**NHS Education for Scotland**

**Transcript of ‘Gender-Based Violence and Bereavement’ (NES Bereavement Webinar, 2023) video**

**Chair**: Lynne Innes, Senior Educator, Grief & Bereavement, NHS Education for Scotland

**Speaker**: Leanne Patrick, Gender-Based Violence Nurse Specialist & Health Development Team Lead, NHS Fife

**Lynne Innes (LI):** Good afternoon and welcome to what is the 19th NES Bereavement webinar. And we're joined this afternoon by Leanne Patrick. Leanne is a Gender-Based Violence Nurse Specialist and Health Development Team Lead working in NHS Fife, and she works directly with victims and survivors of domestic abuse and sexual violence. Leanne's also involved in supporting the development of policy and training at a local and national level, to improve understanding and safety responses to all forms of gender-based violence. And it's really lovely to have you here this afternoon, Leanne.

And it's been lovely to, to start to get to know you through some of my work in Fife as well. So it's lovely that you've, you, it's very kind of you to have accepted the invitation to, to do this webinar because we know everyone is very busy and these things take a bit of time as well. So thanks so much for, for agreeing to do that.

So I am going to put my camera off and pass over to Leanne to offer us some thoughts on gender-based violence and bereavement. Thanks so much, Leanne.

**Leanne Patrick (LP)**: Thank you, Lynne. So, welcome to Gender-Based Violence and Bereavement. My name's Leanne. Thank you for that kind introduction, Lynne. And as mentioned, I'm a Gender-Based Violence Nurse Specialist working in NHS Fife. This is a relatively new specialism and it's unique to Scotland, which I'm quite proud of. And as you... as Lynne had mentioned, what that means is that I'm working alongside victims and survivors every day. A few years ago I completed my masters in Social Research where I looked very specifically at survivors' experiences of disclosing domestic abuse and sexual violence to healthcare staff. And since then I've been researching and writing about all forms of gender-based violence and risk management in health. So all of this is just to give you a bit of context and an idea about my background and the kind of work that I do. So my role's about early intervention, risk reduction and also prevention. But today I'm going to be talking to you about, I suppose, the worst case scenario when someone dies as a direct or indirect result of domestic abuse or sexual violence or other forms of gender-based violence.

This is quite a difficult topic and for some it can be very triggering, so please do take breaks if you need to get away, if you need to get some headspace. Presentation should take about 30-40 minutes with time at the end for questions, which Lynne has very kindly covered. So, I have control of these slides. Hopefully, that's moving along okay.

So this is just a very quick overview of what I'm going to be covering today. I'm assuming there's no prior knowledge about gender-based violence. People come from all different types of backgrounds. Some of you may already be experts, some of you may know a little, but just to bring everyone up to speed, I'm going to briefly introduce what is meant by gender-based violence. I'm going to share some information on prevalence, on causes and what the different types are. I'm then going to move on to talking about types of death or loss where GBV is a cause or a factor. Before getting into the details of how we support families, friends, and loved ones who've been affected by this type of trauma. And then what kind of supports are available to them. And finally, because it's really important to remember that any person working with people experiencing grief or trauma need support too, and that's to reduce the risk of vicarious trauma and burnout. So we're gonna finish by covering up or covering different supports that are available for staff.

So, what is gender-based violence? So, this is again, I've covered a few different types of gender- based violence here. And this little graphic at the side, which I'll cover it in a little bit more detail in a moment, is the power and control wheel. So what is gender-based violence? So some definitions, including the UN and other leading organisations, state that gender-based violence is about men's violence against women and girls, which includes threats, includes coercion and including inflicting physical, sexual or mental harm. People do often ask about men and trans people who can both be victims of domestic abuse and sexual violence. But I do agree with the UN definition and this is most commonly used. And this is because the nature of GBV is that it's rooted in gender inequality. And so gender-based violence is ultimately about harms affecting women as the subordinate social class and it's going to be women that I'm going to be speaking about today.

So, thinking about the prevalence of gender-based violence, roughly a third of women will be subjected to domestic abuse or sexual violence in their lifetimes. And several studies in a recent UN survey of UK women also found that 97% of women experience sexual harassment at some point in their lives. So what the data is telling us is that the vast majority of women will be victims of gender- based violence at some point in their lives, with most being victimised multiple times. And all of this has a very significant effect on the lives, on the wellbeing and on the safety and potential of women as an entire social class. And this is worse again, if a woman is from a minoritized ethnic group, if she's disabled, if she's living in poverty. And perhaps the most profound research finding I've come across was from a World Health Organisation multi country study that found men's violence is the leading contributor to death, disease and disability in women aged 18 to 44. So we're dealing with a really significant yet desperately under recognised pandemic, with dire consequences for half of the world's population. And those consequences can, and all too often do, result in the loss of women's lives, which I'll talk a bit more about later on.

