Domestic abuse

1. Domestic abuse

Around 1 in 5 adults experiences domestic abuse within their lifetime – that's approximately 2 million adults each year in England and Wales. Every week, three to four people are killed as a result of domestic homicide (ONS, 2023).

Despite this, domestic abuse often remains hidden. Many survivors never disclose their experiences, meaning that important opportunities for support are missed.

This article explores what we can do in primary care to recognise domestic abuse early and offer meaningful help for those affected, including for colleagues who may be experiencing abuse themselves.

You might also wish to refer to our associated articles, *Trauma-informed care*, *Adverse childhood experiences* and *Safeguarding children*.

This article was updated in November 2025.

1.1. Key actions for primary care when responding to domestic abuse

Here is a summary of key actions and guidance for responding to domestic abuse in primary care:

- **Ask safely and sensitively** about domestic abuse when there are clinical indicators or opportunities, ensuring privacy and that no potential perpetrator is present.
- **Listen without judgement and respond with empathy**, validating the person's experience and avoiding disbelief, blame or pressure to take a particular course of action.
- **Document concerns clearly and factually** in the clinical record, using the patient's own words. Hide entries from online access and avoid entries that could increase risk if viewed by the perpetrator.
- **Assess immediate safety** for the individual and any children or vulnerable adults, and act promptly by following safeguarding procedures if there is risk of serious harm.
- **Refer to the Multi-agency Risk Assessment Conference (MARAC)** through your local pathway when someone is assessed to be at high risk.
- **Refer or signpost to specialist domestic abuse support** such as an Independent Domestic Violence Advisor or local domestic abuse service, with consent wherever possible.

- **Share relevant information** with safeguarding leads or other agencies when needed to protect the person or dependants, ensuring clear communication and continuity of care.
- **Take care of your own wellbeing and that of your team** by debriefing, accessing supervision and maintaining up-to-date training on domestic abuse.

(*Responding to domestic violence: a resource for health professionals;* DOH, 2017)

1.2. What is domestic abuse?

Under the Domestic Abuse Act 2021, domestic abuse refers to *any* abusive behaviour between individuals aged 16 or over who are personally connected (such as intimate partners or family members), regardless of gender or sexuality.

Abuse can take many forms, including physical, sexual, emotional, psychological, controlling, coercive, violent, threatening or economic abuse. It may occur as a single incident or a pattern of behaviour, and can include actions directed at others, such as a partner's child, when used to harm or control the victim.

1.3. Who is affected by domestic abuse?

Everyone. Domestic abuse affects people across all ages, ethnicities, sexualities and socioeconomic backgrounds. Children are also recognised as victims of domestic abuse if they see, hear or experience its effects.

Women are at significantly higher risk of experiencing domestic abuse than men.

- In England and Wales, 29% of women and 14% of men have experienced domestic abuse. Globally, around 35% of women experience physical or sexual violence (BMJ 2021;373:n1047).
- Women experience more sexual violence, severe physical violence, fear, control and adverse mental and physical health effects than men (although men's exposure to domestic violence may be under-reported).
- Domestic abuse contributes to homelessness for nearly one-third of women in England.

Other risk factors include lower education levels, childhood maltreatment, alcohol misuse and rural isolation, which limits access to support. Younger women, those living in poverty and people with mental health or substance use problems are also more likely to report abuse (BMJ 2021;373:n1047).

1.4. Types of domestic abuse

Domestic abuse is not always physical. SafeLives emphasises that *any* threatening, controlling or coercive behaviour is abuse:

- **Physical and sexual abuse**: includes physical violence, injury, threats or sexual coercion. The WHO estimates that 26% of women and girls aged ≥15y have experienced physical or sexual violence from an intimate partner, and most UK femicides are committed by men known to the victim (WHO, 2021; Femicide Census, 2020).
- **Coercive and controlling behaviour**: a sustained pattern of behaviour to dominate or isolate someone, including criticism, humiliation,

surveillance, extreme jealousy, restricting movement or money, and threats to harm loved ones, pets or property.

- **Economic and financial abuse:** money and resources are used as a means of control. This can involve preventing access to work, benefits or accounts; dictating spending; taking money; or creating debt.
- **Psychological and emotional abuse:** frequent use of words or behaviour to undermine, manipulate or frighten. This can include gaslighting, blame-shifting, humiliation or the silent treatment. It may occur with or without physical violence and often leaves invisible harm.
- **'Honour'-based abuse and forced marriage:** abuse by family or community members to protect perceived 'honour'. It can include coercive control, imprisonment, assault, sexual violence or forced marriage.
- **Stalking and harassment:** unwanted, repeated contact or surveillance, such as constant messaging, uninvited visits, loitering or threats. Often continues after separation. Can occur online or in person.
- **Online and digital abuse:** misuse of technology to harass or control, including tracking, impersonation, publishing private material or threatening to share intimate content.

1.5. The impact of domestic abuse

Domestic abuse is a criminal offence, but also has a huge impact on health and wellbeing, including:

- Increased risk of mental health problems, including depression, anxiety, post-traumatic stress disorder and suicidality.
- Physical consequences, including injury-related disability; gynaecological, cardiac and gastrointestinal problems; and chronic

pain.

