made a very often excused in the horror of it is minimised. We need to use the evidence of this timeline to change the belief systems of professionals. And we need to do this because perpetrators are likely to behave in a dangerous and controlling way again with their next partner unless their control issues are robustly dealt with. An example of this is a man called Theodore Johnson. He killed three of his partners. In 1981, this was considered manslaughter. In 1993, he got off with diminished responsibility. And then finally in 2016, he was sent to prison for murder. So many of these deaths are recorded as misadventure or accident or natural causes when actually more investigation is needed.

And then suicide is also a very big risk with domestic abuse. Between 4 and 10 women kill themselves every week in the UK after recently suffering from domestic abuse.

I was just going to talk a little bit about well-known perpetrators. O.J. Simpson, who lots of us have read about or watched on the telly. He had a history of violence and control against Nicole Brown Simpson before he killed her. And police were aware that he was stalking her when she died. And then Oscar Pistorius, the Paralympian, had a history of possessiveness, jealousy and violence and threat against previous intimate partners. He'd used a gun to threaten girlfriends in the past, and he'd previously locked Reeva Steenkamp in their house. It was recognised that his management of her life was obsessive. And finally, Harold Shipman had been accused of coercive control and domestic abuse. And just imagine if he'd been accused and tried and convicted for that before all of the hundreds of deaths of his patients. You know, we could have changed so many lives if that had been taken seriously.

29:20 **Speaker**: Identifying a controlling person may minimise the damage they cause, but it's not easy because of their sort of cleverness. We can't leave this to common sense. If we recognise the 8-stage timeline, it may help us to protect victims. And I guess if the worst happens, we can use it to hold killers to account.

Male victims of control often believe there in less danger than they may be, and the risk to them is even greater if they're gay or if they use defensive violence. It's really essential that if there's a history of coercive control, then any unexpected death should be investigated. Trials will present plausible narratives which are designed to win an adversarial battle. The Domestic Homicide Review is an important new innovation, which is hoping to push back against that. And through telling these stories, hopefully we will recognise these patterns and recognise these danger signs.

30:29 **Speaker**: Our role is very important as health care professionals. The NHS is likely to be seen as less stigmatising than other organisations and as a consequence, we're in a unique position to help. So just always think about the possibility of domestic abuse and ask. We can't assume that someone else like the police or social services will do something because often no one else will know. We are very well placed as health care professionals to raise issues that lead to disclosure. If that happens, it's essential that people are treated with respect and with dignity. Victims so often feel ashamed or humiliated, very frightened or angry. The slightest hint of scepticism from us or that we're rushed or that we're not bothered will drive them back to isolation and violence. We really must listen and not judge. Talking about domestic abuse will help to end the stigma and let survivors know that they're not alone.

31:38 **Speaker**: It's really important to recognise that the link between domestic abuse and child abuse is so strong that we should usually make a referral to social services in cases where there are children dependent on the perpetrator or on the victim. And this is the case even when an adult victim has capacity and declines the referral. The children don't have to be present at the time of the incident, triggering concern. The professional is making the referral because we are acting as we should, as the advocate for the child.

Domestic abuse has a profound and lasting impact on children. They can grow up thinking that violence is normal or that they're to blame for it. They might get caught in the crossfire and sustained physical injuries. It can impact on every aspect of a child's functioning. It can cause depression or anxiety. So much guilt, fear, insecurity can give them sleeping disorders, eating disorders, nightmares, shame, self-harm. At school it can make it hard for them to concentrate. It can make them more aggressive. Violence is normalised for them. It can make them become sexualised early. It can make them take drugs. It can make them become delinquent. When child abuse is identified, it's likely that there's domestic violence also present, and victims or perpetrator’s common response is that the children were in bed and knew nothing about it. Not right. They usually are aware.

33:14 **Speaker**: Now, Ask and Act which we've talked about a little bit before is really important. It's essential that we are sensitive to cues because women often hope that someone will realise something is wrong and ask them. It's much harder for people to volunteer information themselves. Don't assume that denial means it's not happening. They might be very afraid to acknowledge it. It's a little bit like brief intervention. If you're worried it's happening, you can gently ask more than once. Our job is to try to empower the victims to make informed decisions and recognise that they have some choices. We must respect their confidentiality, but also be clear about the limitations of this. If there's a child at risk, try, if you possibly can, to see a victim on their own, away from their partner and children. The safety of the person and dependent children is paramount, and we must cooperate with other agencies which ups the sort of level of support and help that we can give to victims. Really important. Don't place yourself or your colleagues at risk in a potentially violent situation.

