Solace Women's Aid (Solace) submission to the Department of Health & Social Care's call for evidence for a Women's Health Strategy

About Solace

Solace was established over 45 years ago and is one of the largest single providers of services for survivors of violence against women and girls (VAWG) in the UK. In 2019/20 we worked with 27,414 women, men and children across our services.

Our services are mainly delivered in and across London and include refuge and move-on accommodation; community-based services; therapeutic services; North London Rape Crisis and an Advice line (helpline and casework).

To inform our responses we held focus groups with staff, held one to one interviews with service users and collated case studies from staff with service users' consent.

Recommendations

1. **The women's health strategy should include the identification of and treatment for the impact of VAWG on women's physical and mental health.** Two women a week are killed by men and a further nine are estimated to commit suicide at least in part because of domestic abuse. Women who have experienced VAWG have poor health including complex mental illnesses. Survivors routinely come into contact with health services and last year health services referred around 12% of our services users to Solace.

2. **NHS England should ensure that all parts of the health system have access to Independent Domestic Violence and Sexual Violence Advocates (IDVAs and ISVAs) and IRIS Advocate Educators.** Where health professionals including GPs, major trauma centres, sexual health services and maternity units have access to trained independent advocators professionals feel more confident and disclosures increase. We support SafeLives' recommendations on the number of IDVAs needed for Acute Trusts, Mental Health Trusts and GP practices as a minimum. We also recommend that the Department for Health and Social Care works with practices that have IRIS programmes to assess the impact of different models of appointments on disclosures and referrals.

3. **The Government should introduce a statutory on duty public authorities to train frontline staff to make enquiries into domestic abuse, as recommended by the Agenda Alliance**. NICE recommendations on routine enquiry in maternity, mental health, sexual health and drug and alcohol services are not consistently followed and research by Agenda in 2019 found 15 out of 42 mental health trusts had no policy on routine enquiry.

4. **All health professionals should be given training on survivors' response to the trauma of abuse and in trauma-informed care, including GPs, mental health services and drug and alcohol services. They should also be trained in understanding their own biases towards patients from different backgrounds**. Some survivors of domestic abuse and violence can behave in erratic and inconsistent ways as a result of the trauma they have experienced. Women have reported to our staff that they have been dismissed or disbelieved by GPs, that receptionists act as gatekeepers and that Black women are more likely to be labelled as 'demanding' or 'difficult' than white women.

5. **Every part of the health system should have access to high quality interpreters for women with little or no English and for Deaf women. NHS England should update their guidance to ensure that survivors of VAWG are always asked what gender they want their interpreter to be.** Survivors we work with are not consistently provided adequate interpretation services.

6. **The Department of Health and NHS England should develop training and resources for GP practices and other health services to understand and respond to older survivors of VAWG.** Older women face additional barriers to support, have often lived with abuse for years, are more likely to experience child to parent or grandchild to grandparent abuse and are less likely to self-refer to support services and more likely to come into regular contact with health services.

7. **The Home Office and the Department for Health and Social Care should ensure a firewall between health services and immigration enforcement and lift charges for healthcare for survivors of VAWG**. Migrant survivors of abuse with insecure immigration status and/ or no recourse to public funds are unable to access health services either for fear of being reported to the Home Office or because they are ineligible for healthcare that is free at the point of use. This is exploited by perpetrators to further control women.

8. **The Department for Health and Social Care should work with the Department for Business, Energy & Industrial Strategy (BEIS) to bring in employer leave for VAWG, following the example in New Zealand**. In addition to the estimated £14 billion a year domestic abuse costs the Government in productivity losses, between 36% and 75% of survivors are abused at work using mobile phones, emails, social media or perpetrators showing up unexpectedly at work.

9. **The Department for Health and Social Care should invest in developing a gender and trauma informed approach to mental health, sexual and gynaecological health and maternity care policy and practice for survivors of VAWG.** There is a big gap in specialist, trauma-informed services for survivors of VAWG with high and/ or complex needs and the Department should build on the work of the Women's Mental Health Taskforce to develop an evidence base and embed trauma-informed and gender-informed practice across mental health services. Initiative like My Body Back provide cervical screening, contraceptive care, STI testing and maternity care for survivors of sexual violence but only has two clinics Their approach should be rolled out to mainstream services given the extent of sexual violence women have experienced.

