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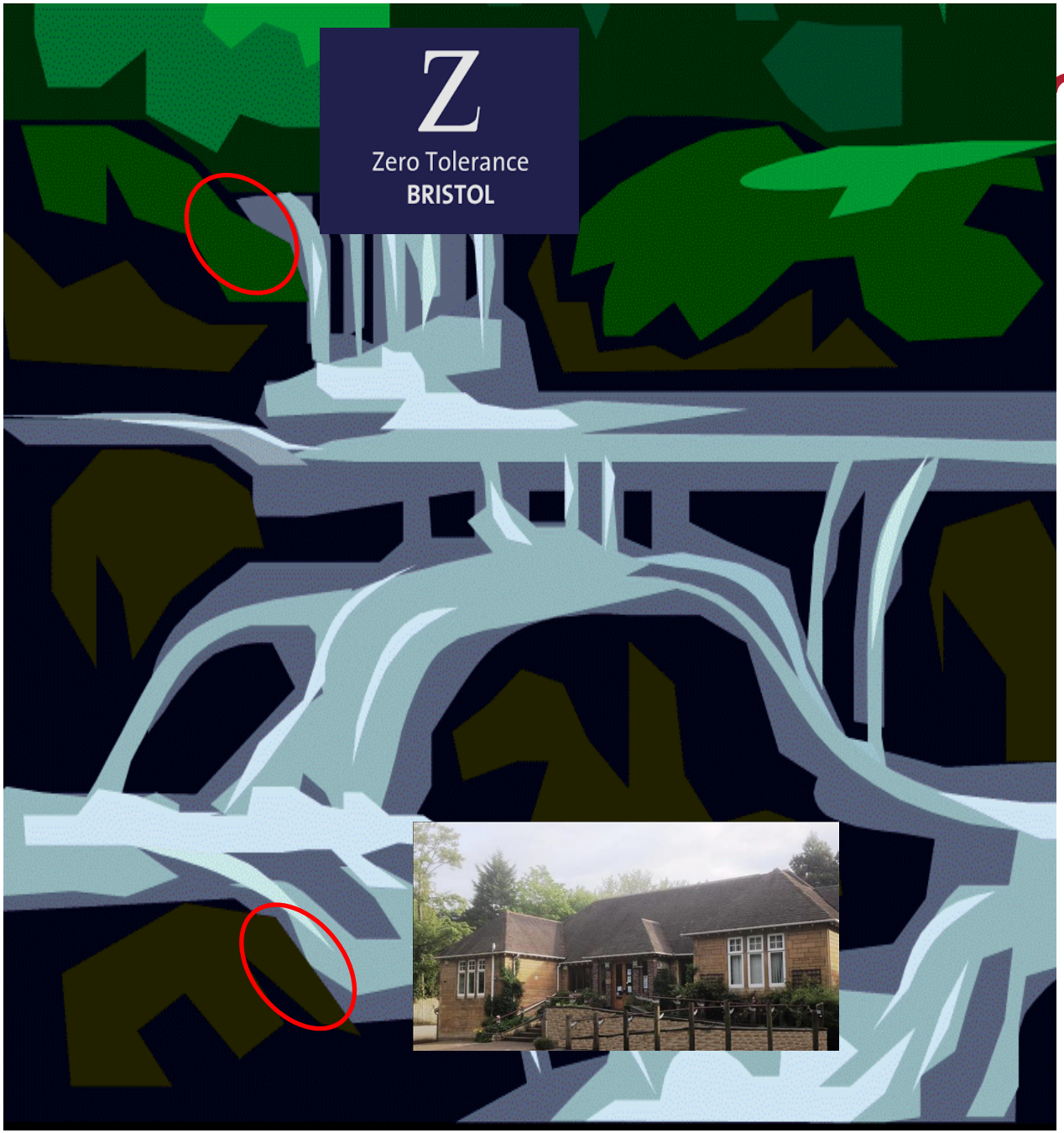
Health care responses to domestic violence: end of the beginning?

Gene Feder

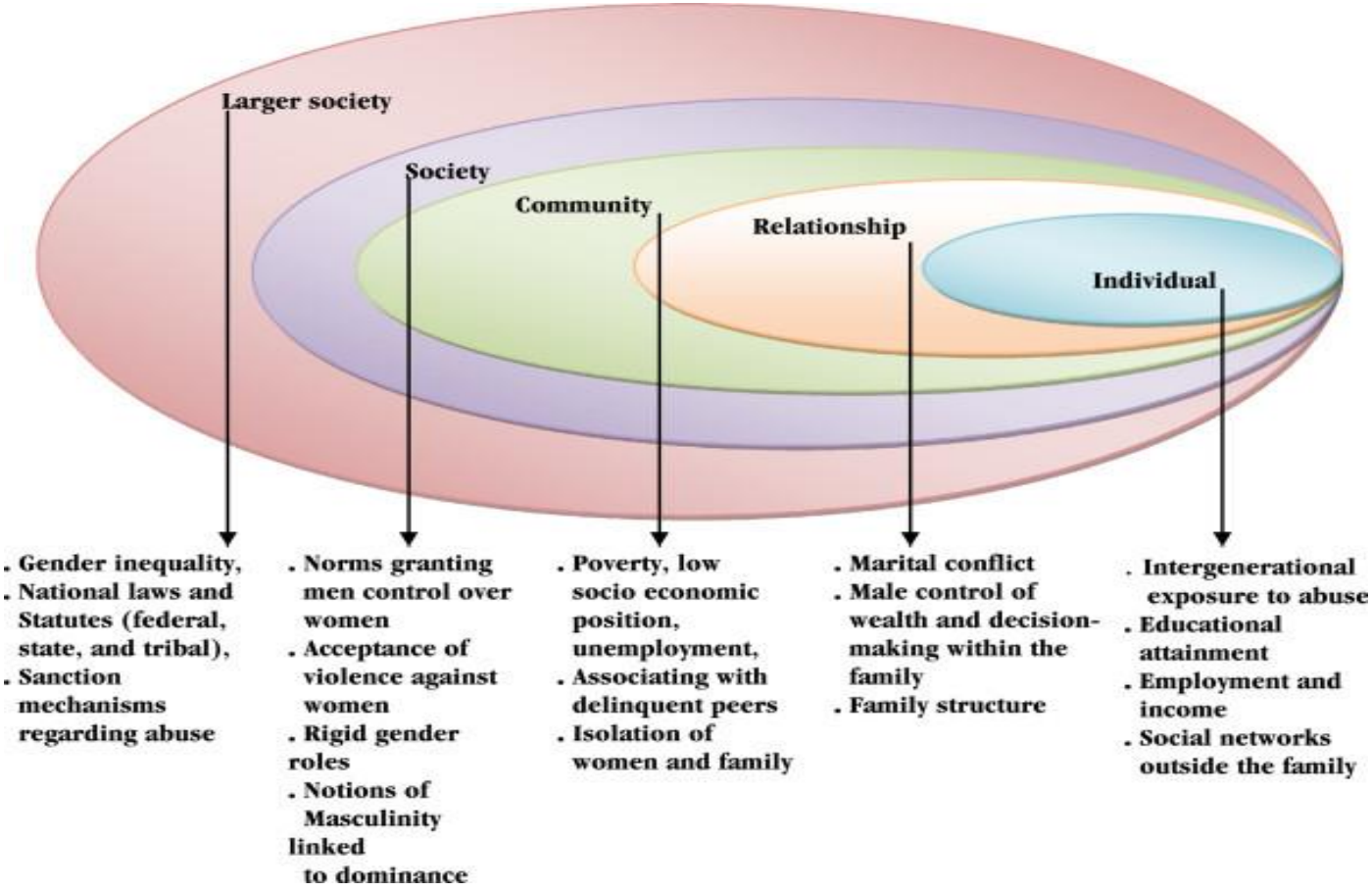
Women's Health Conference
Bristol
International Women's Day 2017