34:32 **Speaker**: It's really important that we recognise that ourselves and our teams may well have a personal reaction to domestic violence. If you think one in four women, one in six men are affected by this, there are many people within our own teams who may have a personal problem with this, and that can affect how they react and how they deal with this. It's also absolutely essential that we know what local resources and services we have available to support victims and to treat perpetrators. We want to increase awareness amongst our staff about the nature and prevalence of this. Let everybody in your teams know how important it is that if they've got a concern, that's useful information for us. You know, the receptionist watching people in the waiting room, dispensers, health care assistance. Everybody has the opportunity to sort of pick up a cue. And if they bring that back to the Safeguarding Lead, then we can do something with that. It's really, really essential that we challenge the belief that domestic violence is not a serious matter and that it's a private matter. It's not. Create an environment in your team which encourages disclosure. Ensure you've got a clear protocol for responding to suspicions, and then use appropriate referral channels as part of a multiagency approach to do the best we possibly can for these victims.

35:55 **Speaker**: Why might a victim be reluctant to disclose what's going on? So many reasons. They might be afraid that we won't be sympathetic. They might not think it's our job. They might be very, very afraid of reprisals when they get home and then an escalation of violence. Many victims are desperately ashamed and embarrassed about what's going on for them. They might well be afraid that their children will be taken into care. You know, if they're resorting to coping mechanisms like drugs or alcohol that the perpetrator may well use, that may say that he will use that so that belief is built on sort of threats already. They may well be terrified they won't be believed, especially, you know, if the perpetrator’s got a high-status profession well known in society. In certain ethnic minorities, there may well be significant cultural stigma attached to this, which we need to recognise. And some people may be terrified that the police may become involved, and they may be deported. Belief is key. We need to sympathise, support and tell our victims that we believe them.

37:11 **Speaker**: And then on the flip side, why is it hard for us to ask as healthcare professionals? I think for me, the biggest one is that these are not ever ten-minute consultations and time constraints is a really significant part of this. We can be afraid of taking the lid off something that's going to get out of control. Some of this might not be quite sure what we should be doing next. It sounds ridiculous, but I've often been in a situation where I'm just wondering if something's going on at home but I'm worried that that suggesting that might cause offence. Some healthcare professionals might feel this isn't our role. It's not what we should be dealing with. And again, as I've said, that personal identification with abuse either as victim or perpetrator can be very important.

38:05 **Speaker**: It's a tricky thing to bring up and I just thought I'd go through some useful questions. Always in medicine open questions are good. You could say:

* Do you do you ever feel frightened of your partner or other people at home?
* Does your partner ever lose his temper with you? If he does, what happens?
* Has your partner ever destroyed or broken things you care about or threaten to hurt you or hurt the children?
* Has he ever forced sex on you or made you have sex in a way that you don't want or equally withheld sex or rejected you in a punishing way?
* Does your partner get jealous of you seeing your friends or talking to other people or going out? If so, what happens?
* Your partner seems really concerned or anxious about you? Sometimes people react like that when they feel guilty.
* Does your partner use drugs or alcohol excessively? If so, how does he behave?

Think what's most appropriate for your patient that sat in front of you. But the key thing is open questions, a concerned approach, and then time, you know, don't rush your patient. This is huge for them.

The signs we should be looking out for are changing attitudes and behaviour. If a patient is always accompanied by a partner, even if they seem super supportive and concerned, a partner who seems to be exerting an unusual amount of control, relying on their partner for decision making, not seeming to have free will, an obsession with timekeeping. You know, I've kept a patient waiting for half an hour because the patient before needed to be admitted to hospital, for instance, and they get increasingly frustrated and irritated, then rush home. That might not be as simple as they're just irritated that I've kept them waiting. There may be more going on. Their partner may be suspicious and disbelieving that they had to wait so long to see me. Patients being secretive about their home life, being worried about leaving the children at home with their partner, unexplained injuries, of course, people trying to minimise injuries or hide them with clothing or make up, substance use, fatigue, sleep disorder. Any of these things could have a completely non-sinister origin. But equally, they're just useful things for us to be upping our sort of sensitivity to.

40:40 **Speaker**: Symptoms that we should be looking out for. Depression and anxiety, of course, self-harm, eating disorders, but then medically unexplained symptoms, you know, chronic pain, chronic pelvic pain, repeatedly attending for sort of odd symptoms. Victims of domestic abuse often have recurrent miscarriages. Often have multiple terminations. They might have repeated vaginal bleeding or sexually transmitted infections. Frequent non- attenders. Again, that can be a concern.

41:26 **Speaker**: What do we do about this? Always, always, if there's an immediate safeguarding risk, we need to report that straight to the police through 101 or 999. Don't use MARAC for that. You may well still need to make MARAC referral. But first priority is to make sure the risk is being addressed. Now, the risk of death peaks at the point the victim tries to leave the abuser and then, as we've said, for a period after separation. We need to offer immediate treatment, assess safety, assess the risk of self-harm or suicide. That's really important. Look back at attempts to get help in the previous 12 months, ascertain the availability of emotional and practical support for the victim. Have they got anywhere safe that they can go and stay? And often that's complicated. You know, they may have three dogs and they can stay with their mum, but the dogs can't. Or, you know, there's always layers of complexity here. And we need to be our patient’s advocate. Try and cut through the through the complications and see if we can find a way. Look for a safe haven. If children are believed to be at risk, then we need to instigate child protection guidelines. Discuss that with the victim. Try and obtain consent if you possibly can. But the interests of the child are, as always, paramount.

