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Cite this as: *BMJ* 2021;373:n1047
http://dx.doi.org/10.1136/bmj.n1047
Published: 07 May 2021

PRACTICE POINTER

Identifying and responding to domestic violence and abuse in healthcare settings

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What you need to know

- Ask about domestic violence and abuse (DVA) sensitively and respond in a supportive manner, asking the person what they would like to happen, informing them of sources of support, and following up the case in your clinical setting where possible
- Get support and advice from safeguarding leads when supporting patients with complex DVA and other needs
- Being well informed about DVA, building links with local support organisations, and addressing barriers to accessing services can improve the care provided to survivors of DVA

Visits to the UK national domestic abuse helpline website increased by 700% in the second quarter of 2020 compared with the first quarter,[1] supporting reports from the voluntary sector that domestic violence and abuse (DVA) escalated during the covid-19 pandemic.[2 3] The World Health Organization considers violence against women an "urgent public health priority."[4 -7] Clinicians play important roles in the multisectoral response to DVA, which has acute, lasting impacts on physical, reproductive, and mental health. Family doctors or general practitioners are often trusted by survivors; they are well placed to listen, offer practical support, and advocate for local commissioning of integrated DVA services within healthcare. Identifying patients experiencing DVA, responding appropriately, and connecting them with specialist support is part of good holistic care.

What is DVA?

Although definitions vary,[8] in England and Wales DVA is defined as any incident or pattern of controlling, coercive, or threatening behaviour, violence, or abuse between current or former intimate partners or family members aged 16 or above.[9] Much DVA comprises intimate partner violence (IPV), perpetrated by partners and ex-partners. DVA includes psychological, physical, sexual, financial, and other abuse. Examples include insults, humiliation, intimidation and threats (psychological abuse), hitting, kicking, slapping or punching (physical abuse), rape and forced non-penetrative sexual acts (sexual abuse), and controlling or withholding of money or access to basic necessities (financial abuse). Digital technologies mean that DVA can continue online, and can include use of tracking devices, social media, and monitoring of women's internet use and communications. Children may be exposed to DVA at home; it is a risk factor for child maltreatment.

Who experiences DVA?

DVA affects people of any age, ethnicity, socioeconomic status, sexuality, and their children. Twenty nine per cent of women and 14% of men in England and Wales have experienced DVA.[10] Thirty five per cent of women worldwide experience physical and/or sexual violence.[11] Lower levels of education, a history of experiencing maltreatment in childhood, and harmful use of alcohol are risk factors for both experiencing and perpetrating DVA.[11] Living in rural areas is also a risk factor, with isolation exploited by perpetrators and limited access to support for survivors.[12] Women in relative poverty, who are younger, or who have mental health or substance use disorders report more DVA.[13] In England, 32% of homeless women cited DVA as a contributing factor,[14] while gay men, bisexual, and trans people all disclose higher rates of DVA than gay women and heterosexual people.[15] So called "honour" based violence (HBV), including forced marriage, is often a form of DVA but it is also perpetrated by non-family members. A UK study of 505 DVA survivors at risk of HBV found that 23% had no recourse to public funds and 26% required an interpreter.[16] Rates of DVA have increased during the covid-19 pandemic (box 1).

Box 1: DVA and remote consulting during covid-19

UK[17] and international[18] observations suggest that help-seeking for DVA and domestic homicides increased during the covid-19 lockdown period.[19] Reasons include increased time spent at home with an abusive partner, exacerbation of inequality between partners (eg, because of unemployment, childcare, and home schooling responsibilities), increased stressors (such as financial, health, and occupational uncertainty), increased drug and alcohol use, greater opportunities for cyber abuse, reduced mobility and financial independence of survivors, and reduced contact with support systems, loved ones, and services which might detect DVA.

Many routine face-to-face clinical services were suspended during covid-19 and much continuing healthcare was delivered remotely, limiting survivors' opportunities to disclose DVA to healthcare professionals outside the home. During any national emergency, patients and families may receive less contact from other agencies, such as schools and community centres, which might usually detect DVA. Guidance on safeguarding[20] and responding to DVA[21] during covid-19 were issued urgently. Some points to consider:

- Be aware of social, emotional, and financial stressors imposed on your patients by lockdown and consider asking about home life and relationships.
- Remember that adults and children experiencing DVA at home may now be trapped inside with their abuser and isolated from support.

- For all telephone and video consultations, check who else is in the room or at home, and if it is safe to talk.
- Consider using closed "yes" or "no" answered questions instead of open questions, to stop the content of your discussion from being understood by someone else in the room.
- Agree a safe word or phrase so the call can be safely terminated if interrupted, eg, "sorry, I'm not interested," and agree how you will follow up if the call ends in this way.
- Offer telephone follow-up, if appropriate.
- Encourage patients to use telephone or online means to connect with friends, family, and professionals.
- Share contact details of relevant support organisations and inform patients that DVA is a justification for breaking lockdown rules.
- Consider whether you need to arrange a face-to-face assessment if you are concerned about their safety. Call 999 in an emergency.
- In maternity settings, partner and family member accompaniment has been restricted. This increases opportunities to inquire about DVA; however, be mindful that perpetrators may try to control women's hospital attendance. Ensure that you follow up all unattended appointments.
- DVA survivors attending emergency departments should still be offered referral to an advocacy service, but remote methods such as telephone contact should be used where safe.

