

**Routine Enquiry about  
Domestic Violence in General  
Practices: a Pilot Project**

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# Chapter One ~ Introduction

## About this report

This report is based on a pilot programme that introduced routine enquiry about domestic violence into self-selected General Practices in Gateshead and South Tyneside. The aims of the pilot were to:

- raise the GPs' awareness of issues related to domestic violence;
- introduce in GP surgeries a routine method of asking about domestic violence;
- develop a simple monitoring system to evaluate the effect of GPs routinely asking about domestic violence and to provide a measure of prevalence and incidence of domestic violence; and
- monitor the implementation of the domestic violence enquiry programme.

In the longer term, the findings will inform the rolling out of the domestic violence enquiry programme across all General Practices in Gateshead and South Tyneside.

Chapter one of this report outlines the previous literature regarding the impact domestic violence has on women's health and research on routinely enquiry about domestic violence. The second chapter describes the how the pilot project was implemented and the research methods used. Chapters three, four and five report the project's findings and chapter six concludes and offers recommendations.

## Domestic violence in the UK

Since the grassroots feminist campaigns of the 1970s and 1980s awareness has been steadily growing in the UK about domestic violence. The early 1990s saw changes to the criminal justice system regarding its responses to women who report domestic violence, and in the latter part of the 1990s the healthcare system began to acknowledge the role it could play in responding to domestic violence (e.g. Richardson and Feder, 1997; British Medical Association, 1998). Although there is still a long way to go to ensure that women experiencing domestic violence get the support they need, the situation at the beginning of the 21<sup>st</sup> century shows a marked shift from the earlier position of domestic violence being solely a 'woman's problem' to it being a problem that all agencies – both statutory and voluntary – should make a co-ordinated effort to combat.

Domestic violence is defined by the Department of Health (2000) in their Guidance Manual as:

*'... a continuum of behaviour ranging from verbal abuse, through threats and intimidation, manipulative behaviour, physical and sexual assault, to rape and even homicide. The vast majority of such violence, and the most severe and chronic incidents, are perpetrated by men against women and children.'* (p v)

Research shows that almost one in four women in England and Wales between the ages of 16 and 59 have been assaulted at least once by a partner or ex-partner (Home

Office, 1999). Domestic violence accounts for one quarter of all violent crime (Home Office, 1998) and this violence ends in death for an average of two women per week (Home Office and Cabinet Office, 1999). Therefore, for some women, living with domestic violence is both a health threatening and life threatening experience:

*'It is clear that a significant proportion of the women who live with men have had their health diminished or even destroyed by violence'* (Doyal, 1995, p 54)

## **Domestic violence and health**

Research into the health consequences of domestic violence highlights the important role healthcare professionals have to play in supporting victims and survivors of domestic violence. Much of the knowledge we have about domestic violence and health comes from research conducted in the USA, although important work has also been conducted in the UK over the last few years. The research shows that:

- Women may be more likely to disclose domestic violence to a health care professional than to the police. Research shows that women are assaulted an average of 35 times before they report it to the police (Yearnshire, 1997). The Department of Health (2000) have recognised the vital role health care professionals may be able to play in relation to domestic violence; *'Early intervention can prevent an abusive situation becoming worse and the level of violence becoming more intense.'*
- Domestic violence causes a wide range of serious physical injuries. Individuals experiencing domestic violence are more likely to be injured than victims of other forms of violence. Nearly one third of domestic violence cases reported to the British Crime Survey required medical attention, 69% of incidents led to an injury and 13% resulted in broken bones (British Crime Survey, 1996). Women who experience domestic violence sustain a wide range of injuries. A study of women who were visiting their GP because of domestic violence found that the injuries reported include: bruising, cuts, black eyes, internal injuries, miscarriages, burst eardrums, broken jaws, noses and cheekbones and burns (Stanko et al, 1998).
- Domestic violence often starts or escalates during pregnancy (Mezey, 1997; Royal College of Midwives, 1997). One study of women who had experienced domestic violence showed that a third had been hit while they were pregnant (McWilliams and McKiernan 1993). In 1998 the Department of Health recognised that maternal and child morbidity and mortality in relation to domestic violence had in the past often been overlooked (p 159).
- Domestic violence may lead to women experiencing mental health issues. Physical abuse is just one form of domestic violence, and women experiencing domestic violence may experience a range of different forms of violence and abuse including sexual, emotional and/or financial abuse. Cascardi, O'Leary and Schlee (1999) reviewed fourteen studies that showed the rate of depression among women who were experiencing domestic violence to be between 38 and 83 per cent. A review of thirteen studies about domestic violence and suicide led Golding (1999) to conclude that there is a heightened prevalence of suicide

attempts among women who are experiencing domestic violence. Because many women will recover from their mental health issues after leaving the violent relationship (Surtees, 1995), Humpreys and Thiara (2003) emphasise that '*Domestic violence is not just one of many problems, but an issue that requires addressing as a primary concern*' (pg. 223).

- There are also secondary health implications for women who have experienced domestic violence. Research shows that women who have survived domestic violence are more likely to abuse alcohol and drugs (Stark and Flitcraft, 1996) and may show signs of Post Traumatic Stress Disorder (PTSD) (Fischbach and Herbert, 1997). These symptoms are more prevalent for women who have fled domestic violence and are residing in a domestic violence refuge than for those who are using community resources (Saunders, 1994). In cases where PTSD and depression co-occur after leaving domestic violence this can cause long-term problems for women's mental health (Freedman, Brandes, Peri, and Shalev, 1999).

### **The local picture**

Previous research in South Tyneside carried out by Hester, Westmarland and Hughes in 2001 estimated that around one in seven women had experienced domestic violence in the previous 12 months. As part of the research interviews were conducted with twenty women and one man who had experienced domestic violence, thirty agencies were surveyed and twenty-four professionals were interviewed.

With regard to healthcare issues, the women who had experienced domestic violence reported that the health visitors had a good understanding of the issues they faced and the health visitors themselves explained that they were able to apply their training on child abuse to understand the situation adult women in violent relationships faced. The GPs, however, were found to have a poor understanding of the issues involved, offered no definition of domestic violence, and were not aware of the domestic violence guidelines issued by the Department of Health.

