Healthcare & Domestic Abuse

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– A North Yorkshire Scoping Review

Time to respond

Healthcare professionals are aware of their role with safeguarding victims of abuse and the importance of early identification. However, consistently across healthcare services there is a feeling that they don't have the same time to respond to cases of domestic abuse as they did in previous years because of increasing pressures across the sector. This can become a barrier in identification and referrals whilst also impacting the relationships healthcare providers can build with their clients.

Remote Healthcare

Many healthcare services moved to remote working during the COVID -19 pandemic. As restrictions have lifted services have maintained more remote working and talking to someone on the phone about healthcare concerns is becoming more of the norm. This bring concerns about identification of individuals being subject to abuse.

Asking difficult questions

Both healthcare professionals and survivors see the need to ask difficult questions around domestic abuse and research has shown that being direct helps with early identification. Healthcare professionals need to feel supported to ask these questions and in the referral pathway that follows a disclosure, while survivors need to feel comfortable and safe to be open about the abuse.

Rural challenges

North Yorkshire is unique in its geography, with large rural areas and communities. Where rural communities often have close knit relationships this brings added difficulties to domestic abuse victims and rurality becomes a risk. With isolation high in these communities the need for supportive and accessible healthcare services becomes paramount.

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Introduction

Domestic abuse is a widely recognised as a major public health problem because of the long-term health consequences for people who have been subject to it, meaning primary care staff play a key role in safeguarding [(1)].

Domestic abuse is an ongoing and prevalent issue in the UK. The Crime Survey for England and Wales estimated that 2.4 million adults aged 16 years and over were subject to domestic abuse in the year ending March 2022[(2)]. This estimation was based on 6 months of data collection and is reliant on victims and survivors telling authorities about abuse, so it is likely that this is figure is underestimated, as many individuals do not tell anyone about the abuse. The UK government definition of domestic violence has also been expanded to emphasise that domestic abuse is not just physical violence but can include, emotional, controlling, or coercive and economic abuse[(3)].

Due to the scale of domestic abuse within communities, focus has been put on the role of healthcare in identifying cases with the Department of Health saying: "Domestic violence and abuse is so prevalent in our society that NHS and other provider staff will be in contact with adult and child victims (and perpetrators) across the full range of health services"[(4)]. Domestic abuse has also been recognised in the Public Health Outcomes Framework as a major public health issue with local authorities and healthcare entities responsible for protecting those that are vulnerable[(5)] .

According to a SafeLives report, 'A Cry for Health', nearly half a million survivors of domestic abuse seek assistance from medical professionals and visited their GP on average 4.6 times in the 12 months prior to seeking support from IDVA services[(5)]. This is further support by research indicating 80% of women in in abusive relationship seek help from health services, predominantly GPs, at least once and this may be their first or only contact with professionals[(6)].

On average 2 women a week are killed by their partner or ex-partner in England and Wales [(7)] and children exposed to domestic abuse are at a higher risk of having mental ill health, poor relationships, and physical health as adults[(8)] making it a key issue within healthcare.

The aim of this report is to build a picture of healthcare's response to domestic abuse in North Yorkshire and identify gaps and make recommendations for improvement. In addition, a review of available literature and existing projects relating to healthcare's response to domestic abuse will be completed to inform the recommendations.

Methodology

A review of existing literature and healthcare projects has been included alongside a review of publicly available healthcare data to provide insights into where domestic abuse interventions may be best placed. The review identified papers from 2014 onwards including research conducted by domestic abuse sector organisations as well as academics. In addition, a review of domestic homicides was undertaken to identify healthcare specific recommendations.

Within this report, healthcare services that have been focused on are GPs, social prescribers, maternal healthcare including health visitors, and A&E. It is likely that these services will have supported survivors of abuse at different points in their life, but it is important to note not all healthcare providers have been captured due to the scale of services offered in primary and secondary care. However, of the services approached, each one may be more likely to encounter the risk factors associated with domestic abuse. For example, pregnancy is a high-risk factor in domestic abuse therefore it is useful to gain insight from maternal healthcare because of this. Likewise social prescribers often support individuals who feel isolated in their community a further risk indicator in domestic abuse.

A questionnaire for healthcare workers was created to try and capture their views including details of the training that has been provided, how confident they feel with asking questions to clients about domestic abuse and their awareness of newer legislation including coercive control and non-fatal strangulation. We had responses from 15 healthcare professionals which included GPs, health visitors and healthcare workers in maternity and A&E departments. Service users' responses were also captured with a questionnaire from which we had 10 responses. The questionnaires were shared among all available healthcare providers including across all GPs in North Yorkshire, safeguarding leads for individual areas and A&E departments.

Alongside the questionnaires, consultations with service users and healthcare professionals were undertaken to gain a more detailed insight into their views on identifying domestic abuse. Consultations with professionals was informed by the prevalence of referrals from healthcare providers and a rationale based on where victims are most likely to have opportunities to encounter health and could converse with a professional in a way that might facilitate disclosures.

Limitations of the review

One limitation of the review was the availability of research and data. For the literature review, papers were included from 2014 to capture research that was informed by the Domestic Abuse Act and inclusion of coercive control. However, there were limitations with the availability of research papers limiting the scope of this review. It was also challenging accessing available data from NHS providers and Public Health England for North Yorkshire and York. Data that was available gave a national picture so may not be representative of the healthcare within our area which, as discussed further in the report, is made up of a variety of different contexts.

A further limitation of the review was gathering the views of healthcare professionals. The use of the questionnaire gained 15 responses, a small sample that is in line with other studies conducted in this area[9]. Nevertheless, it does limit the conclusions that can be drawn from their responses. Responses were also primarily from GPs and health visitors, making it difficult to generalise their views to other healthcare settings as some of the challenges they face may be unique to their specific sector. There was also a challenge with engaging with healthcare professionals for consultations due to time pressures and availability of staff. A wide range of healthcare professionals and social prescribers were consulted across a variety of healthcare settings.

The use of a questionnaire for healthcare professionals and survivors also limits the review due to potential bias. For example, the survivors who completed the survey may have been motivated to complete the questionnaire because they had a particularly negative or positive experience. Other survivors who did not have a lot of involvement with healthcare professionals may have chosen not to complete the questionnaire, therefore any barriers or views they have may not have been captured. Likewise, healthcare professionals who completed the questionnaire may have been motivated by their own interest in domestic abuse or felt they had to respond to questions in a certain way.