(Trauma Violence Abuse 2023;24:1282; DOH, 2017)

1.6. Understanding the victim: why don't they just leave?

This TED talk by a domestic violence victim (and Harvard graduate) explains how domestic abuse can affect anyone, and why it is so hard to leave: TED Talks – why domestic victims don't leave.

They may:

- Want the abuse to end, but not the relationship (e.g. they may have children together, be part of a wider family/community network).
- Be frightened about what will happen – violence can continue and escalate after separation.
- Be financially dependent on the abuser.
- Have a 'trauma' bond, and still feel love and emotional dependency.
- Be low in self-esteem and lack the confidence to leave.
- Worry they wouldn't be believed and that nothing could be done to stop it anyway.
- Experience cultural/religious barriers, and be concerned that they will be rejected by their community, family and friends.
- Worry about immigration status.
- Worry about losing children if social services become involved.
- Suffer associated mental health problems which prevent them from taking decisive action.

- Feel ashamed.
- Not recognise that their experience is abuse.
- Not know where to go for help (especially if they don't speak English).

1.7. The primary care role in domestic abuse

The Department of Health identifies two main responsibilities for primary care in tackling domestic abuse (DOH, 2017):

- Early identification through clinical encounters.
- Active involvement within a coordinated local multi-agency response.

These priorities are reinforced by NICE Public Health Guideline: *Domestic violence and abuse: multiagency working* (NICE 2014, PH50). This sets out how health services and commissioners should work together to prevent abuse and to plan and deliver coordinated care, including the following.

All primary care staff should:

- Be confident in recognising signs of abuse, make safe and sensitive enquiries, record concerns accurately and refer to appropriate support services.
- Ensure consultations take place safely and privately, and communicate clearly how to access advice and support within the practice and locally.

Clinical leads and safeguarding leads should:

- Maintain up-to-date knowledge of local MARAC and safeguarding pathways.
- Promote regular training and reflective learning within the practice

team.

- Strengthen links with local commissioners or Integrated Care Boards to support coordinated multi-agency working and ensure follow-up where needed.

SafeLives and partner organisations developed a Pathfinder Toolkit to strengthen how health services, including primary care, respond to domestic abuse. It highlights:

1.8. Identifying domestic abuse

Despite its profound impact on health, domestic abuse often goes unrecognised in clinical settings.

A survey of women attending general practice found that almost two-fifths had experienced domestic violence, but only a small number remembered being asked about it – even though most said they would welcome being asked by their usual GP (BMJ 2002; 324:271).

Health professionals face a number of barriers to asking about domestic abuse. A Canadian study (BMC Public Health 2012;12:473) highlighted several obstacles, including lack of time, the partner being present, language or cultural barriers, and the complex emotional and ethical challenges involved in disclosure, confidentiality and child safeguarding.

The study also found several factors that may make these conversations easier. Training in domestic abuse, supportive colleagues, clear protocols, routine enquiry about domestic abuse, and access to community resources and patient information materials can all help clinicians feel more confident and better equipped to ask about domestic abuse.

Becoming familiar with the ways that domestic abuse may present in primary care is also essential. We have summarised these in the table below.

1.9. What signs may alert us to domestic abuse?

Signs	Details

Inconsistent relationship with health services.	• Frequent appointments for vague symptoms. • Frequently missed appointments, including delays or lack of engagement in antenatal care. • Non-compliance with treatment or early discharge from hospital.

Physical symptoms.	• Injuries (including bruising, broken bones, burns, stab wounds) which are:
	  • Inconsistent with explanation of cause, or the woman tries to hide or minimise the extent of injuries.
	  • Multiple injuries at different stages of healing or repeated injury, all with vague or implausible explanations (particularly injuries to the breasts, abdomen or genitals).
	• Symptoms or conditions that may be suggestive of possible abuse, particularly if persistent or unexplained, such as:
	  • Headaches, cognitive problems, hearing loss.
	  • Chronic pain.
	  • Sleep problems.
	  • Gastrointestinal problems, including irritable bowel syndrome.
	  • Genitourinary symptoms, including frequent bladder or kidney infections.
	  • Gynaecological or sexual health problems, including pelvic pain and sexual dysfunction, recurrent STIs and vaginal bleeding.
	  • Adverse reproductive outcomes, including multiple unintended pregnancies, terminations or miscarriages; premature labour; low birthweight babies; or stillbirth.

Emotional or	

psychological symptoms.	• Anxiety/panic or fearfulness. • Post-traumatic stress disorder. • Problems with sleep. • Self-harm or suicidality. • Alcohol or drug misuse.
Intrusive 'other person' in consultations (e.g. partner, spouse, parent, grandparent).	• Always attends appointments unnecessarily. • Patient appears submissive or afraid to speak in front of the person. • The other person is aggressive, dominant or overly attentive, talking for the patient or refusing to leave the room.
Presentation in children.	• Injuries. • Aggression or challenging behaviour. • Depression, anxiety, fearfulness, withdrawal. • Self-harm or suicidal thoughts. • Trauma symptoms. • Risky health behaviours.
DOH, 2017; BMJ 2021;373:n1047; RCGP Safeguarding toolkit	

1.10. How to ask about domestic abuse

Although people often wish to be asked about domestic abuse, they may not disclose it unless asked directly. Even if a person does not disclose initially, opening the conversation may help them feel able to seek support later.

