Pathfinder
Enhancing the response to domestic abuse across health settings

Pathfinder Profile: General Practitioners

Guidance for General Practitioners responding to domestic abuse

This guidance paper has been designed for general practitioners, as part of the Pathfinder project, which aims to establish a comprehensive health practice in relation to domestic abuse and wider issues relating to Violence Against Women and Girls in healthcare. It will provide practical advice and outline how to ask about abuse and respond to disclosures from patients, refer and signpost victims/survivors[1] of domestic abuse and share best practice approaches of responding to domestic abuse in general practices. This document should be read alongside resources mentioned in the further reading section.

The UK definition of domestic abuse is "any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial, emotional." It includes coercive control, which is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

Each year an estimated 2 million adults in England and Wales experience some form of domestic abuse – 1.3 million female victims/survivors and 695,000 male victims/survivors[2] with these figures likely to be an underestimate, because all types of domestic violence and abuse are under-reported in health and social research, to the police and to other services.

Domestic abuse costs the health services £2,333 million every year[3] and every practitioner in the health system will already be treating patients who are experiencing abuse. NICE guidelines have created four quality statements[4] which GPs should use as a guide in their response to domestic abuse:

1. People presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion.
2. People experiencing domestic violence and abuse receive a response from level 1 or 2 trained staff.
3. People experiencing domestic violence or abuse are offered referral to specialist support
4. People who disclose that they are perpetrating domestic violence or abuse are offered referral to specialist services.

Asking the question

Victims/survivors find it very difficult to disclose their experience of domestic abuse. SafeLives Insights dataset found that on average, a victim/survivor will experience abuse for three years before getting effective help and will visit their GP on average 4.3 times[5]. The duration of abuse before disclosure is likely to be much longer for some victims/survivors, including older victims/survivors, and those who are BAME and/or disabled. Disclosure is an opportunity for GPs to recognise domestic abuse and provide more effective care and support for their patients.

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[1] A note about language: Language is fluid, we also know that the use of certain terms is disputed and can be cause for concern. In this document if a person is currently living in danger, we talk about them as a 'victim of domestic abuse' but from the moment they start to receive support/move on from the abusive relationship, they are a 'survivor'. We keep our use of language under close review and encourage professionals to adopt whichever language each patient uses to identify themselves.
[2] ONS (2018), March 2018 Crime Survey for England and Wales (CSEW)
[3] Home Office (2019), The economic and social cost of domestic abuse
[4] National Institute for Health and Care Excellence (2016), Domestic violence and abuse
[5] SafeLives, Insights health England and Wales 2018

Victims/survivors (whether adult, child or young person), and perpetrators (again, of any age) experiencing domestic abuse will all present with different symptoms and signs. It is therefore important that GPs are professionally curious and open minded about what those experiencing and perpetrating abuse look like. Although domestic abuse research and services mainly focus on intimate partners, this type of violence and abuse takes many forms. Examples include: forced marriage, violence connected to 'honour', violence against adults by their children, abuse of older people and other intra-familial abuse.

Clinical vs routine enquiry

Some health environments undertake routine enquiry of domestic abuse in all female patients. Whilst it does ensure all female patients are asked about domestic abuse, it can make asking the question routinised and therefore inattentive, which can in turn discourage victims/survivors from disclosing. Gene Feder, a GP in Bristol and Professor of Primary Care at University of Bristol who chaired NICE guidelines on domestic abuse explains:

"We, clinicians, have to ask [about domestic abuse] but it has to be in the context of really wanting to know and it has to be triggered by what the patient is presenting. Your asking is triggered by someone being for example anxious, depressed, chronic pain, maybe difficulty sleeping- a whole range of symptoms we know are associated with abuse."

NICE guidelines state that there is insufficient evidence to recommend screening or routine enquiry in most healthcare settings. Therefore, GPs are recommended to practice clinical enquiry, which sets the threshold for asking low and uses the information from the interaction with the patient to make an assessment.