Domestic Abuse & Healthcare: The National Picture

Despite the prevalence of domestic abuse and the large outreach of healthcare providers there are concerns about the identification and sharing of information about domestic abuse cases in healthcare settings.

- A domestic homicide review in London Boroughs found that in 46% of DHR cases agencies including health missed opportunities to share information. It was recommended that healthcare services need a more joined up approach with regard to appointments across healthcare settings to identify patterns[10].
- A Home Office review of Domestic Homicides Reviews (DHRs) also found that risk assessment and record keeping in health was inadequate in some cases, with particular reference to GPs. Furthermore, health was

mentioned most under the theme of risk. A predominant concern was risk assessments not being completed, risk not being assessed as high enough or incidents being assessed in isolation rather than taking a holistic approach[11].

- Research into GP training has also found variability and inconsistency in domestic abuse education, with 44.2% of respondents reporting they did not have any domestic abuse educational sessions and around 15% saying they were either unsure or believed it was delivered as part of safeguarding[12].
- Furthermore, nursing and maternity students have also reported to feel worried about how to talk about the issue of abuse with service users and feel a lack of preparedness for dealing with cases of domestic abuse when they become registered nurses and midwives[13]. This highlights that there is a concern healthcare providers may lack the understanding to identify cases of domestic abuse and if they do are then uncertain about risk assessment, recording and referral pathways.
- Research with survivors identifies clear barriers faced when disclosing. This includes fear of the consequences of disclosure, fear of being judged by their healthcare provider, or feeling their healthcare provider would not be able to protect them from harm. As such, building a positive relationship with their healthcare practitioner, healthcare practitioners directly asking about abuse and ensuring the setting was safe and confidential all aided disclosure[14].
- Confidentiality has also presented as a barrier for health care providers with a review into guidance documents finding that documents emphasised that sharing information without consent should be exceptional and embeds the assumption that survivors don't want information to be shared[15]. If a healthcare professional feels a survivor will not want information to be shared they may not feel able to ask direct questions about abuse. This may reinforce to the survivor that they are not able to share because the professional is not going to be able to protect them. As such studies have indicated a dynamic of silence between health professionals and victims-survivors due to these barriers[16].
- In the National Crime Survey for England and Wales, questions were asked about the medical support for victims of intimate partner violence[17]. This highlighted that 75% of respondents did not sustain a physical injury. A quarter of victims said they had sustained a physical injury and the report describes the types of injuries as 'minor' with most reporting scratches, minor bruising, and black eyes. 35% of males and 47% of females responding sited mental and emotional problems as the main effects of the abuse. However, the Safelives report 'Getting it Right First Time' suggests that nearly a quarter of victims at high risk of harm and 1 in 10 victims at medium risk attended A&E due to acute physical injuries and victims in the most 'extreme' cases may attend A&E as many as 15 times[18].
- A review of domestic homicides and suspected victim suicides highlighted that, of 215 deaths in 208 incidents between 23rd March 2020 and 31st March, 39 of these were suspected victim suicides[19]. In an analysis conducted by Sally McManus a health expert at City, University of London, for the charity Agenda Alliance found that Women who suffer domestic abuse are three times more likely than their peers to try to take their own life[20]. Those who have experienced sexual abuse within a relationship have an even higher risk of suicide and are seven times more likely to have attempted to end their life.
- Home Office Domestic Homicide Reviews highlight that mental health was a factor in 25 of the 33 DHRs analysed with 21 involving perpetrators with mental ill health, 10 involving victims with mental ill health and 6 where both had mental ill health[21]. Of those 16 perpetrators were known to mental health services and of the 10 victims, all were known to mental health services. Depression was the leading mental health concern for both victims and perpetrators.

These findings point to the prevalence of mental health concerns for victims of domestic abuse as a presenting issue and the need for improved risk assessment and recording within healthcare to improve outcomes for survivors of domestic abuse. An overreliance on physical health indicators to identify domestic abuse could result in healthcare

professionals missing opportunities. Combined with time pressures preventing adequate risk assessment or recording, many victims of domestic abuse will go under the radar. Safelives research suggests that many victims may be presenting multiple times at A&E with acute injuries and that intervention at that point could prove more effective[18]. However, health professionals need clear guidance on how to respond to domestic abuse and robust referral pathways as well as adequate time to engage in professional curiosity, record concerns and assess risk.

Healthcare Interventions

We have reviewed a selection of healthcare interventions, where reports or data is available to assess their effectiveness, to help inform the findings and recommendations of the report.

Pathfinder project – Standing Together

To address the barriers in identification and disclosure, Standing Together conducted a 3-year pilot with other partner agencies which aimed to put forward guidance to support healthcare providers in providing a coordinated and consistent response to domestic abuse[22]. The project funded ten health based IDVAs, three domestic abuse coordinators and two IRIS programmes across 64 GP practices and set up 9 Domestic Abuse Champion networks in NHS trusts. The project also reviewed domestic abuse policies and training packages in NHS trusts. SafeLives estimates the annual potential cost savings of a Health Based IDVA provision at £2,050 per survivor on the basis that commissioners prioritise funding for a minimum of two co-located Health Based IDVAs per acute hospital. The Champion's network is formed through upskilling a core team of healthcare staff to provide support and advice to colleagues when needed, particularly if the Health IDVA is not able to respond immediately to requests. This network in combination with the Health Based IDVA also allows specialist domestic abuse knowledge and expertise to be embedded throughout the healthcare setting. A total of 633 survivors were referred to a domestic abuse support service from a health care setting and went on to engage with this service. These survivors entered a domestic abuse service from a referral pathway created by the Pathfinder project and may not have been identified or supported otherwise. This highlights that clear referral pathways give survivors the opportunity to disclose abuse and receive specialist support but also shows the need for collaboration between specialist third sectors and health.

IRISi Programme

The IRIS programme is a model for training, referral, and advocacy to support clinicians to support patients who may be subject to domestic abuse[23]. The IRISi team work with local commissioners to establish, implement and maintain the programme through an Advocate Educator and Clinical Lead who deliver training and offer support to practices. The Advocate Educator also provides domestic abuse support to patients referred into the service. The IRIS programme brings the health and specialist third sector together to provide better informed practice, responses and support, a key component of the Pathfinder Toolkit. When a general practice signs up it received inhouse training for the whole practice team, a named contact for patient referrals and ongoing support and consultancy. Where the Pathfinder Toolkit goes further is with establishing at least two Health Based IDVA's within NHS trusts and establishing a network of Champions.