10. **The Department for Health and Social Care, Home Office and Ministry of Justice should work together to provide sustainable funding for counselling and therapeutic services provided by specialist VAWG organisations to meet survivors' needs**. Waiting lists for our counselling services for domestic abuse and for sexual violence are frequently closed. Women can be on a waiting list for up to four months for borough based counselling and up to a year for Rape Crisis counselling. The waiting lists had to be closed for all services between March and September 2020 and we estimate all boroughs were closed for at least one third of the year.

Women's voices

Male violence against women and girls (VAWG) is a significant determinant of women's physical and mental ill health, with domestic abuse alone estimated to cost the health service in England and Wales £2.3 billion a year.

A quarter of women in the UK will experience domestic abuse in their lifetime and one fifth will experience sexual assault[i]. 42% of survivors of domestic abuse sustain physical injuries[ii], and women who have experienced domestic abuse are three times more likely to develop mental illness, including severe conditions such as schizophrenia and bipolar disorder, compared with those who have not[iii]. Two fifths of survivors of sexual assault report physical injury, and 65% said it had an impact on their mental or emotional wellbeing[iv].

The number of suicides each year in which domestic abuse was a factor is unknown, but a 2002 study found much higher rates of attempted suicide among women who had experienced domestic abuse than the general population. Based on these figures Professor Sylvia Walby's seminal 2004 study on the cost of domestic violence estimates that 34% of female suicides each year are at least partly caused by domestic violence and abuse[v]. According to the Office for National Statistics, in 2019 1,388 women took their own lives. If 34% were at least partly caused by domestic violence that is a rate of nine women a week.

Routine enquiry

Looking at our own referral data, around 12% of referrals to our services from external sources came from health settings in 2020-21. The average amount of time women in our services experienced their current abuse is 6 years and 4 months, during which time most will have come into contact with health services who may have been able to support them earlier.

National Institute for Health and Care Excellence (NICE) guidelines set out that frontline staff in all health services should be trained to recognise the indicators of domestic violence and abuse and should be able to ask relevant questions to support survivors to disclose abuse. NICE guidance also says that trained staff in antenatal, postnatal, reproductive care, sexual health, alcohol or drug misuse, and mental health services should ask service users whether they have experienced domestic violence and abuse as a routine part of clinical practice even where there are no indicators of abuse[vi].

Our experience is that in practice routine enquiry is still too varied across health services, including in maternity and mental health services. Research by the Agenda Alliance in 2019 found that of 42 mental health trusts that responded to a freedom of information request, 15 had no routine enquiry policy. One trust only asked 3% of patients about their experiences of domestic abuse when they should be asking everybody.

Best practice

IDVAs and ISVAs are experts in domestic violence and abuse and/ or sexual violence. They provide emotional and practical support for survivors. IDVAs usually support survivors at high risk of harm with things like safety planning (which might include considering options for escaping, keeping a packed bag somewhere ready, planning how to respond in different situations), coordinating with other agencies and support services to ensure for example that survivors have somewhere to go, supporting them with the decision on whether to report perpetrators to the police, and being on the phone for day-to-day support. ISVAs tend to support survivors of sexual violence who pursue a criminal justice response, helping them navigate the process and liaising with the police and other agencies to keep survivors informed. IDVAs and ISVAs (and IDSVAs who support survivors of both domestic abuse and sexual violence) are trained and accredited to work with survivors.

We have several health-specific IDVAs, ISVAs and IDSVAs including:

- Two Multiple Discrimination IDVAs, advocating for service users with experiences of multiple forms of disadvantage including complex mental health needs, working closely with local mental health services;

- A community-based health IDVA working with service users in the local service with complex physical and mental health needs; and
- A sexual health IDSVA co-located in a sexual health clinic, training staff and taking referrals for service users identified through the clinic.

In 2020-21, they received over 200 referrals and of the survivors they supported:

- Around 90% had disclosed physical abuse where the abuse was current, for 64% of those survivors the physical abuse had either stopped or significantly reduced;
- Around half had disclosed sexual abuse where the abuse was current, for 65% of survivors the abuse had either stopped or significantly reduced; and
- Around 80% had disclosed controlling behaviour where the abuse was current, and for around half of survivors it had either stopped or significantly reduced.

In addition, 38% of survivors had accessed mental health support most of whom experienced reduced trauma and anxiety, and 11% had been referred to and accessed crisis accommodation.

Case study – Senior health IDVA

Annie lives with her long-term partner Jim, who is also her carer. She has been diagnosed with schizophrenia and during an appointment with her psychiatrist from the local mental health team the psychiatrist became concerned about Annie's presentation and the dynamics between her and Jim. Annie would not communicate for very long, but in response to direct questions she did disclose that Jim was frustrated and hitting her. The psychiatrist had also been concerned about some sexualised content in what Annie had spoken about during the appointment, but after disclosing that Jim had been violent to her and checking that they would not tell him, Annie asked to leave the meeting.