When abuse is suspected, health professionals have a duty of care to enquire about it. This should be done:

- Sensitively.
- Privately.
- Alone.

Use a professional interpreter if needed – ideally one with domestic abuse training or an advocate from a local specialist service. Never use friends, relatives or children because this may place the individual at further risk and compromise safety and confidentiality.

Some useful pointers to have this conversation include:

Communication step	What are we trying to achieve?	What might we say?
Ask safely and sensitively.	To ensure privacy and reduce risk when creating an opportunity to speak alone. Keep the reason neutral and health related so it cannot raise suspicion.	*I just need to examine you briefly – could you come through with me?* *I'd like to check your blood pressure in the other room.*
Create safety and trust.	To show care, confidentiality and routine concern, helping the patient feel safe to talk. To normalise their experience and reduce shame by framing relationship questions as part of holistic care.	*Because stress can affect health, I often ask how things are at home.* *Some people I see with ongoing pain are dealing with difficulties in other parts of life – has*

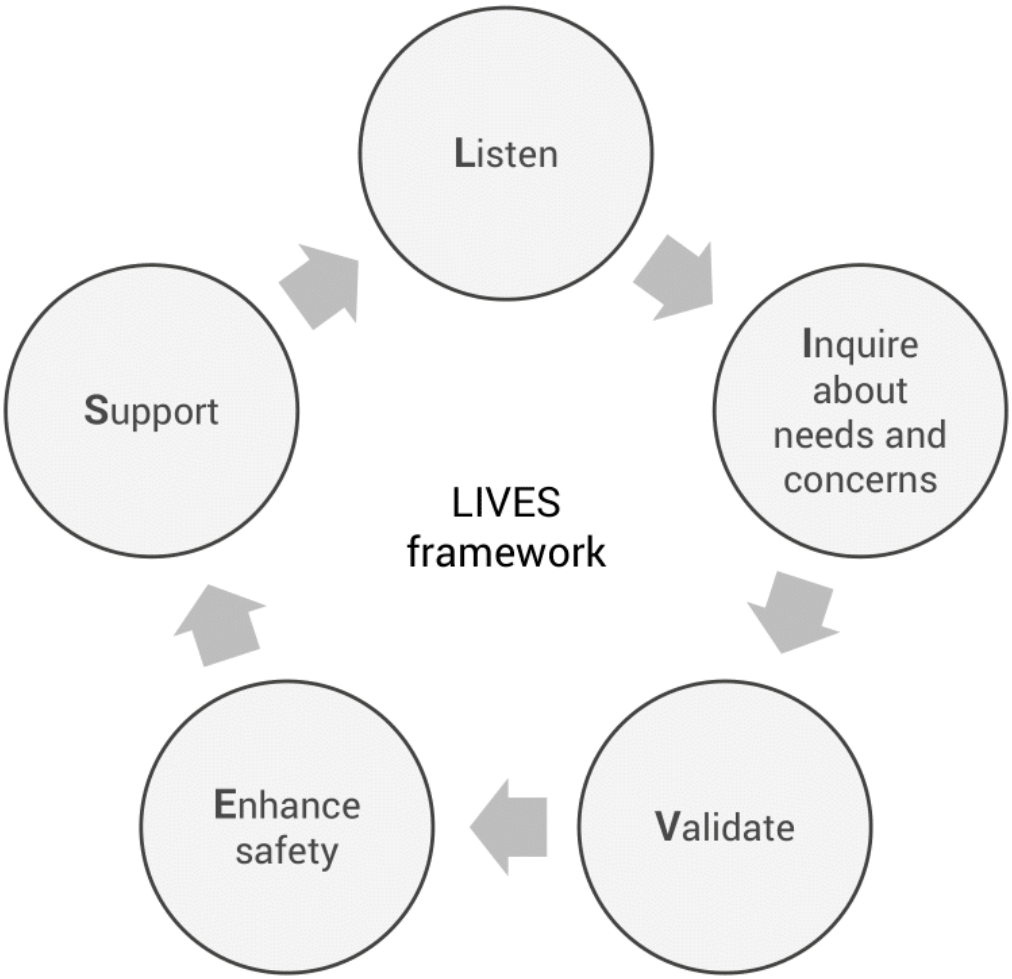
		that been happening for you?
Do not pressure the individual to disclose information.	To help the person stay in control and feel supported, without fear of being pushed to act before they are ready.	*You don't have to tell me anything now – I just want you to know that support is available whenever you're ready.*
Ask more than once.	To recognise that fear or uncertainty may stop disclosure at first, and that gentle enquiry over time can build trust.	*If you ever want to talk about things at home, you can always come back and we'll take the time you need.*
Ask direct, compassionate, clear questions.	To give permission for honest discussion, while maintaining warmth and professionalism.	*Do you feel safe at home?* *Does anyone make you feel afraid?* *Do you feel safe in your relationship?* *Have you been pressured or made to do anything that you did not want to?*
Use the HARK questions (Hurt, Afraid, Rape, Kick).	To use a short evidence-based framework for exploring possible abuse.	**Humiliation**: *Has anyone made you feel worthless or humiliated?* **Afraid**: *Have you felt afraid of a partner or family member?* **Rape**: *Have you ever been forced into*

		sexual activity? **Kick**: *Has anyone physically hurt or threatened you?*

(DOH, 2017; Guidance for General Practitioners responding to domestic abuse, SafeLives 2020; BMJ 2021;373:n1047)

