How to enquire and respond to domestic violence and abuse in sexual health settings

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INTRODUCTION

Domestic violence and abuse (DVA) is a violation of human rights with profound physical, emotional and socioeconomic costs to the individual, families, communities and society as a whole. In the UK, 28.3% of women and 14.7% of men had experienced any domestic abuse since the age of 16.[1] DVA costs the National Health Service £1.7 billion annually, excluding mental health costs; the estimated overall annual cost of DVA in the UK is £15.7 billion.[2] The prevalence of all DVA is higher among women than men. Women also experience much more sexual abuse, as well as more severe and repeated physical abuse and more coercive control.[1] The majority of epidemiological and intervention research on DVA has been in women in heterosexual relationships not men or lesbian, gay, bisexual and transgender (LGBT) communities, though they are also affected by DVA.

WHAT IS DOMESTIC VIOLENCE AND ABUSE?

The UK cross-government definition of DVA 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.[3] Intimate partner violence (IPV) forms the majority of DVA and is defined as any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.[4] It is not necessary to be cohabiting for IPV to occur.

HEALTH IMPACT

DVA damages physical and psychological health. In the UK, two women are killed by their current or former male partner each week[5] and is tallied by the 'Counting Dead Women' twitter campaign in the UK.[6] In the USA, 5.3 million episodes of IPV occur each year, causing 2 million injuries, with 550 000 victims requiring medical treatment.[7] In Australia, IPV is the biggest contributor to death, disability and illness for women of reproductive age, ranking above high blood pressure, smoking, illicit drug use and obesity.[8]

Presentations of DVA in sexual health settings include gynaecological problems, substance abuse, self-harm, suicidal ideation, anxiety and depression, and chronic pain conditions.[9 10] The biggest and most consistent physical health difference between abused and non-abused women are gynaecological problems. Specific associations include STIs, abnormal vaginal discharge, chronic pelvic pain, unplanned pregnancy and induced abortion.[10 11] Sexual health problems indicating DVA affecting men and women patients include sexual risk taking, sexual dysfunction and inconsistent condom use.[12]

DVA ENQUIRY

National Institute for Health and Care Excellence identifies sexual health clinics as a setting in which routine enquiry about DVA should be considered best practice due to the high frequency of presentations and outcomes associated with DVA in sexual and reproductive healthcare.[13]

IRIS (Identification and Referral to Improve Safety) describes in detail multiple aspects of best practice for the healthcare response to DVA, including enquiry. IRIS has its roots in strong evidence from a cluster randomised controlled trial in primary care[14] and promising findings from a feasibility study in sexual health. In primary care, IRIS has now been commissioned in 33 localities. The IRIS intervention is made up of clinically focused training sessions, a DVA clinical champion or lead to promote DVA enquiry and provide support to staff, patient information including numbers for DVA services in the form of posters and discrete cards, and a simple referral pathway for specialist support. This is as recommended by the BASHH guidance on DVA.[15]

IRIS in addition to this includes specifically adapting the electronic records, by using the HARK acronym (see box 1), to prompt enquiry and safely record disclosures. HARK also reminds clinicians to consider all the dimensions of abuse: not just physical, but also sexual and emotional.[16] Emotional abuse, even alone, has been found to produce long-term adverse physical and mental health effects. It also includes a question about fear, which is indicative of coercive control. Coercive control is now formally included as a criminal offence alongside threats to kill, harassment, stalking and putting people in fear of violence. Asking a single question such as 'Have you ever been hit by your partner?' is too limited, missing abuse, as well as illegal behaviours.

IRIS ADViSE (Assessing for Domestic Violence in Sexual health Environments) is the IRIS model developed for sexual health. This has been evaluated using an adaptive pilot study in two sites by the authors of this article, showing that it is feasible, and appears to increase rates of enquiry, identification and referrals for advocacy.[17]

PROMOTING AND MANAGING DISCLOSURE

The steps recommended in this article are consistent with the BASHH guidance[15] and informed

Box 1 ASK

'How are things at home?'
'Has anyone at home/your partner made you feel unsafe or threatened?'
'Are you afraid of anyone at home/your partner?'
'Patients with this symptom/condition may be suffering abuse from a partner or adult they live with; is that something you have ever experienced?'

H: HUMILIATION
Have you been humiliated or emotionally abused in other ways by your partner or your ex-partner?
A: AFRAID
Have you been afraid of your partner or ex-partner?
R: RAPE
Have you been raped or forced to have any kind of sexual activity by your partner or ex-partner?
K: KICK
Have you been kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?

by the authors' joint experience of implementing IRIS and IRIS ADViSE.