So as I mentioned, I put together a list of some of the most common forms of GBV on this slide, and they range from things like coercive control right through to domestic homicides. And it's important to think of those two things and everything in between as existing along the same continuum. At the heart of all gender-based violence is power, control, and as I mentioned earlier, a societal level inequality. And all of this is expressed really neatly in the power and control wheel. The power and control wheel is a tool that's probably more commonly used in America, but it's a really helpful illustration of how we should all start to understand and think about this type of abuse. And it gives us a way of understanding the relationship between power, control and abuse and ultimately how abusers operate and gain control over their victims. The wheel was created as part of what's known as the Duluth Model for anybody interested. And the aim of that model was to focus training and education efforts on how communities can work together, to shift the focus away from blaming women for staying in relationships or choosing bad men or not protecting the children that are the kind of common tropes that we hear. And shifting that toward an understanding of how complex, difficult, and often unsafe leaving these relationships can actually be.

And in fact, leaving an abusive relationship is not necessarily going to be the safest option for many women. If we consider that control and power are at the heart of all gender-based violence, a perpetrator who believes that he has lost control of his victim will really let this slide. So women enter a really dangerous period of time characterised by poor separation, control and abuse when they leave the perpetrator, and this is particularly true when there are children involved. So the abuser will then seek to re-establish control by escalating behaviours in both severity and frequency. And I'm going to move on to talk about domestic homicides in a bit more detail, but this is the potential endpoint of that escalation. If an abuser cannot re-establish control, the risk of homicide is present. So contrary to these very commonly believed myths and media headlines that we might see, domestic homicides are never crimes of passion, isolated incidents, heated spur of the moment things. They are actually very predictable events that follow common measurable stages. So for anybody interested in learning a bit more about that, I would highly recommend Professor Jane Monckton Smith's Homicide Timeline, where you can look at the 8 stages that these cases tend to go through in more detail. And we, we use that quite often in practise when we're thinking about the level of risk that a person might be at. So women often stay is the upshot of this, and fear and experience of escalating abuse are what keep her there, alongside often a lack of means to leave and a fear of shared or lost custody of the children. That's a very common threat, and it's often a frightening reality for many women since domestic abuse is not necessarily considered a barrier to child custody when it comes to family court cases. And that's despite overwhelming evidence demonstrating that children, just as much as their mothers, are primary victims of domestic abuse who live with profound consequences throughout their lives.

So as we move through the rest of this session, I'd invite you to keep in mind how preventable these deaths are and just how much sympathy abusers receive when their murders are framed as crimes of passion. As devastated husbands who can't live without their wives who left them, as henpecked spouses who snapped or often as sex games gone wrong. And when we hear the common questions asking why didn't she leave, what we're hearing is that women are being blamed even for their own murders. And all of this leaves a very profound impact upon families and loved ones. So we're now going to look a little bit more closely at types of loss where GBV is a factor.

So I've covered domestic homicides for briefly just a minute ago. And again, I would really recommend the Homicide Timeline to put this all into a little bit more context and if you're interested in thinking about risk in your own area of work. And I also recommend looking at Karen Ingala Smith's femicide census. And this is where she tracks the deaths of women killed by men in the UK. So we know from the data that at least two to three women die every week in the UK in domestic homicides. Sometimes these are murder suicides where the perpetrator ends their own life after killing their partner or ex. And sometimes this happens in conjunction with a filicide where a father kills his children at the same time. So what we're sometimes seeing is fathers killing their spouse and their children and themselves. And two to three women per week is also an underestimate because these are just the proven cases. But many homicides are considered hidden homicides by criminologists. And that's where they might be homicides that have been framed as suicides and again, as sex games gone wrong, as accidental deaths or as unexplained. And there are actually many examples of this in the press that you might have seen in in recent months and years. Examples of women dying in suspicions, suspicious circumstances where there's a, a known history of domestic abuse, where the victim might have told many people, family members and friends about the abuse. But ultimately not enough evidence or no conviction is brought. So the true number of UK femicides, the actual number is currently unknown, but two to three a week is still a very significant number and many more than this die by suicide. So, people working alongside people at mental health services and in other kind of services where people experience trauma, will know that domestic abuse and sexual violence are both significant risk factors for suicide. And the effects of gender-based violence upon women, as I mentioned earlier, are far reaching. So we're talking about lifelong disabilities, chronic ill health, chronic pain, depression, anxiety, PTSD, trauma. And for those who do manage to leave safely, the abuse still often continues for a long period of time after, particularly when there are children involved. So they may be physically safe. But psychologically, women often find they're still stuck in that abusive relationship when there are children involved or there are other power dynamics at play. For example, if they have shared assets and other things until they can kind of make it a clean separation.