Responding to a disclosure

When a person discloses domestic abuse, the immediate response from a health professional can strongly influence what happens next. Feeling believed, respected and safe is often the first step toward accessing further help. The **LIVES** framework provides a simple structure for responding to disclosures in primary care (BMJ 2021;373:n1047):



LIVES step	What are we trying to achieve?	What might we say?
Listen.	• Give your full attention and listen with empathy, without interrupting or judging. • Acknowledge the courage it takes to speak, and allow the person to talk at their own pace.	*I'm here to listen – please take your time.* *That sounds really difficult. I'm glad you told me.*
Inquire about needs and	• To understand emotional, physical, social and practical needs, and what matters most to the person right	*What's most important to you to focus on today?* *What needs to happen*

concerns.	now.	*first?*
Validate.	• Show that you understand, respect and believe them. Acknowledge any disclosure and the courage it takes to speak up. • Reinforce that the abuse is not their fault.	*Thank you for sharing that with me – it takes courage to be so open.* *You are not to blame for what's happened.*
Enhance safety.	• Assess immediate risk to life, and explore safety planning where appropriate. • Consider using a structured assessment tool such as DASH risk checklist (see below). • Consider children's safety – follow safeguarding procedures and liaise with relevant services. • Document factually and confidentially – record the conversation objectively and store securely.	*Do you feel safe going home today? What would help you feel safer right now?* *Is there anyone you trust that you can talk to or stay with?*
Support.	• Offer options and information so the person can make their own decisions. • Offer referral to local domestic abuse services. • If not ready to engage, provide details of sources of support to access later. • Arrange follow-up with a named clinician where possible.	*There are local services that can support you – we can contact them together if you'd like.* *If you're not ready now, here's a number you can use later.* *Let's arrange a follow-up so we can check how you're doing.*

(DOH, 2017; Guidance for General Practitioners responding to domestic abuse, SafeLives 2020; BMJ 2021;373:n1047).

1.11. Multi-agency Risk Assessment Conferences (MARACs)

A MARAC is a multi-agency meeting to support people at highest risk of domestic abuse. Representatives from the following services come together to develop a coordinated action plan: police, health, child protection, housing, independent domestic violence advisors (IDVAs), probation and other statutory or voluntary services. These meetings aim to:

- Share relevant information about the person experiencing abuse.
- Discuss options for increasing their safety.
- Agree a coordinated action plan.

The main focus is safeguarding the adult survivor, while also liaising with other organisations to protect any children and manage the perpetrator's behaviour. The survivor doesn't attend the meeting themselves, but is represented by an IDVA who advocates on their behalf.

(SafeLives, Multi-Agency Risk Assessment Conference (Marac) Guidance for GPs)

1.12. Documenting domestic abuse

It is essential to document domestic abuse discloses clearly and accurately.

The RCGP (Guidance on recording domestic abuse in the electronic medical record, RCGP 2021) recommends:

- Record the disclosure under the code 'History of domestic abuse',and document the patient's own words.
- Use the online visibility function to hide this consultation from online patient access.
- Document the name of anyone present during the consultation.
- Record the name of any alleged perpetrator when abuse is disclosed.
- Prevent unintended disclosure – ensure that no information is visible to partners or family members during appointments or on printed summaries (e.g. for hospital referrals or admissions).
- Be alert to the risks of perpetrators accessing their own, their children's or the victim's records, including through coercion.
- Code other household members (e.g. children or vulnerable adults) with the code 'History of domestic abuse'where appropriate.
- Do not enter domestic abuse information in a perpetrator's medical record unless they have disclosed it directly, but, if possible, link their record to those of the victim and household members.
- Use record alert systems to record safety concerns appropriately.

1.13. How to respond in primary care

After a disclosure of domestic abuse in primary care, it is essential to be able to recognise, understand and respond appropriately to different levels of risk. Remember that risk is dynamic and can change as circumstances shift or new information emerges. Our responses must therefore remain flexible and adapt over time.

Assessment of risk

The SafeLives DASH risk assessment tool (Domestic Abuse, Stalking and Honour-Based Violence) is often used by specialist domestic abuse workers to identify high-risk cases of domestic abuse, stalking and 'honour'-based abuse. However, the RCGP does not recommend its use in general practice because specific training, sufficient time and expertise are necessary to use it effectively (RCGP Safeguarding toolkit).