Some physical and mental health issues, such as anxiety, depression, chronic pain, difficulty sleeping, facial or dental injuries, chronic fatigue and pregnancy and miscarriage have a strong link to being a victim/survivor of domestic abuse. Patients who present with such symptoms should always be asked about abuse. In addition, in heterosexual relationships abusive perpetrators often exert control over a woman's reproduction; GPs should be alert to indicators such as urinary tract infections, unprotected sex, lesion of nipple, STIs, pregnancy and requests for a termination[6]. Our understanding of who perpetrates abuse and how they might present to a GP by way of symptoms is much less well developed; the best available research from an evaluation of the Drive perpetrator programme[7].

What questions to ask

It is important to note that different patients will be at different stages in their readiness to disclose their experience of abuse and may minimise it. Therefore, it is crucial that enquiring about domestic abuse is done sensitively in a private environment. Do not use friends, family or carers as interpreters, and avoid unhelpful assumptions, for example that two people of the same sex attending together must be friends rather than partners.

Here are some examples of questions you may want to ask:

Has anyone ever made you feel frightened?

Has anyone hurt you?

Does anyone at home make you feel scared?

Four questions were developed as a (HARK) framework for helping to identify victims/survivors of domestic abuse, and have been found to be a sensitive and accurate tool[8]:

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[6] Standing Together Against Domestic Violence (2016), Domestic Homicide Review, case analysis
[7] University of Bristol, Evaluation of Year 2 of the Drive project- A pilot to address high risk perpetrators of domestic abuse (2019)
[8] Sohal H, Eldridge S, Feder G; The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: a diagnostic accuracy study in general practice. BMC Fam Pract. 2007 Aug 298:49

- **H**umiliation: "In the last year, have you been humiliated or emotionally abused in other ways by your partner/family member?" "Does your partner/family member make you feel bad about yourself?" "Do you feel you can do nothing right?"
- **A**fraid: "In the last year have you been afraid of your partner or ex-partner/family member?" "What does your partner/family member do that scares you?"
- **R**ape: "In the last year have you been raped by your partner or forced to have any kind of sexual activity?" "Do you ever feel you have to have sex when you don't want to?" "Are you ever forced to do anything you are not comfortable with?"
- **K**ick: "In the last year have you been physically hurt by your partner/family member?" "Does your partner/family member threaten to hurt you?"

How to ask the right questions

It is not just about what questions you ask but also how to ask them. It is important that you are confident in your enquiry- being comfortable will send a message to the patient that this is not a shameful topic. So ask the questions in your own words which feel comfortable for you.

Medina Johnson, Chief Executive of IRISi, a programme working with GP surgeries to improve their response to domestic abuse (and a partner in the Pathfinder consortium), suggests trying out different questions with colleagues to see which ones feel easy and appropriate for you. It allows you to practice in a safe setting, making you more confident when talking to patients and less worried about whether you are using the right words.

Responding to disclosures

It takes a lot of courage for a patient to disclose an experience of domestic abuse- your initial response is important. You should respond with empathy and understanding, letting your patient know you believe them and remind them the abuse is not their fault.

You should also be able to assess the patient's immediate safety. There are standardised risk assessments, such as the Dash risk checklist, which should be used if you are trained to do so. Whether you complete a risk assessment or not, it is important you refer the victim/survivor onto local specialist domestic abuse services (information on these is publicly available). If they do not wish to be referred to a specialist service, provide them with the National Domestic Abuse Helpline free-phone number **0808 2000 247** (which is run 24 hours a day, 7 days a week and answered by fully trained female support workers and volunteers). The helpline is a member of the Language Line and can provide an interpreter if needed. You can also provide them with Galop's national domestic abuse helpline number for LGBT+ victims/survivors **0800 999 5428** (which is run Monday to Friday at varying times).

