

**STANDING
TOGETHER**
against domestic abuse



**“Cancer made me weaker to abuse and abuse made me weaker to cancer”:
Enhancing the cancer workforce
response to domestic abuse.**

**SETTING THE SCENE: PROFESSIONAL + VICTIM-SURVIVOR
CONSULTATION FINDINGS, APRIL 2022.
BY DR SANDI DHEENSA**

**MACMILLAN
CANCER SUPPORT**

“I never thought about domestic abuse and cancer. I just think all my adults can speak for themselves...It was only when that survey came through, I thought ‘God, obviously,’ because they're more vulnerable to abuse.”
[Consultant]

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FOREWORD

As if being in an abusive relationship wasn't enough, one of you now has cancer. It's a recipe for absolute disaster.

The work that is highlighted in this report is imperative and urgent.

Before I was abused, I thought that domestic abuse was something that you could see. I had only the image of a 'battered woman' that the media and public narratives portrayed.

I now know that abuse is so much more than that. I was bullied, controlled, and punished in ways that I still find hard to talk about. But never once could I have gone to A&E with a significant wound.

And when he got cancer, it got a whole lot worse. Any brakes that he might have put on his behaviour were definitely off and his sense of entitlement grew. He couldn't control the cancer, so he controlled me.

The guilt that I felt for leaving has taken a long time to work through. The pain of what he did may never leave me. The work that we are doing together will help everyone who comes into contact with people with cancer and their carers to be aware of what is happening and to offer the much-needed help and support.

Domestic abuse and cancer is dangerous: please help to keep everyone safe.

- *M, victim-survivor.*

BACKGROUND

This report is the outcome of the first phase of a two-phase project with the overarching aim of improving the cancer workforce's response to patients and their partners and family members who are experiencing domestic abuse. **We want to ensure that the cancer setting offers a safe space and time for victim-survivors of domestic abuse to get the support they need, from skilled and confident healthcare workers and other professionals who work in cancer.**

The project is funded by **Macmillan Cancer Support** and is coordinated by **Standing Together Against Domestic Abuse**.

Macmillan Cancer Support is committed to improving the lives of everyone affected by cancer and inspiring others to do the same. Right now, more than three million people are living with cancer, and that number is set to grow. Macmillan will do whatever it takes to help everyone with cancer live life as fully as they can, by offering practical, emotional, and financial support.

Standing Together was founded 20 years ago with the ambition to eradicate domestic abuse by transforming the way organisations and individuals think about, prevent, and respond to it. Working in various operational settings including health, housing, criminal justice, and community work, Standing Together collaborates with partner agencies to ensure a Coordinated Community Response (CCR) to domestic abuse by improving their understanding and response to victim-survivors and perpetrators. Standing Together's aim is to stop victim-survivors from falling through gaps via these improved responses within and between voluntary and statutory organisations.

Dr Sandi Dheensa is an academic social scientist, and an independent evaluator of third sector gender-based violence programmes, with expertise in the healthcare and public health responses to domestic abuse. She conducted the consultation exercise and authored this report.

The first phase of the project has involved a consultation exercise with cancer professionals and victim-survivors of domestic abuse: this report shares its findings.

EXECUTIVE SUMMARY

Background: Almost 9 million of us in England and Wales have experienced domestic abuse in our lifetimes. Domestic abuse is a violation of basic human rights and a form of gender-based violence. Its impact on mental and physical health is profound and long-lasting. Evidence from the USA shows that this impact extends to screening, care, and treatment for cancer. Healthcare professionals are often the first or only professionals to whom victim-survivors disclose domestic abuse. Complex interventions comprising the delivery of regular training, the establishment of referral pathways to specialist services, and the employment or co-location of a domestic abuse worker have transformed the healthcare response to domestic abuse in a range of clinical practice areas. But, to our knowledge, no complex interventions within England's cancer workforce have been conducted, evaluated, and published. Although there are undoubtedly pockets of good practice in cancer, there is a gap in understanding about what works.

This report outlines the results of a consultation exercise that explores what is currently happening in the cancer workforce and why. Its findings lay the groundwork for an intervention that aims to improve the confidence and awareness of cancer professionals around domestic abuse and to ensure that victim-survivors get the support they need.

Methodology: The consultation comprised surveys and interviews with England and Wales-based professionals who see patients diagnosed with cancer, or their partners or family members, and England-based victim-survivors of domestic abuse affected by cancer.

Key findings: Twenty victim-survivors of domestic abuse, nineteen of whom had cancer and one of whom experienced domestic abuse from a partner with cancer, responded to our consultation. Over 300 professionals responded, mostly from acute or community healthcare. We found:

1. Domestic abuse did not stop and often worsened after a cancer diagnosis. Non-physical coercive control, psychological, and financial abuse were most common and left victim-survivors feeling unsafe and fearful.
2. Abuse affected cancer treatment, surgery, and recovery in ways that led to pain and suffering. Most victim-survivors reported that the abuser stopped them from resting and ridiculed their treatment choices and appearance post-treatment or surgery.
3. Most cancer professionals agreed that they have a responsibility to identify and respond to domestic abuse. Fifty percent had encountered domestic abuse in the past three years, and other professionals said they had likely missed cases.
4. Of the victim-survivors, just 9/20 reported that they had disclosed domestic abuse to cancer professionals. The two biggest barriers were not thinking it was relevant to the professionals' role and not being asked the right, or any, questions.
5. Professionals reported referring victim-survivors to a range of appropriate agencies and services, including domestic abuse services. Victim-survivors also reported such referrals: the cancer setting led them to get domestic abuse support for the first time.
6. Professionals and victim-survivors felt that the cancer setting provided a unique opportunity for domestic abuse to be identified and responded to due to the frequency of contact, length of appointments, continuity of care, and discussion of holistic needs.
7. But lack of confidence and knowledge was a barrier to a good response. Between a third and half of professionals lacked confidence in recognising the signs of domestic abuse and just under half lacked confidence in knowing what to say if someone discloses abuse.
8. To improve the cancer workforce response to domestic abuse, victim-survivors wanted professionals to make the setting a clear safe space for disclosure, to recognise the signs—particularly of non-physical abuse, to enquire safely and provide first-line support, and to refer them to specialist support options.
9. Professionals were eager to improve their response to domestic abuse. As such, they said they want specialist training, education, awareness, and a culture shift wherein all cancer professionals, from surgeons to nurses, see identifying and responding to domestic abuse as their role.

THE CONTEXT: What do we know about cancer and domestic abuse?

Domestic abuse is a violation of basic human rights and a form of gender-based violence. It occurs when a person, or people, use a pattern of coercion, violence, or threatening behaviour to control and frighten a current or former intimate partner or family member. Almost nine million people in England and Wales have lifetime experience of domestic abuse.ⁱ

Domestic abuse is not just physical and sexual violence, and in fact, many victim-survivors¹ will experience non-physical² forms only. It also includes economic, psychological, and verbal abuse, enacted through threats, intimidation, manipulation, humiliation, harassment, and stalking.

An abuser's intent to create a state of coercive control is a frequent dynamic underlying domestic abuse. Coercive and controlling tactics suppress a victim-survivor's autonomy, liberty, personhood, and dignity, keeping them in a state of fear.ⁱⁱ Coercive control is a pattern of behaviour, rather than one-off incidents, and the abuser intends to reduce a victim-survivors' choices and space for action.ⁱⁱⁱ This results in a victim-survivor having to change their usual behaviours to placate the abuser, as they are manipulated into conformity through the fear of the consequences of non-compliance. Although coercive control is deeply harmful to victim-survivors and linked to over 90% of domestic homicides,^{iv} agencies and services tend to overlook its severity in the absence of physical and sexual violence.^v

Anyone can be subjected to domestic abuse: it affects people regardless of their socio-economic background, race, faith, sexuality, and gender. Nevertheless, domestic abuse is overwhelmingly perpetrated by men against women.^{vi} Disabled people and people with long-standing illnesses are also disproportionately affected. The most frequently reported form of domestic abuse is perpetration by partners or ex-partners, but perpetration by other adult family members is also prevalent. Separation, as well as the onset of illness in the victim-survivor or abuser, are known triggers for escalation because the usual methods of control no longer work.^{vii} Post-separation abuse through family court is particularly common, which is one of many reasons that victim-survivors do not 'just leave'.³

Its impact on mental and physical health is profound and long-lasting. As well as the injuries, sexually transmitted infections, and unwanted pregnancies caused by physical and sexual violence, there are indirect physical health consequences of even the non-physical forms, including gastrointestinal conditions, chronic pain syndromes, and cardiovascular risk.^{viii,ix} Domestic abuse is linked to a sevenfold risk of post-traumatic stress disorder, a fourfold risk of anxiety disorders, a threefold risk of depressive disorders,^x and suicide and suicide attempts.^{xi}

¹ We use the term 'victim-survivor' to reference people who have experienced domestic abuse. The term recognises the experience of a crime and acknowledges the possibility of, and trajectory towards, recovery and healing. We value that people prefer different terms and may self-define in different ways at different times.

² The 'non' in this term is in no way intended to imply that 'physical' abuse is the norm and deviations are less important, common, or serious.

³ See the work of campaign group 'The Court Said' <https://thecourtsaid.org/>.

The health impact of domestic abuse extends to screening, care, and treatment for cancer. Although the evidence is mixed, some victim-survivors are less likely to attend routine breast, colorectal, and cervical screening than the general population.^{xii} Victims-survivors have 2.74 times the odds of receiving an abnormal pap smear result^{xiii} and have a 1.5-fold increased risk of discontinuing subsequent follow-up care.^{xiv} Victim-survivors also have over twice the odds of being diagnosed with different types of cancers.^{ix} Domestic abuse limits cancer-related quality of life,^{xv} and affects the timeliness of treatment,^{xvi} and treatment uptake.^{xvii}

Just a handful of research studies have qualitatively explored the impact of experiencing domestic abuse and cancer—all with female participants with breast cancer from the USA. They show that domestic abuse does not stop, and often intensifies, after a cancer diagnosis.^{xviii} Women disclosed that abusers used their cancer against them, such as humiliating them about their appearance after chemotherapy and mastectomy. These women were reliant on the abusers physically and financially. And in this way, they were trapped. Support from healthcare professionals was vital, especially because abusers had isolated them from friends and family.^{xix}

Evidence from wider healthcare shows that healthcare professionals are often the first or only professionals to whom victim-survivors disclose domestic abuse^{xx} and the NHS has more contact with victims and abusers than any other agency or service.^{xxi} In recognition of the unique opportunity that healthcare interactions provide, the World Health Organization recommends that healthcare professionals provide ‘first-line’ emotional and practical support if a victim-survivor discloses domestic abuse. Specifically, they recommend the LIVES approach: healthcare professionals should listen, inquire about needs and concerns, validate what they have said, enhance safety, and support them by signposting or referring to information, services, and social support.^{xxii} Groundbreaking interventions to enhance the healthcare response to domestic abuse have been developed and evaluated within the NHS over the past two decades. These show that the delivery of regular training, the establishment of referral pathways to specialist services, and the employment or co-location of a domestic abuse nurse specialist or advocate together increase professional knowledge and confidence around identifying domestic abuse, and the numbers of victim-survivors referred for support^{xxiii} with improvements sustained over time.^{xxiv} These interventions have transformed the healthcare response to domestic abuse in a range of clinical practice areas, from primary care to emergency medicine. But, to our knowledge, no similar complex interventions within England’s cancer workforce have been conducted, evaluated, and published.⁴ In fact, as far as we know, no peer-reviewed UK research has explored the cancer-domestic abuse intersection at all.