Assessment of risk	When to consider this	What steps to take
Is there immediate safety risk to life?	• The person does not feel safe to go home or has expressed fear of immediate serious harm (e.g. *'I think he is going to kill me'*). • There is a history of previous high-risk domestic abuse. • The person is planning to leave the relationship/situation – this can be a particularly dangerous time.	• Support the person to contact the police on 999, or call on their behalf if they are unable to. • Initiate urgent child/adult safeguarding procedures. • Consider a referral to MARAC (with consent from the patient). Take advice if unsure.
Is there possible high-risk domestic abuse (if no	Consider risk factors such as: • Severe or escalating abuse. • Use of weapons.	• Assess immediate safety. • Share 999 silent

immediate safety risks)?	• Stalking. • Sexual assault. • Attempted suffocation, strangulation or drowning. • Pregnancy. • Perpetrator behaviour, e.g. threats to kill the victim or to harm children, threats of suicide, access to weapons, use of alcohol/drugs, abuse of family pet, history of assaults. • Your own professional judgment.	solution. • Refer to the local domestic abuse agency. • Consider a MARAC referral. • Make a child safeguarding referral if appropriate. • Arrange follow-up.
If there are no current immediate safety risks and no current indication of high-risk domestic abuse.	Consider: • Type and severity of abuse. • What support the patient would like. • Whether there are children in the household/situation. • Whether the adult has care or support needs.	• Signpost/refer to local domestic abuse agency. • Consider child safeguarding or an Early Help referral to assess the family situation and provide support. • Consider an adult safeguarding referral if appropriate. • Arrange follow-up.
(RCGP Safeguarding toolkit)		

1.14. Consent and information-sharing

When domestic abuse is involved, decisions about sharing information can feel complex. Although confidentiality is important, it must be balanced against the need to prevent serious harm.

Where consent cannot be obtained or is refused, health professionals can share information if there is:

- Risk of serious harm or homicide: when not sharing would place the person or others at significant risk.
- Safeguarding concern: when there are concerns about the safety of children or vulnerable adults. Exposure to domestic abuse is itself a safeguarding concern for children.
- MARAC cases: consent is not required when sharing information with a MARAC because the individual will already have been assessed as at high risk of serious harm or homicide by the referring agency.

If you do pass on information without permission, ensure that your decision does not place somebody at risk of greater violence. Document the reasons behind your decision and record the action taken.

If you are unsure whether to share information, you can seek advice from your GP safeguarding lead, your practice's IRIS Advocate Educator or your local MARAC contact.

SafeLives, Multi-Agency Risk Assessment Conference (Marac) Guidance for GPs

1.15. Interventions for domestic abuse

Do not advise a victim to leave their partner without all the necessary support in place, including police involvement, because they are at high risk of injury or murder when they leave a violent or abusive partner.

Responsibilities of primary care

Victims of domestic abuse may need support in several aspects of their lives. Our responsibility is to manage their health needs and refer appropriately (e.g. Sexual Assault Referral Centre (SARC), mental health services). This includes:

- Addressing physical injuries appropriately.
- Referral to appropriate health services such as maternity, substance misuse or for trauma-focused mental health treatment.

We should also facilitate engagement with other agencies to address the social, environmental and wider impacts of domestic abuse. If a victim is below the MARAC threshold and there are no other concerns, help the person contact local specialist domestic abuse services for help.

What do the domestic abuse services offer?

Advice on:

- Changing locks.
- Legal routes, e.g. restraining orders or injunctions.
- Emergency refuge accommodation.

- Independent domestic abuse advisor advocacy, support and help formulating a safety plan.

What is covered in a safety plan?

Issue	Recommendations
Maintaining safety in the relationship.	• Avoiding dangerous places when abuse starts (such as the kitchen, where there are potential weapons). • Details of people a victim can turn to for help when in danger. • Asking neighbours/friends to call 999 if they hear anything to suggest they or the children are in danger. • Places to hide important phone numbers (?helplines) and personal documents. • How to keep the children safe when abuse starts.
Leaving in an emergency.	• Pack an emergency bag and hide it in a safe place. • Plans for who to call and where to go (such as a refuge). • Things to remember to take: documents, medication, keys, phone, money.
Safety when a relationship is over.	• Contact details for professionals who can advise or give vital support. • Changing phone numbers. • Maintaining secrecy of location from their partner if they left home (by not telling mutual friends where they are, for example). • Getting a non-molestation, exclusion or restraining order. • Contacting police or MARAC, if necessary. • Plans for talking to children about the importance of staying safe. • Asking an employer for help with safety while at work.

1.16. Identifying perpetrators

Perpetrators of abuse are our patients as well; as a result, we are in a key position to identify them and assist in the interruption of their harmful behaviour by referral to specialist services.

How might a perpetrator present?

An abuser may present voluntarily for help, or may present with related problems such as alcohol issues, stress or depression. Remember that not all abusers are male.

Adopt a motivational approach

- Express empathy and listen.
- Ask how their problems impact them and their family.
- Ask about any negative feelings, behaviour or actions.
- Point out any discrepancies between personal values and current behaviour.
- Encourage optimism and belief in ability to change.

The first step is to manage the risk to the victim and any children. The second is to address the perpetrator's behaviour and other health needs.

Domestic abuse perpetrator programmes

These are usually run by third sector organisations and aim to:

- Examine behaviour and beliefs about gender and relationships.
- Challenge and support perpetrators in changing this behaviour.