And all of this is compounded by stigma. Women are not commonly believed when they disclose gender-based violence and that includes to healthcare staff, or it's not treated particularly seriously. It's not seen as something that we need to deal with. Often it's seen as a private issue behind closed doors. Maybe it's a toxic relationship - he said, she said, I don't want to get involved. And this is also true of healthcare professionals. So my research that I touched on earlier explored this phenomenon using some publicly available patient feedback on the Care Opinion website. And Care Opinion, for those of you not familiar, is a online health and social care feedback service. It's anonymous, it's transparent, it's not connected to the healthcare services. So patients are able to share their story and ensure that there's a platform where they are heard. And sadly, my research found that women disclosing abuse to healthcare staff is an almost universally awful and traumatic experience. And I found that the more you would expect the healthcare professional to understand, the less likely they actually were to respond positively, with the vast majority of negative feedback being directed toward mental health services and gynaecology. And this ranged in in terms of the feedback from not being believed by staff to being actively blamed and shamed by staff, right through to having their consent completely ignored or overlooked and ultimately being re-traumatised.

And I want to tell you just two stories from the feedback that I looked at that stand out in my mind and illustrate just how badly we are failing women in healthcare. So the first story is of a woman who disclosed to gynaecology staff that she had been raped some years previously. And she specified that she wanted only female staff to be involved in her procedure. And this is a really common request for victims of sexual trauma. And that was really consistent across all of my research and the research that I looked at. However, when she awoke from the procedure it was to a room filled with healthcare professionals and two male physicians examining her genitals. She was also stripped naked by staff and helped to dress in this same room whilst in recovery.

The second story was actually told by a woman's daughter after her death. So this is a woman who was admitted to the ICU after an accident that her daughter suspects was caused by her abuser, a man that she'd separated from many months previously but who had continued to stalk and harass her ever since. So again, that whole separation abuse. And this man was her ex-husband and because of this he was allowed to make decisions related to her care whilst her family were not informed of her accident or her hospital stay until after her death. And this story really struck me. Families and friends are the surviving advocates of their loved ones. And in this case, the voice of the victim and the families were not heard. They were completely lost. So it was interesting to see, as I mentioned about Care Opinion earlier, that there was this space where this person was able to tell their story and ultimately their loved one's story and make sure that it was heard somewhere, which I've touched on earlier is a really hugely important factor in processing this type of grief.

But before I go on to talk about this a bit more, I just want to cover the last section here about hidden deaths. So I've already mentioned hidden homicides, but what I mean by hidden deaths more broadly are the deaths that occur where a gender-based violence has been a contributing factor. So I also mentioned earlier the chronic ill health and mental health that results from GBV, which can and does reduce women's lifespans. And that should be considered a factor or it should, at least it should be considered a factor in those early deaths. But as many of you know, Scotland's drug-related deaths continue to climb year on year. But probably what is less well known is that the fastest growing demographic in drug-related deaths are women's deaths. And prior to working as a Gender-Based Violence Nurse Specialist, I was a substance misuse nurse and it was probably through this kind of work that I developed a really keen interest in GBV. Every day I was seeing childhood sexual abuse disclosures, sexual violence in adulthood, domestic abuse, trafficking, exploitation, all of these were really incredibly common experiences for many women in these services. And sometimes misuse is for the vast majority of people self-medication for trauma. And this is absolutely true for the many very traumatised women that I worked with. And in addition, the expectations are incredibly high for women in these services and with deeply inadequate support. So the upshot of that was many traumatised, unsupported women lost custody of their children, sometimes to their abusers who weren't using substances, or other times to the family members who would abuse them in childhood. And sometimes their children were adopted and they would have no contact with them ever again. And every single time these women were blamed for not trying hard enough, not being good enough mothers and not doing or being enough or more. So the cycle of self-medication is incredibly hard to break for those women because the trauma is relentless and as it goes on, the risk of death increases. So we're failing these women by failing to recognise and address the specific gender trauma they are carrying and they are dying as a result. So the true number of women dying each year where GBV has been a cause or a factor is likely to be in the thousands in the UK alone.