Although there are undoubtedly pockets of good practice around the country, there is also a gap in understanding about what works. Many people diagnosed with cancer today will likely be experiencing domestic abuse. Multiple threads on Macmillan Cancer Support’s online forum are from people affected by both cancer and domestic abuse. The Macmillan telephone support line receives, on average, 25 calls per month from people with a primary, secondary, or tertiary concern about domestic abuse.⁵ And at least a dozen published domestic homicide reviews⁶ have involved a cancer diagnosis.^{xxv} Forum threads and homicide reviews include cases of abusers being diagnosed with cancer and escalating their behaviours, leaving victim-survivors to face either the worsening

⁴ We use the term ‘cancer workforce’ and ‘cancer professional’ to mean anyone who works with people with cancer or their partners or family members (i.e., not just cancer nurses and oncologists, and not just healthcare professionals).

⁵ Macmillan’s safeguarding team shared these statistics with us for Jan 2020 – Oct 2021. The team does not record whether the person is a patient who has cancer or a carer for someone with cancer.

⁶ These reviews are conducted after a homicide or suicide has, or appears to have, resulted from violence, abuse, or neglect.

abuse or endure the guilt and stigma of ending the relationship with the person for whom they are caring.

The time has come for the cancer workforce to receive the same support for their domestic abuse response as other clinical specialities. This scene-setting report outlines the results of a consultation exercise and explores what is currently happening in the cancer workforce and why. Its findings lay the groundwork for an intervention that aims to improve the confidence and awareness of cancer professionals around domestic abuse and ensure that victim-survivors get the support they need.



METHODOLOGY

This consultation exercise involved an online survey for professionals who work with people with cancer or their partners or family members ('cancer professionals' or simply 'professionals' hereafter), to understand their views and experiences of, and perceived responsibility for, responding to domestic abuse.

It also involved an online survey for victim-survivors diagnosed with cancer who experienced domestic abuse, or who experienced domestic abuse from a partner or family member who was diagnosed with cancer, to understand their experiences of abuse and support-seeking behaviours. Regarding domestic abuse from someone with cancer, we primarily sought responses from those who experienced abuse before and after the abuser's diagnosis, rather than after the diagnosis only. The reason was that we wanted to differentiate between harmful behaviours that were solely due to organic or clinical factors (for example, personality changes induced by brain tumours or medication side effects) or emotional reactions to cancer, and patterns of coercive and controlling tactics used with the intent to keep the victim-survivor in a state of fear. Subsection 3.2.1 contains more on the difference between these two situations. The survey primarily asked about cancer and domestic abuse that happened at, or around, the same time. However, the emotional and health-related fallout from domestic abuse is long-lasting and can affect victim-survivors' experiences of diagnosis and treatment many years later. And so, we do touch upon such cases, and despite the report's lesser focus on them, they are no less important.

Both surveys used closed and open-ended free text questions and were promoted online, such as through the social media pages of national cancer charities and cancer alliances. Follow up discussions with survey respondents enabled us to explore survey findings in detail. The Women's Aid Research Integrity Framework^{xxvi} informed our approach to the victim-survivor consultation.

Survey respondents

Victim-survivors' survey

The victim-survivors' survey was open for just over a month, from January to February 2022, and we had 20⁷ responses from respondents in England.

All 20 were women: of these, 18 stated that they had a gender identity, which corresponded to the sex registered at birth, and two did not answer this question. Respondents were mostly heterosexual (n=13) with five bisexual and one gay/lesbian respondent.

Most were aged 36 to 55, making them younger than the typical cancer population^{xxvii} with a breakdown of 18-25 (n=1), 26-35 (n=1), 36-45 (n=6), 46-55 (n=6), 55-65 (n=4), and 66+ (n=1). Most were White British (n=13) and Other White (n=3), with one mixed White and Black Caribbean, one mixed White and Black African, and one Black African respondent. Eleven were Christian and six had no religion. Eleven experienced domestic abuse in pregnancy but none had cancer while pregnant.

⁷ For the purposes of this report, we excluded one response due to the type of abuse falling outside of the scope of domestic abuse, and another as it was from outside of the UK.

The impact of cancer aside, three considered themselves Disabled—in all cases due to a chronic physical condition.⁸

Of the 20, 18 had cancer and experienced domestic abuse at the same time. Of these:

- 17/18 involved domestic abuse from a current or former partner: 16 were male partners, and one was a female partner.
- 1/18 involved abuse from a brother.
- 17/18 were cases where victim-survivors had a relationship with the abuser before their diagnosis. In one case, the relationship started after diagnosis.
- 13/18 involved recent experiences of cancer and domestic abuse (within the past 5 years); 2/18 experienced it 6-7 years ago; and 3/18 more than 7 years ago.

Two had different experiences:

- One victim-survivor had experienced domestic abuse from a female partner many years in the past, was diagnosed with cancer within the past 5 years and found her NHS experience re-triggering and re-traumatising.
- One victim-survivor was a carer to a male partner from whom she experienced domestic abuse before and after his diagnosis, and who was discharged from cancer services over 10 years prior. This victim-survivor provided no free-text comments and was not interviewed, so much of the report focuses on the experience of the victim-survivors who had cancer themselves.

Victim-survivors who had cancer were first diagnosed with breast cancer (n=10), gynaecological cancer (n=3), sarcoma (n=2), haematological cancer (n=1), lung cancer (n=1), and leukaemia (n=1)⁹. None of those who had cancer were receiving palliative care. We conducted five follow up interviews with victim-survivors.

Professionals' survey

The professionals' survey was open for three months, November 2021 to February 2022, and we had 334 responses, reflecting how much of an appetite there is for improving the response to domestic abuse. Respondents were mostly aged 46-55 (46%). Of those who stated their sex, the overwhelming majority were women (90%, with just 9% male respondents). Most respondents were heterosexual (87%), with small numbers who were gay (3%), bisexual (1%), lesbian (<1%), or pansexual (<1%).

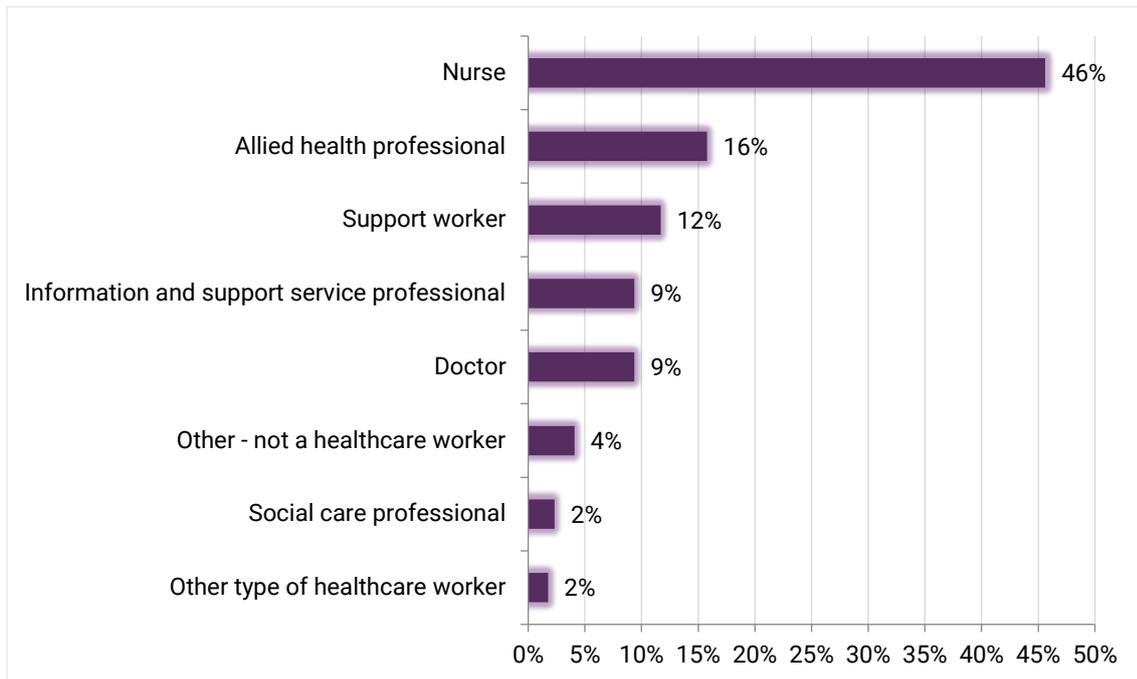
Strikingly, twenty-two cancer professionals were themselves victim-survivors of domestic abuse.

Most respondents worked in an acute health setting (67%), while others worked in a community health setting (13%), Macmillan information and support centre (10%), general practice (4%), or elsewhere (13%), mostly hospices, adult social care, or other parts of the NHS or Macmillan support services. Thirteen percent worked specifically in palliative care. Half of respondents had worked in cancer for more than 10 years and around a quarter (26%) for 6-10 years. As **Figure 1** illustrates, most respondents were nurses, although we had fair representation from allied health professionals and cancer support workers.

⁸ Numbers do not consistently total 20 due to missing data.

⁹ To maintain anonymity, we do not state one victim-survivor's rarer type of cancer, and the type of cancer experienced by the victim-survivor whose abuser was diagnosed with cancer.

Figure 1: Cancer professionals' jobs (n=334)



In the survey, 56% reported they had **not** received domestic abuse-specific training within their current cancer-facing job. In follow up interviews, it became clear that some professionals misinterpreted this survey question and stated they had received specific domestic abuse training when in fact they had received generic safeguarding training only. Thus, the real percentage is likely higher than fifty-six percent. Only 4% of respondents stated that their job descriptions mentioned 'domestic abuse'. We conducted 15 follow up interviews with a mixture of professionals who reported that they had and had not come across domestic abuse in the cancer setting.



KEY FINDINGS

We start our findings with Section 1, which reports the kinds of abusive and violent behaviours victim-survivors experienced, and how these affected the treatment, surgery, and recovery of those victim-survivors who were diagnosed with cancer.

Section 2, on what is happening in practice, starts with cancer professionals' reports about their perceived responsibility to identify and respond to domestic abuse. We then present professionals' reports of identifying, and victim-survivors experiences of disclosing, domestic abuse in the cancer setting. In many cases, these 'disclosures' did not involve the victim-survivor stating that they were 'experiencing domestic abuse' or that they were a 'victim'. Rather, they described some of the abusive and violent behaviours they were experiencing. We end this section with professionals' and victim-survivors' reports of what happened next in terms of referrals and support.

In Section 3, on why this is happening, we explore the factors that enabled victim-survivors to disclose and professionals to identify and respond to domestic abuse and the factors that stopped or hindered disclosure, identification, and response.

Finally, in Section 4, we outline what victim-survivors want from cancer professionals, and what professionals need to improve their domestic abuse response.

All findings are supported with descriptive statistics or quotations, which are attributed to the professional's role and clinical setting (e.g., GI nurse, acute health) or the victim-survivor's ID code (e.g., V-S 1). Identifiable details have been removed.

