

Support for doctors affected by domestic abuse

'This is... a problem that is real and remains hidden. It needs to be brought out in the open. We are making tremendous steps fighting domestic abuse for our patients, but let's not forget to fight for our members.' **Dr Mairi Reid**, ARM 2018

1. Summary

Domestic abuse can have a devastating impact. It affects not only an individual's home and personal life, but also their wellbeing, confidence and performance at work. **Doctors have a key role** in identifying and supporting patients affected by domestic abuse. **Sometimes doctors may experience it themselves and, if they do, the BMA wants to ensure they are properly supported.**

Domestic abuse is a workplace issue. It can affect work attendance and performance. Victims may be targeted by their abuser at work, particularly if they are in public-facing, open workplaces. Employers are in a unique position to support a staff member who is experiencing domestic abuse. This support can include providing flexible working hours, workplace safety plans, and special leave to help victims leave their abuser and access support.

Doctors may face unique barriers in accessing support from their workplaces. These include fear of professional consequences, stereotypes about domestic abuse victims, and concerns about accessing local support services where they might be recognised. Having a designated contact person that staff can talk to confidentially can help encourage staff them to seek support.



Recommendations

All doctors working in trusts and health boards in the UK should have support available to them at work. To ensure this:

- All trusts and health boards should have a domestic abuse policy for staff as well as patients.
 - Trusts in England and health boards in Scotland should ensure their policies align with the NHS Staff Council model policy and Scottish PIN Policy respectively.
- All trusts and health boards that currently have a combined staff and patient domestic abuse policy should consider developing a separate policy specifically about supporting staff.
- All trusts and health boards should ensure they have a trained designated point of contact/s. If the point of contact is in a patient safeguarding role, the trust or health board should ensure they are trained to support staff and staff are aware of this.
 - Scottish health boards should consider implementing the 'confidential contacts' network system as recommended in the Scottish PIN Policy.
- All trusts and health boards should ensure policies are reviewed and updated regularly and are easily accessible to managers and staff.

The BMA contacted all trusts and health boards across the UK to gain insights into what kind of support is currently available to doctors and other staff who experience domestic abuse. (This research was focused on support available to doctors working in secondary care but we recognise that further specific work is needed to ensure that medical students and GPs are also able to access support.)

We found that 32% of the trusts and health boards that responded do not have a domestic abuse policy. There is a huge disparity in the quality of domestic abuse policies too, with some trusts and health boards providing comprehensive guidance for managers on how to support staff and a range of supportive measures on offer, and others providing very limited guidance. Given the difficulties and barriers to doctors accessing support, it is disappointing that just 53% of trusts and health boards have a designated point of contact who a staff member could speak to confidentially.

We are calling for all trusts and health boards to review support. Policies must be comprehensive and provide a range of supportive measures.

We also found examples of good practice and comprehensive policies. We highlighted the Belfast Health and Social Care Trust and Rotherham Doncaster and South Humber NHS Foundation Trust as examples of trusts committed to providing a range of supportive measures to employees.

2. Briefing

What is domestic abuse

Domestic abuse is defined by the UK government as 'any incident 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 their gender or sexuality'.

It is not restricted to physical violence but can also include emotional and sexual abuse, psychological threats and intimidation.

The following behaviours could be present in an abusive relationship:

- Constant belittling, humiliation or degradation of a partner
- Seeking to isolate a partner from sources of emotional support, e.g. by preventing them from seeing friends or other family members
- Controlling finances and restricting access to money
- Forced sex and unwanted sexual advances or contact.

The BMA [report](#) to improve health professionals understanding of domestic abuse provides further guidance.

7.9% of women (1.3 million) and 4.2% of men (695,000) experienced domestic abuse in the year ending March 2018, according to the [National Crime Survey for England and Wales 2018](#). People with some protected characteristics may be more likely to experience domestic abuse and may face additional barriers to accessing support.

There is some evidence that health professionals may be more at risk. [Research](#) conducted by the Cavell Nurses' Trust in 2016 found that nurses, midwives and health care assistants are three times more likely to have experienced domestic abuse in the previous year than the average person.

Why is domestic abuse a workplace issue?

- Domestic abuse may affect work attendance and/or performance.
- A person may be particularly vulnerable at work, especially in public facing workplaces, as their abuser may be able to more easily identify, locate or approach them there.
- Victims of domestic abuse may need time off work or require more flexibility in their work patterns.
- Employers have health and safety responsibilities to keep employees safe at work under the Health and Safety at Work Act 1974.
- Employers also have a role in managing perpetrators. There may be occasions where a perpetrator and a victim work at the same organisation.