So what does all of this mean for friends and loved ones who are navigating this type of bereavement? The first, safety first, always, I would say the safety of surviving family and friends is and needs to be the top priority. So familiarising yourselves with risk assessment and management in this area is key. I'd recommend keeping an eye out for Safe Lives training for all healthcare staff and anyone working alongside potential victims and the perpetrators of violence, which is really anybody working with the public. But the bottom line is, if a potential perpetrator is still in the picture, safety is going to be your first priority, and ensuring the safety of all surviving family and friends, anybody that you're working with. And naturally the aftermath of a homicide, suicide or drug-related death is an already difficult loss to process. But this is often complicated further when GBV is a causal factor. These are generally young, healthy women with their whole lives ahead of them, and they come from all walks of life. So no woman is too wealthy, too famous, or too successful to be immune. And it can be incredibly difficult to make sense of this kind of loss. For some families, friends and maybe co-workers it can come as a complete shock, whereas for others it's going to be the culmination of probably their deepest fears. What I would say is common for both of these groups, despite their different reactions, is a sense of guilt, a sense that they should have known, should have tried harder, a sense that they could or should have done something differently, anything that might have prevented the death. And that's not necessarily unique to this type of loss. And in fact, it's a relatively normal psychological response to search for how something could have been prevented. But it's reinforced by the reality that their loved one was in danger and came to the worst possible harm. And that makes guilt a very powerful emotion for these people. And it can be very difficult to process, and it can be very destructive. So when you are alongside people experiencing this type of grief, be mindful that guilt can be overwhelming and that it can have significant consequences for their mental health.

Some might also feel angry. Naturally, many people will feel anger toward the perpetrator, but it's also common for their anger to be connected to their guilt. So sometimes people will become angry with themselves, wishing they had again done more or know what was happening. And this can also manifest as anger with their deceased loved ones. Perhaps they're angry that they didn't tell them. There's a sense of shame sometimes there too. Why didn't they tell me? And again, anger isn't uncommon in grief, but where GBV is a cause or factor, it is sometimes more complicated, just as with guilt, because there is this sense of searching for how things could or should have gone to avoid this outcome. So it's important to watch out for expressions of these emotions and to acknowledge them. Which doesn't mean to say that you will be agreeing with their sense of guilt or anger. Rather, you're making space for these uncomfortable emotions and expressing understanding with the feelings that underpin these ideas that they have and the powerless that they will ultimately be feeling as they search their minds I suppose over and over for answers and possible alternative endings.

Ultimately, whilst these are normal reactions, I'd say it's important to look out for again safety, any indications of self-harm or suicidal ideation and to feel confident having these conversations. So again, that can be another daunting situation to navigate. I would recommend for anybody who hasn't got any training in this area and is concerned, as an introduction, the Zero Suicide Alliance provides online training which is free. I think it takes about 20 to 30 minutes and it is a good introduction to asking about suicidal thoughts and how to respond to someone who is suicidal. So that's a suicide... the Zero Suicide Alliance training for anybody interested. And I'm also going to share my e-mail address on the final slide for anybody who wants to get in touch with questions after the session.

Um, so alongside navigating these complex emotions and their grief, families and loved ones are also left to deal with the practicalities of the bereavement. Like most, they'll be dealing with estates, with financial issues, with funeral arrangements and other practical details. But some will also be dealing with more complex practical issues in addition, like inquiries, criminal trials and perhaps custody arrangements for surviving children. And this can be complicated by surviving perpetrators who in the case of a suicide or an unexplained death, may retain sole custody of any children and may inherit the deceased persons estate. And some loved ones and relatives may choose to fight this straight away, but others may feel too daunted or hopeless. I'm going to share some information about where people can find specialised help when they're navigating these more complex practicalities. But it's important to mention that much like women when they feel trapped in this endless cycle of abuse, friends and family can also become caught up in this cycle. Often that occurs long before the deaths of their loved ones. But in much the same way, they too, after their loved one has died, can feel trapped in this cycle. So in addition to specialised supports, what tends to make a significant difference that all of us can help with is ensuring that their voices are heard.

So as I mentioned earlier when I was talking about one of the stories from my research, friends and family are the surviving advocates. So when they feel heard, they feel the voice of their loved ones are being heard too. Their loved one's stories being heard, the story of their lives, not necessarily even the story of the abuse. And specialist services can assist with this in more formal ways. But again, we can all play a part in listening, in asking questions, and expressing a sincere interest in their experience, their story and in their loved one's.

In all types of loss, grief is commonly characterised, I would say, by feelings of loneliness and isolation. People often describe a sense of being avoided by people or that people skirt around the issue. They're being treated differently. People are awkward and they don't know what to say or they don't want to say the wrong thing, but what matters most is not so much what you say, but what you allow them to say. So it's really important that you create a space to listen and to hear all of these complex emotions that they might be feeling, to ask questions about how they're getting on in a really sincere and interested way. And create that kind of trusting, supportive, therapeutic relationship that allows them to be honest with you so you can get to the truth of where they're at, no matter how difficult and complicated that might feel. And from there, it's about, you know, beyond the safety and practicalities is making sure that these are people whose voices are heard, that they're understood, and that whichever kind of direction they choose to take this, they have a place to talk, a platform to express and the way to share that story.