Although men's exposure to DVA is likely underreported, women experience more sexual violence, severe physical violence, fear, control, and adverse mental and physical (including reproductive) health effects.[10 22-25] We focus here on women, but these principles remain relevant to male survivors.

Where available, some specialist organisations can support patients facing additional barriers, such as those faced by people from a particular cultural or ethnic group, gender identity, sexuality, or with disabilities. Homelessness, rural accommodation, and uncertain immigration status also affect disclosure.

How do people experiencing DVA present?

DVA damages the health of adults and children exposed to it.[26] Although injuries to the head, face, neck, thorax, breasts, and abdomen should raise suspicion of DVA, patients presenting with acute trauma are less common than other health presentations.[26] Table 1 lists the presentations and conditions associated with DVA.

Table 1 | Adult[25-29] and child[30] health outcomes associated with DVA

	Mental	Physical	Sexual and reproductive
Adult	Suicide and suicidal ideation Depression Anxiety Post-traumatic stress disorder (PTSD) Complex PTSD Substance use disorders	Injuries, including bruises, cuts, head injuries and attempted strangulation Chronic pain Headaches Hypertension and ischaemic heart disease Irritable bowel syndrome	Sexually transmitted infections, including HIV Persistent urinary tract infections Chronic pelvic pain Miscarriage Termination of pregnancy Premature labour and low birthweight babies
Child	Internalising symptoms, eg, anxiety and depression Externalising symptoms, eg, aggression Trauma symptoms Adjustment difficulties and behavioural problems Mental health problems in adulthood, including conduct disorder	Injuries	Engagement in risky health behaviours

Also consider DVA when children miss appointments or present with sleep problems, bedwetting, or distress.

DVA is an interpersonal trauma and violation of human rights, which may occur alongside other traumatic experiences, such as forced displacement from humanitarian settings.[31] Trauma informed care prioritises trauma awareness, safety, trustworthiness, choice and collaboration, and building strengths and skills.[32] Trauma has lasting physical and psychological impacts[31] and when a threat is continuous, can cause complex post-traumatic stress disorder (PTSD). Trauma influences relations to the world, others, and oneself and this may manifest in certain behaviours. For example, lifetime prevalence of IPV is 25% among women accessing termination of pregnancy, and repeated terminations with partners not knowing about terminations is associated with IPV.[33] Consider asking about current or past DVA and historical trauma in patients who frequently attend,[34] or regularly miss appointments or discontinue treatment, which may indicate being prevented from attending. Other behavioural indicators of DVA include

- Appearing fearful, evasive, ashamed, or embarrassed
- Frequent use of analgesia or hypnotic drugs[35]
- Persistent physical complaints
- The presence of an intrusive "other person" in telephone or face-to-face consultations.

Where do survivors of DVA present?

The prevalence of DVA is higher among people attending healthcare settings than in the general population[36]; it presents to all clinical specialties. DVA commonly presents to GPs, emergency departments, women's health, psychiatric, drug, and alcohol services, including for children's symptoms. Clinicians see survivors and perpetrators and may treat both members of a couple, sometimes attending consultations together.[7] Guidelines from the National Institute for Health and Care Excellence (NICE) for England and Wales recommend that trained staff ask service users about DVA when they encounter them at services for women's health, sexual health, substance use, mental health, and the health of children and vulnerable adults as a routine part of good clinical practice.[37]

Despite its substantial impacts on health, DVA often remains invisible to clinicians.[38] UK studies suggest lifetime DVA prevalence

of 22% among adult attendees at emergency departments[39] and 49% (men) to 69% (women) in patients with severe mental illness.[40] DVA can begin before, during, or after pregnancy and continue afterwards.[41 42] Routine inquiry about DVA by trained staff substantially increases detection (by 2.1% in an antenatal care study[43] and 13.8% in an emergency department study).[44] Perinatal DVA is predicted by social adversities, including early parenthood, inadequate housing, limited education, financial difficulties, substance misuse, and police contact.[45] DVA is associated with child abuse and witnessing DVA is associated with adverse outcomes in children.[30 46]

All clinical contacts, including GP appointments, emergency department attendances, psychiatric, drug, and alcohol assessments, and antenatal care, present opportunities to inquire sensitively about DVA and offer support. Consider asking about current and past DVA when inquiring about mental health, family relationships, and other forms of trauma. Integrate questions about new and continuing DVA into clinical risk assessments and revisit DVA at different times.

What do survivors want from clinicians?