Constance

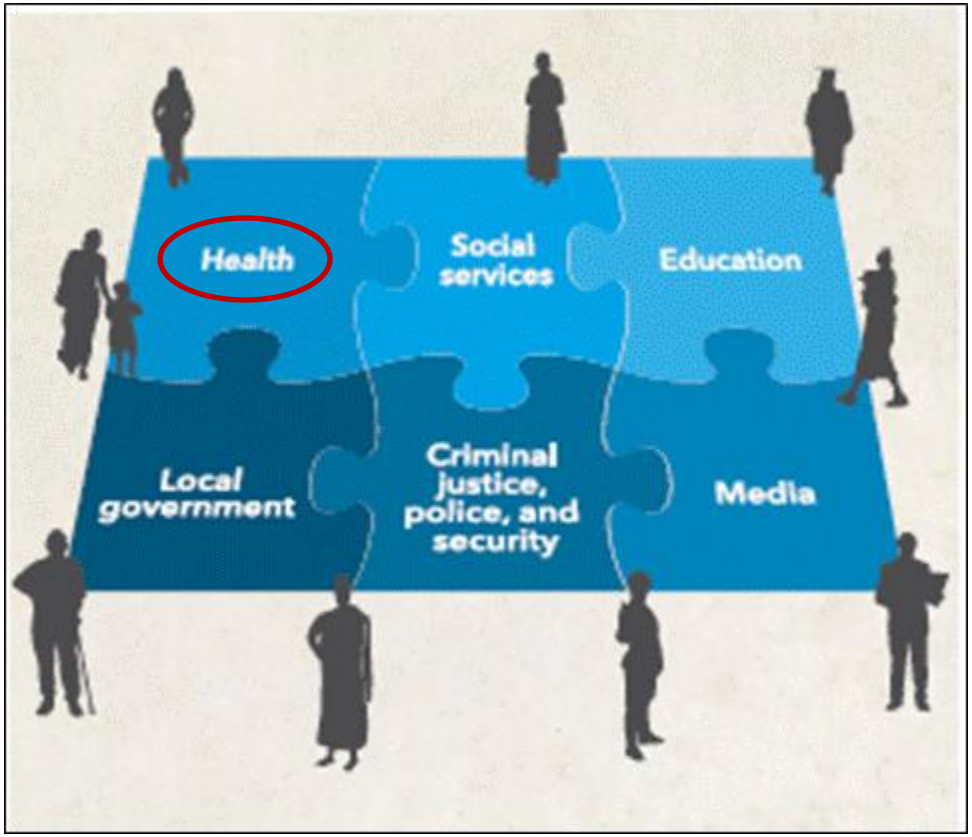
43 year old care worker who had been my patient for 5 years. Two sons, James (13) and Tyrone (4). Partner was Tyrone's father.


Z
Zero Tolerance
BRISTOL
?

public health response is structural (political)