42:54 **Speaker**: The BMA has stressed the need for evidence, especially if the perpetrator is charged. This can be used in the family courts to assess risks in granting access to children to a violent parent. Document injuries as much detail as possible. Document mental health problems. Record domestic abuse incidents in the records of the victims and in any children. Only record information in a perpetrator's record if you are certain that they're aware that the abuse has been disclosed because otherwise they can request their records and suddenly the victim is at much greater risk. Try and use the words that the victim or the perpetrator uses in quotation marks. That's incredibly powerful in court. Much, much more useful than your interpretation of what's been said.

43:46 **Speaker**: So domestic violence, as we've said, creates a significant cost burden for the NHS and it's a key public health issue. The MARAC Multiagency Risk Assessment Conference is a vital tool in assessing safety. And this multiagency partnership is the most effective way to protect people and approach domestic abuse. We've got such an important role to play in the NHS. Women are, as I've said, much more likely to disclose abuse to a healthcare professional than to the police. And almost all victims will come into contact with the health service at some time. The MARAC tool moves responsibility from the victim to a broad group of agencies who can cooperate together to do the very best we can for victims and their children.

The aim of MARAC is to share information, raise awareness of the impact of domestic abuse on children, agree and then implement a risk management plan. They will get an individual domestic violence adviser, an IDVA specialist care worker involved. And all of this is aiming to reduce repeat victimisation.

45:12 **Speaker**: If conversations in society change, then practices will change. And so society needs to let controlling people know that their behaviour is unacceptable. It's in all of our interests to stop giving abusers excuses. If we can identify a controlling person, then that's a huge step towards minimising the damage that they can cause. This is not simply a private or a police matter. Our media, our courts, politics, social lives should not stand in solidarity with perpetrators at any level. We've got to create interventions for each and every one of the eight stages. Domestic violence and coercive control are risk markers for other offending. And the eight-stage model can help us to overturn and challenge old traditional myths. We have the power to change this if we're looking for it.

46:04 **Speaker**: So, in summary, if you have a case enquire sensitively and provide a safe and empathic first response. If there's an immediate risk of harm, you need to address that straight away. Ensure that the victim’s level of risk is identified by someone with domestic abuse training. Use the Safelives DASH risk checklist and always, you know, trust your professional judgement. It's not gut instinct. It's probably years of experience and training that make you think something's going on here. Something's wrong. Speak to your Safeguarding GP Lead if a child or vulnerable adult is involved. Share these concerns with your colleagues, because this is very challenging stuff. Refer to the local domestic abuse support service and read code this appropriately. History of domestic violence is very important down the line because these patients often move from practice to practice. They're much more mobile because of the challenge they have in their lives. You can't guarantee that you'll be the GP next time it happens.

We want to break the silence. There are so many stories from people who have escaped violence and then pick their lives back up which shows that these victims are just normal people who got unlucky. It's never the victim's fault. During this talk, several people will have been the victim of violence. Abuse thrives in silence and shame and secrecy. And we can all make a difference. Shining a spotlight on abuse has the power to end it. Victims need every one of us to recognise the signs. If we show abuse the light of day, we can end it.

And just to finish off, a victim may only reach out for help once. The most powerful words we can say are ‘I believe you’. And that sometimes makes all the difference in the world.

And finally, in the words of one of my heroes, Maya Angelou, ‘History, despite its wrenching pain, cannot be unlived. But if faced with courage, need not be lived again’.

48:14 **Speaker**: We've got some signposting here. Some of this is local to Monmouthshire, but if you contact your local domestic violence centre, they'll give you all of this for your local area. Some really good local resources and it astonishes me how much support there is out there. But it's only powerful if we all know that it's there and know how to access it for our patients.

Lots of domestic abuse resources here from the RCGP, from IRIS, from MIND. There's an awful lot of resources and support here.

Some particularly good books that I read which inform this talk and which are highly recommended.

And then finally, if you're like me and you like narrative medicine and learn through fiction, there are some fantastic books out there. ‘Our Fathers’, which is a book by Rebecca Wait, beautifully written. The most vivid portrayal of coercive control, as well as the long-term consequences of guilt and trauma. There's a graphic novel if that's your style of reading ‘Becoming Unbecoming’. Very, very beautiful book. Lots of good things there.

I think that's the end. And we move on to any questions.

Thank you very much.