Annie was given the mental health team's number and advised that if she felt at risk, she could leave the house to seek help (despite lockdown measures) and call the police or contact them for support. They were not able to discuss a referral to solace at that point but Annie agreed to meet the psychiatrist without Jim there again the following week and gave consent for a Solace Health IDVA to be present as well. During that meeting the Solace IDVA discussed moving into crisis housing to be safe, which Annie wanted to do. They agreed to tell Jim it was for medical reasons however Jim refused to allow Annie to move out, saying she would be at risk of getting Covid-19.

The Solace IDVA continues to work with Annie's mental health team, attending appointments and working with the staff and Annie to ensure she has safety plans in place and knows she will be supported if she asks for help.

In partnership with Redthread, a charity that runs trauma-informed programmes to tackle serious youth violence, we have specialist youth IDVAs co-located in four major trauma centres in London. We support all young people between the ages of 11-25 who are survivors of or at risk of domestic abuse, sexual violence, CSE, forced prostitution, FGM, forced marriage, HBV, and trafficking and modern slavery that present in the Emergency Departments. Our IDVAs support disclosures and work with young people to assess their needs and refer them to appropriate services, providing ongoing advocacy and support where needed. Crucially, we also train and provide support to the clinicians in the hospital which means that staff are able to identify and address abuse and violence more effectively and with greater confidence.

Over the last three years our Redthread IDVAs have had over 400 referrals. The most common form of abuse experienced by survivors they worked with was domestic abuse, followed by rape and sexual exploitation. Our IDVAs' assessment of young people's risk and safety following their intervention found that over half had reduced their risk and increased their safety levels. Around 15% accessed treatment support for their mental health, and a fifth had improved their coping strategies. This is a significant impact given the time it usually takes survivors to access support, and the long-term impact of domestic abuse and violence both in terms of survivors' mental and physical health and cost to the public purse.

Case study – Major Trauma Centre IDVA

17-year-old Letitia was brought to a hospital emergency department in an ambulance following an overdose. She disclosed that the overdose was a result of the emotional, financial and physical abuse she was experiencing from the woman she was living with, who she referred to as her auntie. Her father had brought her to the UK from Sierra Leone but she had only ever stayed with aunties. Her elder sister lived with her, but was due to be married soon, and Letitia disclosed that the aunt had said that once the sister had moved out she would 'sort out' Letitia. She said her father and aunt had also threated Letitia not to tell anyone at the hospital what was going on when they called the ambulance.

Letitia was referred to the hospital safeguarding team who called Letitia's local council and involved social services. A social worker called Letitia's aunt who denied the abuse and the social worker said she was safe to be discharged back to Letitia's aunt's care. Our IDVA and a paediatrician from the hospital flagged the risks to Letitia's safety and following a meeting where Letitia was able to disclose the abuse to the social worker, an emergency foster placement was found for her and she was discharged to a safe environment from where she can continue to attend college and pursue her ambitions.

We also provide IRIS Advocate Educators in six London boroughs. IRIS is an identification and referral to improve safety programme (IRIS). IRIS provides in-house domestic violence and abuse training for general practice teams and a named advocate to whom patients can be referred for support. Where IRIS advocates and IDVAs are embedded in GP practices, GPs and nurses are more confident asking about domestic abuse and handling disclosures.

A randomised control trial of 24 practices with the programme and 24 without, all in Hackney in London or Bristol, found the IRIS practices referred 224 patients to advocacy services compared to 12 referrals from those without, and the IRIS practices recorded 641 disclosures of domestic abuse compared with 224 in the practices without IRIS[vii]. A cost benefit analysis of the randomised control trial found a saving of £3,155 per practice per year[viii].

SafeLives recently mapped provision of health based domestic abuse provision across London and found there are significant gaps, which leaves survivors accessing health services with a postcode lottery of the extent of support and understanding they receive.