Multi-sectoral response to domestic violence



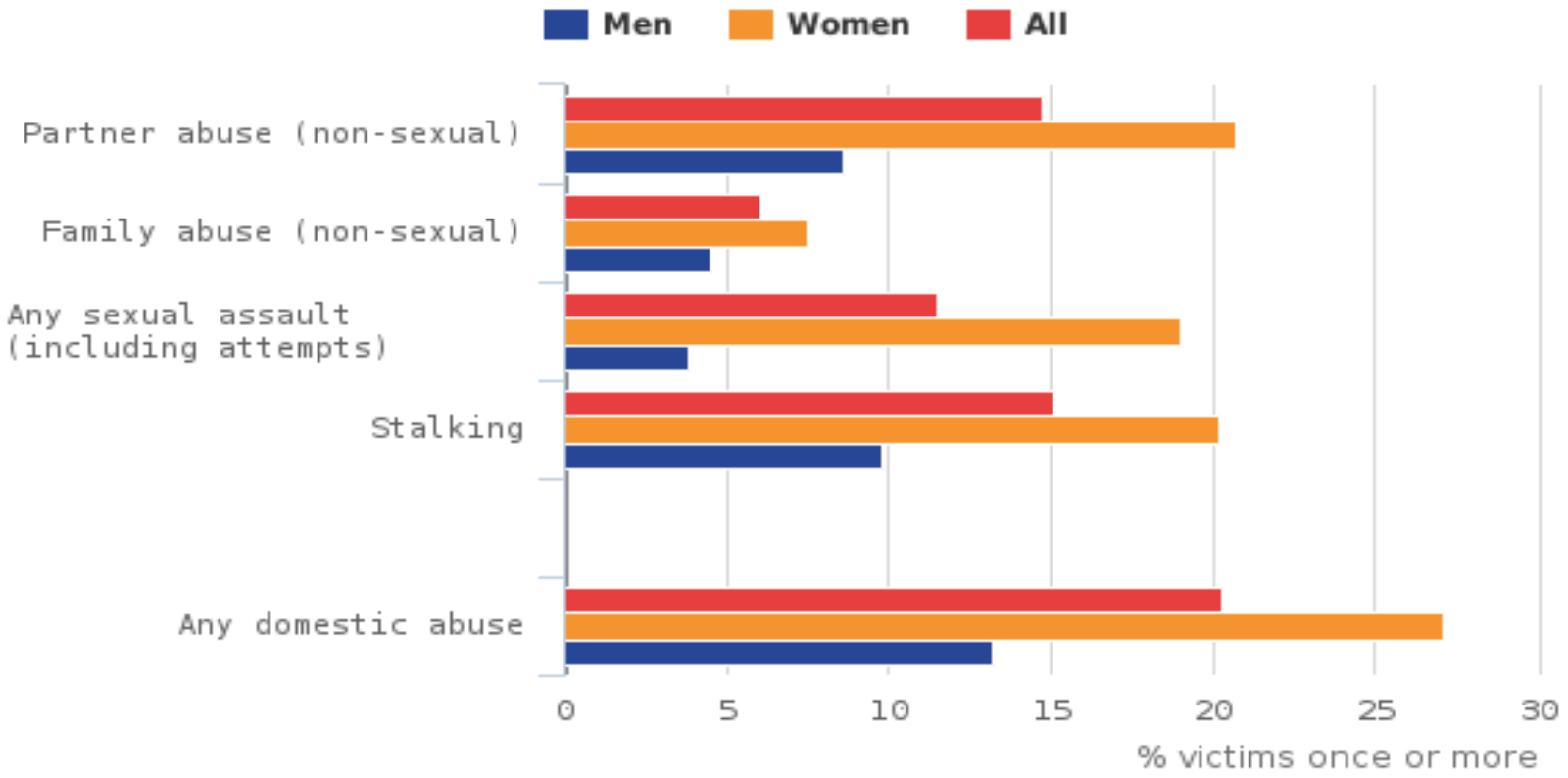
Specific health sector response

Domestic violence is a violation of human rights and a society-wide challenge, particularly to the education and criminal justice system

Why do we need a specific health care response?

- health impact of domestic violence
- survivors' expectations of doctors
- evidence for effectiveness

specific to women's health (gendered)? CSEW 2014



beyond prevalence to impact

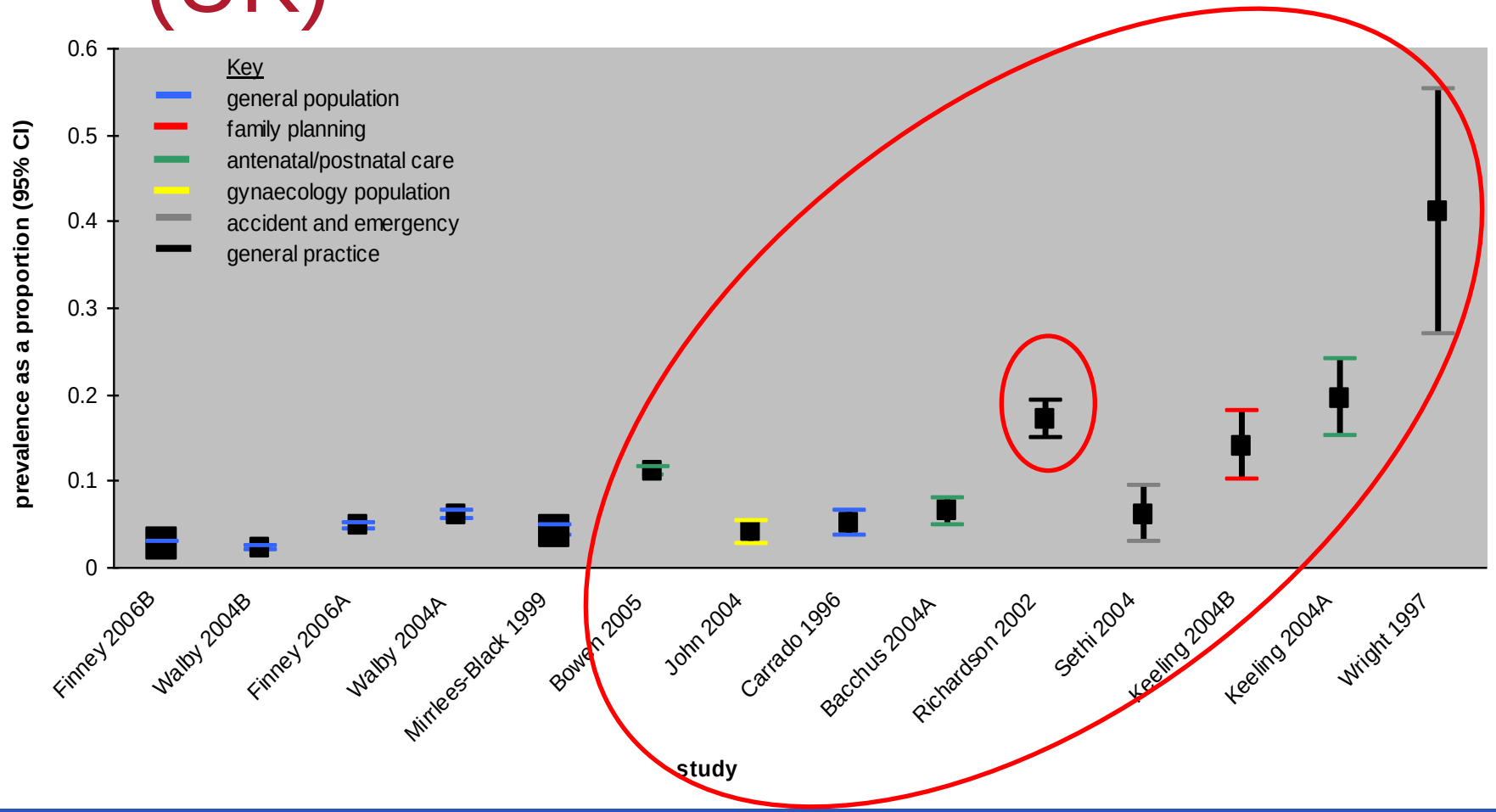
Compared with male DV survivors women are:

- 3x more likely to be injured as a result of violence
- 5x more likely to require medical attention or hospitalisation
- 5x more likely to report fearing for their lives
- 8x more likely to suffer sexual violence

Specific health care response?