1. Victim-survivors' reports of domestic abuse and cancer

1.1 Types of domestic abuse they experienced

Victim-survivors reported a range of types of abusive and violent behaviours. **Non-physical coercive control and psychological and financial abuse were particularly common, often without any physical or sexual domestic abuse.** Abusers most commonly used:

- **Intimidation:** scaring or intimidating the respondent on purpose, for example by smashing things or drink-driving with her in the car
- **Isolation from social or professional support:** pressuring or forcing her to stop contacting family or friends, controlling who was allowed to visit or stay at her home
- **Humiliation:** repeatedly belittling or humiliating her in front of others or privately
- **Financial abuse:** pressuring or forcing her to hand over money or other assets, controlling her access to money, or monitoring her spending
- **Surveillance:** insisting on knowing her whereabouts as a way of monitoring her

Of the 18 victim-survivors who had a relationship with the abuser pre-diagnosis, **almost all reported that the abuser's behaviour became worse after the diagnosis** (13/18). This was unexpected for victim-survivors:

I had thought that cancer would make the abuse stop but it gave an excuse for it to get worse. [V-S 6]

A part of me thought maybe this would change him and ... he would be there for his child. It actually got worse. [V-S 12]

Most domestic abuse and coercive control was after treatment when I was weak and vulnerable and had become a wheelchair user. [V-S 13]

The rest, including the victim-survivor whose partner was diagnosed with cancer, reported that the abuse remained at the same level after the diagnosis. **No one reported that domestic abuse stopped or became less severe after their diagnosis.**

For the victim-survivors diagnosed with cancer, abusers “took advantage” of the way cancer had affected them and their increased “vulnerability”:

He took advantage of me being diminished and having terrible brain fog... which had reciprocal consequences: cancer made me weaker to his abuse and abuse made me weaker to cancer. [V-S 2]

When you're coping with cancer, it's difficult to keep on top of everyday things like paying bills. And it's so easy to just go, 'okay, I trust you: here's my bank card, can you talk to my creditors, can you make sure my bills are paid?'. And that can lead to financial domestic abuse. And this is what happened with me. [V-S 15]

Being unwell and having treatment changed the victim-survivors' day-to-day lives: they needed 'downtime' to recover and suddenly had professionals involved in their care. As a result, abusers were unable to control the victim-survivor in the same way as before the diagnosis, and so in response, they escalated their behaviours:

My partner became more controlling of my whereabouts, because I had a lot of appointments, which was new. [V-S 14]

He was scared that if I was ill, I wouldn't be able to fund his lifestyle...I was laid in the bath, and he stormed in and has a right old go at me ... And I was just, 'I am so ill. You don't know how ill I am. We don't know if I'm going to make this. And you're pestering me about a mortgage, I'm not going to do it'. And then he threw something at me. And I thought, 'my god, if he can do that to me when I am so vulnerable—mentally, physically, and just there naked in the bath—what can you do to me when I'm properly on my feet?' I was scared of him physically after that. There was the continued coercive abuse, but also that thing at the back of my mind, 'am I going to get thrown across the room if I disobey him, if I don't do what he wants, if I don't write a cheque?'. [V-S 10]

I was laid in the bath, and he stormed in and has a right old go at me ...



Cancer diagnoses indeed gave abusers the opportunity to use forms of abusive behaviour that they had not used previously, such as physical threats, control of children, and degrading acts:

He is using my cancer and appearance to try and stop the children being with me at the times they are due...



He is using my cancer and appearance to try and stop the children being with me at the times they are due...I haven't seen my daughter for months. [V-S 17]

When I haemorrhaged, he stepped over me, and my children had to put me in the ambulance. [V-S 6]

Several victim-survivors had to rely on the abuser for support with childcare and other practicalities. Giving this 'support' provided an opportunity for the abuser to use 'emotional blackmail':

He went into screaming fits, swearing at me for hours in the car while driving me to/from hospital. He drove dangerously to intimidate me. He kept using the [transport to] hospital arrangements as a pretext to harass me with abusive messages and phone calls. He kept neglecting our son when I was in hospital, and he kept returning home sick. I ended up in



He went into screaming fits, swearing at me for hours in the car while driving me to/from hospital.

*hospital with neutropenic sepsis four times because of bugs I caught from my child. He 'gave' me £2000 to help with my and my child's expenses, as I could not work during treatment. After my treatment he asked for £3000 back for his 'help'. **Having to turn to my abuser for help during my cancer treatment, after spending years trying to escape the abusive relationship, was the number one source of stress, fear, and misery during cancer treatment—much worse than the treatment and the cancer itself.** [V-S 9]*

Others worried about leaving children alone with the abuser while they were unwell. This fear led them to hide their illness and search for urgent childcare when they were hospitalised:

I actually didn't say that I had sepsis, I didn't say that I was at the hospital...I didn't want him to say, 'well she's not looking after the children then, I'll take them'... I had to have my mother come from [place] to take care of my sons. [V-S 2]

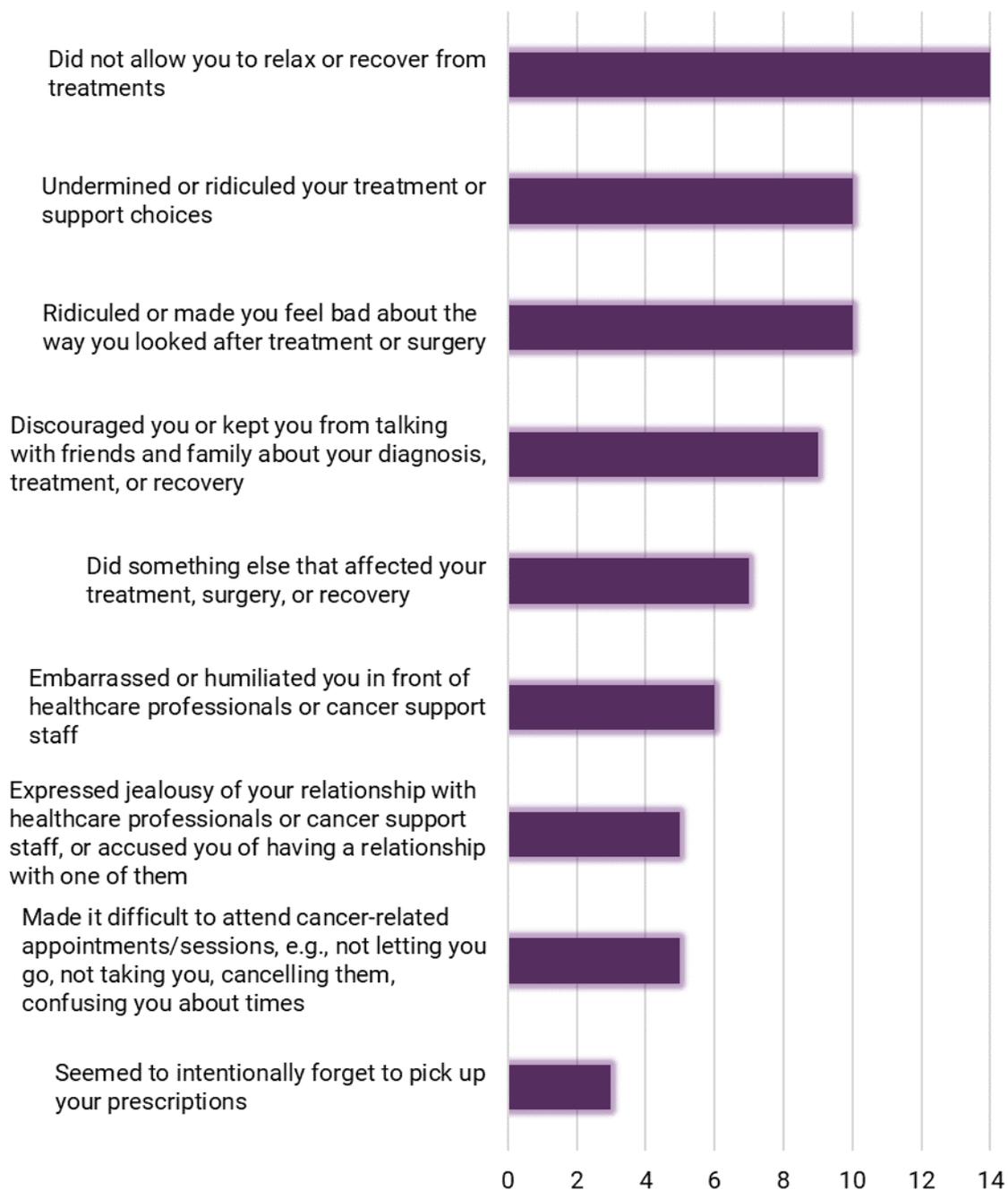
Reliance on the abuser, coupled with their physical and emotional vulnerability, meant victim-survivors could not use protective strategies in the same way as before their diagnosis.

This forced their compliance to the abuser's increasingly worse behaviour. **All victim-survivors reported feeling unsafe, fearful, and under duress all, or almost all, of the time, including during cancer treatment**, and that abusers downplayed, denied, or blamed victim-survivors for their behaviour.

1.2 Impact of domestic abuse on cancer treatment, surgery, or recovery

All victim-survivors who had cancer said that domestic abuse affected their treatment, surgery, or recovery. As **Figure 2** shows, at least three victim-survivors had experienced each example we provided, and each survey and interview illustrated the destructive toll of domestic abuse in the context of recovery from cancer. Most commonly, abusers did not allow victim-survivors to recover from treatments.

Figure 2: Behaviours that affected treatment, surgery, or recovery and numbers of victim-survivors who experienced them



Victim-survivor 2, whom we interviewed, shared an example. She had experienced decades of domestic abuse from the father of her children, from whom she was separated. He was taking her through family court to further his abuse, and the hearings were arranged throughout her chemotherapy treatment:

I have not been able to get any time and space to heal. Chemotherapy, it can be hard. At some points, you need to just sleep after. I couldn't sleep because I had to prepare for the hearing two days after chemotherapy...I was exhausted. I had not been able to allocate any time or energy to my cancer because I needed to face the abuse. And now everybody says how brave you were, how much energy you showed us, you never stopped. I mean, that wasn't my choice: I just couldn't stop. [V-S 2]

This victim-survivor had sepsis around the time of the final hearing and kept requesting early discharge,¹⁰ which her doctors initially denied due to safety. Eventually, she discharged herself before the recommended recovery time:

At first, they said you will stay at least three or four [weeks], but finally, after two I said 'I really can't stay anymore'... So, the [doctors] gave me the rest of my treatment orally so that I could go back home for that. [V-S 2]

Another victim-survivor told us how the abuser would try to control her time while she rested, and punished her for being tired:

He used to leave me lists of things I could do by the side of my bed...If I could sand the woodwork because he didn't like sanding...I never really got over the fatigue of it all. He had a right old go at me because I fell asleep on his birthday when I 'should' have been pandering to him. [V-S 10]

The impact of trying to cope with cancer and abuse was uniquely acute for victim-survivors with young children, especially when abusers refused to pay child maintenance while the victim-survivor was unable to work:

I'm literally having to fend for myself, fend for my child...with the little that I have, and with no financial support from him because he felt like he didn't want to do it that month. I was still getting these text messages from him. If I see him, it's a fight, it's always abuse...It was too much on my plate...I felt like I was being split in different ways. I'm trying to give my attention to recovering and being well, whilst trying to get myself back from the abuse that I'd suffered...and then being a mum as well. So, mentally, it was very straining. [V-S 12]

As **Figure 2** also shows, victim-survivors reported that abusers undermined or ridiculed what was happening to them and stopped them from seeking cancer support— even from healthcare professionals. Victim-survivor 5 wrote that the abuser “belittled [and] minimised pain and treatment to me and everyone else: professionals, family, and friends”. Their abuse thereby extended to the clinical setting: victim-survivors said that abusers embarrassed and humiliated them in front of healthcare professionals and made it difficult or impossible to attend appointments. They took advantage of their status as ‘carers’ and demanded that their needs be prioritised:

¹⁰ Requests for early discharge is one of many common indicators for domestic abuse as recognised by the [Department of Health \(2017\)](#)

He would often come with me [to appointments] but he would try to make sure I was late...I had to go to hospital...I had to beg him to take me...we had to be at the hospital for half 7 quarter to 8. We didn't leave here until gone half seven. He said 'I've got to get a newspaper.... I'm doing what I want to do first'. [V-S 15]

At some point, I banned him from coming to the hospital because he used to come and used to sit there with the oncologist, used to make jokes about it. He used to turn it about himself... I just remember the oncologist just giving him a look. And I felt not cared for [by my husband]. [V-S 10]

Behaviours that affected healthcare, or that were enacted in the clinical setting, could have elicited opportunities for cancer professionals to identify and respond to abuse, but victim-survivors reported that the signs were missed and therefore not acted upon.