In the latest report on the implementation of IRISi, there are some findings that build a picture of the domestic abuse support being accessed due to this intervention[24]. Between April 2021 and March 2022, the IRIS Programme was running in 39 areas across the UK. Programmes received 5,813 referrals during that period, totalling 30,009 referrals since the first programme was commissioned. Referrals dipped following the Covid 19 pandemic and are taking some time to recover to pre-pandemic levels. In the year ending in March 2022, 1,498 practices had been trained and actively had a referral pathway to provide support for their patients. There were 770 trainings sessions in the fiscal year 2021-22 and a total of 1,031 contacts* between A&Es and general practices. Most of the training was delivered online.

Demographic information included in the report sets out that the average age of service users referred to IRIS was 40.6 years old. 1.5% of people referred were younger than 20 years old, and 10.6% were older than 60. The oldest person referred to IRIS this year was 97. 97.0% of service users referred to IRIS were heterosexual. 63.2% of service users referred classified themselves as White/ White British, 20% Asian/ Asian British, 8.1% Black/ Black British, 3.4% Mixed and 5% other. 40.5% of service users referred had children and 2.5% were pregnant. 13.9% were disabled, 6.9 % reported alcohol use and 3.8% drug use. The IRISi programme reports that they can reach older people which they refer to as an otherwise 'invisible' group of survivors. Interestingly, the report also highlights health related issues with mental ill health the predominant presenting factor, followed by physical health conditions, alcohol, and drug use. This is unsurprising as emotional abuse was reported in 87.6% of referrals where the type of abuse was recorded followed by phycological abuse in 71.35 of cases. Physical abuse featured in 52.8% of recorded cases.

13.9% of service users were disabled, an increase on previous years but still below the national average. The programme also reports on the number service users with children and pregnant. 40.5% reported having children and 2.5% were pregnant.

Despite the need for a clear and supported referral pathway in healthcare settings the provisions mentioned above are not found universally across all integrated care boards. Although policies and procedures within the NHS attempt to give a consistent response to domestic abuse, if some areas are employing different service provisions it can cause inconsistency across the UK. As such, this may limit some of the research discussed above involving survivors and healthcare professionals because their experiences will be shaped by available service in one area.

Co-Located Health IDVAs

The SafeLives Themis 'Cry for Health' report was conducted to evaluate the impact of co-located IDVAs in hospital A&E and maternity departments[5]. This work resulted from the 'Safety in Numbers' report, also conducted by SafeLives, which recommended that the healthcare response to domestic abuse was strengthened[25]. The Themis report was the result of a multi-site evaluation, comparing the interventions of hospital based IDVAs with community teams. The results suggested that hospital based IDVAs engaged with survivors 6 months earlier than community-based services and were successful at engaging victims with complex needs such as mental health, drug or alcohol misuse. There was also evidence that many victims who engaged with the hospital IDVA had attempted suicide or self-harmed. Furthermore, 16% of victims had taken an overdose in the last six-months before accessing support from a hospital IDVA. There was also evidence that hospital IDVAs were intervening earlier with a higher percentage still living with or in a relationship with their abuser than were supported community IDVAs. The report evidences an increase in MARAC referrals from hospitals with a Health IDVA co-located. In addition, the report makes the case that co-located Health IDVAs could also support the high numbers of healthcare professionals likely to be subject to domestic abuse themselves. It was also recommended that a Health IDVA be attached to a midwifery unit as it gives the opportunity to detect domestic abuse victims during pregnancy when the risk to them and their unborn child increases. Health IDVAs who developed strong relationships with maternity services were also able to support more pregnant women. Health IDVAs were also vital in the training and professional development of healthcare staff, increasing levels of awareness and understanding and ensuring referral pathways for support were widely known and utilised to safeguard victims. Health IDVAs also play a key role in signposting to longer-term, community-based support services.

Ask for ANI

A further intervention used within healthcare is the 'Ask for Ani' scheme which has been rolled out across pharmacies in the UK[26]. The scheme was set up to allow survivors to discreetly ask for support by "Asking for Ani". This would then alert pharmacy workers to offer the survivor a private space to access support or contact police if needed. The scheme was initially available in 2,300 Boots stores across the UK as well as 255 pharmacies. It is now operational across 5,000 pharmacies across the UK in over 88 cities, towns, and villages. It was developed by the

Home Office and SafeLives and included consultations with survivors' groups and domestic abuse organisations. It has faced criticism from Women's Aid organisations due to concerns over accessibility and safety as well as the need for robust training for staff to effectively safeguard survivors[27]. The rational given by the Home Office for the scheme was that pharmacies provide a safe space for victims if they are isolated at home with their abuser and unable to get help in another way. The scheme is now managed by Hestia. Evaluative data is limited for the scheme, in a press release from UK Says No More in 2022 it reported 100 disclosures of domestic abuse have been recorded since the launch of the scheme, of which 14% led to support from the pharmacist to call police and 8% to make non-emergency call to police[28]. The Home Office in 2023 also reported that since the scheme launched in 2021, it has been accessed on average once a week[29].

IDAS DARE (Domestic Abuse Routine Enquiry)

In Sheffield, IDAS have worked with the Integrated Care Board (ICB) (formerly Clinical Commissioning Group (CCG)) to develop the GP Domestic Abuse Routine Enquiry (DARE) scheme. This involves training whole practices to become 'Prepared Practices', embedding the principles of routine enquiry into their work as well as an improved understanding of domestic abuse and management of disclosures. In addition to 90 minutes training for all practice staff, the Practice is supported by an IDAS Health IDVA and GP Champions are appointed within the practice who receive additional training to manage disclosures and complete risk assessments effectively. This was in response to GP Doctors expressing concerns that making routine enquiries would result in workloads that were not manageable. The scheme was therefore adapted so that risk assessments could be completed by GP Champions. GPs and their staff have been keen to take up the training, however, there remains some resistance about the time pressures and ability to complete risk assessments. In the recent roll out of GP DARE Training, IDAS trainers have been asked to condense training into 60 minutes. To support the scheme, the ICB have been following up on practices that have declined the training, encouraging practices to take up the training, and is updating case management systems to track how routine enquiry is being used by adding a 'tick box' to their system. GPs identify several barriers to this intervention, particularly the time taken to undertake the training and the cost implications for the practice, in addition to the potential increase in workload managing and responding to disclosures. Furthermore, the scheme has had to be condensed and adapted to the point where the intervention could fall short of being effective. Safeguarding and domestic abuse best practice would suggest that disclosures should be managed by the person receiving the disclosure rather than the person needing to repeat information to another person before being signposted or referred for support. The reduction in training and the resistance to undertaking risk assessments on disclosure could negatively impact survivors' confidence in disclosing.