- health impact

past year prevalence of IPV (UK)



physical health consequences

(Coker et al, 2009, Coker et al, 2000)

Survivors experience a range of chronic health problems including:

- chronic pain
- increased minor infectious illnesses
- neurological symptoms
- gastrointestinal disorders
- raised cardiovascular risk
- gynaecological problems

mental health consequences

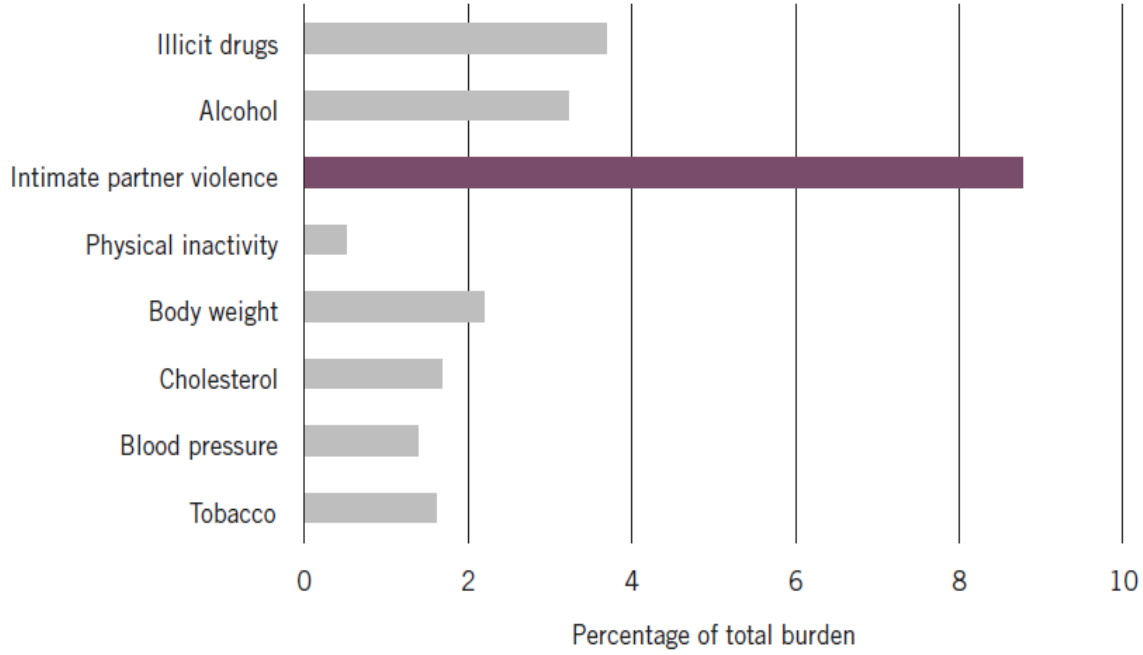
(Howard 2013, *Golding 1999*)

	OR (95% CI)
Depression	**2.8** (2.0 to 3.9)
PTSD	**7.3** (4.5 to 12.0)
Alcohol abuse	***5.6*** *(3 to 9)*
Suicidal thoughts	***3.6*** *(2.7 to 4.6)*

contribution to disease burden

(VicHealth, 2004)

Figure 2: Top eight risk factors contributing to the disease burden in Victorian women aged 15–44 years



impact on children

- Exposure to DVA increases the

risk of negative health outcomes across the lifespan Graham-Bernamm 2011; Waite 2014; Barlow 2012

- Associated with
  - disrupted social development
  - poor academic attainment
  - engagement in risky health behaviours
  - other physical health consequences
  - **higher levels of physical maltreatment of children**, as well as other forms of child abuse, including sexual abuse Shonkoff 2009

- DVA noted in between a third to a half of cases where **children were killed or seriously harmed** Graham-Bermann 2011

Specific health care response?

- health impact
- survivor expectations of doctors (and other health care professionals)

What do survivors want from doctors?

before disclosure/questioning

- try to ensure continuity of care

make it possible for women to disclose

- ask about (current and past) abuse

when issue of partner violence raised

- don't pressurise women to fully disclose

immediate response to disclosure

- ensure that the women feel that they have control over the situation, and address safety concerns