It is worth mentioning at this point that professionals, whose findings we report from Section 2 onwards, also reported cases where domestic abuse was affecting treatment and recovery—both directly and indirectly:

A partner was withholding medication from the cancer patient deliberately because they didn't like the side effects experienced by the partner, resulting in unnecessary pain suffered. [Macmillan counsellor, acute health]

Her partner... was forcing her to have sex when she was on treatment [for anal cancer]. That was wicked, absolutely wicked... She must have been in so much pain. [GI clinical nurse specialist, acute health]

Patient attended for chemo and said that she had started self-harming because of the abuse ...due to the risk of infection following chemo, her chemo was suspended. [Living with and beyond clinical nurse specialist, acute health]

Notably, treatment and surgery could also affect domestic abuse: a few victim-survivors and professionals said it was a chance for 'respite' away from the abuser. This finding shows the cancer setting's potential to be a place of safety:

She was thankful to be in hospital, ridiculous as it sounds, because she could relax. [GI clinical nurse specialist]

That was a bit of respite, being away from him. Go to chemotherapy for respite from your partner! [V-S 10].

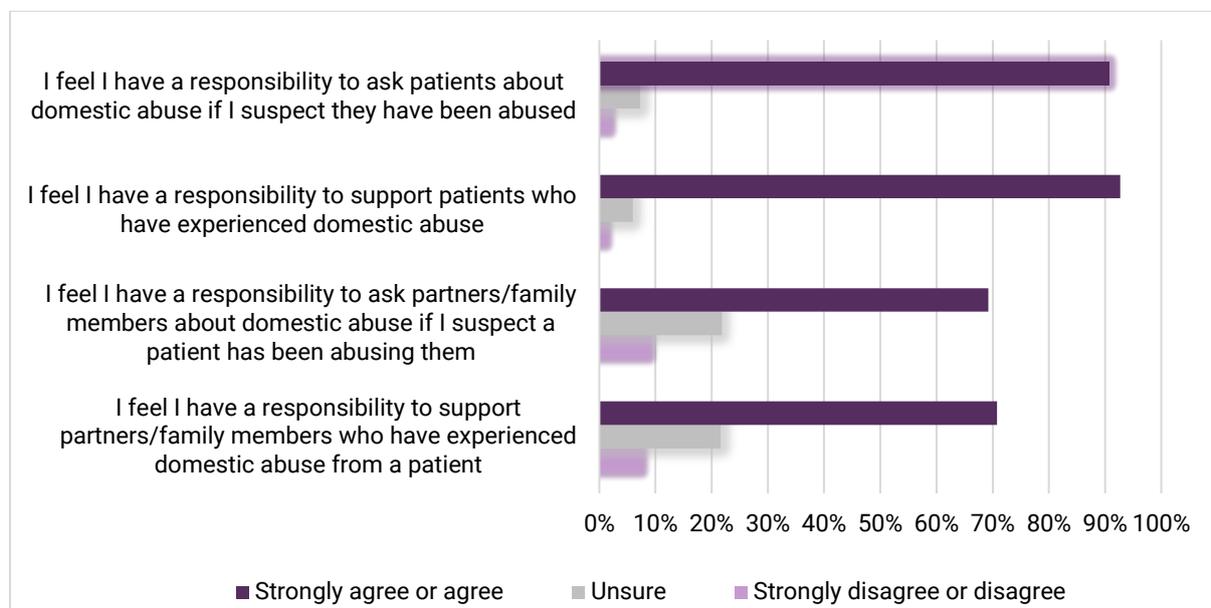
2. What is happening in practice: Identifications, disclosures, and responses

2.1 Cancer professionals' perceived responsibility for identifying and responding to domestic abuse

We asked cancer professionals whether they think identifying and responding to domestic abuse is their responsibility.

Encouragingly, as **Figure 3** shows, most professionals agreed that they have a responsibility to ask patients about, and support patients with, domestic abuse. Only a handful—five participants—disagreed, and three of these were not in caring roles.

Figure 3 Cancer professionals' views about their responsibility around domestic abuse



Elaborating on this finding in an interview, one professional reflected that her main responsibility regarding domestic abuse was to ensure the victim-survivor's safety and to get them support from domestic abuse specialists. **This reflection importantly demonstrates that domestic abuse requires a coordinated response from different agencies and services and that cancer professionals do not need to respond to domestic abuse alone.**

Notably, around a quarter of professionals felt unsure if they had the same responsibility to partners or family members experiencing domestic abuse from one of their patients, and **more professionals explicitly disagreed that they had this responsibility.**

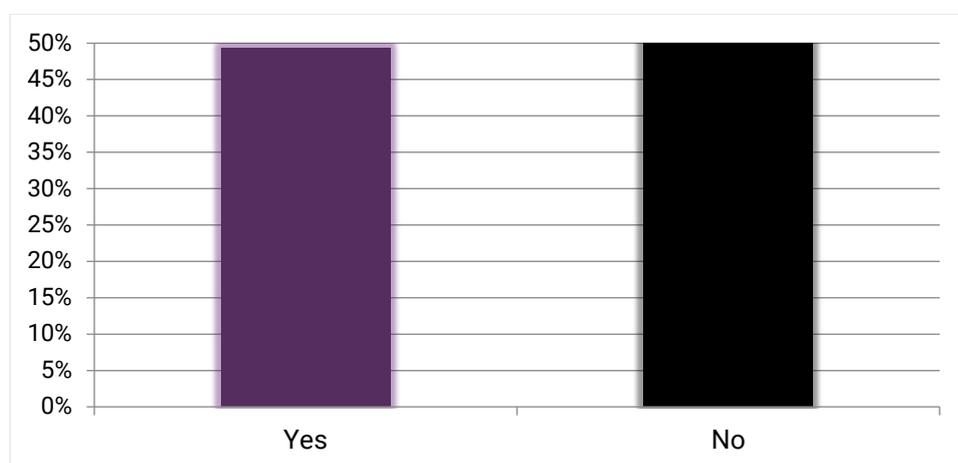
A caveat to these results is that respondents were a self-selecting sample: those who feel domestic abuse is not relevant to their job role may have been less likely to complete the survey. We return to the issue of professionals not seeing domestic abuse as 'their problem' in Subsection 3.2.

2.2 Cancer professionals' reports of identifying domestic abuse

We asked cancer professionals whether patients or their partners or family members had disclosed current or previous domestic abuse to them in the past three years. Importantly, we asked them to additionally consider cases where victim-survivors had not used a label like 'domestic abuse' or 'victim' to describe their own experience or status, but where the victim-survivor had described behaviours indicating domestic abuse or where the professionals had themselves witnessed the domestic abuse.

Just under half of the professionals (49%) stated they had come across domestic abuse and just over half, 51% stated they had not, as **Figure 4** shows.

Figure 4: Percentages of cancer professionals who had ('yes') or had not ('no') encountered domestic abuse among patients (including as abusers) in the past three years (n=302)



Fifty-five percent of those professionals who answered 'yes' stated that they had encountered cases where domestic abuse worsened after the diagnosis. In terms of where victim-survivors disclosed domestic abuse, an outpatients' consultation room, on the phone, and in a Macmillan Information and Support Centre were common places, according to professionals. And during treatment, in follow up support, and at diagnosis were common times. Four specified that a victim-survivor had disclosed during a holistic needs assessment, and five specified they had disclosed at the end of life.

Covid-19 restrictions seemed to affect disclosures. Patients were encouraged to attend in-person appointments alone, which may have provided an opportunity to disclose abuse, but professionals also reflected that video and telephone appointments made it more difficult to identify concerns and have discussions about sensitive issues—both due to the reduction in observable nonverbal cues and the risk that the abuser might hear the consultation. One professional said that the use of interpreters via video links or telephone calls was challenging, leading to more people using family members as interpreters, which can be dangerous in cases where that family member is abusive or complicit with the abuser.

Regarding the identity of the victim-survivor, 112 respondents had come across 293 cases where the patient was the victim-survivor in the past three years: **an average (median) of two cases per respondent.**

They reflected that they had encountered more cases of coercive control and psychological abuse than physical forms—which echoes the pattern and types of behaviours most victim-survivors reported in their survey. But strikingly, one professional reported that she and her team had encountered a domestic homicide many years ago:

I'll never forget, it was Christmas Eve. She finished the treatment. And she went home. Her partner killed her. We all had to be interviewed by the police ... You just couldn't believe that that sort of thing happened in life. A reality check: yes, it does. [Radiographer, acute health]

Professionals gave details of cases in free text survey comments and interviews, highlighting a range of forms of domestic abuse, cases where patients had asked them for help, and cases where patients were still being abused at the end of life.

*It was Christmas eve. She finished her treatment.
And she went home. Her partner killed her.*



One nurse, for example, reported that the husband of a victim, who died from her cancer, refused to bring her young children to the hospice during her final days:

She said that 'Before I die, I want to see, my daughter's birthday'. The husband wouldn't let that happen. [Breast clinical nurse specialist, acute health]

Eventually, hospice staff arranged for her daughter to have a birthday party at the hospice, but it was "only towards the end of her life" and when clinical support was intensified that professionals recognised the domestic abuse and took steps to limit the abuser's harm.

Professionals reported many other

cases where cancer and other professionals had missed domestic abuse until it escalated to the point of "desperation".

Respondents also reported cases where the patient was the abuser. Similar to the victim-survivors' survey, we wanted to differentiate between harmful behaviours that were solely due to organic or clinical factors and patterns of coercive and controlling tactics. The former cases aside, 40 respondents had come across 70 cases in the past three years where the patient was the abuser: **an average (median) of one case per respondent.**

Victim-survivors reportedly felt trapped as the abuser relied on them. They were isolated from support, and again, were abused even into the abuser's end of life stage:

Domestic abuse, physical and emotional, to husband. Husband felt he couldn't do anything about it because of the wife's 'vulnerability'. [Macmillan counsellor, acute health]

*Patient...treated wife as a slave. She refused to see me for months as he would not have strangers in the house. It was only in the last month of his life that I had been allowed to visit.
[Macmillan clinical nurse specialist, community health]*

Husband felt he couldn't do anything about it because of the wife's 'vulnerability'.