We support recommendations by SafeLives for, as a minimum:

- A minimum of 2 IDVAs per Acute Trust to work in hospitals, which would mean 36 in London up from the current 19.
- 2 IDVAs per Mental Health Trust, which would mean 20 in London compared with the 3.4 FTE IDVAs in post

- IRIS programmes in every practice. There are currently IRIS programmes in 16 of the 32 London Boroughs[ix] (SafeLives 2020)

Case study – IRIS

Dina experienced emotional abuse, financial abuse and bullying from her ex-partner Samir and suffered from depression and anxiety as a result. Dina had an informal arrangement with Samir where he agreed to look after the children whilst Dina accessed help with her mental health. Whilst the children were in Samir's care during one of her appointments, suddenly all contact stopped and that was the last time Dina saw her children. Samir moved homes and did not tell her the new address. He later told her that he was angry that she left the relationship and the only way she could see the children was if she agreed to get back together. Dina saw her GP who prescribed her antidepressants and referred her to an IRIS advocate who has supported Dina to access support and advice from a solicitor around contact with her children; apply for a wheelchair through a local disability support team; access welfare support and complete a course of counselling.

Dina told us, *"I am glad my GP asked me those questions about domestic violence. I have found that since I now have a Solace worker, I go to the GP less than I did before. I am hopeful that I will get to hug my kids again and tell them how much I love them."*

Understandably much of the focus of health services' response to VAWG has been on victims and survivors. Health services also need training on identifying and intervening with perpetrators, and the Department of Health and Social Care should work with the Home Office on its forthcoming perpetrator strategy to implement this. Our Sexual Health IDSVA highlighted, for example, that a sexual health nurse might hear a young man talk about the fact his partner wants him to wear a condom but he refuses. This could be an opportunity to address problematic behaviours if the nurse felt confident in doing so.

Information and education on women's health

Trauma- and gender-informed practice

There is a general lack of understanding about the impact of trauma on women's physical and mental health which can impact the diagnoses women are given and the way they are treated by health service staff. This is compounded by other intersecting issues including women's race and ethnicity, with Black women more likely to treated as being difficult and demanding, and having their pain disbelieved.

Trauma-informed practice is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both workers and survivors, and that builds opportunities for survivors to regain a sense of control and empowerment" (Hopper, Bassuk, & Olivet, 2010).

In discussions with Solace counselling, therapeutic services and advice line staff, they raised the way that some survivors are treated and sometime dismissed by GP and other health services because of the way their experiences of trauma present, and a lack of understanding from practice staff. Trauma can cause long-term health problems including chronic pain, fibromyalgia, chronic fatigue, PTSD, stress, depression, and anxiety[x]. It can also result in erratic, unpredictable, and inconsistent behaviour. In supporting survivors of VAWG it is important to understand the impact trauma has and to see those behaviours and symptoms as potentially the result of unresolved

trauma. Women we work with have been told directly they were being 'difficult' and 'demanding' when they were in pain and asking for help, and particularly Black and minoritised survivors.

One risk of the lack of training on the impact of trauma highlighted by one of our health IDVAs was the standardised route to accessing counselling through the Adult Improving Access to Psychological Therapies (IAPT) pathway, where people presenting with anxiety or depression can access talking therapies through the NHS. Someone misdiagnosed with anxiety and depression who in fact has PTSD could be put at risk of being retraumatised if they do not have access to the right kind of counselling or therapeutic treatment to take them through the stages of therapy needed at the survivors' pace.

Multiple disadvantage

We run several projects working with women who have experienced multiple forms of disadvantage including VAWG, street homelessness, problematic substance use, and complex mental health needs. Our specialist advocates use assertive outreach and trauma-informed practice to build trust with women who have often completely disengaged with other services. Through their work survivors are able to access housing, health, and welfare support and address current abusive relationships. Service managers told us that drug and alcohol services often fail to see or understand the dynamics of abuse, for example when women present at their services with perpetrators, they are seen as 'equally bad'.

In addition, mental health services generally will not treat people who are still using, or perceived to be using, substances. This puts survivors in a vicious circle, they use substances to self-medicate because they have not had treatment for their mental health needs or trauma but cannot access services unless they have stopped using substances. Then there is often a long wait for treatment. In some areas there are dual diagnosis workers who can diagnose and support patients with both mental health needs and problematic substance use, which reduces the different agencies women must engage with and means they can access support for both. Of the eight London boroughs we run one of our multiple disadvantage programmes in however, only two have dual diagnosis workers.

Communication barriers

Women who speak no or limited English and Deaf women experience additional barriers to support and should always be supported with an interpreter when communicating with any health services. NHS England's guidance for commissioners sets out best practice for commissioning services and the legislation under which equality of access is required including the Equality Act 2010 and the NHS Constitution 2012[xi]. Survivors however are not consistently provided interpreters and while the guidance states that patients should be asked about their preferred gender of interpreter it should be made clear in the guidance that survivors of VAWG should always be asked and must be provided with an interpreter of the gender of their choice.

