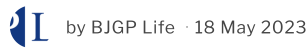
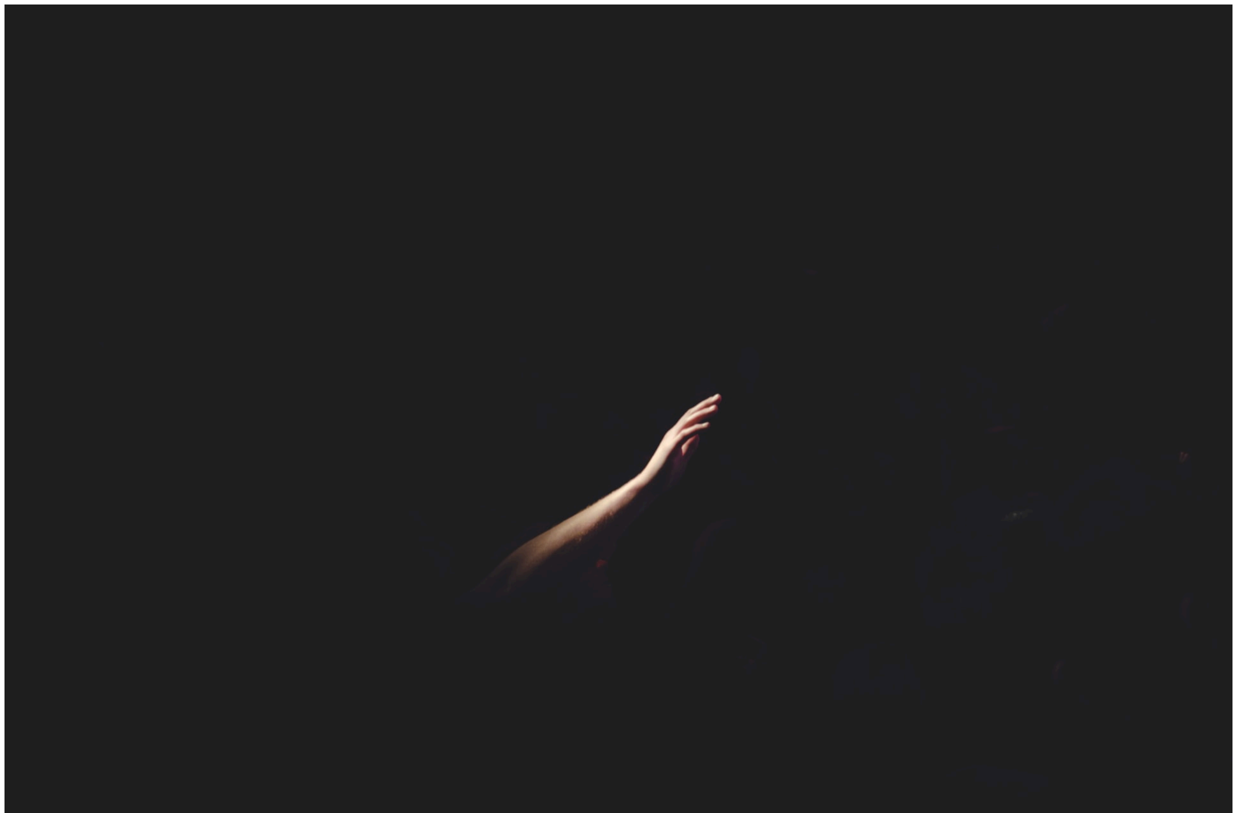
THE HOME OF GENERAL PRACTICE AND FAMILY MEDICINE

BJGP LONG READ / OPINION

Improving the management of domestic abuse in general practice


by BJGP Life · 18 May 2023



Vasumathy Sivarajasingam is a GP in West London and an honorary clinical research fellow at Imperial College London. She is on Twitter: @vasu27765631

Domestic abuse (DA) is a well-recognised safeguarding issue being prevalent globally. In the UK, it affects around 2.3 million adults yearly.[1] One in five homicides is a domestic homicide,[2] and police are identifying new suspected victim suicides with a history of DA. A coroner's inquest in England,[3] for the first time, declared DA as a causative part in death by suicide, stressing the control DA has on mental health and recommending greater recognition of the link between DA and suicide.