Most women are happy to be asked about DVA,[38 47] even though clinicians cite time constraints, discomfort, and fear of offending patients or partners as common barriers to asking about DVA.[48] An American qualitative study with 27 survivors found that asking about DVA and responding appropriately improved patient trust.[49] A qualitative meta-synthesis of 25 studies found that survivors of IPV wanted clinicians to[50]

- Be sensitive, compassionate, non-judgmental
- Allow time, show patience
- Maintain confidentiality and privacy
- Not pressure them to disclose
- Understand the nature, complexity, and chronicity of DVA
- Respect their wishes
- Support them to make their own decisions
- Address safety concerns
- Offer continuity or follow-up, where possible
- Know about local DVA support services.

How will identifying DVA benefit my patient?

With adequate training, support, and referral pathways, clinicians can increase the identification of DVA,[51] support patients, and connect them to specialist services. One survivor said:

The GP took time when I couldn't see it was abuse to ask me more about my husband's behaviour. They didn't know me well but they were kind, respectful, and listened. This led to counselling, then specialist service support. It was the beginning of a long process, but a crucial step. The GP was the first person to say something seemed wrong, and to suggest I had a right to get help.

Support available includes advocacy (eg, independent domestic violence advisers (IDVAs) in England and Wales), to assess risk, discuss options, and develop safety plans. Engagement with an IDVA is associated with improved safety, including reduced DVA escalation, severity, and recurrence.[52]

Record linkage studies[53] suggest that most domestic assaults presenting to the emergency department are not reported to the police. Refer women at high risk to a multidisciplinary panel, where available (eg, multi-agency risk assessment conferences (MARACs) in the UK), so that police, social services, DVA agencies, and other relevant organisations can share information to enhance safety. Sensitivity is required, however, as survivors' willingness to report DVA to law enforcement agencies may be influenced by wider factors, such as immigration policies and mistrust of the police.[54]

How should I ask?

Although women want to be asked about DVA, they may not disclose it unless asked directly.[49] Disclosure of DVA and accessing support may be influenced by the person's "stage of change" (pre-contemplation, contemplation, preparation, action, maintenance).[55] When asked, some survivors may deny DVA because of fear, stigma, shame, or not identifying their experience as abuse.[7] Asking more than once may enable disclosure. Do not pressure women to disclose but support them to, when ready (see "How should I respond" below). DVA survivors experience an average of 50 incidences of abuse before seeking help.[56] Survivors report being more likely to disclose DVA if they have a trusting relationship with their healthcare professional.[57]

Before asking about DVA, ensure that the space is private (eg, a side room, not a cubicle).[4] You may need a reason to see the woman alone, such as weighing in another room. Address additional barriers: use professional interpreters (not friends, family, or children) and involve support workers for patients with intellectual disabilities. Never ask about DVA in front of other adults or verbal children, in case they inform perpetrators about the disclosure, placing the woman at greater risk.[7]

Practise phrasing questions about DVA to find what feels natural for you; tailor your phrasing to individual cases (box 2).

Box 2: Suggested questions for asking about DVA

Open questions

- How are things at home?

Normalising

- Some people I see with pelvic pain that doesn't get better are having difficulties in other parts of their life. How are things at home?
- Often, depression can be triggered after stressful events in our relationships. Has anything like that happened to you?
- We know violence at home is a problem for many women. Is there anyone who is hurting you?
- Sometimes when women miss appointments, we worry that someone at home might be controlling whether they come to see us. Is anyone stopping you coming to appointments?

Direct

- Do you feel safe at home?
- Does anyone make you feel afraid?
- Do you feel safe in your relationship?
- Is there anything that worries you about your relationship?
- These injuries are more than I would expect following a fall. I'm wondering whether someone else might have hurt you?

Specific questions

- Has your partner ever hit you? Have they kicked you? Have they hurt you physically?
- Does your partner ever force you to have sex or make you feel uncomfortable about sex?

- Does your partner ever put you down or say hurtful things?
- Does your partner control when you can go out, who you see, or how you spend your money?
- Are you allowed to see your friends and family as you want?

How should I respond?

Tailor your response to the individual and avoid stereotyped assumptions about their background, culture, needs, or risks. "LIVES" offers a helpful framework:

- **Listen** closely, with empathy, without judging
- **Inquire** about emotional, physical, social, and practical needs and concerns
- **Validate.** Show you understand, respect, and believe her. Assure her she is not to blame, eg, "thank you for telling me," "support is available," "this is not your fault," or "your (and your children's) safety is a priority."
- **Enhance safety.** Does she feel safe to go home today? What would she do if DVA recurred?
- **Support** her to make her own decisions. Help her access information, services, and social support, as a warm, facilitative referral can increase her readiness to access help.[58] She may prefer you to refer or to self-refer. DVA agencies can provide advocacy and accommodation assistance, reducing risks in a continuing relationship or when planning to leave, safely.