Although some of the women in South Tyneside who had used their GPs in relation to domestic violence found them helpful, there were also women who felt they had not been given the help they needed:

*'I stood in the doctor's surgery with two black eyes a broken nose and black hand marks around my neck where he had tried to strangle me and I sat for an hour and a half I wasn't referred anywhere'* (Service user)

*'The GP surgery was absolutely horrible. He was ignorant, he didn't even look up from the desk ...'* (Service user)

These quotes indicated the need for some GPs to be more aware of the issues women experiencing domestic violence face in relation to their health care needs. Concern was also raised that some GPs may be putting women's safety at further and unnecessary risk. One woman described a situation where she had left her violent partner, taken her children to a refuge in South Tyneside and then realised she had left her Hormone Replacement Therapy at home. When she visited a GP in South

Tyneside and explained the situation she was refused a repeat prescription and one of her children had to return to the house they had just fled from to pick up her HRT. This example shows that a lack of understanding about the seriousness of domestic violence can put women and children at a serious risk of harm.

Although the problems described above are not confined to the South Tyneside area, these previous research findings were one of the push factors towards the funding of the pilot programme on which this report is based. Both South Tyneside and Gateshead Primary Care Trusts in funding the programme recognised the health impact of domestic violence and also the role that GPs and Primary Health Care Teams can play.

### **Asking about domestic violence - routine enquiry**

Routine enquiry or 'asking about domestic violence' allows women to disclose their experiences of domestic violence so that they may be given the appropriate health care or be referred to other agencies. Routine enquiry regarding domestic violence is recommended by the Department of Health and involves '*asking about the experience of domestic violence of all people within certain parameters*' regardless of visible signs of abuse (Department of Health, 2000, para 3.11).

In previous studies it has been found that between 45-90 per cent of service users agreed that they should be routinely asked about domestic violence. Gielen et al (2000) found that 48 per cent of women agreed that health providers for domestic violence should routinely enquire, with those abused being 1.5 times as likely to support the policy than non-abused women. Higher support was found by Caralis and Musialowski (1997) who reported 85 per cent of the women in their sample supporting routine enquiry policies and Ferris (1994) who found that 90 per cent of women supported such a policy.

Routinely asking about domestic violence has also been examined from the perspective of health care providers. While most studies show fairly widespread support among women for domestic violence routine enquiry policies, health care professionals perceive it as more problematic. This is exemplified by one piece of research that found while the majority of female patients were in support of routine enquiry, the majority of doctors were not (Friedman et al, 1992). Research by Abbott et al. (1995) in the USA found only 13% of women attending hospital emergency rooms for injuries caused by domestic violence were questioned about the cause of their injuries. Also in the USA, Waalen et al. (2000) conducted a meta-analysis of twelve studies related to domestic violence and routine enquiry and looked at some of the main reasons given by health care professionals as to why they did not generally ask their patients about domestic violence. Health care providers reported the main barriers to routine enquiry as a lack of training, lack of time, and a lack of knowledge about appropriate interventions if domestic violence was revealed. Other issues frequently mentioned referred to patient-related factors, for example fear of offending the patient.

In Waalen et al's meta-analysis (2000) they found that educational interventions alone did not improve the enquiry rate. However, when education was combined with other interventions (e.g. providing information on how to ask questions) most studies showed a statistically significant increase in the number of patients asked or the number of patients disclosing violence.

Ramsay et al. (2002) conducted a systematic review for the UK National Screening Committee. They reviewed 20 papers based on 17 studies<sup>1</sup> and found that although screening for domestic violence would be likely to increase the number of women identified as experiencing domestic violence there is no evidence of the effectiveness or safety of subsequent interventions. This led them to conclude that it would be premature to introduce screening programmes for domestic violence in healthcare settings. Taket et al. (2003) accept there is little research about the outcomes of those who are asked about domestic violence, but argue there is a substantial amount of qualitative evidence pointing to the benefits of routine enquiry for women. They highlight that routine enquiry is one way of ensuring that women can get information about and access to specialised support services. Although they agree with Ramsay et al. that women's safety should be a priority, Taket et al. argue that this concern can be overcome when those who routinely enquire are properly trained and have protocols in place that prioritise safety. This was also the conclusion reached by Mezey et al. (2002) who found that both midwives and women patients found routine enquiry acceptable but only when such enquiry was conducted in a safe environment with support systems in place.

With regard to *routine* enquiry, it has been found that routinely asking women about domestic violence is more appropriate than 'ad hoc' enquiry that may rely on stereotypical views around which groups of women are likely to experience domestic violence. Routinely asking gives the message that it is acceptable to disclose domestic violence and that no-one is being specifically targeted for enquiry (which could have safety implications) (Hester and Pearson, 1998).

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<sup>1</sup> From North America, Australia and New Zealand - no UK studies met their inclusion criteria



## Chapter Two ~ Research design and methods

Ten GPs from four surgeries took part in the pilot project – three surgeries from the Gateshead area and one from South Tyneside. The surgeries were self-selecting and GPs interested in being involved in the project were invited to a meeting to discuss the project in greater detail.

The research was conducted over a nine-month period to allow the programme to be implemented and become embedded into practice. It was divided into three phases: ‘pre-asking’ (before the GPs had been trained about domestic violence); ‘training’ (two training days) and; ‘starting to ask’ (monitoring what happened after the GPs were trained and started asking about domestic violence).

The British Sociological Association’s code of ethical conduct was followed throughout the research and everyone involved in the research was assured that their responses would remain confidential and be anonymous in the report.

### **Phase 1: Pre-asking**

The pre-asking phase took place before the GPs were trained and consisted of interviewing GPs and conducting a patient survey.

**Interviews with GPs** – Semi-structured interviews were conducted with all ten GPs taking part in the research programme (seven GPs were male and three were female). The interviews took place in their surgeries and the GPs were guaranteed anonymity and confidentiality. The interviews included questions about the GPs views regarding the impact of domestic violence on the health of their patients, their previous experiences (if any) with patients who have experienced domestic violence, the actions they took (if any) when suspecting domestic violence and their views on domestic violence screening.

