Life & Times

Health needs of a hidden group:

child residents of domestic abuse refuges

In England and Wales, the rate of domestic abuse of women varies by age, being most common in the 16- to 19-year-old group where 10% of women will experience domestic abuse in a 3-year period. This rate drops to 6% by the time UK women fall in the 55- to 59-year-old group. This abuse includes any controlling, coercive, or threatening behaviour, or violence between family members or intimate partners aged 16 or over.[1]

As a result of domestic abuse, it is estimated that in 2017 there were 13 414 women supported by refuge services in England. They were accompanied by an estimated 14 353 children.[2] The majority of refuge residents have been forced to move from a different local authority area in order to escape the abuse, with 10 161 such journeys across local authority boundaries being made in 2008–2009.[3]

The health needs of the children in refuges are a product of the domestic abuse that they have been exposed to, and of being forced into geographical displacement.

DOMESTIC ABUSE AND CHILD HEALTH

Children exposed to domestic abuse face a number of health challenges: their development is globally affected, their mental health is put at risk, they face an increased risk of vaccine-preventable infections, and there are barriers to secondary care access to overcome.

Exposure to domestic abuse in the first 6 years of life has been shown to double the risk of delayed language and social development. It also triples the risk of delayed gross-motor development.[4] Children in refuges have been shown to have higher rates of mental illness compared with baseline; one study of children in a refuge in Cardiff put the rate of mental illness at 48% compared with a baseline rate of 10–28%.[5]

These children also have reduced rates of immunisation. The Cardiff study found that only 70% had a complete vaccination history, far below the 90–95% required to provide herd immunity against diseases such as measles.[5,6] No research exists that examines the impact of geographical relocation on the health of these children, but parallels can be drawn between them and children with parents in the Armed Forces, who often move region at short notice. It has been shown that Armed Forces children are at risk of having their secondary care access interrupted, with GPs advised to ensure their care is transferred appropriately.[7] The same inequality in secondary care access is likely to affect children in refuges, given that most have moved to a different local authority to enter the refuge.

The health inequalities faced by these children are stark, but GPs are ideally placed at the healthcare front line to tackle them, yet barriers exist to this happening.

BARRIERS TO AND SOLUTIONS FOR ACHIEVING HEALTH EQUALITY

Children in these situations can be difficult to identify, GPs have concerns around documentation of domestic abuse, and there is a lack of guidelines for their management.

By being aware of refuges in their area, practices can identify patients at registration, or by collaborating with refuge staff, and ensure that parents are encouraged to divulge the information and seek additional GP support for their children.

Once identified, the next challenge is in documenting this. UK GPs have expressed concerns that by documenting exposure to domestic abuse they may place a child at increased risk should their parent access their medical notes.[8] However, they should remember that the GMC states that we must *'record concerns, including minor ones, in the child's or young person's records'*.[9] If done using Read codes, such as 'at risk of domestic abuse', all clinicians become aware of a child's vulnerable status and the coding should move with the patient if they change practice.

The RCGP has produced guidance for the management of a number of marginalised groups, including travellers, sex workers, and the homeless, but none exists for this group.[10] This leaves it up to practices to implement their own auditable protocols for these children, which could include: ensuring they all have an appropriate Read code in their electronic medical record, an assessment of vaccination status with a catch-up service, GP assessment of the child's development, and assessment and facilitation of ongoing secondary care needs.

CONCLUSION

If the barriers described here can be overcome and locally appropriate services to support them are implemented, GPs have the opportunity to make a significant difference to the health of these vulnerable and isolated children during the time they are registered with a practice.

"Exposure to domestic abuse in the first 6 years of life has been shown to double the risk of delayed language and social development. It also triples the risk of delayed gross-motor development."