A&E Talk to Me Champions

In addition to the GP DARE scheme, IDAS have worked with Sheffield Emergency Department to embed Champions within the department who have received a briefing and are given badges to identify themselves. The department also distributed posters encouraging patients and staff to 'talk to me', referring to the Champions with badges. This input has seen referrals from A&E double in the quarter following the training input. In Sheffield, October – December 2022, there were 33 referrals from A&E, making up just 2.5% of the total referrals into IDAS services. This increased to 84 referrals, making up 6.90% of total referrals. The ongoing management and oversight of this scheme presents some challenges with A&E departments exceptionally busy and staff turnover requiring repeated training inputs.

Both IDAS Sheffield based inputs have resulted in an increase in overall referrals from healthcare providers within the quarter following the input. Sustaining the uplift presents challenges with pressures on time and resources effecting consistency of delivery and take up.

The review of literature and practice highlight key issues for domestic abuse healthcare interventions, including resourcing, both financial and human, and the ability to sustain and build on interventions over time. All

interventions rely on training, Champions, and robust referral pathways. An overreliance on individuals and lack of long-term funding results in interventions waning in their effectiveness, preventing pathways from truly becoming embedded in any meaningful way. A longer-term plan with sustainable funding and key milestones and evaluations built in would address the current landscape of fragmented interventions in different settings and an overreliance on individuals.

Resistance to domestic abuse routine enquiry within GP settings, and limitations on time and funding available to facilitate training to a greater depth of understanding of domestic abuse are significant barriers to victims accessing support. However, the resistance due to perceived increase in workload is suggestive that GPs are aware of the scale of the problem and a structural shift may be required to address it.

Health in North Yorkshire

Until July 2022 North Yorkshire Clinical Commissioning Group (CCG) and the Vale of York (CCG) were part of the Humber Coast and Vale Health Integrated Care System. This has now been replaced with Humber and North Yorkshire Integrated Care board which is accountable for NHS spend and performance for 1.7million people[30]. Within North Yorkshire and York there are 51 GP surgeries with over 425,000 registered patients. There are also 12 hospitals of which 7 have maternity departments and 4 have A&E departments. Craven is part of the West Yorkshire Integrated Care Board.

North Yorkshire is the largest county in England by area, made up of large parts of rural land, coastline, market towns and a military base. In terms of the health of North Yorkshire[31], life expectancy is higher in this area than the national average in England but the population is aging with 1 in 4 over 65, 25% of whom are estimated to have a limiting long-term illness. Children's health is better on average than England's, in many measures. However, there are more attendances to A&E for children's injuries than the average in England: in 2021-22, 91.0 per 10,000 in North Yorkshire compared to 75.7 per 10,000 in England although decreased from previous years. The variability across North Yorkshire and size of the area masks the differences between regions.

In some areas there are excess road deaths, issues with alcohol consumption and the prevalence of cardiovascular disease and diabetes as presenting issues. Most deaths result from cardiovascular, respiratory diseases and cancer. In general, sexual health is above national average and prescriptions for long-acting reversible contraception are also above average.

The number of people presenting with depression or anxiety is significantly lower than the national average (14%). However, the number of people presenting has increased. Scarborough is the only district with a rate that is higher than England's average with 16% of people over 18 reporting anxiety or depression. Rates of intentional self-harm are comparable to England although rates have increased. In Scarborough and Craven there are significantly higher rates of intentional self-harm than England.

Suicide is a significant cause of death, in North Yorkshire and rates are higher than England.

With North Yorkshire having such a low populations density and large rural areas, this brings risks for domestic abuse victims and challenges for the county. A report by the National Rural Crime Network has highlighted the differences between urban and rural areas and in particular the higher risks associated with living in a rural area[32]. A review of public health data suggests that a significant portion of the population live further than a 30-minute journey by public transport to a GP surgery in Hambleton[31].

In the Annual Report by the Director of Public Health for North Yorkshire for 2021-22 the impacts of the Covid-19 pandemic are explained[31].

Direct negative impacts of the pandemic are 'Mental Health- including exacerbating existing condition, increased loneliness and isolation, fear/anxiety about the pandemic, loss, bereavement/grief' and 'Family violence and abuse, safeguarding'. Among the indirect impacts of the pandemic, 'a rise in domestic abuse' is sited.

In North Yorkshire there are 51 GP practices serving a population of 458,000 people with 431,00 registered with a GP practice. Of those, 20% are under 20 and 24% are over 65.

Craven	Hambleton	Harrogate	Richmondshire	Ryedale	Scarborough	Selby
84.1%	75.1%	85%	86.5%	74.1%	99%	84.6%

In a Primary Care report for 19/20, disease prevalence was recorded 2.5% stroke, 4.3% CHD, 2.2% COPD, 6.6% diabetes and 1.1% dementia.

As a result of the Covid 19 pandemic, many GP appointments moved online, with most happening over the telephone, using patient messaging services or video calling. Although restrictions on face-to-face appointments have lifted some healthcare settings have maintained remote or telephone-based appointments. Reasons for this include time saving, patient access and perceived successes in triaging patients so that there is more time to see those who are assessed as having greatest need. However, this is likely to reduce disclosures of domestic abuse. Concerningly, maternity services are also conducting booking appointments on the telephone. Whilst there has been a gradual return to face-to-face appointments, the demand for appointments is rising and there is an increased focus on triaging patients prior to appointments. Combined, this is likely to reduce disclosures of domestic abuse, however IDAS data suggests that referrals are increasing. This could be a combination of pent-up demand and issues being picked up in face-to-face appointments now service is resuming. This hypothesis may be reinforced by MARAC data for 2021 with 0 referrals from GPs into MARAC. Alternatively, GP practices are more confident with referral routes and have a better understanding of the support available. As GP practices made up 18% of referrals into IDAS from healthcare services, hospital trusts make up most referrals into MARAC, although an explanation for this is that one safeguarding nurse is driving these referrals.