**Patient questionnaires** – Questionnaires were distributed across the surgeries and left in reception areas to be filled in by female and male patients aged 16 years or over. The questionnaire was designed to assess the patients’ views on how comfortable they would feel about being routinely asked about domestic violence and how comfortable they would feel about discussing domestic violence with their GP. Patients were also asked to identify if they had ever experienced or perpetrated domestic violence, and if they had ever been asked about domestic violence by their GP. A total of 621 questionnaires were completed by patients of the participating GPs and inputted and analysed using SPSS.

### **Phase 2: Training**

The training consisted of two full days (10am – 4.30pm) and focused on: raising the GPs’ understanding of domestic violence; highlighting the impact domestic violence has on health; learning and practicing how to ask about domestic violence; and what to do if violence was disclosed. The training was carried out by the research team who have experience of training professionals in the area of domestic violence and it was informed by previous research on asking about domestic violence in healthcare settings and by the responses given by patients and GPs in the first phase. The Head

of Community Safety and area domestic violence co-ordinators attended both training days. In light of national research showing that almost one in four women have experienced domestic violence (Home Office, 1999), it was acknowledged at the start of day one that some of the participants at the training day may be experiencing domestic violence themselves and information was given about domestic violence support services they could discuss this with.

**Training Day One: awareness raising** – The first full training day was centred around raising awareness about domestic violence with a focus on the impact domestic violence has on health. The research team and the GPs thought it was important that all surgery staff should be involved in the domestic violence awareness raising training and the 31 participants present at the first day included GPs, practice managers, practice nurses, health visitors, other health care professionals, receptionists and other administrative staff.

The following topics were covered throughout the day:

- Welcome – introduction to the research team, overview of project
- Developing a common understanding of domestic violence and introduction to the Duluth Power and Control Wheel ([www.duluth-model.org](http://www.duluth-model.org)).
- Presentation based on recent research - Domestic violence, the consequences and concerns for a healthy society.
- Challenging the myths around domestic violence.
- Domestic violence case studies raising issues for GP surgeries.
- Conclusions – summary of day one

It was very difficult arranging a full day when all ten GPs could be available. Despite offers of funding from the PCT for locum cover only five of the ten GPs were able to attend the first training day. Originally the project plan had been to admit onto the project only those GPs who could attend both training days, however this plan proved unrealistic in practice when it became clear that it would be impossible to get all ten GPs together for two full days. The requirements were therefore changed to offer individual awareness-raising sessions with the GPs who could not attend the first training day. The second day remained mandatory for inclusion in the project.

The individual training sessions were a condensed version of the training day and were delivered to the five GPs who did not attend day one by the Head of Community Safety and an area Domestic Violence Co-ordinator.

**Training Day Two: learning to ask** – The second day of training focused on introducing GPs to ways of asking about domestic violence and what to do if violence was disclosed. The 19 participants were made up of all ten GPs and practice nurses who would be involved more directly in asking about domestic violence and dealing with disclosures (administrative staff did not attend this training).

The following topics were covered:

- Presentation - results from Phase One patient survey.
- Asking the question, considering the barriers to asking.
- Role-plays on asking the question, how and when to safely ask.

- Presentation – Area domestic violence co-ordinators outlined the local agencies and explained the services available. Flow charts given to GPs to take back to their surgeries showing who should be referred where and when.
- Group work – Case studies - what to do if violence is disclosed, using local agencies.
- Group work – Case studies - thinking about safety and safety planning.
- Conclusions – summary of day two.

At the end of day two the GPs agreed on a date to start asking about domestic violence and agreed the information they would record for monitoring purposes.

### **Phase 3: Starting to ask**

After the GPs had been trained they began to ask female patients aged 16 and over about domestic violence. Male patients were not asked about domestic violence because research shows that the majority of those who experience domestic violence are female so it was thought that a pilot study should focus only on women. Moreover, the services available in Gateshead and South Tyneside are mainly focused towards supporting women who have experienced domestic violence and specialist support for men is limited.

**Monitoring of asking and disclosures** – a simple system was devised that would enable GPs to record the asking process with their patients on their existing recording system - the computer patient record screen. They were asked to record whether the patient was asked, if they disclosed, and who perpetrated the violence. The questions were written in a way so that if a future visit by the woman to the GP included her partner, the partner would not be able to ascertain that questions had been asked about domestic violence nor any answers provided. The monitoring figures were due to be collated after month one and month two of asking, however as shown later in this report, the information was not always collected and/or made available to the research team.

**Interviews with GPs** – Two further sets of semi-structured interviews were conducted with the GPs approximately one month and two months after they had begun the asking process. The interviews included questions regarding their learning experiences from the two training days, current attitudes to routine asking, number of disclosures, and the identification of any problems experienced. The interviews were designed not only to monitor the use of domestic violence enquiry but also to provide support to GPs and offer advice on any issues or questions that had emerged since the training.

**Patient questionnaires** – GPs were also asked to hand a small questionnaire to women who they had asked about domestic violence, regardless of whether they had disclosed domestic violence or not. By the end of the research period the response rate had been low to this questionnaire. Each surgery was given 25 questionnaires to distribute and one surgery returned all 25 questionnaires, two surgeries' questionnaires were thought to have been returned but were not received by the research team and the fourth surgery did not respond.

## Chapter Three ~ Pre-asking

### The patients' views on being asked about domestic violence

A total of 621 patients from across the four participating surgeries completed the pre-asking patient surveys. Nearly three quarters of the patients who responded were female patients (n=433, 71%). A sample of male patients also responded (n=178, 29%). (See Appendix One for demographic characteristics for those who completed the surveys).

Table 3.1 (below) shows that around three quarters of the patients (73% of women and 75% of men) thought it would be helpful to ask all patients about domestic violence. Only a minority of patients (9% of women and 12% of men) thought that it would not be helpful to ask all patients about domestic violence.