Doctors experiencing domestic abuse can face unique barriers in accessing support

The BMA is supporting a qualitative research study of doctors who have personal experience of domestic abuse. This will help inform our work on this issue and ensure that appropriate support is put in place. We will publish more information about this work in 2020.

Doctors who have personally experienced domestic abuse have particularly highlighted the following issues:

Self-stigmatisation

Many people who experience domestic abuse do not report it, out of fear of being viewed negatively, both personally or professionally. Doctors who experience domestic abuse told us that they had particular feelings of guilt and shame and difficulty reconciling their status as a victim with their identity as a doctor.

Stereotypes

There are some persistent stereotypes about the 'type' of people who are victims of domestic abuse. Doctors who experienced domestic abuse told us these stereotypes added to their fear of not being believed if they spoke up. This was particularly the case in so-called 'medical marriages', where both the victim and perpetrator of violence are doctors, as there are also widespread stereotypes about the 'type' of person who perpetrates domestic abuse.

Accessing support services

There have been cuts to domestic abuse services over recent years, which can mean that there are no or very few local services available, particularly in smaller communities. Doctors often have a visible community profile and may be worried about being seen using these services, or potentially encountering their own patients there.

Professional isolation

Some women doctors who work Less Than Full Time told us that it could be harder to establish supportive networks in the workplace because they spent less time there than full time colleagues. This resulted in an increased sense of isolation and not being comfortable talking to colleagues about sensitive issues affecting their domestic and working lives.

Financial concerns

Some doctors told us that there was a general lack of understanding about financial control behaviours within domestic abuse. This meant there was often an assumption from support services that they were in a financially stable position because doctors are relatively well-paid. This made it more challenging to access emergency financial support.

Fear of professional consequences

Doctors reported concerns that telling people that they were victims of domestic abuse could raise questions about their professional capability. There were fears that perpetrators could make false allegations or referrals to social services or the General Medical Council. They also worried that if patients were aware of their situation it would damage the professional trust that patients placed in them.

Examples of employer good practice and model policies

Having a specific policy on domestic abuse provides clarity to managers and staff about how to identify if someone may be experiencing domestic abuse and what support is available. It encourages people to seek help at work and to recognise the signs of abuse in colleagues.

The NHS Staff Council's Safety, Wellbeing and Partnership Group produced a [resource](#) in 2017 to help NHS organisations increase support for staff and develop a domestic abuse policy. The resource includes guidance about how to best manage employees who are perpetrators of domestic abuse.

Scotland has a [National Gender Based Violence PIN policy](#) and each health board is expected to have a locally developed policy in line with this. The Scottish policy also includes the provision of a temporary mobile phone and encourages health boards to set up a staff network of trained 'confidential contacts'.

We were pleased to find that all health boards in Wales and all but one trust in Northern Ireland have domestic abuse policies covering staff. As NHS Wales and Northern Ireland Health and Social Care do not have a model policy for health boards to use, we assessed health boards in Wales and trusts in Northern Ireland against the supportive measures of the NHS Staff Council's model policy.

FOI research findings

We submitted (FOI) Freedom of Information requests to find out how many trusts and health boards across the UK have specific policies providing support to employees experiencing domestic abuse, or other policies (such as special leave policies) that explicitly reference domestic abuse.

We analysed the policies we received against the [NHS Staff Council's model domestic abuse policy](#) and the [Scottish PIN policy](#).

We checked whether policies included the following support measures:

- Right to confidentiality
- Provision of special leave
- Access to flexible work hours and shift changes
- Safety planning at work
- Safety considerations for the employee's transport to work
- Safety planning if the employee is a 'lone worker'
- Changes to pay arrangements
- Recognition that performance may be affected
- Referral to occupational health.

We also assessed whether policies provided guidance on what to do if an employer is a perpetrator of domestic abuse.

Key findings

The findings are based on an overall 83.3% response rate. Wales and Northern Ireland had a 100% response rate. Scotland had a 80% response rate and England had a 78.8% response rate. Scotland's response rate was 75% and England's response rate was 79.8%.