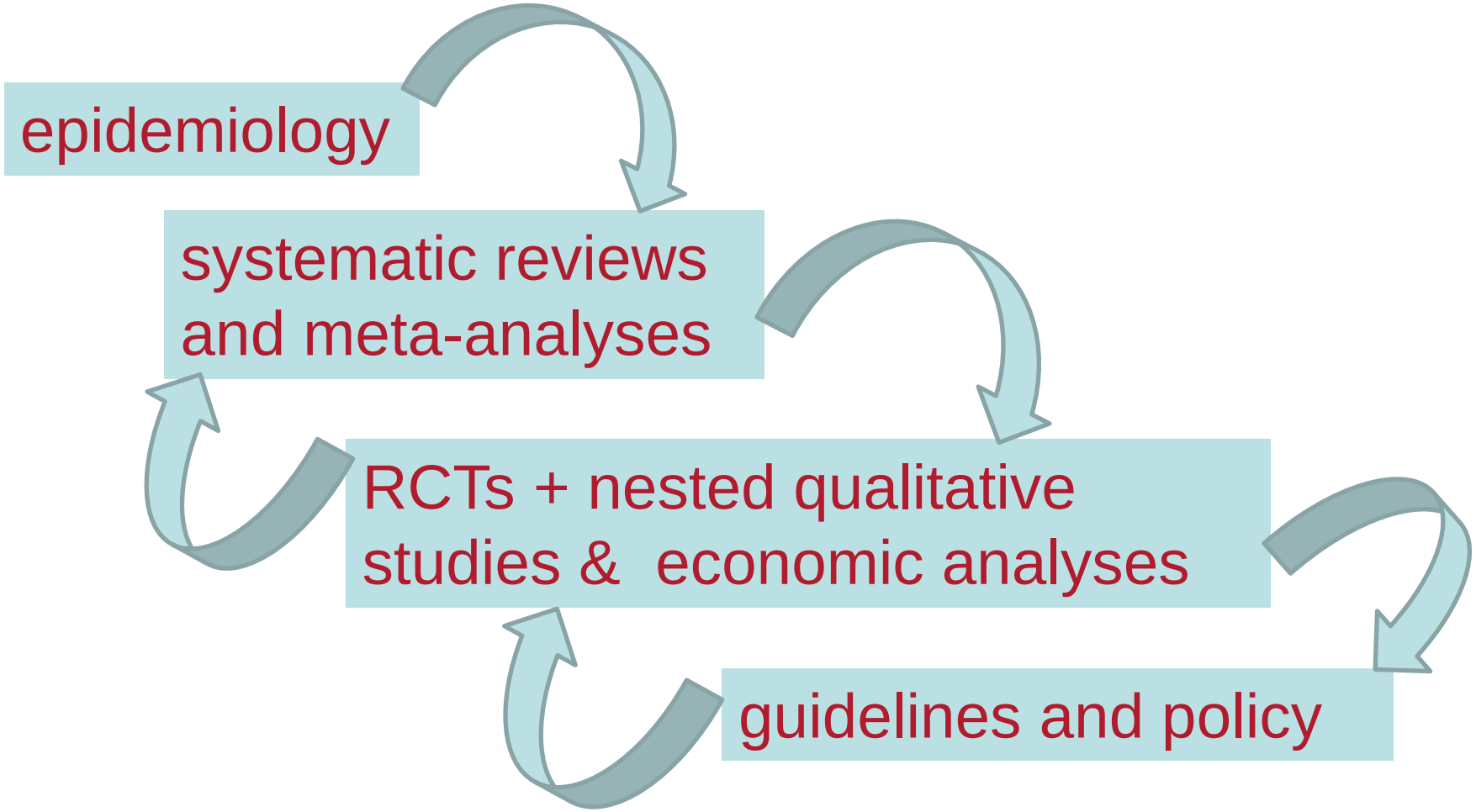
response in later consultations

- understand the chronicity of the problem and provide follow up and continued support

Specific health care response?

- health impact
- survivor expectations of doctor
- evidence of effectiveness

a certain kind of evidence…



Are health care professionals engaging with domestic violence?

Women who experience domestic violence and women survivors of childhood sexual abuse: a survey of health professionals' attitudes and clinical practice

Jo Richardson, Gene Feder, Sandra Eldridge, Wai Shan Chung, Jeremy Coid and Stirling Moorey

SUMMARY

Health professionals do not wish to routinely screen women for a history of domestic violence or childhood sexual abuse. However, over 80% believe that these are significant health care issues. Routine screening should not be prioritised until evidence of benefit has been established.

Keywords: women; domestic violence; childhood sexual abuse; health care screening.

Introduction

DOMESTIC violence aga
lem with major healt
Although it affects around
quently not identified by he
ernment advice states that h
sider routinely screening w
try and increase rates of id
clear whether identification
women and their families. I
how health professionals ac
lence generally.

Childhood sexual abuse a
life and may lead to psych
suggested that routine inqu
hood and adult sexual victir

We decided to investigat
represent the commonest m
and their prevalence is link
tionally charged issues that
fication and management fo

Our study aimed to:

- describe attitudes and
sionals with respect
women and women
abuse, in particular with
- assess the extent of tra
about these issues; and
- identify characteristics
tices in which they wor
tine questioning, the pe
the adult sequelae of
health care issue, and t

Method

The study was based on ar
vey of all 380 general practit
140 health visitors who we
London and the City Health

To identify practitioner characteristics that were significantly related to the probability of agreeing with a particular statement when other predictor variables were allowed for, backwards stepwise logistic regression was applied to the responses with the characteristics of age, profession, previous training, and trainer status as predictor variables. Comparisons between occupations were made, with health visitors as the base category. Additional predictor variables

J Richardson, MRCP, MRCGP, general practitioner; G Feder, M.D., FRCGP, professor of primary care research and development; and S Eldridge, BA, MSc, lecturer in medical statistics, Department of General Practice and Primary Care, St Bartholomew's and the Royal London School of Medicine and Dentistry, Queen Mary and Westfield College, University of London. W S Chung, BSc, MSc, research assistant; and J Coid, M.D., MRCP, FRCPsych, professor of forensic psychiatry, Forensic Psychiatry Research Unit, Department of Psychological Medicine, St Bartholomew's Hospital, London. S Moorey, BSc, FRCPsych, consultant psychiatrist, Psychotherapy Unit, Maudsley Hospital, London.

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Submitted 16 March 2000; Editor's response: 28 June 2000; final acceptance: 1 December 2000.

©*British Journal of General Practice*, 2001, 51, 468-470.

468

British Journal of General Practice, June 2001

Research

Jean Ramsay, Clare Rutterford, Alison Gregory, Danielle Dunne, Sandra Eldridge, Debbie Sharp and Gene Feder

: violence:

itudes, and clinical practice of selected

ealthcare clinicians

INTRODUCTION

Domestic violence is threatening behaviour, violence, or abuse between adults who are, or have been, intimate partners or family members. Such abuse may take various forms, including physical violence [slaps, punches, kicks, assaults with a weapon, choking, homicide], sexual violence [rape or forced participation in sexual acts], emotionally abusive behaviours [stalking, surveillance, threats, preventing contact with family and friends, ongoing belittlement or humiliation, intimidation], economic restrictions [preventing outside working, confiscating earnings, restricting access to funds], and other controlling behaviours.[1]

Domestic violence is a common worldwide phenomenon.[2] Both women and men experience domestic violence but the prevalence and impact, particularly of sexual and severe physical violence, is higher among women.[3] The prevalence of domestic violence among women seeking health care is higher than in the general population.[4,5] A study of women attending general practices in east London, found a lifetime prevalence for physical abuse of 41%.[6]

Chronic physical and mental health problems are common sequelae of domestic violence,[7] with many domestic violence survivors reporting that it is the psychological abuse, rather than the physical violence, which has the most long-lasting adverse effects on their wellbeing.[8] In comparison with non-abused women, those who have experienced domestic violence have higher incidences of gynaecological disorders,[9] chronic pain,[9] neurological symptoms,[9] gastrointestinal disorders,[9] and self-reported heart disease.[10] Likewise, women experiencing abuse more often present with persistent post-traumatic stress disorder, depression, anxiety, suicidal ideation, and substance misuse.[11,12]