Women's health across the life course

Older women

Across our services around 8% of service users are aged 55 and over. Older women often face additional barriers to getting support such as mobility issues, disabilities, age related conditions and abuse from adult children or from their carer. They may also be caring for other people, which can add barriers to their accessing support. Older women's needs can also be more complex as many of the older women we work with have been in abusive relationships for a long time and are often still in those relationships. Retirement and physical disabilities can increase older women's isolation. Their abuser may be their only social contact particularly if they

are controlling survivors' links with other family, friends or support networks. If older survivors do decide to leave facing homelessness is particularly daunting and refuge may feel unsuitable and inaccessible. They are also more likely to experience abuse from an adult child or grandchild, usually sons and grandsons.

One older service user we spoke to was being subjected to verbal and emotional abuse from her son, who struggles with substance addiction and depression. His abusive behaviour escalated during lockdown and she feared for her safety and asked him to leave home but carries a huge amount of guilt for doing so, which is not uncommon. This survivor is on the waiting list for counselling but as she said to us, *"I think I need it now"*. She also described the challenge of having been forced to retire and how the loss of that distraction was exacerbating her anxiety – particularly during Covid-19 and lockdown.

Older women are less likely to seek help and more likely to be referred to services through agencies including GPs and other health services[xii].

We heard from Solace IDVAs that GPs often invite or allow partners or relatives into the consulting room (when seeing patients face to face). When a partner or relative is also someone's carer, or presents as their carer, it can seem like the more sensitive approach to invite them into the consultation but this might be one of very few opportunities the survivor has to disclose abuse. We also find that GP and other health services will ask relatives and carers to interpret for patients who speak little or no English, but they should always use a trained interpreter as again this limits survivors' opportunities to disclose abuse or for health professionals to ask.

Migrant women

Last year we worked with 444 women with no recourse to public funds across our services, and supported 130 women through our Immigration Advice Line. Migrant survivors of abuse with insecure immigration status and/ or no recourse to public funds are unable to access health services either for fear of being reported to the Home Office or because they are ineligible for healthcare that is free at the point of use. This cuts off a crucial avenue for disclosure and support for women whose immigration status is used by perpetrators to control them.

Women's health in the workplace

The Government estimates domestic abuse costs £14 billion a year in terms of work and lost productivity[xiii]. In addition, the Domestic Abuse Act now recognises economic abuse as a form of domestic abuse, which includes limiting or controlling survivors' access to and ability to work. The Department for Business, Energy & Industrial Strategy carried out a consultation on workplace support for victims of domestic abuse last year and published its response in January 2021[xiv]. The review found that in addition to the productivity costs, between 36% and 75% of survivors are abused at work using mobile phones, emails, social media or perpetrators showing up unexpectedly at work.

For survivors, being in work is a protective factor giving them breathing space and social interaction as well as financial and economic independence. Perpetrators deliberately isolate and remove protective factors to exert power and control over all aspects of survivors' lives. There is a legal duty for employers to provide support to their colleagues if they become aware that they are experiencing domestic abuse but it is limited and the BEIS review found unmet needs in the existing framework and employer practice. We recommend the Government adopts the model of paid leave for domestic abuse following the model passed in New Zealand in 2018, giving survivors ten days to find or maintain safety and to get support with the mental and physical impacts of domestic abuse.

Research, evidence and data

Mental health services

There is a real gap in trauma-informed specialist mental health services for survivors of VAWG with high mental health needs, problematic substance use and/ or complex mental illnesses and more research should be done to identify the treatments and therapies that work best to fill the gap.

We provide counselling and therapeutic services for survivors of rape and sexual violence and domestic abuse, mainly through borough commissioned VAWG counselling or through our North London Rape Crisis centre. One to one counselling and group work supports women to explore the impact VAWG has had on their emotional and mental health, and to begin to recover from those experiences. In order to access this type of support, women need to be at a point where they are able to open up to a counsellor or group and talk about their experiences safely. The services are generally unsuitable for survivors who are currently self-harming, living with serious eating disorders or self-medicating with drugs and alcohol.

Similarly, survivors who are need treatment for more complex disorders such Borderline Personality Disorder or schizophrenia often need specialist mental health treatment before they can safely and effectively talk about their experiences of abuse.