https://hub.datanorthyorkshire.org/dataset/public-health-district-profiles-2021

These findings highlight the need to consider the health inequalities across the county of North Yorkshire with some districts facing distinctly different concerns. Rurality is a significant concern for victims of domestic abuse with GP services and other healthcare settings difficult to reach for a portion of the population and inequalities across the county. Furthermore, the county has an aging population which may also impact on the accessibility of healthcare services and exacerbate inequalities. Additionally, as with national findings, mental health is a concern for a significant number of the population with Scarborough and Craven seeing above national average rates of intentional self-harm. The main presenting health conditions are cardiovascular disease and diabetes. In addition, above national average sexual health, and above average prescriptions for long-acting contraception, could point to where domestic interventions could be placed that would reach a significant number of the population. A further consideration is children presenting at A&E for injuries and the screening and support for these cases that may have domestic abuse as a factor. Furthermore, referrals from healthcare in North Yorkshire appear to be connected to individuals who have an increased awareness of and motivation to act on the warning signs of domestic abuse. The pandemic has impacted on the delivery of healthcare services with many benefits, including the diversification of ways of accessing GP support, online support and messaging services being used widely. However, stricter triaging for appointments and more GP and health services being accessed remotely pose the risk of further isolating victims of domestic abuse from support.

Review of IDAS data

Referrals from healthcare settings make up a small percentage of referrals into IDAS services in York and North Yorkshire.

Over the last three years there has been a year-on-year increase in referrals from health, albeit from a low baseline, with over three times the number of referrals from GP surgeries last year on the previous two years. (19/20 = 8, 20/21 = 8, 21/22 = 32).

Anecdotally survivors tell us that GPs have suggested they call IDAS rather than referrals being made by GPs; this may mean that healthcare referrals are being picked up in our self-referral data.

In the year 21/22, over 28 different GP practices referred into our services. This is an increase on the previous two years where we received referrals from 14/15 different named practices. Last year, two GP practices, Priory Medical Centre and York Medical Group made 4 & 3 referrals respectively.

A significant number of referrals come from health visitors. However, there has been a year-on-year decrease in referrals from health visitors offset by an increasing number of referrals from social prescribing routes, including Living Well teams. There has also been a rise in the number of referrals from the SARC. However, the numbers of referrals from healthcare are very low considering the general public's interaction with the wide range of health services available.

Approximately 13% of referrals from health last year were already in service with IDAS and 6% declined support.

15% of the referrals last year were initially assessed as being 'high' risk. The majority were initially assessed as 'medium' risk with only 7% assessed as 'standard' risk.

	Total	GP	Trust	SARC	Health visitors	Maternity	Midwife	Hospital	Mental Health	Social Prescribing	Other
21/22	179	17.9 %	7.3%	11.2 %	9.5%	0.5%	1.7%	5%	3.9%	8.4%	30.7 %
20/21	118	15.25 %	4.23 %	2.54 %	12.71 %	8.47 %	0.85 %	4.23 %	6.78 %	1.69 %	55%
19/20	103	17.48 %	6.8%	9.7%	16.5%	0%	1.94 %	1.94 %	0.97 %	1.94 %	57.2 %

IDAS data suggests that an increasing number of GP practices are aware of IDAS services and are confident in the referral routes into services. This reinforces the notion that referrals into domestic abuse support are reliant on members of staff who understand domestic abuse and are motivated to act on the warning signs. After GP practices, health victors are the next largest referral source, followed by social prescribing routes. Referrals from health visitors are decreasing and social prescribing increasing.

A significant percentage of referrals have been identified as healthcare, but it is not possible to identify the referrer to categorise them. This number is decreasing which suggests an improvement in the recording of referrals.

Social prescribers and care coordinators can take the pressure off GPs and offer more long-term support to assist with factors that may be impacting patient well-being. In York, IDAS have a strong relationship with social prescribers and have well established referral pathways.

A review of IDAS data further cements the findings that there is an overreliance on individuals and a requirement for sustained, regular inputs to ensure staff turnover doesn't prevent signposting and referrals into support. This is evidenced by the decline in referrals from healthcare and the increase in referrals from social prescribing coinciding with strong relationships between IDAS and social prescribers. Multiple referrals being received from two GP practices also suggests that individuals within the practice are driving referrals.

Comparative data to Sheffield requested.

Review of MARAC data

Cases referred to MARAC by healthcare services in York and North Yorkshire make up less than 4% of total referrals. Although there has been a slight increase in referrals from healthcare over the last year, referrals are generally low. Referrals from GPs in 2021 were 0. Recovering slightly last year but making up just 10 of the 1,916 total referrals into MARAC in 2022.

Scarborough and Ryedale MARAC receive most of the referrals from hospital trusts, with an increase in 2021-22, correlating with the appointment of a specialist adult safeguarding nurse who was keen to work with MARAC. This suggests, where an individual staff member has a specific interest in domestic abuse there are likely to be increased referrals, reinforcing earlier findings in this review. This has also been a finding of the review of existing research and domestic abuse and healthcare projects, that the systems do not currently support a consistent approach and domestic abuse best practice is reliant on certain individuals.

Concerns were raised about referrals from A&E being refused due to lack of essential information on the referral making it difficult to list the referral for MARAC consideration.

GP referrals are similarly low, reflecting IDAS data. GPs and domestic abuse survivors reflected similar reasons for this, the pressure of limited appointment times, and for survivors the presence of their partner at appointments.

This data suggests that domestic abuse isn't readily being identified by healthcare professionals. This is a result of an over reliance on individuals, time pressures, a lack of sustained training or clear referral pathways. Risk assessment was identified in a Home Office Review of Domestic Homicides as an area of concern with risk assessment not being completed to an adequate standard[21], the MARAC data also raises this concern with referrals being refused due to lack of essential information.

Intersecting Concerns

Disability

Many clients from the survey commented on the different health issues they presented to healthcare professionals with, including reproductive health and fibromyalgia. With the responses from healthcare professionals indicating a focus on physical presenting symptoms there are concerns that disability or health issues may mask the presentation of domestic abuse. For example, Fibromyalgia is a condition characterised by widespread pain in the body and is thought to be made worse by stress. If a client presents to their GP because their condition has got worse the GP may focus on treating the presentation and not be able to explore what may be impacting the condition due to time limits. Older clients may also be more susceptible to physical health difficulties and disabilities and additionally may then face barriers to support which other clients may not. As evidenced in a 2019 Joint Strategic Needs Assessment Deep Dive on Learning Disabilities in North Yorkshire, older women are more likely to have a learning disability due to longer life expectancy and are therefore twice as likely to die from something that could have been prevented, indicating a health inequality[32]. Combined with an increased likelihood of being a victim of domestic abuse, this cohort requires specific interventions.