Some women decline referral for specialist support, for example if they are in the pre-contemplation or contemplation stage of change.[55] Although this may feel frustrating, respond non-judgmentally. The time may not be right or she may not be ready to conceptualise her experiences as abusive, even if disclosing DVA provides relief. Listening and providing first-line support can help you work together to meet her needs. Consider whether women declining support are at risk of serious harm (box 3) and require police involvement.

Box 3: Immediate risk of harm

Risks, including femicide, can escalate when the woman tries (or is suspected of planning) to leave, and after separation.[23 59] Other high risk indicators[60-62] include

- Escalating violence
- Substance misuse
- Poor mental health
- Stalking
- Credible threats to kill
- Assault or threatening with a weapon
- Controlling or excessive jealous behaviour
- Assault during pregnancy
- Strangulation

Survivors value continuity of follow-up. Check how she can be contacted again, if safe. Offer a follow-up appointment, where possible, or let her know how to make contact.

How can I prioritise safety?

For many women, DVA is a chronic problem, with dynamic risks. Explore specific concerns about the safety of the woman and other adults and children affected by DVA, and assess whether they are at any immediate risk of harm (box 3). Consider any care and support needs that make adults vulnerable to DVA. For example, physical and intellectual disabilities, mental health problems, and substance misuse influence an adult's ability to protect themselves from DVA. Always take details and inquire about the welfare of children at home. If your service has protocols for "safeguarding" vulnerable patients, consult these and colleagues in leadership roles. In mental healthcare, ensure to take DVA allegations seriously, whether or not they arise during a psychiatric episode.

Women may fear disclosing DVA during pregnancy because of the anticipated involvement of child and family social services, the fear of worsening abuse, or threats to children. Address such concerns by emphasising professionals' focus on making families safer. In some settings, specialist midwives can coordinate antenatal care for women disclosing perinatal DVA.

Deciding to leave an abusive relationship is not straightforward and benefits from specialist support. If a woman cannot safely return home, discuss a safe place she can go instead, or refer her for safe housing (eg, a DVA crisis service or refuge, where available).[7] Depending on the situation and the setting, you may need to involve the police; ensure that you know your legal obligations in your local area.

In the UK, police and DVA specialists complete checklists such as DASH (domestic abuse, stalking, harassment, and honour based violence) to identify perpetrators at high risk of harm.[63] Alternatives include the common risk assessment framework (CRAF) in Australia, and the domestic violence screening inventory—revised (DVSI-R) in the US.[64] Although each DASH item only weakly predicts DVA recurrence,[65] the associated guidance can help you consider risks that women face.[63]

How should I document DVA?

Document DVA disclosures clearly and accurately; records may be used in legal proceedings. Use pictures or body maps to document injuries.

GPs—follow guidance[66] and agree how your practice will code DVA disclosures in survivor and children's notes. DVA must be hidden from accessible online records.[67] Consider whether DVA should be redacted for subject access requests.

Avoid unintended disclosure (eg, avoid documenting DVA in perpetrators' primary care records unless confident that they know about allegations).

Use record alert systems to record safety concerns.

Document DVA risks in your organisation's preferred mental health risk assessment format.

How should I share information?

Where DVA poses a substantial risk to the woman or someone else, you may need to inform other agencies. In the UK, guidance from the General Medical Council,[68] Department of Health,[69] and SafeLives[70] explains how General Data Protection regulations affect information sharing with MARACs.[70]

Discuss with the survivor the need to involve other agencies, emphasising the person's safety.

Seek guidance (see below) if safeguarding concerns warrant breaking confidentiality, eg, where children live with the woman and perpetrator, or an adult's care and support needs (including

mental health and substance use disorders) make them vulnerable to DVA.

Ensure that DVA identified during out-of-hours attendance or inpatient admission is communicated to the patient's continuing care team.

Avoid documenting DVA in handheld maternity records, because of the risks of abusive partners reading them, but ensure to inform their GP.

Use team meetings to share information about risks posed by others.

Consider making DVA a standing agenda item in clinical team meetings.

What should my service do?

Consider what protocols, training, local links, and referral pathways your service needs. For example:

Ensure that staff know how to contact your local DVA agency for referral or advice, and provide clinicians with cards detailing local DVA services. Demonstrating awareness of DVA and the support available may encourage disclosure.

Display information posters in waiting rooms and toilets, in languages spoken by your local community, so that women know how to access help.

Consider covert disclosure systems, eg, placing a sticker on urine samples if wanting to speak privately.

Ensure your service has protocols for inquiring about DVA, safe documentation, and for information sharing with relevant professionals and supporting women to access specialist support. This includes a policy on documentation in perpetrators' records which does not place survivors at risk (see "How should I document DVA?").

Every service needs a DVA lead (box 4).