The abuse we see is only the 'tip of the iceberg'. Accurate data on DA incidences are somewhat sparse. DA is hidden from the public eye due to its sensitive nature and a myriad of

barriers.[4] Even when victims present to healthcare professionals (HCPs), DA may be poorly

Raising public awareness and encouraging the health sector to play an active role in prevention and early intervention are the key priorities in the Domestic Abuse Act 2021,[5] WHO guidance,[6] and the 10-year Women's Strategy for England.[7] Several approaches have been established globally to mitigate the incidences and impacts of DA – campaigns raising public awareness and supporting services' visibility; screening tools identifying high-risk groups in clinics such as sexually transmitted clinics; education and training of HCPs, and structured referral pathways following victim's disclosure. Unquestionably, these interventions are essential in tackling DA. Of equal importance is implementing preventative strategies. Such an approach has not been prioritised or widely exercised to reduce DA incidences within primary care in the UK.

Current practice and challenges

> *Accurate data on domestic abuse incidences are somewhat sparse. [It] is hidden from the public eye due to its sensitive nature and a myriad of barriers.*

NICE guidance[8] encourages targeted enquiries during consultations in general practice and expects clinicians to use their judgement to ask about DA. This was proposed pre-pandemic when the majority of consultations were primarily face-to-face. It is not uncommon to ask questions about DA during a busy clinic. Clinicians cite time constraints, discomfort, and fear of offending patients or partners as common barriers to asking about DA.[9] HCPs may share the same cultural norms and prejudices with victims or perpetrators of DA, which could affect their professional attitudes and perceived system support. We also need to be mindful of HCPs who are or had been victims of DA – a global meta-analysis of HCPs highlighted about 42% of female HCPs were survivors of DA.[10] Training, integrated referral pathways, and system-level support can increase detection, documentation, and referrals,[11] still, clinicians remain reluctant and feel discomfort in delving into such conversations despite having the training.[11] An added challenge is the implementation of digital consultations, as part of the NHS long-term plan, further reducing the opportunity in identifying victims.

What we know now and opportunities

The United States is one of the few countries with a policy of screening for DA.[12] The evidence for screening in healthcare settings is contradictory.[12] Hence the inconsistency between the Cochrane review on which the NICE guidance is based and the systemic review supporting the U.S. Preventive Services Task Force guidance.[12] Besides, screening programmes are not all that different from targeted enquiry,[12] and harms have not been reported.[13] A survey of female patients[14] revealed that 77% of women with a history of DA and 70% of women without a history of DA believed that physicians should do the routine screening; women screening positive for DA are more likely to experience abuse in the coming months. A systematic review of qualitative studies[15] highlighted that DA victims want to be asked by their doctors about DA.

General practice can play a fundamental role in assisting in raising awareness and supporting primary prevention, early identification, and intervention of DA.

Raising awareness

First, the implementation of screening tools would not only raise awareness but also reiterate

steps to end it. Patients have a good understanding of the impacts of DA, but many fail to recognise specific instances or events in their daily lives contributing to DA.[4] DA is a learned behaviour and primary care can educate and shift behavioural changes.

Achieving earlier detection

Second, screening improves early detection of DA in general practice.[16] Being proactive and using the already established screening tools increases opportunities to identify victims presenting with vague symptoms and struggling to disclose their experiences – in particular, sexual, financial, coercive, and emotional abuse. This may encourage people to talk about the issues more openly and combat potential reasons for unreported DA, such as taboo, shame, or fear of reprisal. Additionally, it could prompt perpetrators to accept and seek support.

Introducing universal screening tools for such sensitive topics may also make it easier for clinicians to initiate conversations and reassure victims that they are not alone in their experiences.

Introducing universal screening tools for such sensitive topics may also make it easier for clinicians to initiate conversations and reassure victims that they are not alone in their experiences. It could improve practitioner awareness and vigilance, raising sensitivity and detection rates among non-specialists.

Getting ahead

Despite these benefits, there may be concerns that screening for DA could escalate workload by increasing the identification of those at risk or victims of DA. We know that self-administered DA screening is as effective as a clinician interview[17] in relation to disclosure, comfort, and time spent screening. Hence, there is value in including screening tools as part of the new patient/annual health checks, mental health reviews, and antenatal and postnatal checks in general practice.

Further research is helpful to determine the benefits of using the already established screening tools in tackling DA, principally the reduction in DA occurrences and associated crimes coupled with the harms and costs of such an approach, while understanding how this approach can be incorporated within routine general practice in a way that is acceptable to clinicians and patient population.