Women experiencing abuse have frequent contact with primary care clinicians,[13,14] and consider it appropriate to be asked about domestic violence by doctors and nurses.[15] They also identify healthcare professionals as potential sources of support if this is delivered in a non-judgemental and non-directive manner, and an appreciation of the complexity of domestic violence is shown.[16] Historically, however, the quality of care for women experiencing abuse has been poor worldwide.[17,18] Many clinicians agree that domestic violence is a healthcare issue, but often they are reluctant to ask about abuse or do not respond appropriately if domestic violence is disclosed.[19–21] Such ambivalence is attributed to a number of factors but most frequently cited are a lack of domestic violence knowledge and training, and a perceived lack of time and support resources.[22,23]

In recognition of the importance of education, over the last 10–15 years domestic violence training has been incorporated into the curricula of most medical schools and postgraduate

Conclusion

Primary care clinicians' attitudes towards women experiencing domestic violence are generally positive but they only have basic knowledge of the area. Both GPs and practice nurses need more comprehensive training on assessment and intervention, including the availability of local domestic violence services.

Keywords

cross-sectional studies; domestic violence; primary health care; women.

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E-mail: gene.feder@bristol.ac.uk

Submitted: 13 December 2011. **Editor's response:** 2 February 2012; **final acceptance:** 28 March 2012.

This is the full-length article (published online 28 Aug 2012) of an abridged version published in print. Cite this article as: **Br J Gen Pract 2012; DOI: 10.3399/bjgp12X654623.**

Not (yet)

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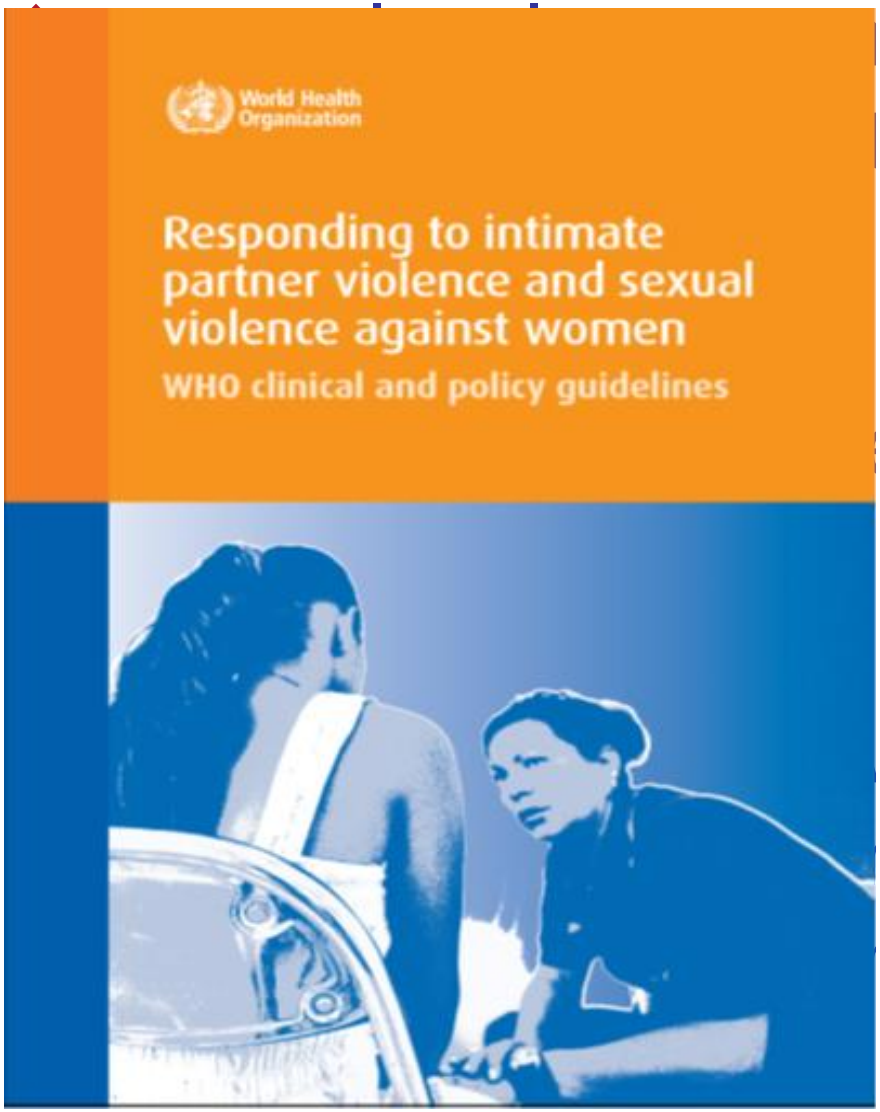
(some) evidence of effectiveness



NICE National Institute for Health and Care Excellence

Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively

Issued: February 2014

NICE public health guidance 50
guidance.nice.org.uk/ph50

NICE has accredited the process used by the Centre for Public Health Excellence at NICE to produce guidance. Accreditation is valid for 5 years from January 2010 and applies to guidance produced since April 2009 using the processes described in NICE's 'Methods for the development of NICE public health guidance' (2006). More information on accreditation can be viewed at www.nice.org.uk/accreditation

NICE accredited

What should health care providers do?

- know about and be aware of violence and abuse in their patient populations
- ask about violence and abuse safely

Should we be screening in health care settings?