Patient ... treated wife as a slave



In both types of cases, but mostly when the victim-survivor had cancer, red flags reported by professionals included an “*atmosphere*” between abusers and victim-survivors’ adult children, possessive behaviour including in waiting areas (*he made her sit on his knee*), body language (*you see the woman involuting or recoiling*), abusers not letting victim-survivors speak or be alone with professionals, aggression towards female staff, victim-survivors asking professionals to call when the abuser is not around or not send letters to their home, and non-compliance with clinical advice:

She was talking about going home one day that he'd want fish and chips. 'I don't think you should really be trying fish and chips when you're halfway through your treatment because you won't be able to swallow it and it'll be really painful.' So even those things were coercive, 'I want this, and this is what we're going to have for tea'. [GI clinical nurse specialist, acute health]

Signs of financial abuse were especially common, usually emerging during discussions about Macmillan Cancer Support grants and included victim-survivors requesting grants to be paid into particular accounts, and not knowing about their own financial affairs:

That's happened numerous times...the patient will say, 'can I have it not paid into the joint account' or 'I don't know how much I actually take home because my husband runs all of the finances, I have no control'. [Consultant breast surgeon, acute health]

Professionals said they discussed red flags with others in the team to gauge whether they were indeed indicators of risk.

My husband runs all of the finances, I have no control.



Importantly, cancer professionals who reported that they had not come across domestic abuse recognised that they had likely missed cases (and subsection 3.2 later outlines reasons that this happened):

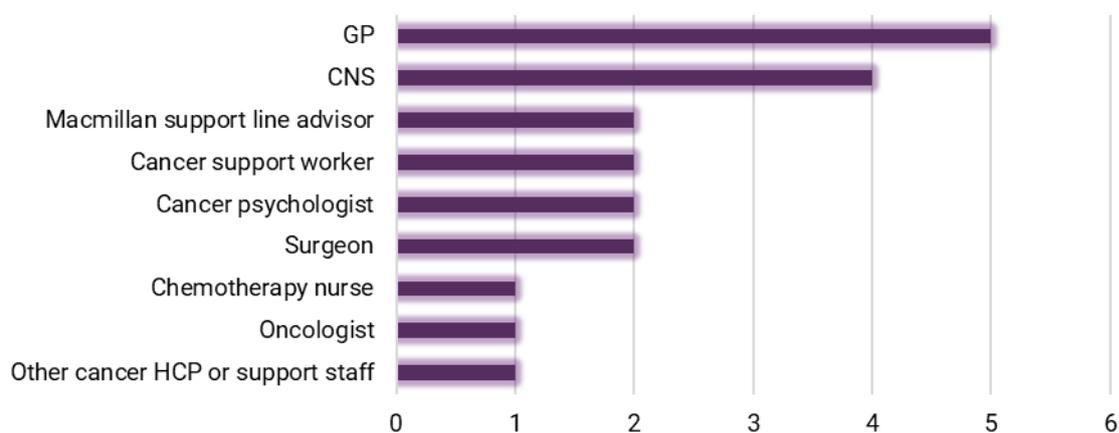
I haven't had anyone come forward to me personally as a nurse...which is upsetting, because there's bound to be people across a 20-year career who have been in that situation, that you haven't been able to help. [Uro-Oncology clinical nurse specialist, acute health]

This reflection is consistent with what victim-survivors told us. Overall, their reports indicated that professionals rarely knew or understood that they were experiencing domestic abuse, as the next section outlines.

2.3 Victim-survivors' reports of disclosing, or not disclosing, domestic abuse to cancer professionals

In our survey, we asked all victim-survivors, including those whose abuser had a cancer diagnosis, whether they had disclosed domestic abuse to cancer professionals. An important finding is that less than half, 9/20, of victim-survivors reported that they had talked about the abusive behaviours or explicitly disclosed domestic abuse to cancer professionals. These were all victim-survivors who had cancer themselves. **Figure 5** shows to which professionals the victim-survivors disclosed: most commonly GPs (whom they saw during cancer treatment) and clinical nurse specialists.

Figure 5: Numbers of victim-survivors who disclosed domestic abuse to different cancer professionals



* GP = general practitioner, CNS = clinical nurse specialist, HCP = healthcare professional

Five disclosed to more than one professional. During treatment and follow up were the most common points at which they disclosed domestic abuse. In terms of where, an outpatients' consultation room was the most common location, followed by a GP's surgery, and chemotherapy unit. These findings generally align with those of cancer professionals. Similar to the professionals' reports, during a phone consultation or phone call was also one of the most common 'places'.

We asked victim-survivors—those who disclosed to professionals and those who did not—about the barriers that stopped or delayed them from doing so: these are listed in **Table 2**. **The two biggest barriers victim-survivors faced were related to their perception of cancer professionals:** not thinking it was part of the cancer professionals' role to respond to domestic abuse and not being asked relevant questions by cancer professionals.

Table 2: Numbers of victim-survivors who experienced different barriers to disclosing domestic abuse to cancer professionals

	Those who never disclosed (n)	Those who eventually disclosed (n)	In total (n)
*I did not think it was a part of their role to deal with domestic abuse	4	6	10
*They did not ask me any questions about my relationships	5	5	10
I felt guilty, ashamed, or upset	5	3	8
I feared what the abusive person/people would do if they found out	5	2	7
It was not a priority for me compared with cancer care	3	3	6
I was trying to put up with the behaviours	3	3	6
I was trapped because I rely on the abuser(s), or they rely on me	3	3	6
*They were too busy for me to bother them	3	2	5
I did not feel confident talking about it	3	2	5
*I did not get to speak to anyone in private	1	2	3

* Barriers related to perception of cancer professionals.

As one victim-survivor we interviewed indicated, not being asked the right—or in her case, any—questions about domestic abuse made it seem like the clinical setting was not a safe space for disclosure:

Certain questions aren't asked, so you don't feel comfortable enough to tell them, 'This is what I'm going through'. I wouldn't have just openly said, 'I'm going through this'. The questions weren't [asked] to prompt me to open up. [V-S 12]

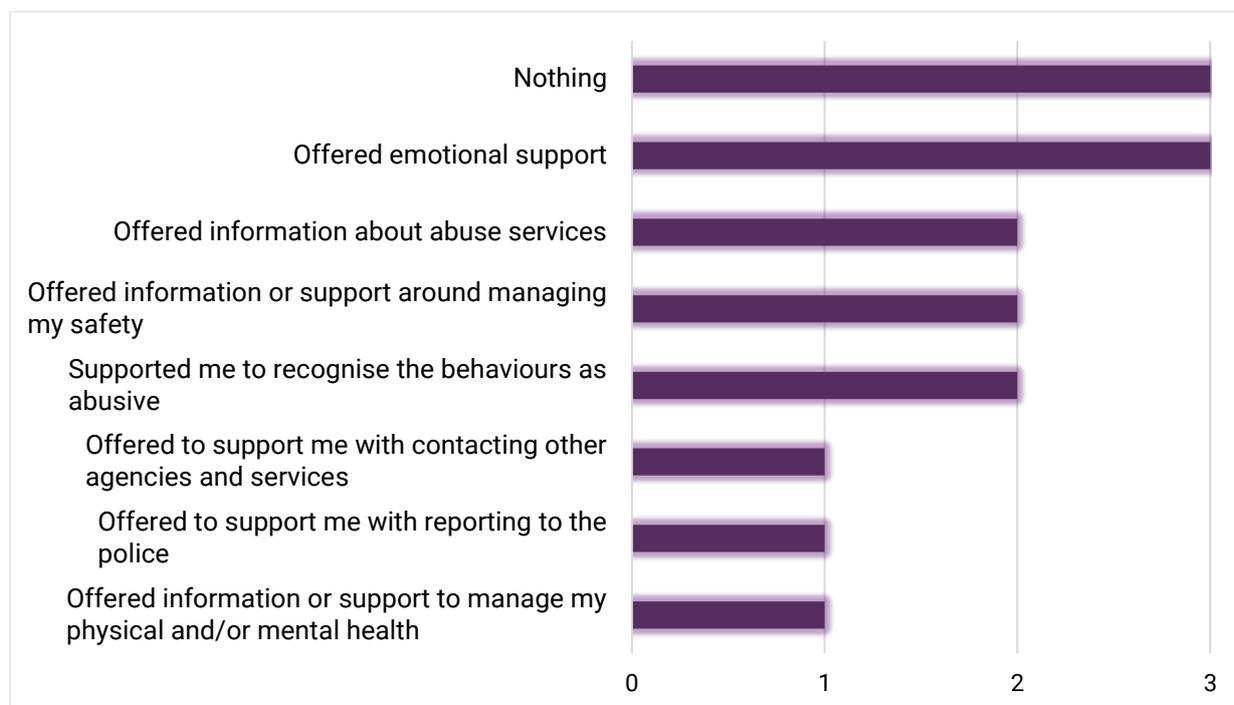
In terms of the victim-survivors' perceptions of cancer professionals' immediate, first-line responses, most who disclosed (6/9) felt 'listened to' by professionals, but otherwise, professionals did not always provide a helpful first-line response. **Few reported that professionals took them seriously (2/9), believed them (3/9), reassured them (4/9), showed empathy (4/9), or understood (4/9).**

Illustratively, victim-survivor 19 was asked at assessment whether she had experienced domestic abuse. But, she wrote, the approach felt like a box-ticking exercise. She reported that professionals did not validate her experiences, or recognise that the consequences of domestic abuse, even from many years in the past, can be physical, mental, long-lasting, and severe:

I was asked had I ever been the target of domestic abuse. So, I simply said yes. They then asked, was I 'in' that relationship still. They did not encourage me to talk about my ex-partner...I think because I said I was no longer in the relationship they somehow thought it wasn't relevant to me anymore. I told them I believe I am to blame for my cancer because I stayed for many years...Everyone says stress can sometimes cause cancer and of course...chronic daily abuse causes stress overload...All they said was domestic abuse does not cause cancer. [V-S 19]

We asked victim-survivors about the types of support cancer professionals offered: these are listed in **Figure 6**.

Figure 6: Numbers of victim-survivors who were offered different types of support by cancer professionals after disclosing



As the figure shows, three victim-survivors stated that **cancer professionals did nothing in terms of offering support** (including offering or making referrals, as Subsection 2.4 explores). Victim-survivors will sometimes want a professional to do nothing, but of these three, two specifically stated that **they in fact wanted the professionals to do something**, and for the third, what she wanted was unclear.

Five victim-survivors who disclosed to cancer professionals reported that professionals offered support. As the figure also shows, the most common type of support offered was emotional support. Two out of nine victim-survivors also stated that the professional supported them to recognise the behaviour they were experiencing as domestic abuse—which is especially important for victim-survivors who are still trying to make sense of what is happening to them or who want validation that the behaviours are indeed domestic abuse.

However, for other victim-survivors, a range of professionals—clinical nurse specialists, oncologists, and surgeons—did not recognise what they were experiencing as domestic abuse. Importantly, as one victim-survivor wrote, professionals’ non-recognition was in some ways down to them seeing her partner’s behaviours as a ‘normal’ response to something as distressing and traumatic as cancer:

It helped that she [the nurse] listened and supported that he was wrong, but I do not think she recognised it was abuse. There are also the discussions around how hard it is for partners, spouses etc which I understand – unfortunately, abusing men will use this to their benefit. When someone shouts and swears at you creating an argument it’s abuse—not behaviour of someone also finding it hard. I wish she had asked me a little bit more. [V-S 3]

The difference between domestic abuse and a 'normal' response to cancer and domestic abuse is one to which we return in Subsection 3.2.1.

