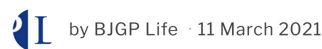
CLINICAL

How we proactively identify and support our victims of domestic abuse in our practice



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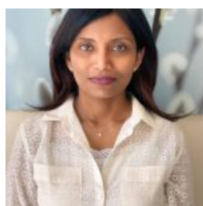

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Domestic violence and abuse (DVA) is a prevalent public health issue affecting societies worldwide that affects every layer of society. However, there are specific risk factors associated with DVA victimisation, including female gender, younger age, substance misuse, financial difficulties, social isolation, and history of child abuse, witnessing abuse as a child, poverty and having a mental disorder.[1] DVA has a deteriorating effect on society by affecting victims, their children, families, and friends, as well as social and financial relationships.

In March 2020 (the UK's first Covid-19 lock down), our practice embarked on an initiative to offer "wellbeing health checks" to vulnerable patients. We soon recognised the impact on patients experiencing domestic abuse. The number of reported cases of domestic abuse has escalated since the COVID-19 outbreak. More people at risk were being forced to stay indoors with their abusers as a result of the lockdown restrictions deemed necessary to control the spread of the disease. Social restrictions and stay-at-home mandates also amplify pre-existing mental health (eg depression, anxiety) and psychosomatic distress reactions (eg insomnia, OCD).[2]

Collectively, we decided to take a few steps towards help identify and support our patients who might be experiencing domestic abuse.

Reported cases of domestic abuse have escalated since the COVID-19 outbreak.

We embarked on this journey in two stages. Firstly, we decided to educate our staff in recognising the signs of domestic abuse in addition to being aware of support and onward referral pathways. Secondly, our intention was to promote patient awareness of the impact and consequences of DVA, and the support available.

Training our team

Data from SafeLives found that on average, a victim will experience abuse for three years before getting effective help and will visit their GP on average 4.3 times. The duration of abuse before disclosure is likely to be much longer for some victims, including older victims, BAME and the disabled.

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Reasons for failing to detect cases of DVA vary.

Clinicians suggest that a lack of basic knowledge and skills on DVA, such as how to recognise and support a victim of DVA, and fear of offending or endangering the victim may contribute to ignoring risk factors and a low detection rate.[1] Trained clinicians feel more knowledgeable and skilled to handle individuals who had experienced DVA. Time constraints are an important barrier for identification of DVA and might therefore lower instead of increase the chance of hands-on DVA experience.[1]

Dealing with DVA is not straightforward, and many clinicians tend to be reticent about asking about abuse directly.[3] They don't want to open Pandora's Box. However, women experiencing abuse often have frequent contact with healthcare professionals and surveys have shown they consider it appropriate that doctors and nurses ask direct questions about domestic violence.[3] Many people experiencing abuse believe that their GP can be trusted with disclosure, and that GPs can offer practical support to protect people who disclose abuse.[4]

In addition, victims face barriers seeking help because of stigma and shame, a "private matter", fear of reprisal, financial implications and perceptions that help or support may not be available. A few do not realise they are experiencing DVA. Psychological abuse compared to physical violence has the most long-lasting adverse effects on victim's wellbeing.

We decided to educate ourselves – both clinical and non-clinical team.

With this in mind, we decided to educate ourselves – both clinical and non-clinical team. We revisited the knowledge and skills that we gained during the formal training by Southall Black Sisters several years ago. This was done in stages during staff and clinical meetings. The presentation included statistics (pre-Covid and since lockdown), why it matteres to the NHS and to General Practice to identify and offer support to victims, and how we could help support victims. We went through our step by step guide, "Flowchart for responding to domestic abuse", developed based on guidance from the DOH document.[5] We reminding each staff member how to safely ask, respond, refer, record and follow-up when a patient discloses experiencing abuse. The importance of reassurance, the confidential nature of conversations including the limits of confidentiality when children or vulnerable adult safety is involved was stressed.

During the discussions, we pointed out that as health care professionals we have an important role and duty of care to vulnerable patients; we are often the victim's first or only point of contact who could provide a lifeline to safety. In addition, we have a good relationship (or able to develop one) with a person over time and hence increase the chance of patients disclosing abuse and seek advice.

We emphasised the importance of being vigilant and to "look beyond what the patient is saying" during any patient contact. We encouraged staff to discuss any concerns with the safeguarding lead, line manager or on-call doctor. Any contact with the clinician should be thought of as a window of opportunity to identify abuse.

> *The importance of being vigilant and to "look beyond what the patient is saying".*

We also stressed the fact that abuse can happen to anyone regardless of age, class, ethnicity, disability or life-style. Signs that an employee might be experiencing abuse were shared, and we reiterated as an employer we have a duty of care and legal responsibility to provide a safe and effective work environment.

The introduction of "Domestic Violence Champions" and "Mental Health Wellbeing Champions", in addition to the Safeguarding Lead, was welcomed by the staff. This is in addition to the Employee Assistance Programme that was already in place for the staff at the practice.

We took this opportunity to develop a "Domestic Violence and Abuse Policy" and "Domestic Abuse Support Services Directory" with helplines and links (eg National domestic violence helpline, Men's advice line, NSPCC, LGBT). The idea was to share the details with victims who needed support. "Safeguarding" was introduced as a recurring item on practice and clinical meeting agenda to ensure any concerns related to DVA is raised.