References:

1. Office for National Statistics website. Domestic abuse in England and Wales overview: November 2022. www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandv 14 February 2023).
2. Lis Bates KH, Thien Trang Nguyen Phan, Phoebe Perry, and Angela Whitaker. Vulnerability Knowledge and Practice Programme (VKPP), Domestic Homicides and Suspected Victim Suicides 2021-2022 Year 2 Report. 2022:144.
3. Harris L. Regulation 28: report to prevent future deaths (1). 2022. https://www.judiciary.uk/wp-content/uploads/2022/11/Jessica-Laverack-Prevention-of-future-deaths-report-2022-0344_Published.pdf(accessed 8 Feb 2023).
4. Sivarajasingam V, Webber I, Riboli-Sasco E et al. Investigating public awareness, prevailing attitudes and perceptions towards domestic violence and abuse in the United Kingdom: a

qualitative study. BMC Public Health 2022; 22 (2042).

2021. https://www.legislation.gov.uk/ukpga/2021/17/section/1/enacted(accessed 8 Feb 2023).
6. WHO. Violence against women: WHO; 2021 [Available from: https://www.who.int/news-room/fact-sheets/detail/violence-against-women.
7. Department of Health & Social Care. Women's Health Strategy for England, Policy paper. England GOV.UK; 2022.
8. National Institute for Health and Care Excellence. Domestic violence and abuse. QS116.2016. https://www.nice.org.uk/guidance/qs116(accessed 8 Feb 2023).
9. Leah Kirk and Kim Bezzant. What barriers prevent health professionals screening women for domestic abuse? A literature review. British Journal of Nursing 2020;29(13):754-760.
10. Dheensa S, McLindon E, Spender C et al. Healthcare professionals' own experiences of domestic violence and abuse: a meta-analysis of prevalence and systematic review of risk markers and consequences. Trauma Violence Abuse 2022: 15248380211061771.
11. Roxanne CK, Sharli P, Sarah D. Domestic abuse is important risk factor for suicide. BMJ. 2022;379.
12. Feder G. Beyond identification of patients experiencing intimate partner violence. American family physician. 2016;94(8):600-5.
13. O'Doherty L, Hegarty K, Ramsay J, *et al.*Screening women for intimate partner violence in healthcare settings. *Cochrane Database Syst Rev*2015; 2015(7): CD007007.
14. Chuang CH, Liebschutz JM, editors. Screening for Intimate Partner Violence in the Primary Care Setting: A Critical Review2002.
15. Feder GS, Hutson M, Ramsay J, Taket AR. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. Arch Intern Med. 2006;166(1):22-37.
16. Chen P-H, Rovi S, Pan K-Y, Johnson MS. Costs effectiveness of domestic violence screening in primary care settings: a comparison of 3 methods. Journal of Community Medicine and Health Education 2013; DOI: 10.4172/2161-0711.1000253.
17. Chen P-H, Rovi S, Washington J, Jacobs A, Vega M, Pan K-Y, et al. Randomized comparison of 3 methods to screen for domestic violence in family practice. Ann Fam Med. 2007;5(5):430-5.

Featured photo by Cherry Laithang on Unsplash.

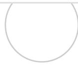
BJGP LIFE LATEST POSTS

The BJGP is the world-leading primary care journal. At BJGP Life we add multi-media comment and opinion for the primary care community.

Subscribe Login

Join the discussion

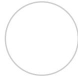
This site uses Akismet to reduce spam. Learn how your comment data is processed.



How can we play a part in ending domestic abuse? - Vasu Siva 2 years ago

[…] Read an article by Dr Siva on domestic abuse. […]

0 Reply



BJGP Life 1 year ago

Vasumathy Sivarajasingam is a GP in West London and an Honorary Clinical Research Fellow at Imperial College London. She is also the Northwest London Primary…

0 Reply

PREVIOUS STORY

Is it me or GP? Notes for a profession in difficulty

NEXT STORY

Hummingbirds and foxes (… and what it means to be a GP)

LATEST FROM BJGP LONG READ

Beautiful Lives: How we got learning disabilities so wrong, by Stephen Unwin

The book presents a critique of our current care of people with learning disability and how

The Power of Self-Compassion

Though it might seem soft or understated there is a quiet power in practicing self-compassion. Maiedha

Shaking hands again

"We tended to turn door knobs with our elbow or to press elevator's buttons using our

Treating doctor-patients and work colleagues: a need for some international principles

The treatment of one's self, family and colleagues and being a physician-patient are aspects of clinical

Improving healthcare for marginalised communities: A call from GPs for business involvement

Poor health in marginalised communities leads to greater healthcare costs, a less productive workforce, and a

© 2025 - ALL RIGHTS RESERVED.

2