<b>Table 3.1 Do you think it would be helpful to ask all patients about domestic violence? (N=604)</b>			
<b>Patient gender</b>	<b>Yes</b>	<b>No</b>	<b>Don't know</b>
Female (n=429)	315 (73%)	39 (9%)	75 (17%)
Male (n=175)	132 (75%)	21 (12%)	22 (13%)
<b>Total</b>	<b>447 (74%)</b>	<b>60 (10%)</b>	<b>97 (16%)</b>

Similarly, very few patients (7% of women and 13% of men) said that they would feel offended if their GP asked them about domestic violence (see Table 3.2 below).

<b>Table 3.2 Would you feel offended if your GP asked you about domestic violence? (n=608)</b>			
<b>Patient gender</b>	<b>Yes</b>	<b>No</b>	<b>Don't know</b>
Female (n=430)	31 (7%)	347 (81%)	52 (12%)
Male (n=178)	23 (13%)	134 (75%)	21 (12%)
<b>Total</b>	<b>54 (9%)</b>	<b>481 (79%)</b>	<b>73 (12%)</b>

Table 3.3 (below) shows that around three quarters of the patients (76% of women and 73% of men) responded that they would feel comfortable discussing domestic violence with their GP. Male patients were twice as likely as female patients to say they would not feel comfortable discussing domestic violence with their GP.

<b>Table 3.3 Would you feel comfortable discussing domestic violence with your GP? (n=610)</b>			
<b>Patient gender</b>	<b>Yes</b>	<b>No</b>	<b>Don't know</b>
Female (n=433)	330 (76%)	29 (7%)	74 (17%)
Male (n=177)	129 (73%)	24 (14%)	24 (14%)
<b>Total</b>	<b>459 (75%)</b>	<b>53 (9%)</b>	<b>98 (16%)</b>

The majority of patients (58% of women and 63% of men), regardless of their gender, said that if they wanted to discuss domestic violence with their GP it would not matter whether their GP was male or female (see Table 3.4 below). Where patients did report a preference it was most likely to be female patients saying they would prefer to talk to a female GP (36%).

<b>Table 3.4 If you wanted to discuss domestic violence with your GP would you prefer to talk to a female or male GP? (n=604)</b>				
<b>Patient gender</b>	<b>Female</b>	<b>Male</b>	<b>Wouldn't matter</b>	<b>Don't know</b>
Female (n=429)	156 (36%)	13 (3%)	249 (58%)	11 (3%)
Male (n=175)	15 (9%)	46 (26%)	110 (63%)	4 (2%)
<b>Total</b>	<b>171 (28%)</b>	<b>59 (10%)</b>	<b>359 (59%)</b>	<b>15 (2%)</b>

Table 3.5 shows that very few patients had ever been asked about domestic violence by their GP (5% of females and 3% of males).

<b>Table 3.5 Have you ever been asked about domestic violence by your GP? (n=608)</b>			
<b>Patient gender</b>	<b>Yes</b>	<b>No</b>	<b>Don't know</b>
Female (n=432)	21 (5%)	404 (94%)	7 (2%)
Male (n=176)	5 (3%)	166 (94%)	5 (3%)
<b>Total</b>	<b>26 (4%)</b>	<b>570 (94%)</b>	<b>12 (2%)</b>

### **Patients' experiences of domestic violence**

Tables 3.6 and 3.7 (below) show that a quarter of women (25%) and just over one in ten of the men (11%) said that they had occasionally or often felt frightened because of the behaviour of a partner or someone at home and over a quarter of women (27%) and one in seven of the men (14%) had occasionally or often experienced violent behaviour by a partner or someone at home.

<b>Table 3.6 Have you ever felt frightened because of the behaviour of a partner/someone at home? (n=604)</b>				
<b>Patient gender</b>	<b>No, never</b>	<b>Yes, occasionally</b>	<b>Yes, often</b>	<b>Don't know</b>
Female (n=427)	311 (73%)	76 (18%)	32 (7%)	8 (2%)
Male (n=177)	149 (84%)	14 (8%)	5 (3%)	9 (5%)
<b>Total</b>	<b>460 (76%)</b>	<b>90 (15%)</b>	<b>37 (6%)</b>	<b>17 (3%)</b>

<b>Table 3.7 Have you ever experienced violent behaviour by a partner/someone at home? (n=605)</b>				
<b>Patient gender</b>	<b>No, never</b>	<b>Yes, occasionally</b>	<b>Yes, often</b>	<b>Don't know</b>
Female (n=427)	306 (72%)	83 (19%)	33 (8%)	5 (1%)
Male (n=178)	148 (83%)	22 (12%)	4 (2%)	4 (2%)
<b>Total</b>	<b>454 (75%)</b>	<b>105 (17%)</b>	<b>37 (6%)</b>	<b>9 (1%)</b>

Of those patients who disclosed experiencing domestic violence in the questionnaire, around a quarter of the patients said they had discussed this with their GP (26% of women and 23% of men).

The patients were also asked about their experiences of perpetrating domestic violence. Table 3.8 shows that 6% of women and 15% of men disclosed that they

occasionally or often behaved in a manner that made a partner or someone at home feel frightened (see Table 3.8 below). Table 3.9 (below) shows that 9% of women and 16% of men reported that they occasionally or often behaved in a violent manner towards a partner or someone at home.

<b>Table 3.8 Have you ever behaved in a manner that has made a partner/someone at home feel frightened? (n=604)</b>				
<b>Patient gender</b>	<b>No, never</b>	<b>Yes, occasionally</b>	<b>Yes, often</b>	<b>Don't know</b>
Female (n=429)	378 (88%)	21 (5%)	4 (1%)	26 (6%)
Male (n=175)	127 (73%)	25 (14%)	2 (1%)	21 (12%)
<b>Total</b>	<b>505 (84%)</b>	<b>46 (8%)</b>	<b>6 (1%)</b>	<b>47 (8%)</b>

<b>Table 3.9 Have you ever behaved in a violent manner towards a partner/someone at home? (n=605)</b>				
<b>Patient gender</b>	<b>No, never</b>	<b>Yes, occasionally</b>	<b>Yes, often</b>	<b>Don't know</b>
Female (n=428)	373 (87%)	40 (9%)	2 (0%)	13 (3%)
Male (n=177)	138 (78%)	27 (15%)	2 (1%)	10 (6%)
<b>Total</b>	<b>511 (84%)</b>	<b>67 (11%)</b>	<b>4 (1%)</b>	<b>23 (4%)</b>

Out of those patients who disclosed perpetrating domestic violence, few (4%) had ever discussed their behaviour with their GP.

