CARD 12
Domestic violence and abuse
It has been estimated that one woman in three, and one man in five, will experience domestic abuse. Two women a week are killed by a current or former male partner. Domestic violence and abuse are a central part of adult safeguarding, and a wide range of detailed guidance is available. Doctors who are likely to work with adults at risk of abuse should familiarise themselves with both local procedures and more detailed guidance. Links are given at the end of this toolkit.

**What are domestic violence and abuse?**
The UK Government’s definition of domestic violence is ‘any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass but is not limited to psychological, physical, sexual, financial and emotional abuse.’

It can also include:
- coercive control
- digital/online abuse
- so-called ‘honour-based’ violence
- female genital mutilation.

Doctors need to ensure they have appropriate training to identify patients whose physical or psychological symptoms indicate that they may be subject to domestic violence or abuse. Emotional factors can include:

- agitation and anxiety
- depression
— a constant state of alertness that makes sleep or relaxation difficult
— a sense of hopelessness because they believe they will never escape the control of their abuser.

Physical symptoms can include:

— physical signs such as bruising or cuts
— headaches
— gastrointestinal problems
— chronic pain
— restless sleep or insomnia
— genital soreness
— pelvic pain
— back pain.

**Responding to concerns**

Where doctors are concerned that an individual may be at risk, the first response should be sensitive, safe and empathetic. When asking questions about domestic abuse it is important to ensure, as far as possible, that the environment is both safe and conducive to raising such a sensitive issue — questions about domestic abuse should not be asked in the presence of others, including any children over two years old. If there are language issues, professional interpreters should be used, not family members.

Where doctors have concerns about domestic violence, it is important to ask the question directly. Euphemism and indirection should be avoided. Guidance from NHS England recommends questions along the lines of: ‘Are you in a relationship with someone who hurts, threatens or abuses you?’ or, ‘Did someone cause these injuries to you?’
It is important that doctors are familiar with local procedures for responding to disclosure, and know what to do when there is immediate risk of harm to patients and their children.

Doctors must make clear, contemporaneous records of any concerns and discussions regarding domestic abuse, including evidence of any injuries. These records should be kept securely – they may be required later for evidential purposes.

**Sharing information**
Sharing information with appropriate agencies can be an important part of keeping people safe. Many people who are subject to abuse are understandably anxious about information being disclosed, in case it gets back to the abuser and puts them at further risk. It is therefore vital to be clear that, in almost all circumstances, the patient’s information will only be disclosed with their consent. It may be appropriate for doctors to encourage disclosure where it is necessary for their protection, and this can include warning about the risks of not disclosing, but doctors should ordinarily respect the wishes of adults with capacity, even if their decision leaves them at risk of harm.

In exceptional circumstances – for example, where a third party such as a child or other adult is at risk of harm – it may be necessary to share information without consent. Information should not be disclosed without consent unless there is clear evidence of immediate risk.
Some cases considered at multi-agency risk assessment conference (MARAC) meetings may constitute exceptional circumstances because MARACs discuss the most serious cases of alleged or suspected domestic abuse.

Information about responding to concerns about female genital mutilation is available from the BMA.