So, umm, talk a bit now about you as staff. So what is it that you as people are going to sometimes potentially be working alongside when you're working with distressed grieving family members and loved ones? Perhaps the grief is recent, or perhaps they're still struggling with this after many years and have entrusted you with this disclosure. This can be difficult and emotionally fraught terrain to navigate, and there are probably a few different things to consider for yourself. So I'd say the first is practical supports and how the service that you work within supports you to navigate these complex situations. So, supervision, it has many benefits, but this is especially true for people working up close with grief, distress and trauma. There's a risk of vicarious trauma when people are regularly engaging in a supportive, empathetic or therapeutic way with survivors. And it's really important that we make sure we are looking out for ourselves and also any staff that we work with or are responsible for. So supervision can provide an important sounding board for how you're feeling about all these different traumatic situations that you're encountering, the hopelessness of people's situations that you sometimes hear. And if it's not available to you in your place of work or for whatever reason, it's not useful, accessible, psychologically safe, depending on the culture of the organisation, I would encourage you to still seek out external supervision. And it is still part of knowing our limits, I would say. So that's really important, not just to ourselves, but to the people that we work with. If we can't recognise that we are becoming burned out and that as a result we're emotionally blunted and less able to engage in a meaningful and therapeutic way, we're essentially risking harm, not just to ourselves, but to the people that we work with. So please always prioritise yourself and your wellbeing first and foremost.

The next thing that is important to consider is knowing what to do. So this is really key. When it comes to gender-based violence and bereavement, in the context of gender-based violence, people tend to avoid the situation and to avoid talking about it with people if they're unsure of what to say or how to respond. And that's true across all kinds of services. So no matter how skilled or experienced people may appear to be or be expected to be, that's not necessarily always the case. And that's why gender-based violence training can be incredibly helpful in this process. And it's useful for every person working in any capacity with the public to essentially ensure that you feel prepared, that you feel confident, and that you feel skilled enough to have some really difficult conversations. And that you know what to do if somebody tells you about gender-based violence or they tell you about the kind of complicated grief feelings that they're carrying around where gender-based violence has been a factor. So again, I would encourage you to either kind of contact myself by e-mail at the end for information about training, or you can contact your local GBV coordinators, which I'll talk a bit more about, or your local women's services. And that's just to explore what options you have available to you in your local areas. But there's always something available in your local area.

And lastly, the, the last important factor I would say is partnership working and a sense of shared responsibility. And this is particularly important for risk management. But it's key in reducing that overwhelming sense of responsibility that many people feel when they're working with such sensitive or sometimes high risk situations. And one of the key practises in the violence against women sector is partnership working and the understanding that one person or one service cannot be all things to all people. We ultimately serve people better by taking a joined up, coordinated approach to support and care. You know, if we all offer what we're best at in a coordinated way, then people get the benefit of a community of support rather than just one service that's trying to plug all of the gaps. So again, link in with your local GBV coordinator or Violence Against Women Partnership and seek out support and advice for what's happening in your area. And please, please honestly feedback the gaps in support. Your advocacy matters and it helps to ensure that we continue to shape and design supports and services around the needs of those who use them. And you know, even though we work in this area every day, they'll still be blind spots there. So remember Care Opinion, remember that there are places where people's voices can be heard. And no matter how trapped, powerless or hopeful they may feel, the power of your advocacy, your listening, sharing platforms to be heard, all of that is incredibly powerful. And it's much more impactful than you might think.

So, now we're going to talk about the different kinds of supports that are available. Some of you might be familiar with the American television host Mr Rogers and why I have titled this slide, 'Who are the Helpers?' So I think it was in 1983, in a book that Mr Rogers wrote that was intended for parents of small children, he very famously said, "when I was a boy and I would see scary things happening in the news, my mother would say to me, look for the helpers. You will always find people who are helping." And this is true here too. So in the depths of grief and trauma, there are people out there who are helping. You're not alone as staff in supporting people through complex grief experiences. And they're not alone in their grief. The gender-based violence services that have been founded and grown over the years have been led by thousands of determined women and survivors who understand very keenly what support is needed for women, children and their families and surviving family members.

So I've included a section, well a selection here of some of those specialist services, but there are many, many more dependent upon where you live, but these are available to everybody across Scotland. What I would say to you is that again, every health board has a gender-based violence lead and their e-mail addresses are all provided online, just a quick Google of GBV leads, or if you want to drop me a question, I'd be happy to kind of link that for anybody who's interested. And they're able to assist with any locally available services and support options, along with your local Women's Aid, Rape Crisis and Victim Support and your local Violence Against Women partnerships. So please reach out. There are people who are keen to help, have specialist supports available to support you, to support you in the work that you're doing, and to support people who are affected by complex grief in the context of GBV. And I know many of you will be familiar with Cruse also, but I just wanted to include them here and point out that they will support all kinds of grief experiences. But perhaps the most notable services for practical and specialist supports in Scotland are the Victim Focus support for families bereaved by Crime Service and Petal who support people experiencing loss in the context of murder, suicide and culpable homicide. So I just wanted to include those contact details there because they're probably the most specialist services that we've got for this very specific type of grief and trauma that families will be carrying around. So there are specialist services again, who can help support you in your work, who can support families and who are there to help.