### **The GPs views about asking about domestic violence**

It was clear from the interviews that were conducted before the GPs started the pilot programme training that many already had some awareness of the health impacts of domestic violence. They recognised that women experiencing domestic violence may experience a *'potential myriad of problems'* and that women may experience mental health issues as well as physical injuries:

*'... it's often through discussing their mental health rather than physical, but it can be either'*

*'... besides the physical injuries they make experience stress, it may affect their children, their health and also immediate family members.'*

All but one of the GPs believed that domestic violence affected the health of their patients and understood that domestic violence had a wider definition than physical injuries:

*'I had one bloke who was stabbed in his heart by his wife, so domestic violence can have physical effects, but with women it is mainly psychological. I've seen more men who are victims of domestic violence than women.'*

Most of the GPs said that they had some previous knowledge of patients who had experienced domestic violence. The response was more varied when they were asked whether they had ever suspected someone was experiencing domestic violence when

it was not disclosed. Some GPs preferred not to pursue the matter if there was no disclosure:

*'I tend to deal with complaints as they come rather than lifting stones and the like. Sometimes I'll skirt into it, if they are depressed, I kind of skirt around it, like "how is your marriage or relationship going". I've never asked directly about domestic violence.'*

However the majority of GPs said they would ask about domestic violence if they suspected it was the cause of the individual's health problems:

*'I've challenged if injuries are not consistent, but patients will stick to stories of denial'*

*'I have raised it with them, but I often get denial. I question bruising etc, but there's not much you can do if you get denial. But once raised, it does open the door to further possible action and the patient might raise it at a later date.'*

*'Yes I asked them, I have had a variety of responses from denial to admittance. In sensitivity, it's similar to asking about child sex abuse, sometimes they're just relieved to talk to somebody about it.'*

Because the GPs had different levels of experience with domestic violence, the responses to the question 'Is there anything that would enable you to deal with domestic violence more effectively?' varied. Responses ranged from very simple to more complex answers which demonstrated an awareness of the needs of women experiencing domestic violence:

*'Anything would, because I don't really address it at the moment.'*

*'Its disappointing, the resources are there but getting an adequate response is difficult – they say 'not in our age group, not in this, not in that ... '*

*'Be nice to know a little bit more about what happens in agencies, what do they do? Need clear pathways between agencies.'*

A number of GPs also commented that there was a lack of services for violent men who want to change their behaviour.

Three of the GPs expressed concern about the effect routinely asking about domestic violence would have on patient care:

*'It's more helpful to wait for disclosure, sometimes it might not be helpful to force the issue too early.'*

*'I would certainly feel uncomfortable asking everyone who came in ... the Pandora's box thing is quite a disincentive.'*

*'You have to be very careful about who you ask – some of them don't like to be asked.'*

However the majority of GPs reported ambivalent attitudes towards the effect asking about domestic violence might have on patient care, giving responses such as *'I don't know'*, and *'maybe [it would be useful]'*

Similarly, the GPs had mixed beliefs about how their patients would react to being asked about domestic violence:

*'I think they'd find it intrusive, unless they were being bopped around by their husbands, in which case they may be somewhat relieved.'*

*'Some might be alright if they understood what was happening. Some might take the hump.'*

The GPs own personal concerns about asking about domestic violence centred on two factors: the myth of domestic violence being a 'private' issue; and the time restraints placed on them:

*'It's a bit like asking about sex lives and stuff. I suppose if we do it routinely it might not be too onerous...'*

*'It has implications for the length of the consultation. I have concerns about the impact on workload and the level of back-up services. Is the GP practice the best place to do this?'*

## **Summary**

As previous research has found (e.g. Friedman et al., 1992), the GPs expressed more concerns about asking about domestic violence than the patients actually had. The primary concerns raised by GPs were related to available support following disclosure, time restraints, and asking 'intrusive' questions about a 'private' problem. The GPs had different levels of awareness about domestic violence, although most recognised that that the term domestic violence encompassed more than only physical abuse. Some had asked women about domestic violence in the past, while others had never had the confidence and knowledge needed to ask directly.

Based on the GPs responses and the patient questionnaires was clear that many more women had experienced domestic violence than the number who had discussed it with their GP. The number of women who had experienced domestic violence was reflective of national prevalence figures.



## Chapter Four ~ Training and Starting to Ask

### Views on training

Positive feedback was received from all the GPs who attended the first awareness-raising training session. The training day appeared to have worked as anticipated, with three GPs explaining that the day widened the way they defined domestic violence, with a marked move away from a narrow emphasis on physical violence. The Duluth power and control wheel ([www.duluth-model.org](http://www.duluth-model.org)) was identified as being useful in understanding the power and control elements that form the basis of domestic violence. The presentation that highlighted the extent of domestic violence had also increased the GPs knowledge base. Overall, the GPs welcomed the opportunity to have time to ‘think’ about domestic violence and said they now recognised the seriousness of the issue.

Most of the GPs attending and interviewed following the second training day gave positive feedback about the day. In particular, they said it helped them develop personal styles of indirectly asking about domestic violence and made them feel it was acceptable to ask about domestic violence, particularly when the question was framed in the context of the study (e.g. we are part of a pilot study which involves asking all women about domestic violence). The GPs said the training day made them feel less embarrassed about asking about domestic violence, especially once they were confident they were not asking questions the women may find insulting or that might make the situation worse:

*‘... I think specifically learning how to ask so that the lady would not feel guilty and possibly think that the violence was her fault. For example knowing not to ask the question ‘what did you do to make this happen or did you do something etc’. That was very useful. I had not thought about that before.’*

### Starting to ask

All the GPs reported that they had implemented the piloting of routine enquiry on 1<sup>st</sup> April 2003. However, although they were all asking it was clear that not all were asking routinely:

*‘... it’s been a bit hitty missy’*

*‘... I have, but not in the routine way. I think it’s more to the forefront of my mind now’*