No

How far does screening for domestic (partner) v different health-care se criteria for a screening Systematic reviews of n National Screening Con criteria

G Feder, J Ramsay, D Dunne, M Rose, C Arsene, R Norman S Kuntze, A Spencer, L Bacch G Hague, A Warburton, and A

March 2009
DOI: 10.3310/hta13160

Health Technology Assessment
NIHR HTA Programme
www.hta.ac.uk

violence in healthcare

Davidson L, Feder G

laboration and published in *The Cochrane Library*

Screening women for intimate partner violence in healthcare settings (Review)
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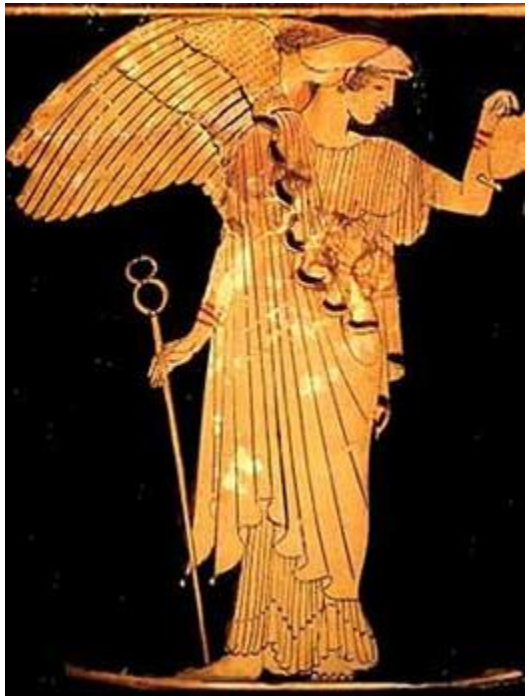
health care providers supporting patients

- knowledge and awareness about violence and abuse
- ask about violence safely
- non-judgemental supportive response
- facilitate access to
  - violence support/advocacy services
  - access to trauma-informed mental health services

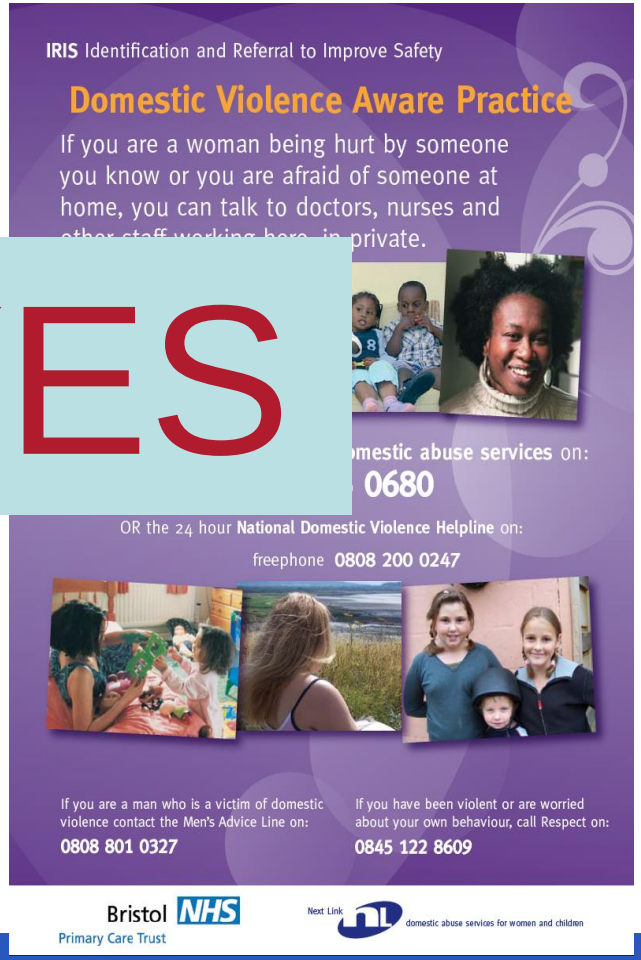
NHS and local authority support to providers

- training about violence to all health and social care professionals
  - undergraduate
  - post-graduate
  - continuing professional development
- *intergrated (joint)* commissioning
  - DV services
  - trauma-informed mental health services
- systematic data collection

Can we improve the response of clinicians to domestic violence?



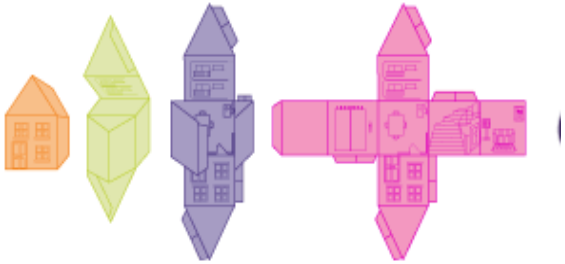
YES



IRIS

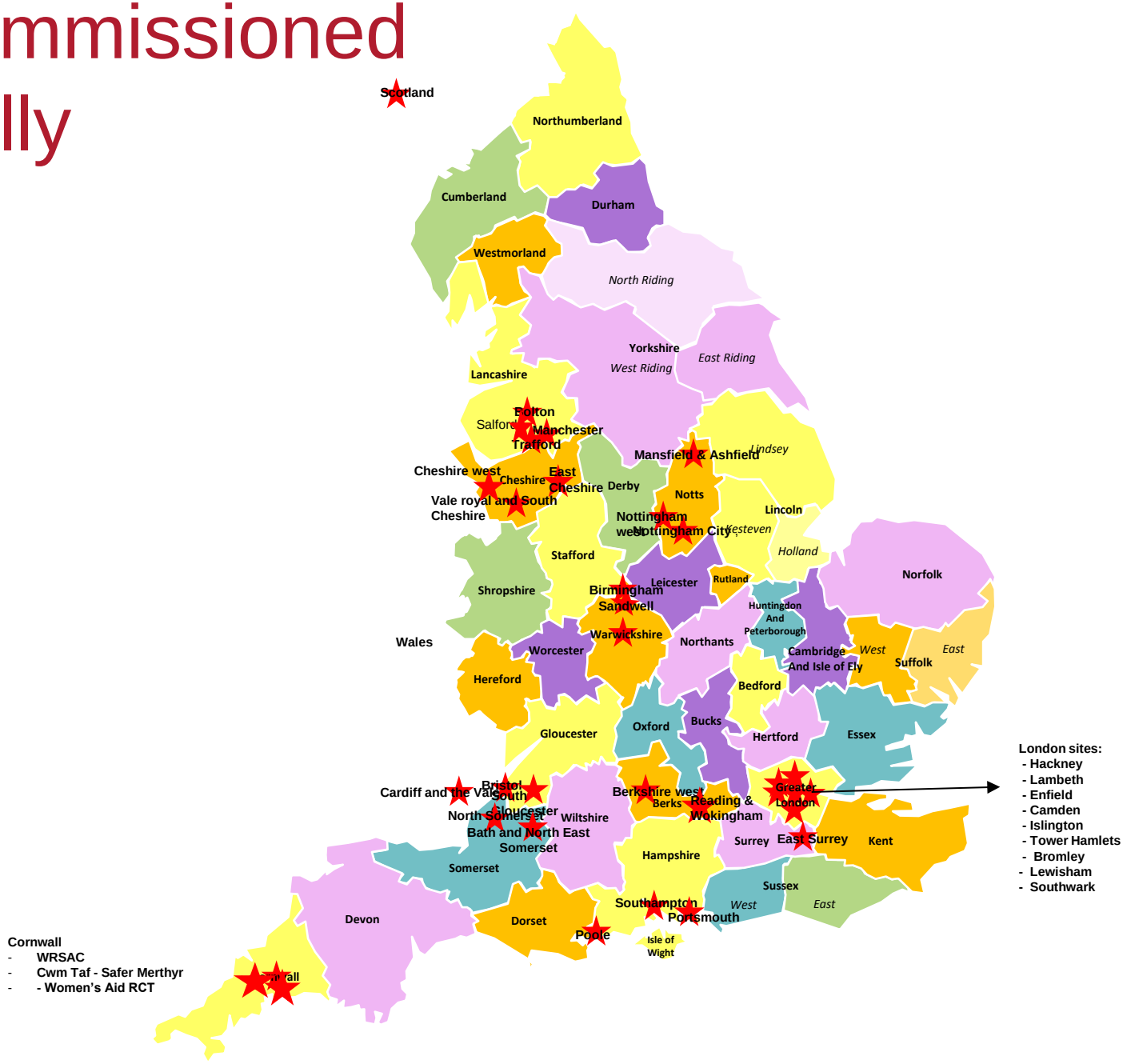
- but only in partnership with domestic violence advocacy organisations…