Victim-survivor 2 told us that in her case, neither the clinical nurse specialist, oncologist, nor the surgeon identified nor recognised her experiences. As with her repeated requests for early discharge mentioned earlier, her repeated requests to move appointments, illustrated in the following quotation, were missed signs that something was going on. Even when she explicitly talked to her cancer team about what was happening, she found that they did not validate it, understand, or offer anything:

I had many surgeries, I had sepsis, I was in the hospital every week, and sometimes when they gave me an appointment, I said 'I can't because I have this hearing, can you adapt it?', and they'd say 'it's very difficult because we've postponed every treatment [due to Covid] so you should be happy' and I said 'yes I'm happy and grateful but the fact is, if I am in a remote hearing, I can't be at the hospital'. And they never—they could have said, many times, 'OK, things are difficult for you, can we refer you to someone or can we help?' [V-S 2]

This victim-survivor recognised that healthcare professionals were struggling during the pandemic, but she also sensed that professionals felt her 'personal' problems were '*none of [their] business*'. She did not expect them to do everything—what she wanted was validation and a referral to a service that could help.



2.4 Cancer professionals' and victim-survivors' reports of referrals to agencies and services

Although victim-survivors shared experiences of not being offered support or referrals, cancer professionals reported that they did refer victim-survivors to a range of agencies and services. The most common agencies and services are presented in **Table 1**. As indicated, over 100 professionals reported that they made referrals for patient victim-survivors, and 60 for partners or family members of abusive patients.

Table 1 Professionals' reports of referrals made (n=116 and 60)

	Percentage and n who referred a patient victim-survivor (total n=116)	Percentage and n who referred a partner or family member of an abusive patient (total n=60)
NHS safeguarding teams	57% (66)	30% (18)
Adult social services	31% (36)	20% (12)
External domestic abuse service	27% (31)	18% (11)
Psychology team in NHS cancer services	26% (30)	10% (6)
Mental health services	18% (21)	8% (5)

Echoing the findings about professional responsibility in **Figure 3**, subsection 2.1, **fewer professionals reported referring partners or family members experiencing domestic abuse from their patients**. One professional acknowledged that getting support to partners was challenging given their clinical focus on the patient, but, as her example demonstrates, it is possible through the offer of support options to carers, and through initiative-taking and teamwork if a risk is identified:

I run workshops for wives/partners of men [with cancer]. One lady was struggling... and told the group about how her husband treats her and how this has got worse since his cancer diagnosis... it was difficult to take this further because her husband was in...a room next door so they left together...I spoke to my clinical nurse specialist team and the patient's allocated clinical nurse specialist and she was able to suggest support services to the lady...if it hadn't been for the workshop, we may not have been made aware of her situation. [Macmillan Cancer Support Worker, acute health]

Overall, the most common referral was to safeguarding teams in the trust. In interviews, professionals reflected that safeguarding teams were immensely helpful, reliable, and easy to access. However, they also suggested that **there is an over-reliance on safeguarding referrals and that these referrals are "inadequate" in some cases**, particularly because safeguarding teams are so busy, and their remit is much wider than domestic abuse:

[Domestic abuse] is lumped together with other things... [I wonder] whether we should be looking at it more in-depth as a single area. [Counsellor, Macmillan cancer centre in acute trust]

I don't think it goes far enough—picking up signs and then just phone safeguarding— [our response] needs to go much deeper. [Consultant breast surgeon, acute health]

They said phoning safeguarding in the absence of other actions was like shifting responsibility for domestic abuse onto others and felt clinical teams should instead shoulder responsibility for domestic abuse together and engage multi-agency specialist input.

Professionals shared more specific drawbacks to safeguarding referrals. In one case, a GI clinical nurse specialist felt that the scope of what safeguarding could do was limited: she reported that because a victim-survivor had (perhaps through fear) decided to rescind her request for support, safeguarding leads decided not to come to see her. Many professionals moreover reported that they received no feedback on what happened after a referral, and as a support worker said, this meant all the risk was held by her:

The safeguarding team, social service, and the [cancer] service aren't that connected. Because that patient was able to get in contact with me more easily [than other services, she] was still coming to me, saying, 'well, what's happening. I've not heard anything' and that was quite difficult. And just the person I am, then I start digging and chasing these services to say 'right, what is happening. I'm meant to be providing some form of a care plan for her and I'm not able to report anything because I've had no feedback'. [Cancer support worker, acute health]

Three of the victim-survivor survey respondents stated that they received referrals to domestic abuse, mental health, and housing support services. But others found they were not given the referrals they wanted. One wrote that she would have liked a referral for “victim support” or “psychological support”. A focus on safeguarding was moreover worrying for another victim-survivor—her referral to a hospital psychologist caused her anxiety and led her to disengage. She received no other support for domestic abuse:

I didn't like the approach: I found it a bit tick box-y and she was overly concerned about safeguarding of my kids (they weren't in danger, but I had a few concerns) so we didn't get into my state of mind. I didn't want to go back in case she raised a safeguarding alert, which would have caused more trouble. [V-S 7]

In total, 42 referrals were made to external domestic abuse services, and from our victim-survivor survey, we also know that **professionals' intervention led two respondents to get domestic abuse support from specialist services for the first time**. This is a valuable outcome and shows the potential for cancer services to reach victim-survivors who are as yet hidden from these services. The next section highlights factors that encouraged or hindered these kinds of positive outcomes.

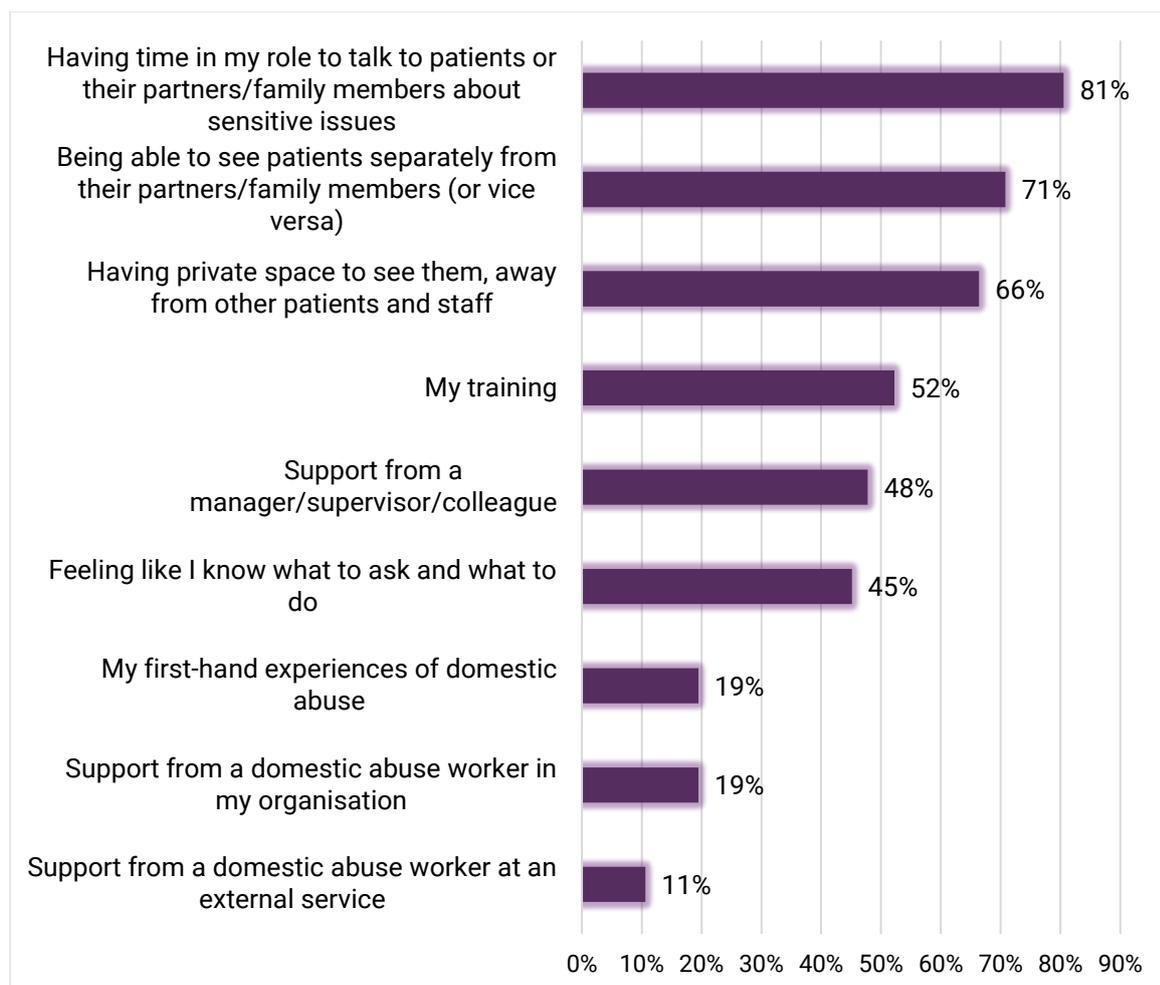
3. Why this is happening: Helpful and hindering factors

3.1 Factors that enabled victim-survivors to disclose, and professionals to identify and respond

We asked cancer professionals to share factors about their abilities, role, and experience that had helped them to identify and respond to domestic abuse in the past three years. These factors are displayed in **Figure 7**. We also asked victim-survivors who disclosed to professionals what it was about the professionals that made them want to do so. These factors are displayed in **Figure 8**.

For professionals and victim-survivors alike, confidentiality and privacy—time and space away from the abuser, as well as other patients and staff—facilitated victim-survivors’ disclosures and professionals’ ability to identify and respond to domestic abuse.

Figure 7: Percentages of professionals who experienced different factors that helped them to identify and respond to domestic abuse in the past three years (n=113)



As **Figure 7** illustrates, other factors that enabled cancer professionals to better identify and respond to domestic abuse were ‘having time’ in their role, as well as training, and support from colleagues.

As reported earlier, few professionals had domestic abuse specific training, but interviews and free text answers suggested that safeguarding and advanced communication training were somewhat helpful. In interviews and free text comments, professionals additionally cited having years of relevant experience working sensitively with patients as a helpful factor.

Cancer professionals who were themselves victim-survivors of domestic abuse said this experience helped them to respond to cases. Professionals we interviewed explained how their personal experience elicited a deeper sense of empathy, a greater level of understanding, and a stronger feeling of responsibility to help:

I spent a long time in that situation. You know the signs and you know the situations and you can pick up on it... People are like 'I'd never let anybody do that'. And I think, 'You can't say that; you really can't say that 'til you're in that position'. I know how difficult it is to admit it. I know how difficult it is to actually do something about it, to get out of it. Just the fact that I did, after all those years, makes me want other people to be given that chance as well. [Nurse, anonymised]

Some of the professional-reported factors from **Figure 7** help to explain the factors (in **Figure 8**) that made victim-survivors want to disclose domestic abuse to them. Professionals with more time, relevant training, and better support might feel more able to build a good relationship with the victim-survivor, show they are listening, ask the right questions, and elicit trust and comfort.

Figure 8: Factors that made victim-survivors want to disclose domestic abuse to cancer professionals



We asked those with professional experience from outside of cancer whether aspects of the cancer setting made it easier or harder to identify and respond to domestic abuse.

Most professionals who answered (mainly clinical nurse specialists, other nurses, and support workers, but also a surgeon, psychologist, and occupational therapist) indicated that **the cancer setting provided a unique opportunity in which to identify and respond to domestic abuse**. Its unique aspects included frequency of contact, length of appointments, continuity of care, and the chance to discuss holistic needs, which are not as readily available in other clinical specialities.