Box 4: Integrating DVA services into healthcare

DVA services integrated into healthcare can be commissioned by local policy makers (clinical commissioning groups in England). GPs are well placed to communicate local needs to commissioners, for services such as

- In the UK, a scheme ("Identification and referral to improve safety:" IRIS) can link DVA advocate educators based in DVA specialist agencies with primary care.[51]
- In inpatient settings (acute and mental health trusts in England and Wales), hospital independent domestic violence advisers (IDVAs) can identify survivors not identified by community services, and provide intensive support and access to resources. Hospital IDVAs can also provide team training, which should be attended by reception, management, and administrative staff, as well as clinicians.[71]

Leaders and managers should embed and promote safeguarding within the team, empowering staff to discuss DVA and raise concerns.

Many healthcare staff experience DVA.[72] Team leaders should foster an open culture, and be trained to detect signs of survivorship or perpetration, and how to respond. Consider a policy outlining how to support staff and address perpetration allegations.

Even if not personally affected, support and advice from safeguarding leads can help staff to navigate complex cases involving DVA.

Education into practice

- What protocol does your service have for safely asking about DVA and managing a disclosure?
- What local support services and information can you offer a patient disclosing DVA?
- Think about the last time you suspected that a patient was experiencing DVA. What helped you or stopped you from asking more? What could you do next time to facilitate a conversation about their needs?

How survivors were involved in the creation of this article

- Author UL contributed to writing and editing this article as a representative of the DVA voluntary sector and individuals with lived experience. Her perspective is based on many years' professional experience within the DVA sector.
- UL added points about the benefits of clinician education, the mental health impact of DVA, the need for understanding of the stages of change, the importance of documentation, and keeping DVA on clinical team agendas, the risk of domestic homicide, the experiences of pregnant women, the need to collaborate with local DVA agencies, and the potential for clinical staff to be both survivors and perpetrators.

Questions for future research

- Should women attending the antenatal booking appointment unaccompanied be part of routine practice?
- What influence has covid-19 had on disclosure of DVA?
- What are the impacts of distancing measures on the health and wellbeing of DVA survivors?
- How can healthcare services support DVA survivors while working differently, such as through remote consulting?

Additional educational resources

- King's College London. Linking abuse and recovery through advocacy for victims and perpetrators (LARA-VP): https://www.kcl.ac.uk/psychology-systems-sciences/research/lara-vp-download-form
- BMJ Learning. Domestic violence and abuse: asking and responding to women. https://learning.bmj.com/learning/module-intro/-women-domestic-abuse.html?moduleId=5003147&searchTerm=%E2%80%9Cdomestic%20violence%E2%80%9D&page=1&locale=en_GB
- Ades V, Goddard B, Ayala SP, Greene JA. Caring for long term health needs in women with a history of sexual trauma. *BMJ* 2019;367:l5825.
- Kirby N, Kilsby A, Walker R. Assessing low mood during pregnancy. *BMJ* 2019;366:l4584.
- National Institute for Health and Care Excellence. Domestic violence and abuse NICE pathway 2014. https://pathways.nice.org.uk/pathways/domestic-violence-and-abuse
- RESPONDS. Training for primary care professionals in safeguarding. 2015. http://www.bristol.ac.uk/primaryhealthcare/researchthemes/responds/training-pack/2015-06-24/

Information resources for patients (free and do not require registration)

- Women's Aid. https://www.womensaid.org.uk/information-support/
- Refuge. https://www.refuge.org.uk/get-help-now/
- Specific regional agencies for ethnic minority groups listed at IMKAAN. https://www.imkaan.org.uk/get-help
- Karma Nirvana. Support for victims of honour based abuse and forced marriage. https://karmanirvana.org.uk/help/

- Respect Men's advice line. https://mensadviceline.org.uk/
- Healthtalk.org. Women's experiences of domestic violence and abuse. 2020. https://healthtalk.org/womens-experiences-domestic-violence-and-abuse/getting-help-from-doctors-and-other-health-professionals-for-domestic-violence-and-abuse

How this article was created

This article was written collaboratively, including some content from the relevant BMJ Learning module before adding evidence based content relevant to clinical general practice, emergency medicine, women's health, and mental health services. Survivor perspectives were incorporated through the contributions of author Ursula Lindenberg. Medline searches were used to identify the latest epidemiological evidence for the section, "who experiences DVA?" using search terms pertaining to "domestic violence," "domestic abuse," and "risk factors." Expert perspectives were obtained from Joy Shacklock.

Acknowledgments: Thank you to Joy Shacklock for helpful and instructive comments and to Louise Howard and Gene Feder for their support and encouragement of this article.

Competing interests: We have read and understood the *BMJ* policy on declaration of interests and declare no competing interests.

Further details of *The BMJ* policy on financial interests are here: https://www.bmj.com/about-bmj/resources-authors/forms-policies-and-checklists/declaration-competing-interests

Provenance and peer review: commissioned, based on an idea by the authors; externally peer reviewed.