It appeared that only four out of the nine GPs interviewed after the first month of ‘asking’ were actually asking routinely with regard to all women over 16 years old who attended the surgery alone. The other five GPs gave a variety of reasons as to why they were not managing to ask routinely:

*‘I’ve asked females up to the age of 75. I have not asked in some cases for example really elderly, single, and cheerful women.’*

*'I have asked a number of ladies aged between 18 and 67. I'm just asking when appropriate, I find that the time scenario may dictate when I ask, each consultation is allocated 10 minutes, even with that I find that there is not enough time to explore all the issues when a disclosure is made.'*

Others were tending to ask only where they thought domestic violence might be an issue:

*'Those that make my antennae twitch. It's kind of subliminal, and then you react.'*

*'... anyone who has clear psychological problems. Many people I see with psychological problems aren't in relationships so I haven't asked them. I haven't really asked about past problems, I think they would be more likely to come out with the counsellor. I am careful only to ask women on their own, I haven't seen anyone with current injuries that might be related to domestic violence.'*

*'Mainly women who I have not asked before, but have previously thought that they might be experiencing domestic violence.'*

Generally the GPs felt that asking about domestic violence had become easier since the training days:

*'I find it's much easier now actually knowing how to ask.'*

*'I've not had any problems, people are quite willing to answer, in fact it's led to some really interesting discussions.'*

*'I still feel a bit awkward, but it's definitely got easier. I think about my asking and wonder whether I have a kind of inverse snobbery about who I might offend, I know that in reality it is impossible to judge.'*

*'Fine about asking, it has been something which has always been a concern to me. Yes it has got easier, mainly because I am more aware now on how to ask. I feel that I am not putting ladies under duress, by simply through ignorance, asking incorrectly.'*

### **Patients' reactions to being asked**

GPs concerns about how their patients would react to being asked about domestic violence and whether it would have an adverse effect on the doctor-patient relationship were flagged up by the GPs on the training days. However, when the GPs started asking they realised that these concerns were largely unfounded, with only one patient initially reacting negatively to being asked:

*'... there was only one who was quite shocked and said 'Oh No', she then felt she had to take time telling me what a good relationship she had with her partner. She wasn't upset, she just felt she had to let me know what a good relationship she had.'*

The GPs explained that they had given a ‘preamble’ to the question (as suggested in the training) and most had situated the question within the context of the study (again as suggested in the training) and it was thought that this had reduced the possibility of negative reactions to being asked.

One of the most common reactions received by the GPs was to be told about a friend, family member or colleague who was experiencing domestic violence or who had done in the past. Another common response was for the patient to use humour, for example *‘my partner wouldn’t dare’*.

Overall, the GPs were confident that the doctor-patient relationship had not been adversely effected:

*‘I’m really pleased because it doesn’t appear to have caused any problems between me and my patients, that was the only thing that had worried me, whether it would interfere with that relationship.’*

### **Disclosing domestic violence**

Four of the GPs had had no current domestic violence disclosures, although some had found women talking about past experiences.

*‘Yes, but all from the past, and this has been from all age groups. They want to tell me how they have handled the situation.’*

In the cases where past disclosures were made the GPs tended to listen to the patients story but not take the issue any further; *‘it was not a can of worms that had to be revisited’*.

Importantly, the GPs understood that even if disclosures were not made on the first occasion, this did not mean that asking about domestic violence was a waste of time:

*‘I know that once we have spoken about the issue, then if there are any current experiences they might tell me next time. I have learnt that I might just need to wait.’*

The number of current disclosures varied from GP to GP, from those who had had none up to a maximum of five by this stage in the research. One GP had had two disclosures alone on the day they were interviewed. The usual response of GPs to current disclosures was to listen, discuss their options and safety and then give the woman the leaflet they had been supplied with on the training day which detailed help that was available to them.

*‘... she talked through it, is handling it well, and just wanted to discuss it, didn’t want any other intervention from me.’*

In the cases where referrals were made, all GPs referred the women concerned to the Safer Families project in Gateshead.

The GPs described positive experiences when domestic violence was disclosed in terms of such as knowing what to do and where to refer, for example:

*'The fact that the patient did talk to me about it, and then actually took away the help information.'*

*'... 3 or 4 weeks ago she came back, I asked her about domestic violence, and she said that all those years ago we had unpacked her suitcase of worries and dealt with them and said 'since we had our talk I've been fine'.'*

None of the GPs described any negative experiences resulting from disclosures, although one GP had been unsure how to react in one situation:

*'... the only strange experience occurred when a woman disclosed an experience she had had in the past, she was puzzled as to why I had asked, and what I would do with the information, how I might use it. For a moment I was not quite sure how to respond.'*

### **Difficulties asking about domestic violence**

A lack of time was mentioned again as one of the difficulties regarding whether to ask about domestic violence, as was the appropriateness of the situation (example given was if woman was already upset for example following a bereavement). Early on in the study simply remembering to ask was seen as a difficulty.

However, in general there was evidence that the GPs were beginning to see asking about domestic violence as just another question:

*'As I say, I think it's the stock in trade of being a GP. It is difficult to ask but not more so than other sensitive issues.'*

### **Attitudinal and practice change**

Attending the awareness training and starting to ask about domestic violence had clearly changed the way in which the GPs worked in relation to domestic violence. In most cases it was simply that they were more aware and confident in dealing with the issues that surround domestic violence:

*'Probably, I think that it's one of these things that brings the issue to the front of your mind, it brings it out of the mire at the back.'*

For others, the project was seen as simply the start of a much wider future change:

*'Oh yes, the training and research project has broken the ice, it's now in people's consciousness. This project has given us a lever to address the issue.'*

*'I now feel it is a legitimate thing to need to know about, before I was concerned there was an element of voyeurism. Now it's on the agenda as a health issue we can do something positive about it.'*

Confidence in the skills and knowledge of others as well as their own skills was clearly important in relation to this change:

*'It was also extremely positive meeting people who are involved in Safer Families, it was good to know they are skilled professional practitioners, not a group of people who want to 'do good'. It left me with a lot of confidence in them and making referrals to Safer Families.'*

The GPs were able to recognise the advantages of asking about domestic violence, rather than just seeing it as something additional they had to do on top of their already heavy workload.