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REFERENCES

1. Office for National Statistics. *Domestic abuse in England and Wales: year ending March 2017*. 2017. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwales/yearendingmarch2017 (accessed 1 Feb 2019).
2. Davidge S, Magnusson L. *Survival and beyond: the domestic abuse report 2017*. 2017. https://www.womensaid.org.uk/survival-beyond-report/ (accessed 1 Feb 2019).
3. Women's Aid. Domestic abuse services. 2018. https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/domestic-abuse-services/ (accessed 1 Feb 2019).
4. Gilbert AL, Bauer NS, Carroll AE, Downs SM. Child exposure to parental violence and psychological distress associated with delayed milestones. *Pediatrics* 2013; **132(6):** e1577–e1583.
5. Webb E, Shankleman J, Evans MR, Brooks R. The health of children in refuges for women victims of domestic violence: cross sectional descriptive survey. *BMJ* 2001; **323(7306):** 210–213.
6. Sadarangani M. Herd immunity: how does it work? Oxford Vaccine Group, University of Oxford, 2016. https://www.ovg.ox.ac.uk/news/herd-immunity-how-does-it-work (accessed 1 Feb 2019).
7. Children's Commissioner. Kin and country: growing up as an Armed Forces child. 2018. https://www.childrenscommissioner.gov.uk/wp-content/uploads/2018/06/KIN-AND-COUNTRY-Growing-up-as-an-Armed-Forces-child.pdf (accessed 1 Feb 2019).
8. Drinkwater J, Stanley N, Szilassy E, *et al*. Juggling confidentiality and safety: a qualitative study of how general practice clinicians document domestic violence in families with children. *Br J Gen Pract* 2017; DOI: https://doi.org/10.3399/bjgp17X689353.
9. General Medical Council. Protecting children and young people: the responsibilities of all doctors. 2012. Updated on 25 May 2018. https://www.gmc-uk.org/-/media/documents/Protecting_children_and_young_people___English_1015.pdf_48978248.pdf (accessed 1 Feb 2019).
10. Gill P, Macleod U, Lester H, Hegenbarth A. *Improving access to health care for Gypsies and Travellers, homeless people and sex workers. An evidence-based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards*. London: RCGP, 2013. https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/RCGP-Social-Inclusion-Commissioning-Guide.ashx?la=en (accessed 12 Feb 2019).

ALL THE LITTLE LIGHTS

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CHILD SEXUAL EXPLOITATION LAID BARE

'Art helps you see'[1] and we can all probably think of an example of a film, book, or even TV soap influencing our thinking on challenging topics. Those of us who watched telly in the 1980s will remember the brutality of unemployment and poverty in *Boys from the Blackstuff*. More recently, Helen's story of being the victim of intimate partner violence and coercive abuse from the terrifying Rob in *The Archers* has certainly made sure screening questions about violence at home are more prevalent in my consultations. The reach of these programmes should not be underestimated, nor the potential impact they can have.

Recently, I visited the Guildhall School of Music and Drama to watch a powerful and brave student-produced performance of *All the Little Lights*, written by Jane Upton in 2015. It tells of three teenage girls who meet to try to celebrate one of their birthdays. What would normally be thought of as a joyous event soon demonstrates that these vulnerable young people have had their childhoods taken away from them by child sexual exploitation (CSE). Their norms and expectations have been recalibrated through grooming, and their lives are no longer their own. At one point Joanne explains that she plucked up courage to approach the authorities, but was met with, *'there are thirteen year old girls and there are thirteen year old girls, if you get what I mean'*. From that moment she became ever-more caught up in a web of control and dependency. Upton wrote this fictional tale inspired by the truth, much based upon the reality of the Rochdale tragedies of the systematic and organised rape and sexual abuse of vulnerable young girls. Sadly there have been similar cases in the East Midlands, Huddersfield, and Rotherham — in fact probably most regions in the country.

Upton met up with the Derby-based charity Safe and Sound,[2] who work with victims of CSE. The play was first staged in Nottingham and a run in the West End followed. The three inspirational young actors who delivered such a heartfelt performance in the new year left me an emotional wreck, fired up with indignation and injustice. As a GP I am all too aware of the consequences of CSE and feel frustrated that all I can do is try to treat some of the horrific symptoms the victims display and raise awareness.[3] Also, some of our patients may benefit from the current listening exercise offered by the Independent Inquiry into CSE.[4]

In an ideal world we would eradicate CSE, but, although we can comment on and advocate for this, it is probably beyond the scope of most of us jobbing GPs. However, what we *can* offer is our compassion and careful listening to our most vulnerable patients; early intervention goes a long way to improving the lives of victims. The fantastic work done by charities such as Safe and Sound is doing exactly that, and the arts are playing their part too. If we can raise awareness using the power of art then we stand a chance to change attitudes where it matters, to fund mental health and bespoke services properly, so that vulnerable young people can be supported to recover or at least move their lives forward from their abuse.

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REFERENCES

1. All Party Parliamentary Group on Arts, Health and Wellbeing Inquiry. *Creative health: the arts for health and wellbeing. The short report*. 2017. https://www.artshealthandwellbeing.org.uk/appg-inquiry/Publications/Creative_Health_The_Short_Report.pdf (accessed 30 Jan 2019).
2. Safe and Sound. Fighting CSE. 2019. https://safeandsoundgroup.org.uk/ (accessed 30 Jan 2019).
3. STOPCSE. National Child Sexual Exploitation Awareness Day. 2018. http://www.stop-cse.org/national-child-exploitation-awareness-day/ (accessed 30 Jan 2019).
4. Truth Project, Independent Inquiry Child Sexual Abuse. I will be heard. What is the Truth Project? 2019. https://www.truthproject.org.uk/i-will-be-heard (accessed 30 Jan 2019).