1 Office for National Statistics. Domestic abuse in England and Wales overview: November 2020. 2020. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2020.
2 Fraser E. Impact of covid-19 pandemic on violence against women and girls London, UK: VAWG helpdesk. 2020. https://www.sddirect.org.uk/media/1881/vawg-helpdesk-284-covid-19-and-vawg.pdf.
3 Sherif D. Covid-19 and the surge in domestic abuse in the UK Centre for Women's Justice 2020. https://www.centreforwomensjustice.org.uk/new-blog-1/2020/11/10/covid-19-and-surge-in-domestic-abuse-in-uk.
4 World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines 2013. https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf;jsessionid=E19DCC3CDAB9BE390EE6F8360C6F1D7E?sequence=1.
5 World Health Organization. RESPECT women: preventing violence against women. 2019. https://www.who.int/reproductivehealth/publications/preventing-vaw-framework-policymakers/en/.
6 World Health Organization. Caring for women subjected to violence: a WHO curriculum for training health-care providers. 2019. www.who.int/reproductivehealth/publications/vaw-curriculum/en.
7 World Health Organization. Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. 2014.
8 Rutherford A, Zwi AB, Grove NJ, Butchart A. Violence: a glossary. *J Epidemiol Community Health* 2007;61:676-80. doi: 10.1136/jech.2005.043711 pmid: 17630364
9 UK Home Office. Information for local areas on the change to the definition of domestic violence and abuse. 2013. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/142701/guide-on-definition-of-dv.pdf.
10 Office for National Statistics. Domestic abuse prevalence and trends, England and Wales: year ending March 2019. 2019. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseprevalenceandtrendsenglandandwales/yearendingmarch2019.
11 World Health Organization. Violence against women. 2017. https://www.who.int/en/news-room/fact-sheets/detail/violence-against-women.
12 National Rural Crime Network. Captive & controlled: domestic abuse in rural areas. 2019. https://www.nationalruralcrimenetwork.net/news/captivecontrolled/.
13 SafeLives. Who are the victims of domestic abuse? 2020. https://safelives.org.uk/policy-evidence/about-domestic-abuse/who-are-victims-domestic-abuse.
14 Hutchinson S, Page A, Sample E. Rebuilding shattered lives: the final report. St Mungo's; 2014. https://www.mungos.org/publication/rebuilding-shattered-lives-final-report/.
15 Magić J, Kelley P. Recognise and respond: strengthening advocacy for LGBT+ survivors of domestic abuse. Galop. 2019. http://www.galop.org.uk/wp-content/uploads/Galop_RR-v4a.pdf.
16 SafeLives. (2017). Your choice: 'honour'-based violence, forced marriage and domestic abuse. 2017. https://safelives.org.uk/sites/default/files/resources/Spotlight%20on%20HBV%20and%20forced%20marriage-web.pdf.
17 Kelly J, Morgan T. Coronavirus: Domestic abuse calls up 25% since lockdown, charity says. *BBC News* 2020. https://www.bbc.co.uk/news/uk-52157620.
18 Graham-Harrison E, Giuffrida A, Smith H, Ford L. Lockdowns around the world bring rise in domestic violence. *The Guardian* 2020. https://www.theguardian.com/society/2020/mar/28/lockdowns-world-rise-domestic-violence.
19 Roesch E, Amin A, Gupta J, García-Moreno C. Violence against women during covid-19 pandemic restrictions. *BMJ* 2020;369:m1712. doi: 10.1136/bmj.m1712 pmid: 32381644
20 Royal College of General Practitioners. COVID-19 and Safeguarding. 2020.
21 IRISi. Guidance for general practice teams responding to domestic abuse during telephone and video consultations. 2020.
22 Hester MJ. Who does what to whom? Gender and domestic violence perpetrators in English police records. *Eur J Criminol* 2013;10:623-37doi: 10.1177/1477370813479078
23 World Health Organization. Understanding and addressing violence against women. 2012. https://www.who.int/reproductivehealth/topics/violence/vaw_series/en/.
24 Bewley S, Welch J. *ABC of domestic and sexual violence*. John Wiley & Sons, 2014.
25 World Health Organization. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. 2013.