*'Yes, it's more or less self evident, if someone has a problem then it's good for them to be able to talk about it.'*

*'Yes, women who want to come forward, now know that they can. Prior to this, women may have been reluctant, not knowing how I would react if they told me. They might think I would not take it seriously, they would not know whether I would be sympathetic or not, I might dismiss it.'*

*'This is a problem that has been too long neglected. It's good to be able to do something about it.'*

Moreover, the benefits were seen to apply to both the patients and to the GP:

*'For patients definitely. I've found patients who have had past experiences get very chatty. From a GP point of view, it's very useful. I think it's a wonderful idea.'*

*'I deal with a lot of people who experience multiple physical problems, I now have another perspective to consider with their symptoms, it has given me another differential diagnosis.'*

### **Additional comments**

Two of the GPs brought up the issue of gender of patient and GP. They felt concerned that a female GP should ask women about domestic violence, for example:

*'I have concerns about the appropriateness of asking men to ask women about domestic violence problems, I felt uncomfortable with that, it is difficult for men to get in to women's experience. I have serious doubts about male GPs asking women about domestic violence.'*

From the patient survey it was apparent that, although the majority of women did not mind the gender of the GP asking about domestic violence a sizeable minority (one third) said they would prefer to be asked by a female GP.

## CHAPTER FIVE ~ RESPONSES TO BEING ASKED

### Monitoring by GPs

This chapter is based on the monitoring by the GPs and the responses from the patient survey. The GPs were asked to monitor responses to patients being asked about domestic violence by collecting the following information:

*Was the patient asked?* (yes, first time/ yes, repeated/no)

*How were they asked?* (directly/indirectly)

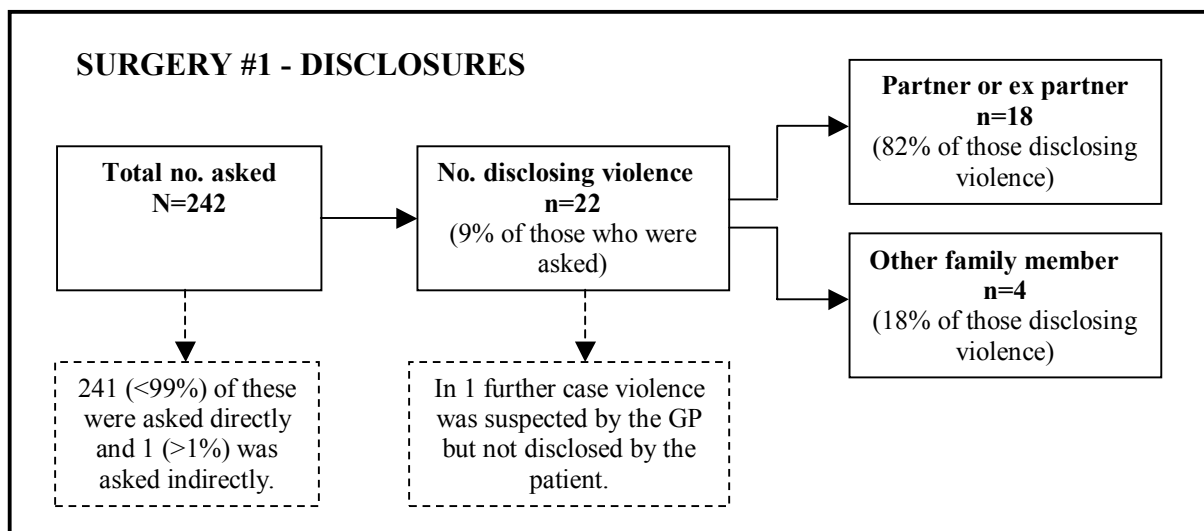
*Was violence disclosed?* (yes/no, but suspected/no)

*If yes, who was the violence from?* (partner or ex/family member)

It was arranged for these questions to be entered into a 'tick box' format on their existing electronic patient record forms to allow monitoring without form filling. However, the monitoring information the researchers received was extremely sketchy from some surgeries.

### Disclosures made when asked about domestic violence

**Surgery #1** provided most of the information required for a three-month period (April, May and June 2003). The figure below refers to the total number for the three months.



The figure above shows that nearly one in ten (9%) of those asked about domestic violence disclosed that they had experienced domestic violence. These were not necessarily all current disclosures, and many may have been disclosures of past experiences. What these figures show is that many women are willing to disclose experiences of domestic violence when asked sensitively and directly about it.

The other surgeries did not provide enough information for any meaningful analysis, nor were enough patient surveys returned to draw any conclusions from them.

## **Responses to being asked – the GPs perspective**

Although the GPs still found it difficult to find the time to ask, by the end of the pilot they reported that it had become easier to ask about domestic violence:

*'... it is easier, its become rather like asking about whether they experience headaches, its part of the whole consultation.'*

*'... now I see it as a valid and useful thing to ask, especially when someone is coming in with non-specific vague symptoms.'*

*'... I feel there is still more to come. People don't disclose until you ask.'*

*'I had a lot of hang-ups about asking about it before. I don't now.'*

They reported a positive response from their patients when they were asked, especially when the patients were aware of the pilot project:

*'... we now have leaflets and posters in the waiting area, people are expecting me to ask'*

*'We have got signs up, so people are prepared and they don't appear to mind.'*

*'Usually those that have made disclosures have cried, I have had a polite dismissal from others. There have been no indignant replies to the question.'*

*'... some are good humoured and say things like 'their partner wouldn't dare'*

The two main benefits to asking about domestic violence cited by GPs were that it improved the relationship between themselves and their patients and that it was likely to get to the basis of their symptoms rather than just treating them:

*'... it creates an atmosphere of trust. Women know they can trust their GP, and they are able to come forward if they are experiencing difficulties'*

*'... I think that there is a sense of relief among patients, just being able to trust their GP and let them know what's happening to them.'*

*'The main advantage to me is that I'm not sitting on a psychological problem treating it with drugs, that I am actually dealing with the real problem'*