If the victim/survivor is BME, they may face additional barriers preventing them from accessing the help they need. They may prefer to access a specialist BME service – please support your victim by finding out what your local specialist BME services are and what support they provide. Alternatively, the national helpline mentioned above will also be able to provide you with information on local, specialist services.

Remember that children living with families experiencing domestic abuse will also experience it themselves. Please follow your local routes for safeguarding children. Additionally, SafeLives Insight data has found that children's outcomes significantly improve after support from specialist children's services[9]. Some specialist domestic abuse services will provide support for children – please find your local service which does this to ensure effective support is also provided to children experiencing abuse.

How to support vulnerable patients

Some victims/survivors will be at a high risk (established using a formal risk assessment form) or will have additional and complex needs which make them particularly vulnerable. This group of victims/survivors may benefit from being able to see the same GP who knows their case. They should be offered an appointment with a named GP, one they feel comfortable speaking to. Whilst this cannot be offered to all victims/survivors, those who are at the highest risk and want to have continuous support from the same GP should be able to access it. For patients who might face additional barriers connected to their identity – for example those who are disabled, older, BME, identify as LGBT or who have insecure immigration status – this consistency of relationship is particularly important in building trust.

[9] SafeLives (2014) In plain sight: Effective help for children exposed to domestic abuse

How to support yourself and colleagues

There is no typical victim/survivor of domestic abuse. People impacted by domestic abuse are in every office, live on every street, behind every kind of front door. The information shared here is not only for patients. It is for anyone affected by domestic violence and abuse including yourself and your colleagues. If you are affected by domestic abuse or know someone who is then please ask for help through one of the channels suggested here or pass on that information.

It is likely some of your colleagues are experiencing abuse - over 50,000 NHS staff are estimated to have experienced abuse in the last 12 months[10]. It is especially difficult to recognise signs of abuse in GPs, as they tend to work in isolation and due to limited capacity often do not have time for supervision and thus lack the space to voice issues they may be dealing with. Ensure you take time to speak with your colleagues and look out for signs, such as frequent absence, lateness, obsession with time keeping, change in manner of dress, isolating themselves from colleagues. For further information on how to support colleagues, please read SafeLives' guidance paper on responding to colleagues experiencing domestic abuse[11]. The Pathfinder Toolkit, which will be published in 2020, will include guidance on staff policy and should also be used when seeking further information.

Disclosure and data recording of domestic abuse

Disclosures of domestic abuse made to health practitioners are not always recorded- this can be due to inconsistent recording, lack of understanding of abuse, no structural framework requiring such data to be recorded, concerns over GDPR legislation and many others. It is, however, important to collect and record such information, as it will allow practitioners to better understand the driving cause of some of the medical conditions the patients are presenting with and offer better support. Without it, there is little evidence to show the work practitioners already do to support victims/survivors of abuse.

Not only is effective data recording useful for practitioners, it is also helpful for victims/survivors themselves. Recording disclosures in case notes means victims/survivors do not have to repeat their story to multiple professionals, which can be traumatising and impair their mental health and wellbeing. Every practitioner who is working with and supporting the victim/survivor should know about their experience of abuse. This means that disclosures of domestic abuse must be clearly recorded in a factual manner on case management systems. Note details of the abuse as told to you by the victim/survivor. A Case Analysis Report produced by Standing Together Against Domestic Violence, a Pathfinder partner, found that consistent and comprehensive record keeping are crucial in ensuring appropriate continuity of care and an integrated response.[12]

Practitioners need to be aware of safety implications of this for themselves and the victim/survivor and ensure this is done sensitively- the perpetrator should not be able to gain access or be able to see that this has been recorded. Ensure that case notes are not visible on the front screen during appointments (as often perpetrators will attend appointments with the victim/survivor).