A study of intimate-partner homicides suggests that depression, mental health problems and suicide risk are indicators of high-risk perpetrators. This means that other issues (e.g. mental health, drug and alcohol issues) may need addressing – although ideally not in isolation from perpetrator services.

1.17. Honour-based violence

Honour-based violence is abuse committed in order to defend or protect the perceived honour of a family or community. It may involve domestic and sexual violence or forced marriage. Perpetrators of honour-based violence can kill close relatives and/or others for what might seem to be a cultural transgression.

There are a number of charities that can provide advice and support for victims and professionals (e.g. Karma Nirvana, the HALO project: see useful resources, below, for details).

1.18. The impact of domestic abuse on children and young people

Under the Domestic Abuse Act, children are recognised as victims of abuse in their own right. Around one in five UK children are thought to witness domestic abuse, which is the most common factor in social care assessments and serious case reviews. Children may be involved in conflict, directly witness violence or remain at risk after parental separation through

ongoing coercion or manipulation (Domestic Abuse Commissioner, 2021).

Abuse can affect children's emotional, cognitive and physical development. However, fear, stigma and complex family dynamics may prevent parents from seeking help, with concerns about not being believed, losing custody or making the situation worse (NSPCC, 2021). The impact of domestic abuse on children includes:

- **Emotional and behavioural changes:** withdrawal, anxiety, fear, aggression or risk-taking behaviour.
- **Mental health problems:** guilt, hopelessness, nightmares, self-harm or suicidal thoughts.
- **Impact on development and wellbeing:** negative impacts on emotional regulation, learning, concentration, sleep and social confidence.

Children affected by domestic abuse benefit from trauma-informed, coordinated support that involves multi-agency collaboration; stable relationships with trusted adults; safe spaces for expression; and support for non-abusing parents. Education about healthy, respectful relationships can also reduce risk and help identify early signs of coercion or control. However, access to specialist help remains inconsistent across the UK.

Abuse in teenage relationships

Abuse can also occur in teenage relationships and often goes unnoticed. Many young people struggle to recognise unhealthy behaviour or feel unable to seek help. Those with limited relationship experience – particularly if exposed to abuse at home – may find it harder to identify what is safe or respectful.

The Children's Society has called for national guidance on teenage relationship abuse, including clearer prevention, early identification and

accessible specialist support for both victims and those who display abusive behaviour, because these patterns often reflect trauma or unmet needs (Missing the Mark, Children's Society, 2020).

Child and adolescent to parent violence and abuse

Child and adolescent to parent violence and abuse (CAPVA) is a serious but often overlooked form of family abuse. It involves children or adolescents using repeated harmful behaviours – physical, verbal, emotional, psychological, sexual or financially damaging – towards parents or caregivers. These behaviours go beyond typical teenage conflict and involve a repeated harm. Behaviour is considered violent if family members feel threatened, intimidated or controlled, or when they change their own behaviour to avoid potential violence.

Definitions are still debated, and the UK prevalence is uncertain due to limited high-quality research. CAPVA occurs across all types of families, but mothers – especially single mothers – are much more likely than fathers to experience aggression. It often begins in early to mid-adolescence, peaks at 14–16y, and may continue into adulthood.

These situations are often complex and difficult to identify and talk about. Many parents feel ashamed, fearful, isolated or responsible for what is happening, making them reluctant to seek help or involve the police.

CAPVA can have profound impacts on the whole family:

- Parents may experience injuries, fear, chronic stress, anxiety, depression, financial strain, guilt and difficulty maintaining boundaries.
- Young people may experience injuries, emotional distress, trauma, disrupted education, damaged relationships and legal consequences.
- Siblings may feel frightened, witness violence and develop anxiety or

low mood.

- Family life can be destabilised through damaged relationships, property destruction, reduced social contact, threats to employment or the need for family separation to maintain safety.

A range of factors can contribute to how CAPVA develops and persists. These include:

- Mental health, neurodevelopmental and behavioural difficulties, and substance misuse.
- Exposure to domestic abuse or child maltreatment.
- Poor parent–child communication.
- Parenting approaches that lack boundaries or use harsh or overly-controlling methods.
- Peer influences, school stress and socioeconomic hardship.

There are rarely simple solutions. Families need an appropriate domestic abuse response, and any child displaying harmful behaviour requires a safeguarding assessment and support to understand what is driving their actions. Support varies depending on local services, although long-term evidence for specialist programmes is limited.

- Support ranges from self-help and peer groups to specialist programmes.
- Work with parents often focuses on recognising abuse, improving communication and boundaries, and reducing shame.
- Work with young people centres on managing emotions, understanding triggers, improving communication and taking responsibility.
- Better prevention and support are likely to be beneficial, focusing on earlier identification and providing effective family support.

(Understanding CAPVA, Domestic Abuse Commissioner's Office, 2021; RCGP Safeguarding toolkit)

1.19. Legal frameworks

Clare's Law - the Domestic Violence Disclosure Scheme

The Domestic Violence Disclosure Scheme (DVDS), known as Clare's Law, enables police to disclose information about an individual's history of violence or abuse to help protect potential victims. It was introduced in England and Wales in 2014, following the murder of Clare Wood by her ex-partner in 2009, and similar schemes have subsequently been implemented in Scotland and Northern Ireland.