Older people

North Yorkshire has an aging population and older people are often 'invisible victims' of domestic abuse. Many face abuse from their adult children or grandchildren with economic abuse being a factor. This type of abuse may not be as widely known or understood and a focus on physical presentation or symptoms may not encourage disclosures of economic abuse or adult child to parent abuse. Furthermore, older people who rely on their families for care may be reluctant to disclose abuse for fear of consequences for their family, the disruption or cessation of the care they provide, and loneliness and isolation. Older people are more likely to attend GP surgeries routinely, presenting an opportunity for elder abuse to be identified. The IRISi report suggests that the interventions with GPs resulted in more referrals from older people.

Rurality

North Yorkshire, as previous discussed, is made up of large rural areas and has many small rural communities. Findings from the National Rural Crime Network found abuse lasts 25% longer in the most rural areas, rurality and isolation are used as weapons by abusers and there is a general decline in support networks and escape routes for victims[33]. The report evidences the reduction in rural GP practices as part of the decline in support networks. It also discusses the dynamic of rural communities in comparison to urban communities, for example rural communities tend to be close knit and made up predominantly of men holding positions of power. This can present as a barrier to disclosure by survivors, particularly if their healthcare providers know the abuser or the abuser is in a position of power within the community. Their report shares the story of one survivor who says they did not share the abuse despite visible bruises because they were worried their GP wouldn't believe them as the abuser was well known to the GP. However, the report also highlights the importance of healthcare providers in aiding disclosure alongside the barriers. For example, a similar proportion of survivors seek support from GPs and health visitors in rural areas as in urban areas. This report concludes the important source of help healthcare professionals provide and that they are most likely to be allies in rural settings. This highlights a further intersecting issue faced particularly by survivors in North Yorkshire.

LGBTQ & Minoritised communities

It is important to note LGBTQ+ survivors and those from minoritized backgrounds also face intersecting issues. For example, a survivor whose first language is not English may face barriers accessing information or feel they are not able to share what they are being subject to because of the language barrier. Likewise, an LGBTQ+ survivor may not feel able to disclose if they feel they would not be believed because they aren't in a heterosexual relationship or face stereotypes and assumptions that act as barriers to disclosure. These would both further lead to a survivor feeling isolated and without sufficient training and provision in place may fall through the gaps in terms of support. These are areas that would need further research to fully appreciate the scope of the issues faced.

Survivor responses

The review combined individual conversations with survivors of domestic abuse who are known to IDAS and have engaged with healthcare and self-selecting surveys. There was a stark difference between survey responses and the conversations held with IDAS clients who were selected by practitioners. Overall, survivors who talked about their experience with an IDAS practitioner spoke neutrally or positively about their support from healthcare providers, however the level of support varied. Those who responded to the survey reported more negative experiences.

Most often survivors have said their GP was supportive and particularly once the abuse was recognised were helpful both for an initial referral to IDAS and for longer term support as well. From the survey, participants said they wanted healthcare professionals to help them but some commented that they didn't want professionals to know to start with or that they were guarded about disclosing. It was noted by one survivor that their GP offered her mental

health support which was not appropriate for her and that was all the support she felt she was offered. One survivor said talking about domestic abuse felt like a “taboo subject” and their GP “talked about symptoms not the cause and nothing regarding mental health support other than medication”. This highlights potentially how symptoms of mental ill health can overlap with that of domestic abuse and may lead to gaps in support if domestic abuse is not recognised as a primary factor in poor mental health.

From those that had support from their GP, markers could also be put on their children’s medical records to notify other professionals of abuse allowing for a more coordinated response and avoiding the need for clients to repeat themselves to different workers about their situation. The survivors that had support with maternity and health visiting teams said their workers picked up on verbal and emotional abuse often before the survivors themselves had recognised abuse. Again, the support can vary with others commenting that they weren’t able to talk to their midwife due to their partners attending appointments with them and others feeling staff were busy and not able to speak. Based on the responses from healthcare professionals, partners attending all appointments, was recognised as a risk factor but not placed above physical presentations of abuse such as visible bruising.

Fewer clients attended A&E than those who spoke to their GP but of the ones that did attend A&E, their overall feeling was not being able to disclose either because they were fearful that their partner might find out or because they knew they had to get home to be with their children. With A&E departments reporting high levels of demand for services and understaffing[34] it may create a difficult environment both for staff not having the time or resources to follow up on concerns and for survivors not feeling able to make disclosures. One survivor said “it would be useful to provide a questionnaire to patient whilst in the waiting room that asks the question ' have you been impacted by domestic abuse ' as it isn't easy to bring up and talk about domestic abuse”. Potentially this would take pressure off staff and if a client is screened as reporting abuse then this can be followed up with a referral. This could be utilised in triaging appointments.

Healthcare professional responses

Key points from survey

- There were responses from healthcare workers in all areas of North Yorkshire and York except Craven.
- Healthcare professionals on average had 27 years of experience (range 9-40).
- 11 out of 15 responses said the Domestic Abuse Act was not included in their training but 13 out of 15 responses said their training covered risk factors.
- Healthcare professionals recognised the impact on children even if they do not directly witness abuse.
- Almost all healthcare professionals (84%) felt confident or very confident with referring to domestic abuse support services like IDAS.
- Overall, healthcare professionals said they would welcome more training.
- The greatest challenge healthcare professionals reported was time constraints with 10 out of 15 responses making reference to this.

Among healthcare workers many comment that time and consistency present the greatest challenge when supporting survivors of domestic abuse. Many comment that the reduction in face-to-face appointments makes identifying cases difficult and appointment times are limited so their focus is to address the primary health concern in front of them rather than exploring other issues. GPs for example said they see survivors weekly or monthly, but health visitors said they see them daily or weekly.

A local breast cancer screening team talked about the impact of having just 7-minute appointment times. When they had encountered a victim who had visible bruising from the abuse, they hadn’t been able to act due to time constraints and a follow up call to safeguarding wasn’t followed up because the patient had left. Furthermore, a

locum GP talked about the impact of appointment times and the way appointments were structured on their ability to ask questions and explore issues with patients. They commented that GP surgeries and appointments are managed very differently. In one surgery they encourage patients to complete an online form which can assist with managing the appointments. There could be opportunities where such screening is in place to ask questions about safety at home and within relationships, as previously discussed by the survivor in the survey.