26 Campbell JC. Health consequences of intimate partner violence. *Lancet* 2002;359:1331-6. doi: 10.1016/S0140-6736(02)08336-8 pmid: 11965295
27 Coker AL, Smith PH, Bethea L, King MR, McKeown RE. Physical health consequences of physical and psychological intimate partner violence. *Arch Fam Med* 2000;9:451-7. doi: 10.1001/archfami.9.5.451 pmid: 10810951
28 García-Moreno C, Pallitto C, Devries K, Stöckl H, Watts C, Abrahams N. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence: World Health Organization; 2013. https://apps.who.int/iris/bitstream/handle/10665/85239/9789241564625_eng.pdf?sequence=1.
29 Cloitre M, Stolbach BC, Herman JL, etal. A developmental approach to complex PTSD: childhood and adult cumulative trauma as predictors of symptom complexity. *J Trauma Stress* 2009;22:399-408. doi: 10.1002/jts.20444 pmid: 19795402
30 Howarth E, Moore THM, Welton NJ, etal. IMPRoving Outcomes for children exposed to domestic VIolencE (IMPROVE): an evidence synthesis. *Public Health Research* 2016;4:1-342. doi: 10.3310/phr04100 pmid: 27977089
31 Van der Kolk B. The body keeps the score: Mind, brain and body in the transformation of trauma: Penguin UK; 2014.
32 Holly J. Mapping the maze: Services for women experiencing multiple disadvantage in England and Wales. London; 2017.
33 Hall M, Chappell LC, Parnell BL, Seed PT, Bewley S. Associations between intimate partner violence and termination of pregnancy: a systematic review and meta-analysis. *PLoS Med* 2014;11:e1001581. doi: 10.1371/journal.pmed.1001581 pmid: 24409101
34 Boyle A, Jones P, Lloyd S. The association between domestic violence and self harm in emergency medicine patients. *Emerg Med J* 2006;23:604-7. doi: 10.1136/emj.2005.031260 pmid: 16858090
35 Parr JM, Kavanagh DJ, Young RM, McCafferty K. Views of general practitioners and benzodiazepine users on benzodiazepines: a qualitative analysis. *Soc Sci Med* 2006;62:1237-49. doi: 10.1016/j.socscimed.2005.07.016 pmid: 16143440
36 Feder G, Ramsay J, Dunne D, etal. How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technol Assess* 2009;13:iii-iv. doi: 10.3310/hta13160 pmid: 19272272
37 National Institute for Health and Care Excellence. Domestic violence and abuse. NICE Pathway 2014. https://pathways.nice.org.uk/pathways/domestic-violence-and-abuse.
38 Richardson J, Coid J, Petruckevitch A, Chung WS, Moorey S, Feder G. Identifying domestic violence: cross sectional study in primary care. *BMJ* 2002;324:274. doi: 10.1136/bmj.324.7332.274 pmid: 11823360
39 Boyle A, Todd C. Incidence and prevalence of domestic violence in a UK emergency department. *Emerg Med J* 2003;20:438-42. doi: 10.1136/emj.20.5.438 pmid: 12954683
40 Khalifeh H, Moran P, Borschmann R, etal. Domestic and sexual violence against patients with severe mental illness. *Psychol Med* 2015;45:875-86. doi: 10.1017/S0033291714001962 pmid: 25180908
41 Lewis G, Drife J. Why mothers die: report from the confidential enquiries into maternal deaths in the UK (1997/9). London; 2001.
42 Daoud N, Urquia ML, O'Campo P, etal. Prevalence of abuse and violence before, during, and after pregnancy in a national sample of Canadian women. *Am J Public Health* 2012;102:1893-901. doi: 10.2105/AJPH.2012.300843 pmid: 22897526
43 Bacchus L, Mezey G, Bewley S, Haworth A. Prevalence of domestic violence when midwives routinely enquire in pregnancy. *BJOG* 2004;111:441-5. doi: 10.1111/j.1471-0528.2004.00108.x pmid: 15104607
44 Morrison J, Chunsuwan I, Bunnag P, Gronholm PC, Lockwood Estrin G. Thailand's national universal developmental screening programme for young children: action research for improved follow-up. *BMJ Glob Health* 2018;3:e000589. doi: 10.1136/bmjgh-2017-000589 pmid: 29564160
45 Bowen E, Heron J, Waylen A, Wolke D, Team ASALSPAC Study Team. Domestic violence risk during and after pregnancy: findings from a British longitudinal study. *BJOG* 2005;112:1083-9. doi: 10.1111/j.1471-0528.2005.00653.x pmid: 16045522
46 Herrenkohl TI, Sousa C, Tajima EA, Herrenkohl RC, Moylan CA. Intersection of child abuse and children's exposure to domestic violence. *Trauma Violence Abuse* 2008;9:84-99. doi: 10.1177/1524838008314797 pmid: 18296571