*'The main benefit is it gets to the root of the problem'*

*'... if someone does disclose you can get to the root cause of their problems rather than pussy footing around lots of little issues and refer them onto helpful agencies.'*



Concerns about finding the time to ask about domestic violence and the corresponding impact on consultation time continued to be raised by the GPs. In addition, some GPs found it difficult to remember to ask about domestic violence. The concern about whether their patients would return after being asked about domestic violence was only mentioned by one GP in this final set of interviews:

*'... one lady was able to talk about some abusive sex acts that had happened to her in the past that she had not spoken about before, I hope that it is being able to get it off her chest and not embarrassment that has contributed to her decrease in return.'*

The GPs found non-disclosure difficult when they believed that the women were experiencing domestic violence and were not always sure about what to do next, especially where women were from Black or minority ethnic communities:

*'I believe that there is a lot [of domestic violence] in the Asian Community but they are not disclosing it. I know this because I have been involved in the physical results.'*

*'She had a broken jaw, a terrible injury. It leads you to think, what do I do next? ... she doesn't have good English ... I feel I need to know more about handling cultural differences in situations like these, extra training in this area would be helpful.'*

However it was felt that even if domestic violence was not disclosed it was still useful to ask:

*'I have had one person who was very evasive when I asked her, although I suspect it to be a factor. At least I now have it on record, and I have recorded my concerns and can keep trying.'*

## Chapter Six ~ Conclusions and Recommendations

### Conclusions

The pilot project 'asking about domestic violence' project aimed to: raise the GPs' awareness of issues related to domestic violence; introduce in GP surgeries a routine method of asking about domestic violence; develop a simple monitoring system to evaluate the effect of GPs routinely asking about domestic violence and to provide a measure of prevalence and incidence of domestic violence and; monitor the implementation of the programme.

The initial patient survey showed that a quarter of women (25%) and just over one in ten men (11%) said that they had felt frightened because of the behaviour of a partner or someone at home and over a quarter of women (27%) and one in seven men (14%) had experienced violent behaviour by a partner or someone at home. Few patients (7% of women and 13% of men) said that they would feel offended if their GP asked them about domestic violence and the GPs generally expressed more concerns about asking about domestic violence than the patients actually had.

Where the GPs were concerned, prior to the training or implementation of enquiry, ambivalent attitudes were expressed towards asking about domestic violence and they were concerned and had mixed beliefs about how their patients would react to being asked. The GPs reported that the training had widened their understanding of domestic violence and made them feel more able to ask about it. Some of the GPs found it a problem that they had different levels of knowledge about domestic violence at the start and complained that the training was too basic rather than using it as an opportunity to share their skills and experience with the other GPs in the group and reassess what they knew and how they asked.

Only four out of the nine GPs interviewed after the first month of 'asking' were actually asking routinely. In most cases the GPs who were selecting who to ask rather than asking routinely were those who had not attended the first training day and had had a 'catch-up' session instead. This emphasises the need for the GPs to attend both training days and we would recommend this for future programmes.

The monitoring of the use of domestic violence enquiry proved difficult in practice, and most surgeries did not provide the researchers with the required information. The one surgery that did provide complete information showed that one in ten of the women who were asked about domestic violence disclosed either current or previous domestic violence.

At the end of the pilot programme GPs felt more comfortable about asking about domestic violence and recognised this as useful in terms of the doctor-patient relationship and in tackling the basis rather than just the symptoms of the patients' ill health. Although the GPs found it difficult when patients did not disclose violence when they suspected it was being experienced, they still recognised that it was useful to ask and be aware of the situation. Time constraints and remembering to ask were the only issues remaining as difficulties for the GPs by the end of the pilot programme.

The attitudinal change of some GPs after training and starting to ask compared with initial interviews was vast. The table below shows some examples of quotes given by the same GP pre and post-training:

<b>Examples of GPs attitudinal changes</b>	
<b>Pre-training</b>	<b>Post-training</b>
I tend to deal with complaints as they come rather than lifting stones and the like. Sometimes I'll skirt into it, if they are depressed ... like 'how is your marriage and relationship going'. I've never asked directly about domestic violence.	If someone does disclose you can get to the root cause of their problems rather than pussy footing around lots of little issues and refer them on to helpful agencies.
I think its an awkward thing to ask people about.	... I see it as a valid and useful thing to ask, especially when someone is coming in with non-specific vague symptoms.
A few might get angry and tell me to mind my own problems.	... its become rather like asking about whether they experience headaches, its part of the whole consultation.

## **Recommendations**

We offer the following recommendations in relation to the rolling out of the routine enquiry pilot project across Gateshead and South Tyneside:

### **Training**

- Training should be last a minimum of two full days and cover both awareness raising and asking about domestic violence, including role-play workshops.
- It is vital that GPs attend both training days rather than the 'catch-up' model we offered to GPs who were unable to attend the first day.
- If possible administrative support staff and other medical practitioners in the practice should attend the awareness raising workshops along with the GPs.

### **Implementation**

- GPs should be supported in the first six months of the implementation period. This may be done by peer support by those more experienced at routine enquiry or by those conducting the training.

### **Monitoring**

- GPs need to make more of a commitment to the monitoring stage of the programme. This adds only marginally to the time taken in a consultation and is particularly important due to the concerns raised about time restraints.
- Collation of the results of the monitoring should be carried out on a regular basis (perhaps by the Community Safety Team) and feedback given to surgeries.

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**Appendix One: Demographic characteristics of patients completing ‘pre-asking’ questionnaire**

<b>No. returned from each surgery (n=621)</b>			
Surgery #1	Surgery #2	Surgery #3	Surgery #4
187 (30%)	165 (27%)	89 (14%)	180 (29%)

<b>Age range (n=611)</b>					
16-20	21-30	31-40	41-50	51-60	61+
35 (6%)	87 (14%)	122 (20%)	127 (21%)	124 (20%)	116 (19%)

<b>Marital status (n=587)</b>				
Single	Living with partner	Married	Separated/divorced	Widowed
108 (18%)	66 (11%)	322 (53%)	60 (10%)	31 (5%)

<b>Number of children (n=602)</b>			
None	One	Two	Three or more
124 (21%)	120 (20%)	200 (33%)	158 (25%)