So that brings us on to my last slide and I think now we'll probably go to the questions. Please feel free to take down my contact details and get in touch with me. Happy to field any questions people aren't comfortable to ask in the questions here or if you've got anything specific to local services or, or healthcare that you want to ask, but happy to take some questions now.

**LI**: Thanks so much, Leanne. It's such an interesting topic and, or issue, and you, it's not the right, the word, but, but you present it really, um, sensitively and tenderly. And I've heard you a couple of times now speak about it and every time, um, you're kind of knowledge and understanding of the subject comes through really clearly. And there's, you know, a kind of something different in each, in each time that, I learn something different each time you present it. So thank you so much. There aren't lots and lots of questions and somebody's just wanted to provide an observation really, I think she just wants to give some feedback on, this was, this is excellent and, and you're very knowledgeable and umm, so it's just kind of providing that feedback to you. Someone else is asking, and I think you said you might come back to this anyway, but interested to find out if there are GBV nurse specialists across all health boards and how, how to find the nurses. Um, this person's saying they've tried to find them, but they can't quite locate them.

**LP**: So, unfortunately not. There is a GBV coordinator in every health board, but they're not always nurses and sometimes they, it's just part of their remit in, in another job, maybe they are a public health professional or they might be a doctor and it's just part of their job. We're very fortunate in the East region to have dedicated GBV nurses and services. And in Fife, we are really, really lucky that we have the largest service in Scotland. So in Fife we have the gender-based violence team coordinator and three specialist nurses available to work with people in the Fife area. The second largest is in NHS Forth Valley - they have two and then I think in Lothian there's one and I think there had been one in Tayside who's now moved across to a different role. So though we've been quite fortunate in the East region to have a number of different specialist nurses, but it's a new specialism. Part of the reason why I'm keen to do so many kind of presentations and talk to different people is to kind of get awareness of this specialism out there and the value that it contributes in the healthcare context. So the short answer to that is that there isn't one in every health board, but there is a GBV coordinator in every health board. So if you're not able to find that information online, please just drop me an e-mail and I'll help you to get in touch with your local coordinator.

**LI**: Oh. Thanks, Leanne. The next question is from a, a midwife working in substance misuse, a specialist midwife, and she's relating a lot to the, some of the points that you've raised. She's particularly interested in navigating support for women through child protection processes and she's wondering if you've got any kind of recommendations or experience for her around how she facilitates effective support?

**LP**: Through the child protection process?

**LI**: Yeah, yup.

**LP**: I suppose that it depends where you are. I would say, again, it comes down to partnership working and that very much comes down to what are your locally available services to ensure that those kind of partnership workings are effective, coordinated, joined up. But it again, it very much depends upon where you are. I wonder if that's somebody who would be happy to just drop me an e-mail...

**LI**: Get in touch with you. Yeah.

**LP**: [inaudible]...what that looks like locally because it's heavily dependent upon the local services. Some will have great coordinated supports, some sadly not so much. But ultimately it does come down to that kind of partnership working, and, family nurse partnerships available, but that tends to be for younger people. So that kind of model is, is really effective for younger people, for anybody who's kind of familiar with it. But please do, do get in touch by e-mail.

**LI**: Thank you. This question is slightly different. So somebody saying thanks so much for this, but can you recommend good training or resources to improve listening skills? It strikes me that being a safe, good listener is a key ask for healthcare professionals in this and lots of other areas, but um, particularly in this area.

**LP**: So I would probably recommend the TURAS trauma programme up to level 2 for probably just about every healthcare professional. And that's a good introduction to, you know, what trauma looks like in lots of different contexts and how to engage with people in a trauma sensitive way. And it also gets people thinking about designing and delivering trauma informed services. So it's appropriate for everybody across the board. So that would probably be a go-to for whatever kind of healthcare professional you are. It's free and it's accessible and it'll get you up to a good level where you feel confident about navigating a variety of different traumas I would say.

**LI**: Okay, um, just getting next question. I wonder have, have you encountered women, I think this is a midwife, have you encountered women who have experienced concealed pregnancy due to domestic violence in practise or in... or in your research?