Step 1: Ask

Clinicians sometimes express concern about asking about DVA as they are worried about making a patient uncomfortable. However, systematic reviews of questionnaire and interview-based studies of women show that enquiring about IPV is generally acceptable.[18] In one study, women emphasised that they viewed being asked about IPV as an opportunity to receive information and support rather than solely as a method to identify IPV.[19]

Certain factors promote the likelihood of disclosure. These are usually already practised in sexual and reproductive healthcare when enquiring about other potentially sensitive issues, such as sexuality and sexual behaviours. These include:

- creating a safe and confidential environment by seeing patients alone (including without young children as they may report back to a controlling partner);
- being non-judgemental and showing compassion;
- giving a reason for asking (association with a particular symptom/diagnosis or the ability of the service to offer tailored support);
- not pressuring a patient to disclose.

It is important for the clinician to avoid asking about DVA as a 'tick-box' exercise. Open questions are a good starting point. An appropriate time to enquire about abuse could be when discussing partners as part of a sexual history, following cues when the patient mentions intimate or family relationships, or relating it to specific presentations. The latter method may promote disclosure as it can help patients understand the clinical relevance of these questions. Some useful questions are listed in box 1.

Step 2: Respond

This has two components:

Validate

Patients who disclose have frequently harboured fears of, or previously experienced, being judged or not believed. The clinician should validate the patient's experience by saying that they believe them, asserting that the perpetrator's behaviour is unacceptable and sometimes criminal, and offering support. Possible validation statements are listed in box 2. It is helpful to explain that DVA can damage health, is not limited to physical abuse, and support that is offered can improve health, safety and well-being.

Assess

The clinician should make a brief assessment of immediate safety. Phrases such as 'Are you safe to go home?' or 'Are either you or your children in immediate danger?' are explicit. Other ways of exploring this include asking about increasing frequency or severity of violence, and whether a perpetrator can access weapons. Escalating physical violence and access to weapons are major risk factors for fatal violence. If there is any suggestion of immediate harm, then the patient should be helped to urgently contact a specialist DVA service or the police. There should be a private room available for the patient to wait without fear of being found or overheard by a perpetrator.

Step 3: Action

All patients who disclose DVA should be offered a referral to local and/or national specialist DVA advocacy services regardless of the type of abuse and the timescale over which it has happened. Even if patients decline referrals, they will know that they can discuss the problem at the clinic, be aware of help available and can self-refer or request a referral when they feel ready. A simple referral pathway saves clinicians' time. It requires readily available details of local and national services, including the free phone 24-hour national domestic violence helpline run by *Women's Aid* and *Refuge* (0808 2000247). The local authority normally has a domestic violence coordinator with knowledge of the local services available. A contact should be identified in local services to facilitate direct referrals to domestic violence advocates and support clinicians managing DVA.

IRIS ADViSE offers referral to a specialist DVA advocate-educator (AE), who may be available on site in the sexual health clinic but is managed by a local DVA service provider. The AE is a unique role that provides advocacy for the patient and ongoing education for clinicians.

The AE and generic DVA services provide support for current and historic abuse. This includes in-depth risk assessments, immediate emotional support, access to psychological support services, housing, criminal justice, social services and help to plan safe exits. They also often support relatives and friends who are concerned about someone else being affected by DVA. They can also refer to Multi-Agency Risk Assessment Conferences (MARACs). These aim to develop and implement a coordinated safety plan for patients at high risk of murder or serious harm. For women, leaving an abusive situation is a high-risk period for violence; expert input facilitates safe exits.[20]

Box 2 Validate

'Everybody has the right to feel safe at home'
'You don't deserve to be hit or hurt. It is not your fault'
'Thank you for telling me. You are not alone. Help is available'
'You are not to blame. Abuse is common and happens in all kinds of relationships.'

Step 4: Record

There should be a consensus within clinics on how to record DVA. Records should be adapted to ensure that abuse can be recorded and coded confidentially, as well as flag DVA disclosures for future consultations. Clear medical notes are important as they can support successful prosecution of perpetrators. IRIS ADViSE provides the HARK electronic prompt to facilitate this process.