The law operates through two routes:

- Right to ask: anyone aged 16 or over can request information from the police if they are concerned about a current or former partner, or about someone else who may be at risk.
- Right to know: police can proactively share information if a person has a known history of violent or abusive behaviour and they believe someone may be at risk of harm.

The Domestic Abuse Act 2021 made the DVDS part of statutory guidance, meaning all police forces must follow the same national standards when using it. Every disclosure should be supported by a clear, personalised safety plan to help protect the person at risk.

Injunctions to protect individuals from domestic abuse

Victims of domestic abuse can apply to the court for an **injunction** to help protect their safety. This may include one of the following:

- **Non-molestation order:** prevents the abuser from harming or threatening the individual or their children.
- **Occupation order:** decides who can live in or access the family home.
- **Domestic Abuse Protection Order:** currently available only in specific areas of the UK, offering protection from all forms of domestic abuse.

Breaching an injunction is a criminal offence. Applications are free, and individuals may be eligible for legal aid or support from specialist domestic abuse services when applying for or extending an order.

1.20. Domestic abuse in health professionals

There is growing evidence that health professionals – a predominantly female workforce – experience higher rates of domestic abuse than the general population. Health professionals are also listed among the most common occupations of women killed by a partner (Femicide Census, 2020).

A 2023 meta-analysis found (Trauma Violence Abuse 2023;24:1282):

- The lifetime prevalence in health professionals was 31%, with 10% reporting abuse in the past year.
- Rates were higher in women (42%) than men (15%), in nurses (35%) than physicians (12%) and in lower- and middle-income countries (64%) than high-income countries (21%). Non-physical abuse was more common than physical or sexual abuse.
- Risk factors included being female, having children, financial strain and a history of mental health problems.

- Work-related factors such as relocation, isolation and the demands of caring roles also increased vulnerability.

A cross-sectional survey of UK health professionals – from roles including general practice, dentistry and secondary care – found that most abuse was perpetrated by male partners or ex-partners. Over one-third were still experiencing abuse at the time of the survey. In 11%, the abuser also worked in healthcare (Occ Med 2024;74:514).

The impact of domestic abuse on clinicians

Domestic abuse has wide-ranging effects on clinicians' health, wellbeing and ability to work safely. There may be:

- Physical and mental health consequences, including injuries, chronic fatigue, miscarriage, poor sleep, depression, anxiety and suicidal thoughts.
- An impact on work performance. Many describe difficulties with concentration, memory and confidence, as well as feeling unsafe or triggered at work. Some may take sick leave, make clinical errors or leave their jobs entirely.
- Perpetrators may also directly impact clinical work through attempts to control, disrupt or sabotage a survivor's professional practice, for example by depriving them of sleep before shifts, harassment during working hours, making false accusations to colleagues or sabotaging transport to work.
- Survivors often describe burnout and moral distress from attempts to uphold professional standards while coping with personal trauma.
- Clinicians with lived experience of trauma can bring deeper empathy and understanding when caring for patients experiencing domestic abuse, but this can also lead to re-traumatisation and moral injury,

particularly when patient encounters or educational sessions evoke distressing memories of personal experiences of abuse.

(Trauma Violence Abuse 2023;24:1282, Occ Med 2024;74:514)

Barriers to seeking help

Health professionals face significant barriers to disclosure and accessing support for domestic abuse. These include:

- Fear of stigma, judgement, damage to professional reputation and disbelief. This may outweigh the perceived benefits of disclosure. Many worry that colleagues will think less of them, or that their experiences may be minimised or dismissed.
- A belief that domestic abuse 'should not happen' or 'does not happen' to health professionals. This contributes to shame, self-blame and difficulty recognising or naming experiences as abuse, along with a sense of failure and disbelief that abuse could happen to them.
- Concerns about professional standing, registration and future career prospects. Many feared that disclosure could trigger regulatory scrutiny or questions about fitness to practise.
- Confidentiality was a major concern. Many feared that disclosures would not remain private, or that information may be shared with managers, colleagues or professional bodies without consent.
- Some abusers can use a clinician's professional status as a means of harm, including making threats of referral to regulatory bodies such as the GMC, or making allegations of mental illness.
- Time pressures, unpredictable working hours and lack of access to private spaces during the working day make it harder to seek confidential support.

- Difficulties accessing help outside work, with fears of encountering patients or being recognised by colleagues.
- A strong internal pressure to maintain a 'highly functional' professional image despite personal distress, leading many to hide their experiences and continue working through exhaustion or trauma.

(Trauma Violence Abuse 2023;24:1282, Occ Med 2024;74:514; BJGP 2021;71:e193)

Workplace support for staff experiencing domestic abuse

The Domestic Abuse Act 2021 highlights employers' duty of care to consider how domestic abuse affects employees. However, workplace support within the NHS remains patchy and often limited.