**LP**: Yes. So part of my role is that we umm, so part of what I do is I'm a, a... I work in the MARAC team in our local area, so I'm the health, one of the health representatives for MARAC. So that's something that I probably more commonly tend to see in that area. And we also work alongside our specialist safeguarding midwives as well. So sometimes there are suspected concealed pregnancies and that can be for a number of different reasons, whether it's because they are being prevented from accessing healthcare by their partner. That's quite common, you know, not being allowed to get a job, not being allowed to go to appointments. And then also there's the threat from the partner of what will happen if somebody finds out. And those threats start quite early. So in pregnancy, you'll have this child taken away from you. Here's all the reasons why you would be an unfit parent. Perhaps if her children taken away in the past. So really it's about identifying any woman who is at risk of or who is experiencing domestic abuse and trying to get in there early to make sure that women feel supported and they don't get stuck and trapped in situations where they aren't or they're having to conceal for whatever reason. So these are really complex situations, but I suppose my area of work is more in when we have the suspicion that there might be a concealed pregnancy. And MARAC is that multi agency partnership approach to managing risk in that area. So I'm sure you'll be kind of familiar with MARAC in your area as well. But that's, tends to be the, the, the majority of the time where I would see cases like that and we would manage it again in that kind of partnership way.

**LI**: Okay, thank you. I'm aware that some of these, these questions are probably not quite bereavement-focused and that, and...

**LP**: Yup, yup.

**LI**: ...that's okay, I hope you're okay with that.

**LP**: Yes that's fine.

**LI**: But um, but just kinda just aware of that. And, and this next question is, is there anything we can or should do if someone reveals something about abuse, but then declines help and doesn't want to report it or take it forward in any way?

**LP**: So this is probably a lengthy answer really, because this is about risk assessment and risk management. So, the short answer is, yes, there are things you can do, but it's important to navigate it safely and sensitively. So somebody discloses abuse to you, it depends upon the kind of information that you get. If you get information to suggest that they are in immediate danger, then it's always going to be the police that is going to be your first port of call. And that's, you know, immediate threats to life and safety essentially. There's an urgent risk that needs to be dealt with right now. I wouldn't advise that for, you know, there's an ongoing level of abuse in the household. It's not always appropriate to call the police, for example, if they talk about coercive control. Sometimes calling the police when there's not an immediate risk to life and safety and the police going around and doing a kind of welfare check can actually increase risk because that person may then deny there's any abuse and then there's potential backlash from the, the, from the partner. And I suppose it's important to say that even when you do call the police, that isn't the end of the risk.

So once you've kind of ensured the immediate safety of the person, it's about looking at what is the, the ongoing risk. And that's going to depend on what information you've got. So if we're looking at a high risk domestic abuse case, that would be referral into MARAC. And MARAC is the Multi Agency Risk Assessment Conference that looks at risk reduction across all different agencies like health, police, education, housing, social work, criminal justice. All of those agencies come together to look at risk in, in these cases and how we can plan around and reduce them.

But you might not always have much information to know whether or not it's high risk or not. So that's why I kind of recommended Safe Lives earlier. Safe Lives provide risk assessments or Dash risk assessment screening and they can provide training on that. So I recommend anybody kind of go and look to get training on risk assessment in relation to domestic abuse from them or enquire with their local Women's Aid. But using the Dash risk assessment tool is how you would probably determine whether or not something was high risk or if it met the high risk criteria.

That said, there again, there are lots of situations, that's why this is a long answer, where you might not have the opportunity to sit down and go through a risk assessment with somebody. Perhaps you've been told something or perhaps you've seen something. Essentially, you can still refer into MARAC without completing the Dash risk assessment if in your professional judgement this person is at risk and you have enough reason to think this person, is at a high risk of ongoing domestic abuse. So that's probably where your local GBV coordinator is going to come in, if you're looking for some advice about this and you're not sure, this is really the first time you're hearing about all of this information and you're not sure if you can make that referral by, you know, break confidentiality or do it without their consent. You can do that. Again, this is a really long answer - I do whole training sessions on this question. So you can, you can break consent and confidentiality to make a MARAC referral, but many people are very daunted by that because they're not sure if it's appropriate if they've not been able to sit down and do the risk assessment. So always lean on your local GBV coordinator for advice about whether or not it is appropriate or indicated, or your local MARAC team in your local council, or your local Fife Violence Against... not Fife, local Violence Against Women Partnership. I'm obviously stuck in Fife mode and thinking about our violence partnership.