Bristol Next Link
domestic abuse support services for women



- advocate educator
- specialist referral service
- part of coordinated community response

IRIS commissioned nationally



Sustainable?

- commissioned by CCGs and local authorities in 35 English localities and the training delivered to 144 general practices
- current annual rate of referral of DVA survivors from IRIS practices in England to specialist agencies is >1500/year
- the programme started implementation in 5 areas in Scotland in June 2013 and in south Wales in 2014

AUSTERITY

New questions, new(ish) answers

What about male patients?

Open Access Research

BMJ Open

Occurrence and impact of negative behaviour, including domestic violence and abuse, in men attending UK primary care health clinics: a cross-sectional survey

M Hester,[1] G Ferrari,[2] S K Jones,[2] E Williamson,[1] L J Bacchus,[3] T J Peters,[4] G Feder[2]

To cite: Hester M, Ferrari G, Jones SK, *et al*. Occurrence and impact of negative behaviour, including domestic violence and abuse, in men attending UK primary care health clinics: a cross-sectional survey. *BMJ Open* 2015;**5**:e007141. doi:10.1136/bmjopen-2014-007141

► Prepublication history for this paper is available online.

ABSTRACT

Objective: To measure the experience and perpetration of negative behaviour, including domestic violence and abuse (DVA), and investigate its associations with health conditions and behaviours in men attending general practice.

Design: Cross-sectional questionnaire-based study conducted between September 2010 and June 2011.

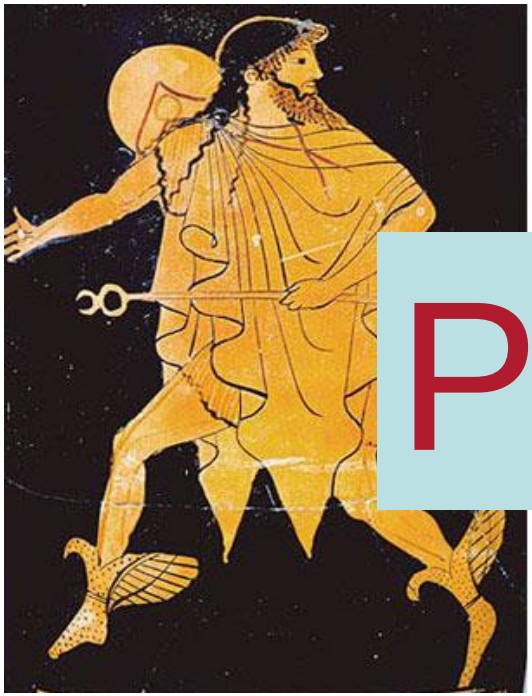
Setting: 16 general practices in the south west of England.

Participants: Male patients aged 18 or older, attending alone, who could read and write English. A total of 1403 of eligible patients (58%) participated

Strengths and limitations of this study

- This is the first survey of a European clinical population to measure prevalence of DVA experience and perpetration in male patients in primary care, and the largest such primary care study internationally.
- The study is unique in combining prevalence of experience and perpetration along with perceived impact and self-reported domestic violence and abuse (DVA) status. Unlike most population studies of men and DVA, it has no upper age limit

Can IRIS be extended to male DV survivors and outside of primary care?



LINKING ABUSE AND RECOVERY

ADVOCACY

ADVISE

Possibly

HEalth professionals **R**esponding to **ME**n for **S**afety

Can we improve outcomes for women who engage with DVA services?

Uncertainty

advocacy/

- probably r)VA
- mixed res ng mental health anc s for women re

Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse (Review)

Ramsay J, Carter Y, Davidson L, Dunne D, Eldridge S, Feder G, Hegarty K, Rivas C, Taft A, Warburton A

THE COCHRANE COLLABORATION®

University of BRISTOL

- improved mental health outcomes

Can health care services respond to children exposed to DVA?

RESPONDS

Resea **imary**
car **arding**

Possibly

- IMPRoving Outcomes for children exposed to domestic ViolencE

unanswered questions

- How should health care respond to perpetrators?
- How do we extend training and pathways to achieve a safe and effective response to ***all*** survivors and their children?
- What does trauma-informed care mean for the health care response to domestic violence?

IRIS+

& group perpetrator programme for men

It is not OK to hurt your partner It is OK to ask for help

Call us to join a research study to explore ways of supporting men to change their behaviour. Men aged 21+

Constance

- Contacted nia project in Hackney
- Given refuge and moved away

Thank you

to colleagues

to funders

The Health Foundation

NHS National Institute for Health Research

MRC Medical Research Council

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