Health professionals who have experienced domestic abuse report uncertainty about available support and lack of clear organisational policies (Occ Med 2024;74:514):

- Many clinicians were unsure whether a domestic abuse policy existed in their workplace, and few had access to measures such as flexible working, special leave or occupational health support.
- Only 10% said their organisation had a designated domestic abuse contact.
- Respondents wanted clear, confidential and compassionate support, including trained staff, flexible working options and access to counselling or advocacy.
- Feeling believed and listened to was described as validating, yet many felt dismissed or unsupported.

The BMA report *Support for doctors affected by domestic abuse* (BMA, 2019),

identified similar shortcomings. Where policies existed, quality and scope varied widely. The BMA called for stronger, consistent workplace policies and greater awareness to ensure staff that can access safe, confidential and compassionate support. Every organisation should:

- Have a specific domestic abuse policy for staff that is aligned with national guidance.
- Appoint and train a designated contact for staff support.
- Regularly review and promote domestic abuse policies.
- Offer practical measures such as special leave, safety planning, flexible working and confidentiality safeguards.

Supporting colleagues at risk of domestic abuse

Being alert to colleagues who may be experiencing abuse is vital. Warning signs can include frequent absence or lateness, changes in behaviour or appearance, reduced concentration or social withdrawal.

If you're concerned about a colleague:

- Speak privately and express your concern without judgement: "You seem under a lot of pressure lately. Are you OK? Is anything happening that is causing difficulties?"
- Listen and believe them, without pressing for details.
- Reassure that help is available and information will be treated confidentially.
- Know where to signpost: occupational health, employee assistance programmes, staff wellbeing services, domestic abuse leads or specialist helplines.
- If abuse is disclosed, don't investigate or counsel – ensure safety and

help the person to access specialist support.

(SafeLives Guidance for General Practitioners responding to domestic abuse, 2020; NHS Employers, 2022)

1.21. How can I get more training in domestic abuse?

RCGP

On its website, the RCGP has resources for approaching domestic violence in primary care: RCGP – domestic abuse.

IRIS

The Identification and Referral to Improve Safety (IRIS) system is a general practice-based domestic abuse training support and referral programme that has been evaluated in a randomised controlled trial and found to be cost-effective (Lancet 2011;378:1788).

The national IRIS team provides commissioning guidance and a training for trainers' programme in areas that implement the model.

Domestic abuse

- Domestic abuse affects around one in five adults and is frequently missed in clinical settings.
- Children who see, hear or are affected by domestic abuse are recognised as victims under the Domestic Abuse Act.

- Domestic abuse can be physical, sexual, emotional, psychological, controlling, coercive or economic.
- Asking about abuse safely requires privacy, sensitivity and ensuring the potential perpetrator is not present.
- Effective responses include non-judgemental listening, showing empathy, validating the person's experience and avoiding pressure to disclose or act before they are ready.
- Clear, factual documentation using the patient's own words is essential, and must be hidden from online access to maintain safety and confidentiality.
- Immediate safety risks require urgent action, involving safeguarding procedures and emergency services where appropriate.
- CAPVA and teenage relationship abuse are recognised forms of domestic abuse that require support and safeguarding responses.
- Health professionals experience higher rates of domestic abuse than the general population and face significant barriers to seeking help.
- High-risk cases should be referred to a MARAC through local safeguarding pathways.
- Do not advise a victim to leave their abuser without support and safety planning in place.
- The primary care role involves managing ongoing health needs and facilitating access to specialist domestic abuse services and other relevant agencies.

Do you know how to contact your local domestic violence service?

Useful resources:

Websites (all resources are hyperlinked for ease of use in Red Whale Knowledge)

Support for victims of domestic abuse:

- Women's Aid (information and support on domestic abuse_
- Refuge (a range of services to support survivors of abuse, including running the National Domestic Abuse Helpline)
- SafeLives (support for people experiencing domestic abuse and resources for professionals)
- SafeLives - domestic abuse helplines (services across the UK)
- Galop (helpline and support for LGBTQIA+ people experiencing any form of abuse or violence, such as hate crime, domestic abuse or sexual violence)
- Silent Solution (a police service for when someone needs to call 999 but cannot talk – ensuring that people can alert the police and get help when they are in need but unable to speak)
- Safe Spaces (offers access to discreet areas in consultation rooms of many shops and banks where people experiencing domestic abuse can contact friends, family or specialist support)
- Bright Sky (a free app for anyone experiencing domestic abuse or concerned about someone else. It helps users recognise signs of abuse, respond safely and access support)
- Respect Men's Advice Line (offers confidential phone, email and webchat support for men experiencing domestic abuse)
- Doctors Association UK offers resources and research on domestic abuse in healthcare, including:
    - Resources for doctors and health professionals experiencing domestic abuse
    - Resources for NHS employers to support staff affected by domestic abuse
    - Research and guidance on domestic abuse in healthcare professionals

Support for forced marriage and honour crimes:

- Karma Nirvana (runs the national Honour Based Abuse Helpline, trains professionals, gathers data to inform policy and services, and campaigns for change)
- Halo Project (provides information, advice and support for

	Black and minoritised women and girls at risk of forced marriage, honour-based violence and FGM) • gov.uk – forced marriage guidance *For perpetrators:* • Respect Phoneline (offers phone, email and webchat support for people who want to stop using violence or abuse, and guidance for professionals working safely with perpetrators)