The cancer setting additionally involved *“more time spent...in quiet/private environments”*—including the home—where *“signs [can be] picked up on more readily”*. These factors enable a trusting and *“closer”* relationship.

At the same time, cancer professionals were ‘outsiders’ with a level of professional distance. Victim-survivors’ interviews and free text comments highlighted that they were reluctant to talk to family and friends about domestic abuse as they feared judgement and thought they might not be able to help. They wanted to talk to professionals because they were desperate, fearful, in shock that the abuse was continuing, and they had no one else to turn to. Professionals’ close relationships with victim-survivors and their simultaneous professional distance encouraged patients to *“open up honestly”*.



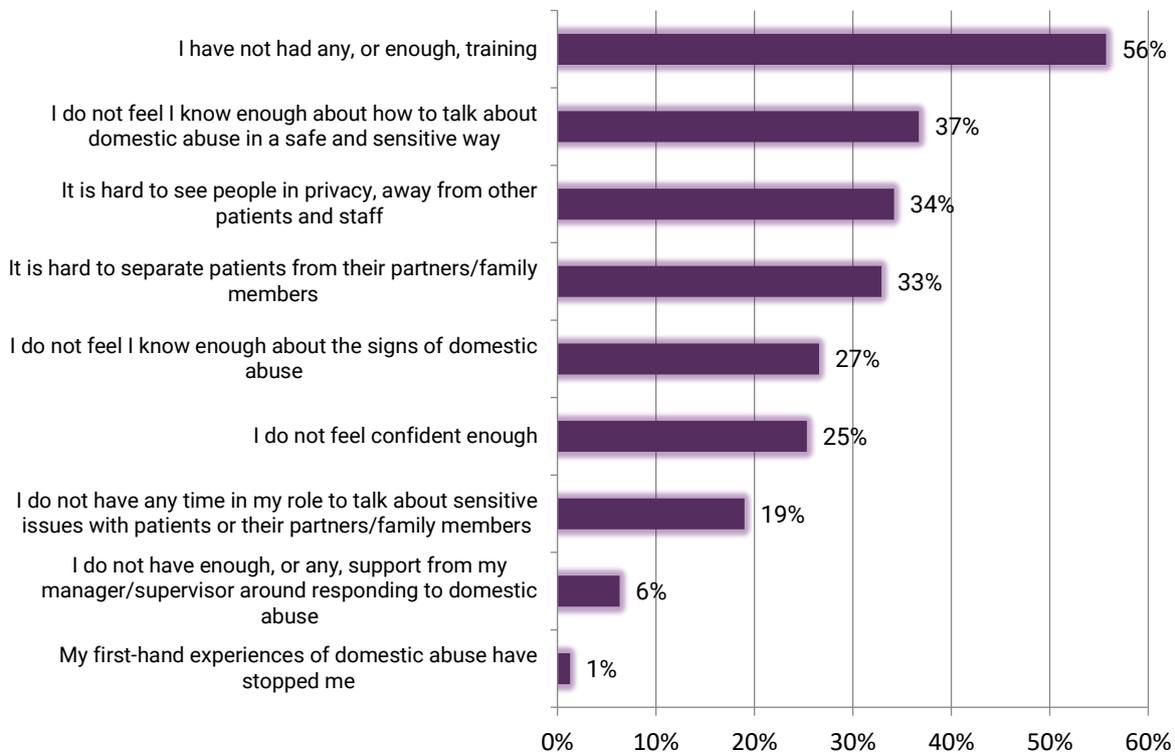
3.2 Barriers and hindrances to cancer professionals identifying and responding to, and victim-survivors disclosing, domestic abuse

We asked cancer professionals about the challenges they faced in identifying and responding to domestic abuse, related to their abilities, roles, and experiences. These are shown in **Figure 9**.

Some of the most common challenges were the converse to the helpful factors reported in the previous subsection, such as insufficient training (56%) and no privacy from partners and family members (33%) and other patients and staff (34%). In interviews and free text comments, professionals reported that specialist training was not available, and that the layout of clinics made it difficult to separate patients from visitors. One head and neck clinical nurse specialist raised that they rarely saw patients alone, which she recognised was a barrier to asking about domestic abuse, but she was particularly worried about making partners and family members “*feel excluded*” since they are usually “*a massive help in treatment for the patients to get through [it]*”. But she felt this barrier was surmountable, such as by asking radiotherapy teams to check in with the patient during scans, which patients routinely attended alone, or talking to partners and family members at this time.

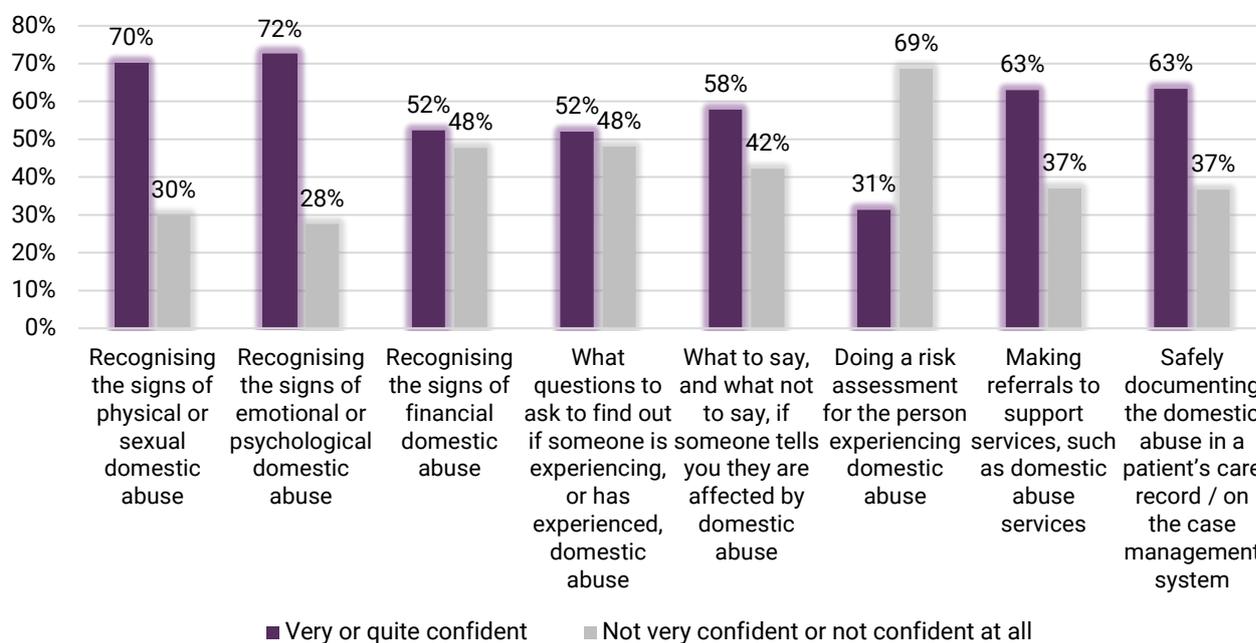
Privacy aside, the biggest barriers were lack of confidence (25%) and knowledge of signs (27%), and knowledge of how to talk about domestic abuse safely and sensitively (37%).

Figure 9: Challenges professionals faced when dealing with cases of domestic abuse in the past 3 years (n=79)



We asked professionals specific questions about how confident they are in various aspects of identifying and responding to domestic abuse, the results of which are shown in **Figure 10**.

Figure 10 Cancer professionals' confidence in identifying and responding to domestic abuse (n=302)



Aside from conducting risk assessments—which most respondents lacked confidence in—a small majority of respondents had confidence in recognising the signs of domestic abuse and knowing how to respond. But this left:

- a third of professionals who did not feel confident recognising the signs of physical, sexual, emotional, or psychological abuse
- just under half who did not feel confident recognising the signs of financial abuse
- just under half who did not feel confident knowing what to say if someone discloses
- over a third who did not feel confident making referrals to support services or safely documenting domestic abuse in the patient's record.

It is important to recognise that lacking confidence is a barrier not because professionals are 'inept' at identifying and responding to domestic abuse, but because **broaching domestic abuse can indeed be difficult, even for skilled professionals with time**. Professionals were worried that the consequences of asking about domestic abuse badly may be greater than the consequences of not asking about it at all. 'Punishment' for victim-survivors if abusers found out about discussions and damage to their professional relationship with knock-on consequences for care were particularly worrying outcomes:

If I broach the subject...but then they shut down, they don't just shut down from the abuse situation, they shut down on so many levels. And then it can take a long time to get back that connection to look after them—because I worry that patients will then be very, very guarded about letting us in about anything. If we ask them, do they need any financial support, they're thinking, 'oh no, that's it, they're going to come at my family, and then I'm going to get in trouble from him for talking about my finances'. So, I think if it's the wrong time or [if you] say it the wrong way...the consequence is almost greater because then [it affects] their care in other ways as well. [Consultant breast surgeon, acute health]

The breast surgeon felt that even when words are chosen carefully, they might ‘land’ badly for victim-survivors who are especially anxious or frightened: She continued, “*it’s a very subtle thing because everyone will be listening in different ways*”.

Professionals also lacked confidence in structures and processes—due to having no, or obscure, domestic abuse response processes in place:

*I don’t really know what the process is...I don’t think we have got a very good process.
[Oncologist, acute health]*

The lack of confidence stopped professionals from asking potential victim-survivors about suspected domestic abuse:

I’ve suspected things in the past but didn’t know if I’d be making things worse by asking. [Lead nurse, acute health]

Aside from confidence, time was a barrier cited by 19% of professionals, but one oncologist countered this view and said this was not an acceptable barrier:

People will say time whenever we’re asking them to do something ...but this isn’t something that can wait. Domestic abuse is going to affect every aspect of their care. And if as doctors, we haven’t got enough time to ask about that, I think we should all give up our jobs and go home. It doesn’t necessarily have to be a big conversation. [Oncologist, acute health]

A breast surgeon had observed another unacceptable barrier: the perception that domestic abuse is ‘not my job’ by certain other professionals—namely male doctors and surgeons:¹¹

The worst instance is when...all our cancer patients are discussed in a meeting where there are surgeons, oncologists or the nurses and we will look at CT scans and a radiologist will say...there are fractures of different ages in this woman in her fifties. And I will say, ‘you need to have a conversation with her about abuse’...And you can see the consultant male surgeon go, ‘it’s not my job,’ and give it to a nurse. And that is letting the patient down that we’re supposed to look after. [Consultant breast surgeon, acute health]

The barriers reported by professionals can help to explain the factors that stopped victim-survivors from disclosing to them, illustrated earlier in **Table 2**: professionals lacking training, knowledge, and confidence likely stopped them from conveying, or indeed accepting, that identifying and responding to domestic abuse is part of their role; from asking the right questions; and from making appropriate space and time for disclosures.

In the next section, we outline some more barriers to identifying and responding to domestic abuse that are particular to the cancer setting.

¹¹ Tellingly, although most survey respondents felt that domestic abuse was their responsibility (Figure 1), no male surgeons and just one male oncologist responded to our survey.

