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Enhancing the cancer workforce response to domestic violence and abuse: the time is now

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Domestic violence and abuse (DVA) affects at least 8.8 million of us in England and Wales, and includes physical, sexual, economic, psychological, verbal and other forms. Although perpetration by current and former partners is the most frequently reported type, DVA perpetrated by family members is also prevalent. Women and people with disabilities and/or long-standing illnesses are disproportionately affected (Hamberger and Larson, 2015; Office for National Statistics, 2020).

The impact on mental and physical health, both directly and indirectly, is profound and long-lasting (Campbell, 2002; Devries et al, 2011; Garcia-Moreno et al, 2012; Trevillion et al, 2012; Chandan et al, 2020). Some evidence suggests that victim-survivors of DVA are less likely to attend routine breast, colorectal and cervical screening (Farley et al, 2001; Dutta et al, 2018; Massetti et al, 2018) than the general population. Victim-survivors have 2.74 times the odds of receiving an abnormal pap smear result (Reingle Gonzalez et al, 2018), have a 1.5-fold increased risk of discontinuing with follow-up care after such a result (Coker et al, 2006), and have over twice the odds of being diagnosed with different types of cancers (Reingle Gonzalez et al, 2018). DVA limits cancer-related quality of life (Coker et al, 2017), and affects the timeliness of treatment (Martino et al, 2005) and treatment uptake (Jetelina et al, 2020).

Crucially, qualitative research participants have reported that DVA did not abate, and often intensified, after a cancer diagnosis (Sawin et al, 2009; Sawin and Parker, 2011; Speakman et al, 2015; Johnson, 2017). Moreover, participants experienced cancer-specific abuse, such as being prevented from recovering, talking to others about their cancer or accessing treatment, and being humiliated about their appearance post treatment and surgery. Since they relied on their abusers physically and financially, victim-survivors were trapped. Support from nurses was vital, especially in cases where abusers had isolated them from friends and family (Johnson, 2017). One study participant said, ‘I had a lot of nurses that tried to help me with my self-esteem and build it back up … they made me feel like I was going to be okay’ (Sawin et al, 2009: 690).

Health professionals are widely trusted and are often the first or only professionals to whom victim-survivors disclose DVA (Ansara and Hindin, 2010; Australian Institute of Health and Welfare, 2019). The NHS has more contact with victims and abusers than any other agency or service in the UK (Home Office, 2016). For these reasons, the role of nurses in identifying
and responding to DVA is well-recognised. Nurses should typically receive ‘level 2’ DVA training, enabling them to enquire safely, respond to disclosures empathically, assess immediate safety, and offer referral to specialist services (National Institute for Health and Care Excellence (NICE), 2014).

NHS-based intervention research from the past two decades has shown that ongoing DVA training (Salmon et al, 2006; Price et al, 2007), coupled with the employment of a DVA nurse specialist or advocate (Feder et al, 2011; McGarry, 2017; Halliwell et al, 2019; Dheensal et al, 2020) increases professional knowledge and confidence around DVA, and the number of victim-survivors identified and referred for specialist support. We know of one oncology-based intervention from the USA where health professionals asked all patients if they felt safe at home (Owen-Smith et al, 2008). But, as far as we know, no other interventions targeting the identification and response to DVA have been conducted and evaluated within the cancer workforce. In fact, although one UK study has shown that breast cancer survivors think adult patients should be given the opportunity to disclose childhood abuse in the cancer setting (Clark et al, 2014), to our knowledge, no UK research has explored the cancer-DVA intersection at all.

This is a huge gap in knowledge and practice. Users of Macmillan Cancer Support's online forum and callers to the telephone support line frequently report experiencing both cancer and DVA (personal communication), and at least a dozen domestic homicide reviews have involved a cancer diagnosis (for example, Pearce, 2020). Unlike the cases described in published research, those from the forum, support line, and domestic homicide reviews include cases of abusers being diagnosed with cancer and then escalating their behaviours. Research about domestic homicides indicates that an abuser's diagnosis of illness can indeed be a trigger for their abuse to escalate (Monckton-Smith, 2021). The impact on victim-survivors in such cases is complex, as they face the worsening effects of DVA as well as the consequences of guilt and stigma if they end the relationship.

Standing Together Against Domestic Abuse, Macmillan Cancer Support and a team of experts-by-experience are working to fill this knowledge and practice gap. We want to ensure that victim-survivors of DVA—those with, and those caring for someone with, cancer—are offered a chance to disclose in the cancer setting and be referred for specialist support—support they may not otherwise receive.

We want to make sure that cancer nurses and other cancer professionals have the skills, confidence and resources to identify and respond to DVA in practice. To this end, we have conducted a consultation exercise to explore stakeholder views and experiences of DVA and cancer care and, with our findings, we are developing a training and support intervention to be delivered in NHS trusts. The findings will additionally inform good practice guidance for responding to DVA in cancer settings. Importantly, the guidance will be shaped by the voices of victim-survivors and the professionals who support them.

Interested readers can visit our website for updates: www.standingtogether.org.uk/macmillan-project.

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References

- Monckton-Smith J. In control: dangerous relationships and how they end in murder. London: Bloomsbury Publishing; 2021
- Price S, Baird K, Salmon D. Does routine antenatal enquiry lead to an increased rate of disclosure of domestic abuse? Findings from the Bristol Pregnancy and Domestic Violence Programme. Evidence Based Midwifery. 2007;5(3):100–106

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