Domestic abuse policy

- 62 (32%) trusts and health boards do not have a domestic abuse policy for staff.
- 2 trusts and health boards (1%) did not have a domestic abuse policy but held information in other policies that explicitly referred to domestic abuse and support measures.¹
- 11 (5.6%) trusts and health boards do not currently have a domestic abuse policy but are in the process of developing one.
- Of the 134 trusts and health boards (68%) that have a domestic abuse policy, 69 trusts and health boards (51%) have a policy specifically aimed at supporting employees. The other trusts and health boards have a joint policy about supporting patients and staff.

Designated point of contact

- 103 trusts and health boards (53%) have a dedicated point of contact that staff can confidentially talk to.
- 44 of those trusts and health boards have a person or team in a patient safeguarding role acting as the designated point of contact.

Support for staff and patients will be different and it is important that if the designated point of contact is in a patient safeguarding role, that they are trained to provide support to staff also.

Some trusts and health boards have a designated point of contact for staff, despite not having a domestic abuse policy for staff.

Supportive measures

Only two trusts and health boards had all ten supportive measures that we assessed for. Generally, trusts and health boards that had a separate policy for staff had better and more detailed explicit measures.

Some trusts and health boards had a domestic abuse policy for employees that included general statements of support but did not provide guidance on any specific support measures.

Most common support provided:

The supportive measures most commonly provided were guidance about what to do if an employee is a perpetrator of domestic abuse (95 trusts), the right to confidentiality (94 trusts), safety planning (89 trusts), and provision of special leave (84 trusts).

Least common support measures provided:

- Recognition that domestic abuse may impact performance (we counted this if the policy included that this be taken into account if there are performance issues and did not count if it only stated that under-performance is an identifying feature of domestic abuse).
- Safety considerations for the employee's transport to work.
- Support for lone working employees.

¹ Some trusts and health boards did not have a domestic abuse policy or other policy containing support for domestic abuse, but did provide other policies that provided support to employees. For the purposes of this research, we did not count the support provided in these policies unless there was explicit reference to the support being available for a domestic abuse situation.

Safeguarding and the right to confidentiality

The right to confidentiality was usually qualified by the exception that if the employee had children in their household, or an unborn baby, the trust had safeguarding responsibilities and may have to contact social services with concerns.

This may be a barrier to some staff feeling comfortable in seeking support. There was a range of ways that this was worded by trusts and some wording was much blunter and more unsympathetic than others.

Case studies

Belfast Health and Social Care Trust

Belfast Trust developed a domestic and sexual workplace policy and support service delivered by a group of staff – both female and male -from a range of different grades, geographical locations, and professions in partnership with Trade Union colleagues. The officers are all trained by Women's Aid, Nexus, Men's Advisory Project, Rainbow Project and Social Work and the Police Service of Northern Ireland. This allows them to offer a compassionate and sensitive service to any colleague experiencing domestic or sexual abuse. The role of the support worker is to offer a listening ear, emotional and practical support in the workplace and to signpost to specialist agencies who can help them- support officers are not there to rescue the person or tell them what to do.

Other elements of the service provided by the trust in partnership with trade unions include:

- A workplace policy on domestic and sexual abuse or violence (which is regularly reviewed).
- Awareness sessions for staff and managers to raise awareness of potential signs of abuse.
- Organising paid time off for appointments, a salary advance or diverted into a new account, a personal safety alarm, change of location, change of working hours, safety arrangements in the workplace.
- Dedicated workplace email or telephone number to access a support officer.
- Facilitating preference of support officer e.g. gender, location, profession.
- Providing details of external support e.g. a weekly one stop shop in Women's Aid with all the respective agencies housing, legal profession, benefits, social work, community organisations.
- Posters and A4 Calendars advertising the service with a specific logo – which is gender neutral to ensure that men will also use the support service.

Rotherham Doncaster and South Humber NHS Foundation Trust

RDASH provides focussed training for staff in relation to domestic violence, and specific enhanced training for core staff who work in Safeguarding, Human Resources and Freedom To Speak Up and Health and Safety roles. They consult with staff who have experienced domestic violence to better enhance the support available and these staff have helped coproduce training and advice and review policies related to employee wellbeing and leave.

Judith Graham, Freedom to Speak Up Guardian at RDASH says, 'We are committed to supporting our staff who experience domestic violence. Our approach is to provide sensitive and compassionate support, and enable staff to 'Speak Up' about experiences they have that they wish help with.' She adds: 'We know our staff may have differing needs in terms of their home situation, therefore all of our support teams work together to provide bespoke support, advice and safety plans.'

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