However, specialist mental health services are not necessarily trauma informed or trained in VAWG despite the causal relationship between trauma and mental illnesses and experiences of male violence and abuse[xv]. We support recommendations put forward in 2018 by Professor Kathryn M. Able and Dr Karen Newbigging and the British Medical Association, calling for a gender informed approach to mental health policy and practice, taking into account gender-based violence[xvi].The Women's Mental Health Taskforce has begun the work needed to improve the response to women's needs, the women's health strategy should ensure that trauma-informed and gender-informed practice is embedded across services and develop an evidence base for specialist mental health services where there are gaps[xvii].

Our Rape Crisis Centre is currently piloting a safeguarding hub where we can assess potential high-risk referrals – risk of suicide or self-harm, use of alcohol or drugs as coping mechanisms or where there are complex mental health support needs. We work with survivors through the hub to link them into specialist support services to stabilise before accessing full therapy with us, which means we remain in contact and on the referral pathway, so do not have to start again when they are ready to access our therapeutic support.

Case study – Rape Crisis Hub

Mary experienced child sexual abuse and rape as an adult and was referred to rape crisis for counselling. She has complex PTSD, physical paralysis and pains, dyslexia, and is awaiting test results for Huntingtons disease related to memory loss she is experiencing. Mary was initially offered six sessions of one-to-one counselling through Rape Crisis; however, it quickly became clear that the multiple difficulties she was experiencing including dyslexia and memory issues were affecting her ability to stay engaged in the session.

Through the safeguarding hub, Mary was referred to a counselling advocate who supported Mary to register with a new GP practice and mental health referral. The Counsellor Advocate spent a long time engaging with Mary and with the GP and attended her appointment with Mary while she had Part One of her two-part psychiatric assessment. Mary's communication difficulties could have been a barrier to her assessment and the relationship her Counsellor Advocate had built with her was key to the successful assessment. Mary has also been supported with her housing issues and is now awaiting part two of her assessment.

Sexual violence

Survivors of sexual violence can find intimate health care very traumatising. Initiative like My Body Back provide cervical screening, contraceptive care, STI testing and maternity care for survivors of sexual violence but currently only has two clinics, one in Glasgow and one in London. Their approach should be rolled out to mainstream services given the extent of sexual violence women have experienced.

Impact of Covid-19 on women's health

The increase in incidences and levels of violence against women during lockdowns has been well documented and the levels of demand for our services has been sustained over the year. At Solace, we saw a 117% increase in calls to our advice line in March this year compared to last year and our refuges are still full meaning we are still turning away referrals.

Not only has this year locked survivors in with abusers, but it has also been triggering for survivors who are no longer in abusive situations but have been and continue to be – like many people – very isolated. Being cut off from their support networks has impacted survivors' mental health and women are calling our advice line more frequently and with higher and more complex mental health needs. We refer women to more appropriate mental health services or encourage them to go to their GP when our counselling waiting lists are full, but we have been finding that those services refer women back to us even when they have greater needs than we can accommodate, sometimes because other services are closed or because they too are full.

Our Rape Crisis Helpline has seen an increase in the complexity of survivors' needs, with the average length of call increasing by 30% between 2019-20 and 2020-21. This has been compounded by the closures of our waiting list for counselling through the Rape Crisis Centre. We offer six weeks of one-to-one counselling as standard, with an extension available where needed. Women can be waiting up to a year for the counselling though we keep in touch with them and update them on progress. Despite increasing the waiting list to 18 months during the pandemic, we had to close the waiting list from March 2020 until September 2020 and have fluctuated opening and closing the list ever since, taking referrals for between a month and six weeks before closing them again for four weeks or a month.

Through the pan-London Ascent Advice and Counselling and Ascent Advice Plus partnership, we provide counselling services in 12 London boroughs, offering up to 15 one to one counselling sessions or six pre-trial sessions. Women can be on a waiting list for up to four months. The waiting lists had to be closed for all services between March and September 2020 and we estimate all boroughs were closed for at least one third of the year.

The move to online and telephone appointments only during lockdown removed one of the key avenues for disclosure and support for some survivors, while others adapted well and found it easier to talk to their doctors from their own environment. Face to face contact can be critical for picking up signs of abuse, and as we move out of all restrictions it will be important for GP practices to reinstate sufficient appointments so that survivors who need it can still access in person contact. For some of the women we work with their access to online systems is limited by lack of digital devices or data and it is crucial that women can phone or go into practices to register and for appointments. We recommend that the Department for Health and Social Care works with practices with IRIS programmes to assess the impact of different models of appointments on disclosures and referrals.

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