Due to limited contact with patients, some professionals commented on needing "evidence" that a person is being abused. There was a recognition of coercive control among healthcare professionals but when ranking risk factors, physical presentations are ranked higher than the risks that indicate coercive control. This was also mentioned in consultation with Pharmacists who said they relied on being able to spot warning signs rather than asking questions if there was concern. This highlights the difficultly with "evidencing" coercive control both healthcare professionals and survivors face which may become a barrier to clients disclosing.

GPs talked about the role of social prescribers and care coordinators in supporting with disclosures or concerns about domestic abuse.

Nearly all the healthcare professionals who completed the survey had domestic abuse training within the last 5 years which covered the risk factors of domestic abuse. However, 11 out of 15 respondents said the training did not cover the Domestic Abuse Act 2021 or non-fatal strangulation. This raises the question as to whether healthcare providers own individual attitudes or interest in domestic abuse would impact the support survivors receive. This is supported by a report finding that healthcare practitioners readiness to address domestic abuse is influenced by their personal commitment to the issue[9]. For example, if the Domestic Abuse Act 2021 is not included in all healthcare providers training, only those who are aware of it would be able to implement it into their practise. Again, this may indicate why some survivors have a good relationship with their healthcare professionals and feel able to disclose.

It was also highlighted that domestic abuse training was part of wider safeguarding training rather than a standalone training. Some healthcare providers commented on the challenge of getting survivors to recognise the impact abuse can have on their children but also showed an awareness of safeguarding procedures when children are involved. It is positive that healthcare professionals recognise the impact of abuse on children because it shows they acknowledge children can also be victims even if they are not directly subject to abuse. However, it does raise the question, is a safeguarding referral more likely to be made if a client has younger children? This potentially indicates a challenge in identifying cases in older survivors or survivors in same sex relationships because the family dynamics may be different.

Included in the professional's survey was a scenario question based on presentations survivors have spoken about for needing to go to the GP. The question was open to interpretation to see how healthcare professionals would respond. Many of the healthcare professionals discussed looking at the mental health presentation and how this could be addressed. There was a pattern for healthcare professionals who were not GPs to recommend the survivor speak to their GP about any mental health concerns. From a GP perspective there was a focus on ruling out physical health symptoms. This potentially highlights a barrier survivors may encounter of being passed from one service to another and if the next service does not ask further questions there will be a gap in support. Having time for exploratory questions at the first point of contact could help to gain insights into domestic abuse as a possible contributing factor to the physical, emotional, or mental health symptoms and presentation. Some professionals did comment that they would ask direct questions such as "Do you feel safe?" "Do you feel scared?" which may lead to a disclosure and as previous research has highlighted, survivors find being asked directly useful in aiding a disclosure. Only one healthcare professional mentioned giving the IDAS helpline number.

Many healthcare professionals who took part in consultations were hesitant about conducting risk assessments or were not aware of what a risk assessment entailed. Some were asking questions that form part of the DASH risk

assessment, but many wouldn't consider attempting to complete an assessment at an appointment. This inconsistent approach and resistance to risk assessments is supported by the research and evidence from DHRs[21].

Pharmacists shared an interesting perspective on how rurality and close-knit communities, with one healthcare professional within pharmacy suggesting that people attend pharmacies that are not local to them to obtain emergency contraception, or similar sensitive treatment, to avoid speaking with pharmacists known to the community. Pharmacists also mentioned having an insight into the communities they work with as most of the employees would live in the local area, whereas the Pharmacist themselves may live outside the area. One mentioned observing patient interaction with their partners and being concerned. In response to being asked whether pharmacists could ask routine questions about domestic abuse in consultations, there was concern that this would be asking too much of an already stretched workforce. However, there was openness to training and information being provided.

Overall, there is a general feeling among healthcare professionals that their experience of identifying and supporting domestic abuse survivors can be challenging, with one professional saying- it is "getting harder as the years go by". Many of the responses highlight that service availability has become limited, face-to-face appointments have reduced and healthcare teams have been scaled back compared to previous years. This is compounded by concern about routine questions resulting in increased workload. This is mirrored with survivor experiences of feeling healthcare professionals were busy and not able to speak. With the COVID pandemic, many services had to become functional remotely but since restrictions have lifted the return to face-to-face service does not seem to have followed this. Many of the healthcare professionals were open to further training but again highlighted the difficulty of time constraints. This is also supported by the GPs in the Sheffield DARE scheme who infer that if they asked about the domestic abuse they know is happening they would be overwhelmed and reiterates the need raised by IRIS about having well trained staff who are supported to support survivors.

Quotes from professional surveys.docx

Recommendations

Coordinated, place-based interventions to address an aging population and rurality.

North Yorkshire has an aging population, combined with rurality making access to support services more challenging. Domestic abuse in older people is complicated by factors including dementia and Alzheimer's, caring responsibilities, and the predominance of adult child to parent abuse. GPs, Care Coordinators, Social Prescribers and Pharmacies are well placed to assist with the identification of abuse in older people and offer place-based support. In addition, social prescribers and care coordinators can visit older people in their homes. Specific interventions are required, including, training, screening tools that take into consideration the presentation of domestic abuse among older people and clear referral pathways. GPs could utilise social prescribing and care coordinators, as well as Domestic Abuse Champions within their practices to assist with the time constraints and pressures of restrictive appointment times. Furthermore, gathering more information at appointment booking or when patients are in the waiting room could enable more opportunities for disclosure.

Domestic abuse becomes a mandatory CPD requirement.

A recurrent theme is the requirement for training. Feedback suggests that a 'little and often' approach would be preferred, be easier to access and ensure the most up to date information is shared. Healthcare professionals all cite the importance of training and express positive intentions towards undertaking training. The findings are clear that a sustainable model of delivering training that builds confidence and consistency across teams would reduce the reliance on individuals within healthcare and help to embed a whole systems-based response to domestic abuse. In North Yorkshire, the IDAS online training programme is gaining traction among healthcare professionals with

excellent feedback on the impact the training has had on their practice. Additional healthcare specific training could be offered through the existing training programme, including presentation of different patient groups, an understanding of the intersections between mental health and domestic abuse, disability, older people, and LGBTQ people. Additionally, the latest legislation including coercive and controlling behaviour, economic abuse and non-fatal strangulation should be covered. Healthcare and domestic abuse training programmes should be mandated, making domestic abuse training a requirement for healthcare professionals Continued Professional Development (CPD). Working with the ICB, a programme of training, supported by robust referral pathways and information sharing across healthcare settings could lead to transformation and achieve a more consistent experience for victims and survivors as well as NHS staff impacted by abuse.