Further, we encouraged all our staff to revisit online modules on Safeguarding Adults, Safeguarding Children, Domestic Violence Awareness (eg Blue stream Academy, https://portal.e-lfh.org.uk/) and NHS Employers resources.[6] We also signed up for the formal training with IRIS Programme.

A substantial part of these actions, we hoped will not only improve knowledge and skills, but also changed our attitudes and perceptions towards domestic abuse. A recent study in the BJGP highlighted DVA impacts on the work and wellbeing of female doctors, who faced unique barriers to seek and report domestic abuse.[7] The internalised stigma of abuse affected participants' sense of identity and belonging as a doctor, causing social and professional isolation. The main barrier to accessing support concerned confidentiality. Participants found peer support helpful, as well as consulting health professionals who were empathic towards them.

Patient awareness

We uploaded information on domestic abuse on our surgery website, including support services and "Signal for Help" sign.[8] This is in addition to the posters with supportive information in all toilets and waiting rooms, should the survivor wish to self-refer.

To further help support our victims, we are in the process of installing a dial out phone line to domestic abuse support services including NSPCC in our sound proof parenting room at the surgery to help victims who have no means of ringing from home and who need a safe private place.

Going Forward

The usual channels of support are now jeopardized by lockdown restrictions and stay-at-home orders, and the victims, many of whom are isolated with their abusers, need to find alternative ways of support and safety.

> *Not only improve knowledge and skills, but also changed our attitudes and perceptions towards domestic abuse.*

The challenge is how best to identify, approach and support patients experiencing DVA with our "new ways of working" in the primary care, with clinicians dealing with the majority of problems via video, email and telephone consultations. Physical contact with such patients within the primary care is scarce during the pandemic. It is rare that we see such victims coming to the surgery alone. With video consultations, it is hard to assess who is on the other side. Many victims may find it difficult to say what is happening to them at home during remote consultations because of the potential presence of the perpetrator, or even due to the impersonal nature of remote consultations.

> *The challenge is how best to … support patients experiencing DVA with our "new ways of working".*

In practice, it is testing for clinicians when consulting remotely to ask and encourage patients to talk about underlying issues, especially in a busy clinic.

Our strategy did not reach everyone. As health care professionals, we need to look at a variety of ways of how we could identify and support our victims.

We have a dual role as providers, seeing victims and perpetrators of domestic abuse. Standardized routine enquiry of all patients, regardless of their reasons for seeking medical attention, will not only help with identification of victims but also increase public awareness and help survivors to openly discuss and encourage receiving support, in addition to empowering victims to recognise and acknowledge the abuse they are experiencing, avoiding potential reasons for unreported cases.

This led me to do a literature search on DVA assessment tools, in the hope of finding a universal healthcare screening tool that increased victim identification in primary care settings, especially if we are to continue with remote consultations beyond pandemic. Given the time constraints of a busy clinic, ideally we need a shortest, simple, precise, validated and safe screening test. It would be best to have "words" in a screening tool that do not directly ask about violence – some clinicians and patients might prefer this for cultural reasons.

The WAST-Short (Women Abuse Screening Tool-Short) questionnaire has been widely used in other countries.[9] It has a sensitivity of 91.7% and a specificity of 100%, validated by both CDC and NIH.[10] It is a relatively unobtrusive, simple, non-gender specific questionnaire, that can easily be used during routine busy clinics for assessing abuse. It contains the first two questions of the 8-item WAST tool.

The WAST tool

1. In general, how would you describe your relationship?
a. No tension b. Some tension c. A lot of tension

2. Do you and your partner work out arguments with…
a. No difficulty b. Some difficulty c. Great difficulty?

If a patient answers 'c' to these two questions, the clinician can then use the remaining WAST questions, or other appropriate questions to elicit more information about their experience of abuse.

I decided to offer WAST-Short questionnaire as routine enquiry to patients contacting the clinician – it takes one minute. Patients were given the choice of receiving the Domestic Abuse Support Services Directory, via SMS or email.

Thus far, we collected data from 200 patients. 6 patients (4 females, 2 males) came forward as experiencing domestic abuse. They were given appropriate support and follow-up. The WAST-short screening tool was acceptable to our patients and they welcomed the idea. Of all the patients who answered the questionnaire, 38% (n=76) were happy to receive supportive information via SMS; they felt this information can be shared with others who might be suffering DVA.

I am aware that this approach only targets patient who contacts the surgery. Nevertheless it contributes towards raising public awareness of the detrimental consequences of DVA. This might also prompt the perpetrator to acknowledge the abuse and potentially get support. Furthermore, our view is that even if we identify and offer support to one victim, we will make a huge difference to their lives and their families including children, and friends.

Conclusion

> *If we identify and offer support to one victim, we will make a huge difference to their lives and their families.*

Awareness is the key to prevention. I strongly believe by meaningful engagement with patients we can empower and motivate them to work towards positive health outcomes, to maximise their physical, emotional, and social wellbeing.

Greater factual knowledge about DVA does not of itself necessarily translate into readiness to address DVA or increase referral rates to DVA services.[1] Self-confidence of health care professional to handle DVA needs to be addressed also. Clinical training programmes should focus on developing skills towards DVA management as well as provision of knowledge. Follow-up training and long-term support of the staff and clinicians is necessary to ensure development and retention of obtained knowledge and skills.[1]

Going forward, we plan to continue proactively to identify, refer and support our patients experiencing DVA. This will be in addition to regularly updating our clinical knowledge and skills towards DVA management.

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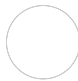

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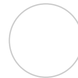

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