3.2.1 What aspects of the cancer setting make it more difficult to identify and respond to domestic abuse?

Interviews and free text comments from professionals highlighted that organic or clinical factors can lead a person diagnosed with cancer to act abusively or aggressively, and, more commonly, the distress and uncertainty caused by diagnosis and treatment can lead to harmful emotional reactions from either the patient or their partner or family member:

People can behave not so well during a cancer diagnosis: I see that with relatives, I see that with partners, and I see that with patients...[There's] abuse and clear violent or physical or coercive behaviour, and then there's that bit, probably much more common, which is bullying and taking it out on the people they love. [Oncologist, acute health]

Professionals reflected that domestic abuse, which is used with the intention to exert control and fear, is different from these other, more common, types of cancer-related abusive behaviours, which may be distress, fear, and stress-related responses to the situation. However, they also recognised that low-level behaviours pre-cancer may escalate into domestic abuse after the cancer diagnosis. Professionals said that it is not always clear which 'type' of abuse a person is experiencing and whether the abuse pre-dated cancer, but they felt that all cases of abuse were unacceptable and required a response:

My gut reaction is, irrespective of the origin, if those are the behaviours that are being exhibited, then, is there a need to differentiate? Because it's the behaviours that you're trying to target. As opposed to necessarily the reasons behind that. [Nurse director, cancer services]

Rather than judging for themselves what type of response would be most appropriate, professionals said they wanted to be victim-led, and were mindful not to automatically mislabel situations as domestic abuse:

I would take it from the patients, really. And I think that woman who I'm thinking about [whose partner with cancer is using poor behaviour in response to cancer] would be horrified if she thought I was talking to you about her. Because she wouldn't consider it [as domestic abuse]...So where is the line drawn? It's sort of up to the person, isn't it? [Oncologist, acute health]

A risk in these types of situations is that some professionals might *misinterpret* domestic abuse behaviours as the 'commonly-seen' types of cancer-related abusive behaviours, especially if the victim-survivor does not feel ready to label their own experience as domestic abuse: this assumption may lead to a less robust response. Several professionals, for example, discussed referring couples to couples counselling, which can be dangerous for victim-survivors of domestic abuse.¹² A related consideration is that, as an earlier quotation from victim-survivor 3 stated, abusers can take advantage of the expectation that cancer is difficult for partners, using it to conceal domestic abuse from professionals and justify it to victim-survivors. **The entangling of different types of abuse and situational factors can be a barrier to an appropriate response.**

¹² See <https://www.co.washington.or.us/CommunityCorrections/VictimServices/Services/upload/12-Reasons-Why-Couples-DV.pdf>

4. What improvements are needed

4.1 What victim-survivors want from cancer professionals

Victim-survivors were overall extremely positive about their cancer care and thought these professionals were well-placed to 'make a difference' regarding domestic abuse:

Some amazing health workers out there who could make such a difference. [V-S 3]

They thought cancer professionals' response to domestic abuse should be improved in a variety of ways. We present them here as a series of overlapping reasons. First, they thought cancer professionals ought to be aware of the signs of domestic abuse, particularly non-physical abuse. Second, they wanted cancer professionals to make clear that the cancer setting was a safe space for disclosure by asking the right questions (i.e., not 'are you experiencing domestic abuse?'), safely and in privacy. Third, they wanted professionals to provide first-line emotional support:

[There] needs to be more awareness of invisible types of abuse and that it's never typical. [V-S 7]

Asking about your support and partner may have helped. I did not think it was a topic [I could] discuss in that setting. [V-S 14]

If healthcare professionals had done domestic abuse training and they'd seen the signs, it might have picked up where we were at [and] they could have talked to me ...it's a matter of arranging an appointment, 'we're seeing patients only, we're not seeing partners at the moment'...and that's when they can ask the patient, 'how are you? Are you OK?' And if somebody's constantly late, 'is there a problem with your transport? Is there a behaviour from somebody that you're worried about?' [V-S 15]

Fourth, they wanted cancer professionals to help them to make sense of their experiences, highlighting the role they could play in supporting victim-survivors to recognise domestic abuse for what it is:

[I wish they had] helped me understand what was going on. He made me feel like I was crazy. [V-S 10]

Domestic abuse awareness is absolutely key to support... [Professionals need to] recognise the signs and gently unpick them...The signs can always be justified in our heads: they need to be gently challenged. [V-S 3]

[If they had asked me if I was experiencing domestic abuse] I would have said 'no because he's not hitting me'. If they had said 'are you in control of your finances?' I would have spoken up and said, 'actually he's taking money out of my account, and I haven't got the money to pay this, I haven't got the money to do that'. [V-S 15]

Fifth, they wanted cancer professionals to recognise the mental and physical health impact of cancer and domestic abuse and support them with these health-related effects:

The most important [thing that the cancer workforce needs to know about domestic abuse] is the mental effects. Things could easily spiral out of control very quickly if your mental health isn't sorted out first. [V-S 12]

Sixth, and most crucial, they wanted the cancer setting to be a route through which they could be referred for specialist domestic abuse support, or at least signposted to support options:

If a cancer nurse gets some learning about abuse but after that, she has no time to give because she has too many patients, she has no brochures about abuse, she has no contacts about community IDVAs [independent domestic abuse advisor], victim support services, to refer a person to, she has no means to help, what's the point? She will say 'I can recognise you are abused but I can't do anything'. So it's the same [situation], it helps to promote awareness but if there is nothing material with that, it's no use. [V-S 2]

I am not sure what I wanted or needed. I didn't know who could help so knowing about professional support would have been helpful. [V-S 14]

The types of specific support that victim-survivors wanted to be referred or signposted to included advocacy, financial, transport, and psychological support services:

[At my hospital's cancer centre] they said, we have yoga sessions, we have Nordic walk sessions, we have group talk sessions, you can see a financial advisor...Why not say 'we also have an IDVA, do you want an assessment? What is your situation, how is it at home, are you facing some abuse, are you well supported?' [V-S 2]

Offer hospital transport for patients living outside London who have to be treated in London hospitals. I had to rely on my abusive ex for help. He had spent years isolating me from my support system, so I had nobody else whom I could turn to. [V-S 9]

Advice on what to do if women are scared of their partners, therapy, or maybe even financial support as well. Because you end up getting into financial trouble when they're not helping [with child maintenance]. [V-S 12]

They suggested having information in the form of leaflets and helplines and placing support services in cancer support centres, which feel more “cosy” and less “clinical” than hospital settings, and so help people feel more “relaxed and open”.

These improvements were especially important because cancer professionals were sometimes the only professionals with whom the victim-survivor had contact:

My healthcare professionals were fantastic, but it wasn't something I thought they would understand or know how to help with...that would be an advantage for patients who don't see many other people. [V-S 1]

These findings once again reiterate that cancer was a window of opportunity for safety to be assessed and support to be offered: as one Macmillan counsellor we interviewed said, “once they've left the hospital setting, who knows what could happen?”.

4.2 What professionals need to improve their domestic abuse response

We asked professionals how their awareness and response to domestic abuse could be improved. More than half of the 98 respondents who answered this question **wanted more training, education, and awareness on domestic abuse**. Domestic abuse training, according to professionals, should be in-depth and separate from safeguarding training, possibly with a domestic abuse-and-cancer focus, in a workshop format, and offered face-to-face with regular updates and e-learning options. To ground their training in real life, they wanted case studies and ‘stories’ from victim-survivors affected by cancer and domestic abuse. Importantly they wanted training for whole teams, “*not just nurses and support staff*”.

Key aspects on which professionals wanted training were “*picking up the signs, bringing the subject up, [and] how to react if somebody is clearly shutting down*”. They especially wanted to better understand the signs of coercive control and non-physical forms of domestic abuse.

Professionals also said they had a role to play in breaking down the taboo around domestic abuse. And so, they wanted training on how to normalise discussions about domestic abuse, with learning taken from other areas of practice involving difficult conversations:

Talking about it, learning about it, bringing it to the forefront. That is the only way that we're going to be able to help more people. [Uro-Oncology clinical nurse specialist, acute health]

We shouldn't be scared to call it what it is... It's like other conversations about Do Not Resuscitate. We're always worrying about having those conversations, but actually, once you start normalising it... it isn't a big thing. [So] we need better training. Get over your embarrassment. Be courageous. Don't make assumptions about anybody—male or female, rich or poor. It's about enhancing people's quality of life and making sure that we intervene—as we would with any medical condition. [Oncologist, acute health]

As indicated, professionals wanted to move away from myths about what a ‘typical victim’ looks like and to consider domestic abuse as relevant as any other health problem.

The holistic needs assessment was mentioned by several professionals as a key touchpoint where learning from training could be integrated and domestic abuse could be broached.

In terms of practical resources, professionals wanted posters and leaflets to raise everyone’s awareness of domestic abuse, with examples of abusive behaviours for those who “*experience [domestic abuse but do] not identify*” it as such, and QR codes for staff to get more information. These resources would signal to victim-survivors that cancer settings are safe disclosure spaces. Professionals wanted information to be made available in different languages, and for some resources to be “*small enough to be secreted in a pocket*”.

For themselves, **they wanted clear and easily accessible protocols and flowcharts about how to respond to domestic abuse:**

I need a go-to guide I can have in my office or on the wall, where I've got straightaway information—this is where you go, this is what you do: clear, concise information. [Uro-oncology clinical nurse specialist, acute health]

They importantly wanted information about local and national helplines and services: in particular, services without long waiting lists.

One cancer support worker importantly pointed out a need for emotional support for staff *“because some of the information that we get...can be shocking”*.

Finally, respondents wanted a culture shift wherein all cancer professionals—surgeons, doctors, nurses, support workers, and others—see domestic abuse as their role, and work collaboratively to share information about and respond to risk and need, ensuring a truly holistic approach for patients, partners, and family members in the cancer setting.



NEXT STEPS

The outcomes of this consultation exercise have highlighted that the cancer setting provides a unique opportunity for domestic abuse to be identified and responded to, but that further intervention is required to ensure cancer professionals have the confidence, knowledge, and resources they need to identify and respond safely and appropriately. Insight into the needs and opportunities for development have been outlined. Further understanding of a best practice response to domestic abuse in the cancer setting is now required.

To meet this requirement, based on the previous work of Standing Together and the Pathfinder best practice guidance¹³, Phase 2 of this project will involve an intervention involving the placement of Domestic Abuse Coordinators within two hospital trusts. The role of these Coordinators will be to work with the trusts in a 'test and learn' exercise to develop and embed safe and effective processes to support people affected by both cancer and domestic abuse. Learning from this report will form the basis of the work of the Coordinators, who will focus on promoting existing good practice within trusts, as well as supporting training, awareness-raising, network building, and the development and promotion of policies and processes. Sustainability of the intervention will be a core focus of Phase 2, with the aim of embedding lasting change. An academic partner will evaluate the intervention.

A focus of further learning in Phase 2 will be to understand the needs and experiences of those who have experienced domestic abuse perpetrated by someone with cancer, and the role of healthcare professionals in supporting them. This consultation demonstrated that professionals were unsure whether, or disagreed that, they had the same responsibility to partners or family members experiencing domestic abuse from one of their patients. We heard from only one victim-survivor who had this experience. Further exploration of an appropriate response in such situations is needed. Additionally, further targeted work and clarification will be required in supporting professionals who are unclear whether abusive behaviours identified are the result of clinical or emotional responses to cancer, or coercive control. Work will need to focus on supporting professionals to identify the dynamics of coercive control and ensuring they do not make assumptions or decisions in isolation, but instead, hear the voices of victim-survivors and reach out to experts, including specialist domestic abuse services.

With the support of a national project group comprising experts-by-experience and professionals in cancer and domestic abuse, a toolkit will be developed to outline a best practice response to domestic abuse in cancer settings. We hope that this will be just the start of a journey to bring the cancer setting into the forefront of the whole-health response to domestic abuse.

¹³ https://www.standingtogether.org.uk/s/Pathfinder-Toolkit_Final.pdf

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