Embed domestic abuse routine enquiry across healthcare settings.

Discussions with healthcare professionals, and the findings of the review, highlight a hesitance around screening, risk assessment or routine enquiry by some healthcare professionals. However, survivors who shared their experiences broadly felt that being asked about domestic abuse would have helped them to get support. Hesitance is largely due to workload and time pressures. Many healthcare professionals explained that time constraints are a significant barrier to raising concerns about domestic abuse. However, where routine enquiry is embedded, through the IDAS DARE programme and IRISi, referrals from GPs increased.

There are several ways that screening, risk assessment and routine enquiry could be embedded into healthcare that are not solely reliant on individuals asking questions. Indeed, a survivor identified that being given the opportunity to write down what they were experiencing might lift some of the barriers of having to tell someone. Additionally, the role of Social Prescribers and Care Coordinators should be considered in the response to domestic abuse.

Survivor and professional responses highlight that there need to be multiple touch points to aid disclosure and that building relationships over time can assist with disclosures. Healthcare professionals often feel that asking the question will inevitably increase their workload, however there are support services that can complete this work. Furthermore, a culture of openness around domestic abuse will contribute to victims feeling more likely to be believed. It may take numerous healthcare professionals raising the issue before a disclosure is made. When applied collectively, routine enquiry sends a clear message that healthcare is ready to respond to disclosures and that healthcare professionals acknowledge that domestic abuse has a serious impact on people's health and well-being. Routine enquiry also encourages healthcare professionals to look beyond presenting symptoms to what might be behind some patient's health concerns. For example, many survivors who took part in this consultation and evidence from DHRs suggests that patients presenting with mental ill health may be doing so as a direct result of the domestic abuse they are being subjected to. Similarly, physical health issues may be exacerbated by the abuse. Routine enquiry would help to reveal correlating issues. This review has identified the challenges faced on the front line of our health services, such as GPs and A&E departments, whilst interventions here are important, it may be that interventions in places that are more conducive with relationship building and that foster environments for less time limited conversations could prove more successful at increasing referrals from healthcare.

Such touch points could align with the predominant presenting issues for the population. For example, presentations for mental ill health may indicate that further investigation, screening, and triage for domestic abuse is required. Social Prescribers identified that they often have more time to build relationships and the review identifies this as being a growth area for referrals. The use of screening tools may assist Social Prescribers with understanding the full picture of support needs rather than responding just to the initial presentation. Furthermore, survivors identified that reproductive health care was a reason that they presented to health settings. North Yorkshire healthcare data suggests that take up of long-lasting contraception is high in North Yorkshire which suggests that these appointments may also provide opportunities for discussions about domestic abuse and healthy relationships. Aligning domestic abuse routine enquiry with reproductive health appointments provides multiple opportunities for

touch points with women who may be subject to domestic abuse. Indeed, pregnancy is a well-documented risk factor for domestic abuse. Furthermore, routine cancer screenings and 'Well Woman' checks may also provide opportunities for conversations that may result in disclosures. Support for screening teams to enable them to respond to disclosures and have longer conversations could assist and encourage screening teams to take up routine enquiry. Pharmacists have already been identified as a possible place where survivors could access support, as set out in the 'Ask for Ani' scheme. There is the possibility that more could be done with pharmacists to tie routine enquiry into requests for emergency contraception, for example.

Screening tools and embedding routine enquiry across healthcare settings, combined with high quality training, offered in bitesize sessions aimed at building confidence in both the identification of, response to domestic abuse, and referral pathways, will all contribute to a systems-based healthcare response to domestic abuse. Domestic Abuse Routine Enquiry should be embedded across all healthcare settings and elevated beyond a simple tick box exercise with, screening tools, recording and clear referral pathways that all healthcare settings can implement.

Health IDVAs and Champions working across healthcare settings.

This review has highlighted an overreliance on individual healthcare professionals signposting to domestic abuse support rather than a systems-based approach. However, the value of experts and single points of contact within multi-disciplinary health teams is clear. Individuals can rally people to a cause and can champion services, ensuring healthcare teams are up to date and feel connected with local community domestic abuse support. Health IDVAs should be embedded in the Safeguarding structures within healthcare trusts, with Champions across GP practices, mental health, health visitors, midwives, and cancer screening teams to name a few. Health IDVAs should be employed by local domestic abuse services to ensure that they are able to access the wealth of domestic abuse expertise and case management provided within these settings whilst also being able to flexibly, co-locate within hospitals and different health departments. Enabling Health IDVAs to work with multiple departments, including mental health, would enable rich data collection and learning about the challenges and barriers faced in different healthcare settings. Similarly, Champions could be supported by Health IDVAs so that knowledge can be shared and inform best practice.

A systems-based approach: Going beyond time-limited domestic abuse healthcare interventions.

Training, routine enquiry, Champions and Health IDVAs can play a significant role in increasing referrals from health care, as evidenced by this review. However, systems must be considered to ensure that interventions move beyond time-limited, individual staff member reliant initiatives to fully embedded, sustainable approaches that develop and improve over time. This requires healthcare systems to build in methods for prompting questions and recording responses as well as ICBs coordinating approaches with overarching strategies and clear policies. Sheffield DARE programme highlights the role of the ICB in encouraging healthcare settings to adopt rigorous approaches to domestic abuse and adapting case management systems to track this.

The review highlights that healthcare professionals are not always aware of what they could do if someone discloses, that they may wait for a full disclosure before signposting for support or avoid asking questions as this might result in an increased workload. However, if systems prompted and encouraged professional curiosity, alongside clear referral pathways and knowledge of local services, healthcare professionals would see the response to domestic abuse as being an integral part of the health service rather than a concern that is additional to or separate from an individual's health and well-being. They would also benefit from understanding the support structures around them so that they don't feel so overwhelmed by the issue and can effectively signpost for support in a coordinated and considered way.

A systems-based approach requires a long-term plan with sustainable funding, key milestones and evaluations built in. This would address the current landscape of fragmented interventions in different settings and an overreliance on individuals. A considered, coordinated approach is required to improve the overall response in healthcare settings.

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