Multi agency work with local specialist services

General practices hugely benefit from strengthening their relationships with local specialist domestic abuse services. Such links can lead to:

- Training for primary care staff- specialist domestic abuse workers could provide basic training to staff to increase their understanding of domestic abuse and the signs of abuse
- Develop a referral pathway- general practitioners would have better knowledge of the services available for victims/survivors and perpetrators of domestic abuse as well as how to refer patients to such services

Asking the services to come to the practice and introduce themselves, explain their provision and referral routes will help GPs to be more confident in speaking to their patients about such services. The interpersonal relations created in this process between domestic abuse support workers and GPs will also help for referred patients to feel more comfortable with receiving the support. If they know the name

[10] SafeLives (2016), Cry for health
[11] SafeLives, Respond to colleagues experiencing domestic abuse: practical guidance for line managers, human resources and Employee Assistance
[12] Standing Together Against Domestic Violence (2016), Domestic Homicide Review, case analysis

of the person they are going to speak to or the support offered by the service is explained in detail by the GP, they will feel more involved in the process, trust the specialist workers and be more likely to engage.

Responding to perpetrators

General practitioners are not expected to identify perpetrators. However, you should be able to respond appropriately in case a patient makes a disclosure. People who disclose that they are perpetrating domestic violence or abuse should be able to access evidence-based specialist perpetrator services and programmes. We understand such services do not exist in every local area. You can find your nearest accredited behaviour change programme by calling the national Respect phoneline **0808 802 4040** (open Monday to Friday 9am-5pm)**.**

How can general practices improve their overall response to domestic abuse?

This practice briefing is created to support clinicians in improving their response to domestic abuse. Whilst this document covers some of the standards required to provide effective support, it is not a substitute for the Identification and Referral to Improve Safety (IRIS) programme. We encourage all general practices to implement IRIS in order to give their patients the best support by providing effective identification and response to domestic abuse.

The IRIS model was set up to improve the response of primary care to domestic abuse. It is a domestic abuse and violence training, support and referral programme for GP practices. Core areas of the programme are ongoing training sessions for both clinical and ancillary staff, clinical enquiry and care pathways for primary health care practitioners and an enhanced referral pathways for all patients with the experience of domestic abuse. The work is completed by a full-time Advocate Educator (AE) working with up to 25 practices. As well as providing training to all staff in the practice, advocate educators will also hold a caseload, offering practical and emotional support to patients who have experienced domestic abuse.

The IRIS model has been shown to be effective in the identification and referral of victims/survivors of domestic abuse, with one study finding referrals to domestic abuse agencies in the intervention practices being 21 times larger than in the control practices[13]. Blackpool, a Pathfinder site, has implemented IRIS in 25 of their GP practices in collaboration with the acute health trust. Staff in community care are leading on the project.

Training of general practitioners is fundamental to providing an effective response to domestic abuse in primary care. IRIS is the best practice model- if your general practice does not have IRIS, speak to your CCG lead and ask for specialist domestic abuse training to ensure you are adequately supporting victims/survivors of domestic abuse.

GPs are only one piece of the puzzle in the response to domestic abuse

General practitioners are not specialist domestic abuse workers and are not expected to provide a specialist service. However, they are in a unique position to support and help victims/survivors of

[13] Devine, A., Spencer, A., Eldridge, S., Norman, R., & Feder, G. (2012). Cost-effectiveness of Identification and Referral to Improve Safety (IRIS), a domestic violence training and support programme for primary care: a modelling study based on a randomised controlled trial. *BMJ open*, *2*(3).

domestic abuse, spot the signs and allow for other specialist services to help by creating effective relationships with them and referring victims/survivors to those services. The average of three years living with abuse before disclosure is too long. For some children it is a lifetime. We welcome changes being made to shorten this duration, which is also proven to relieve pressure on the health system.

Further reading:

- National Institute for Health and Care Excellence (2016), Domestic violence and abuse
- SafeLives (2014), Responding to domestic abuse: guidance for general practices
- Royal College of General Practitioners (2017), Guidance on recording of domestic violence and abuse information in general practice medical records
- MDU (2019), Domestic abuse: Your legal and ethical duty
- Standing Together Against Domestic Violence (2016), Domestic Homicide Review, case analysis