But if you're indication is that this is not a high risk case, it's not meeting the criteria, you've not been given information to suggest that it's high risk, then your responsibility as somebody working with this person or who has had contact with this person, it's just to let them know about when or where they can get help if they want to. And not everyone's going to take you up on these offers, as you say, sometimes they might decline to then take up any kind of further help and support. Your only responsibility is to determine whether or not it's high risk enough that you can go against their consent and put a referral into MARAC anyway. Or if it's not meeting criteria for a high risk domestic abuse case, to make sure they know where they can get help and support. And a really good example of where people can go and get support really quickly, for those of you who haven't heard of the Ask for Ani campaign, that's a campaign that's national and it's for all participating pharmacies, which is every single pharmacy in Fife. Our service has trained every pharmacy in Fife to make sure that they, again, I'm in Fife mode, they are all essentially equipped and trained to respond to somebody who goes in and asks for help. But it should be most services or most pharmacies across Scotland. So the idea of the Ask for Ani campaign is that a person can walk in off the street and ask to speak to Ani and Ani is called for 'Attention Needed Immediately'. So all pharmacies should really, and all participating pharmacies that have a poster in the window should really be able to respond to somebody going in and asking to speak to Ani. So I'm not sure I would necessarily advise that out with Fife, but it is a really good safeguarding intervention I think. So the just to kind of shorten this very long answer right down, your responsibility is, is this high risk? Is this not high risk? If it is, MARAC, get some support to do that if you're not totally sure. If it's not, then it's letting them know where they can get help.

**LI**: Thank you Leanne and I know I am sticking with the Fife mode, I know that you provided us in the spiritual care team recently with MARAC training for, for everyone within the team. And I suppose I'm wondering for folks that don't have a GBV team, what, can they have MARAC training from local councils if it's not provided within a, a GB..GBV team? Do you know? You may not know the answer.

**LP**: Well, it depends on the local council really. Or the Fife, sorry, the local violence against women partnership will be able to give good information on whether or not they can provide that training to non-specialist services. But MARAC training is also available again via Safe Lives. So if you go onto the Safe website, they often run MARAC training as well. But just ask, I would say. Ask around, ask your local coordinator, ask your local partnership, ask your local Women's Aid even, who's heard of training in this area. It's really valuable because for health and social care professionals, risk management is your bottom line at the end of the day. So that's what your professional responsibility would be. So I would definitely recommend it for anybody working with anybody in a health and social care capacity, but it's very dependent upon again, your local area.

**LI**: Right, okay. I suspect people are seeing that, but I know that the, I think Phil and Clare have put the Safe Lives links into the chat there for folks. So they should be able to see it. I think maybe just one final question, because I'm aware that we're kind of just about 3 minutes to go and this is one probably about bereavement. So how, how do we know... no, do we know how well supported family and friends feel around bereavement when related to a GBV death?

**LP**: Can you ask me that one again?

**LI**: So, the question. I'll ask you again. Do we know how well supported family and friends feel around bereavement when related to GBV death?

**LP**: I think the general consensus is that most feel that... so I mentioned in the kind of the presentation that in the context of grief, people generally feel isolated, that they're treated very awkwardly, the supports can be sometimes there at the start and then gradually kind of fall away and they find themselves lonely and isolated, feeling like they're kind of still going on about it and everyone else has moved on. And that can be especially true for GBV because GBV is so heavily stigmatised already. So they're kind of dealing with a double whammy there. Not only are they navigating the grief process and that kind of common experience of those variable supports, but also people's awkwardness about GBV. Do they understand, you know, their, their kind of supports around them. So I would say people don't necessarily know where to get specialist support and certainly their family and friends aren't always able to provide the kind of... they can provide listening spaces, but they can't necessarily provide them with the kind of specialist advice and support that a person might be looking for, especially if they're carrying around those really complex emotions and trauma. So on the whole, the consensus is that people are not getting enough support in this area. And so it's important that we're mindful of, when we're thinking about domestic homicides or suicides, the people who are often left to navigate that loss and the lack of support services that are there. So there are two national services, which is excellent, but locally it really falls upon people to ask for help. So if we can be mindful of those services, then we're going to do a better job of catching those people and making sure that they get the support that they need.

**LI**: Thank you so much, Leanne. That's been really fascinating to hear about it. And I've written down GBV and bereavement in terms of do we need to be thinking about a learning resource from a NES kind of perspective as well, because it is such a kind of valuable kind of learning. I don't want to say topic, but I'm going to say it. But, um, so thanks so much for, for taking the time to do this today.

Just finally to say thanks to everybody who, who's come on the webinar. And there, there are other questions, I was aware of that, we just kind of run out of time. There's quite a lot of comments thanking you for doing this, Leanne, and appreciating what you've offered today. And just finally to say that our future webinars will be advertised via Twitter, but also on our website. And if you want to sign up for our Quarterly Bereavement e-newsletter the information is on the screen just now. And thanks to everybody for joining. Have a good afternoon.

The film was produced in April 2023 and can be found at [www.sad.scot.nhs.uk](http://www.sad.scot.nhs.uk/) or <https://vimeo.com/811986847>

For more information visit [www.sad.scot.nhs.uk](http://www.sad.scot.nhs.uk/) or contact [supportarounddeath@nes.scot.nhs.uk](mailto:supportarounddeath@nes.scot.nhs.uk)

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