47 Boyle A, Jones PB. The acceptability of routine inquiry about domestic violence towards women: a survey in three healthcare settings. *Br J Gen Pract* 2006;56:258-61.pmid: 16611513

48 Beynon CE, Gutmanis IA, Tutty LM, Wathen CN, MacMillan HL. Why physicians and nurses ask (or don't) about partner violence: a qualitative analysis. *BMC Public Health* 2012;12:473. doi: 10.1186/1471-2458-12-473 pmid: 22721371

49 Battaglia TA, Finley E, Liebschutz JM. Survivors of intimate partner violence speak out: trust in the patient-provider relationship. *J Gen Intern Med* 2003;18:617-23. doi: 10.1046/j.1525-1497.2003.21013.x pmid: 12911643

50 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;166:22-37. doi: 10.1001/archinte.166.1.22 pmid: 16401807

51 Feder G, Davies RA, Baird K, etal. Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. *Lancet* 2011;378:1788-95. doi: 10.1016/S0140-6736(11)61179-3 pmid: 22000683

52 SafeLives. Safety in numbers: a multi-site evaluation of independent domestic violence advisors. 2009. https://safelives.org.uk/sites/default/files/resources/Safety_in_Numbers_full_report.pdf.

53 Boyle A, Kirkbride J, Jones P. Record linkage of domestic assault victims between an emergency department and the police. *J Epidemiol Community Health* 2005;59:909-10. doi: 10.1136/jech.2004.028597 pmid: 16166369

54 Amuedo-Dorantes C, Arenas-Arroyo E. Police trust and domestic violence among immigrants: evidence from VAWA self-petitions. *J Econ Geogr* 2021; doi: 10.1093/jeg/lbab007

55 Reisenhofer SA, Hegarty K, Valpied J, Watson LF, Davey M-A, Taft A. Longitudinal changes in self-efficacy, mental health, abuse, and stages of change, for women fearful of a partner: findings from a primary care trial (weave). *J Interpers Violence* 2019;34:337-65. doi: 10.1177/0886260516640781 pmid: 27036157

56 Walby S, Allen J. Domestic violence, sexual assault and stalking: Findings from the British Crime Survey: Home Office. 2004. http://nomsintranet.org.uk/roh/official-documents/HomeOfficeResearchStudy276.pdf.

57 Rose D, Trevillion K, Woodall A, Morgan C, Feder G, Howard L. Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *Br J Psychiatry* 2011;198:189-94. doi: 10.1192/bjp.bp.109.072389 pmid: 21160053

58 Ghandour RM, Campbell JC, Lloyd J. Screening and counseling for Intimate Partner Violence: a vision for the future. *J Womens Health (Larchmt)* 2015;24:57-61. doi: 10.1089/jwh.2014.4885 pmid: 25405270

59 Campbell JC, Webster D, Koziol-McLain J, etal. Risk factors for femicide in abusive relationships: results from a multisite case control study. *Am J Public Health* 2003;93:1089-97. doi: 10.2105/AJPH.93.7.1089 pmid: 12835191

60 Reducing the Risk. Reducing the risk of domestic abuse. Identifying risk indicators. 2020. https://reducingtherisk.org.uk/

61 Monckton Smith J. Intimate partner femicide: using Foucauldian analysis to track an eight stage progression to homicide. *Violence Against Women* 2019;1077801219863876. doi: 10.1177/1077801219863876 pmid: 31378158

62 Snider C, Webster D, O'Sullivan CS, Campbell J. Intimate partner violence: development of a brief risk assessment for the emergency department. *Acad Emerg Med* 2009;16:1208-16. doi: 10.1111/j.1553-2712.2009.00457.x pmid: 20053241

63 SafeLives. SafeLives dash risk checklist: quick start guidance. 2014. https://safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL.pdf.

64 McCulloch J, Maher J, Fitz-Gibbon K, Segrave M, Roffee J. *Review of the Family Violence Risk Assessment and Risk Management Framework (CRAF).* Monash University, 2016.

65 Turner E, Medina J, Brown G. Dashing hopes? The predictive accuracy of domestic abuse risk assessment by police. *Br J Criminol* 2019;59:1013-34doi: 10.1093/bjc/azy074

66 Feder G, Potter L, Johnson M. Guidance on recording of domestic violence and abuse information in general practice medical records. 2017. https://www.rcgp.org.uk/clinical-and-research/resources/toolkits//-/media/Files/CIRC/Toolkits-2017/Safeguarding-adults-at-risk-Toolkit/Guidance-on-recording-of-domestic-violence-June-2017.ashx.

67 Dheensa S. Recording and sharing information about domestic violence/abuse in the health service. Pathfinder project: University of Bristol; 2020. https://research-information.bris.ac.uk/en/publications/recording-and-sharing-information-about-domestic-violenceabuse-in.

68 General Medical Council. Confidentiality: good practice in handling patient information. 2017. https://www.gmc-uk.org/-/media/documents/gmc-guidance-for-doctors-confidentiality-good-practice-in-handling-patient-information--70080105.pdf?la=en&hash=08E96AC70CEE25912CE2EA98E5AA3303EADB5D88.

69 Department of Health. "Striking the balance": Practical guidance on the application of Caldicott guardian principles to domestic violence and MARACs (Multi Agency Risk Assessment Conferences). 2012. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/215064/dh_133594.pdf.

70 SafeLives. The General Data Protection Regulation (GDPR): a briefing for Maracs. 2018. https://safelives.org.uk/sites/default/files/resources/GDPR%20Briefing%20for%20Maracs__0.pdf.

71 Halliwell G, Dheensa S, Fenu E, etal. Cry for health: a quantitative evaluation of a hospital-based advocacy intervention for domestic violence and abuse. *BMC Health Serv Res* 2019;19:718. doi: 10.1186/s12913-019-4621-0 pmid: 31638998

72 McLindon E, Humphreys C, Hegarty K. "It happens to clinicians too": an Australian prevalence study of intimate partner and family violence against health professionals. *BMC Womens Health* 2018;18:113. doi: 10.1186/s12905-018-0588-y pmid: 29940948