SEXUAL ABUSE

Most sexual abuse occurs within pre-existing intimate relationships.[1] Sexual health clinics are usually already well prepared to manage disclosures of sexual abuse. All patients should be offered a referral to sexual assault referral centres regardless of whether they want to prosecute. An in-depth discussion is beyond the scope of this article and comprehensive clinical management is detailed in the BASHH guidelines on management of sexual assault.[21]

LGBT COMMUNITIES

BASHH guidance highlights LGBT communities as particularly vulnerable to DVA and potentially less able to access help. In one UK study in sexual health services, 33.9% of men who have sex with men (MSM) have ever experienced a negative potentially abusive behaviour,[22] while another survey suggested that half had been affected by DVA. MSM who have experienced IPV are more likely to be substance misusers, suffer from depression, be HIV positive and have unprotected sex.[23] Twenty-five per cent of women who have sex with women are affected by DVA. Up to 80% of the transgender population have been affected by DVA ever.[24] Men appear to be less likely to take up referrals,[25] though it is not understood precisely why. LGBT people may be less likely to report to police because of fears of prejudice, being judged or revealing sexual/gender identities.[26] Despite the relative paucity of evidence into DVA in LGBT communities, we do know that sexual health services are better placed to identify these groups than other settings. It is appropriate to provide the same response and support described in this article, consistent with BASHH and IRIS ADViSE, to these patients, along with specialist knowledge about DVA services that provide expert support to LGBT communities.

CHILDREN AND ADOLESCENTS

Exposure to DVA damages the health and development of children, even if they do not directly witness the abuse. The clinician should enquire whether children are present in the household and explore their risk. The child is at greater risk if he/she is under 7 years of age, the mother is pregnant or the mother or child has special needs. Adolescents are a highly vulnerable group that may be exposed to DVA including IPV and dating violence. It is important to emphasise that perpetrators do not necessarily need to be someone sharing a household, but can be anyone with whom they have an intimate or family relationship. Where there are concerns regarding children or vulnerable adults, safeguarding procedures must be initiated. A judgement about whether a case requires safeguarding intervention can be complex. If there is any uncertainty, it should be discussed with the safeguarding clinical lead and the trust's child protection services.

CONCLUSION

To deliver comprehensive sexual and reproductive healthcare, all sexual health clinicians should be competent in safely and compassionately asking about DVA, responding to disclosures and referring to DVA services. Sexual health services should support professionals by providing training and developing links with local DVA services. Further detailed information on DVA on health professionals' training and supervision, risk assessments, MARAC referrals and vulnerable groups can be found in the BASHH guidance and the book 'ABC of Domestic and Sexual Violence'.[15 27 28]

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VIGNETTE

Culture of the gonococcus: a reliable gold standard?

> There are differences of opinion as to the value of cultures in the diagnosis of gonorrhoea. Personally I think them indispensable in the case of women…[1]

For most of this Journal's existence laboratory culture of *Neisseria gonorrhoeae* provided definitive identification. However, even at its apogee, a single culture lacked 100% sensitivity. Multiple sampling, from multiple sites, was necessary to diagnose, to exclude and to assess advances in culture's efficiency.

Today, gonococcal nucleic acid amplification tests (NAATs) have their own sensitivity and specificity compared (invariably favourably) with 'culture', whose published details may lack data on sample-handling, transport and quality control.

Duncan Catterall's 1970 article[2] highlights sharp contrasts with today's practice, procedures and prevalence:

> A full physical examination was performed on all the patients.
>
> Every patient had at least 4 pelvic examinations and the majority had 6 or more genital tests.
>
> gonococci were found in 31.6%
>
> They were all observed for at least 3 months.
>
> …even with a first-class cultural service, repeated examinations are needed to establish the diagnosis of gonorrhoea in women
>
> gonococci were found [by microscopy] in only 67 (69%) of 95 consecutive cases

This last quote demonstrates how 'a poor culture service flatters the microscopist'. Catterall used McLeod's culture medium and diagnosed 60% of gonorrhoea at the first visit. Other Centres reported figures between 88% and 95%. At St Thomas's, the use of Ian Phillips' VCNT (Vancomycin, Colistin, Nystatin and Trimethoprim) combined with scrupulous attention to detail, improved this to 98% by 1978 (St Thomas' Hospital microscopy had 50% success compared with Catterall's 69%).

When you next read of a commercial test's superiority, consider whether the culture was as good as the best of the 1970s.

Thoughts for the 21st century:

- A poor culture service flatters the ~~microscopist~~ NAAT.
- Epidemiological treatment precludes repeated culture/comparative analysis.
- 'Culture' sensitivity may vary in 2017 as it did in the 1970s.

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Notes