Short Article

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Should Routine Screening of Domestic Abuse Be Implemented to Raise Public Awareness?

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Domestic abuse (DA) impacts on both mental and physical health and has ramifications throughout the family, especially short and long-term consequences to children. It can affect anyone, regardless of age, ethnicity, gender, sexuality, class, life-style or geographic location [1]; some groups in the population are at higher risk of abuse, namely individuals with a chronic illness, disability or mental ill health [1]. Often people suffering domestic violence have unnecessary investigations and medications for nonspecific or mental health symptoms (eg: chronic pain, frequent attenders).

The financial cost of DA to the health service is enormous as a result of the physical and psychological impacts on the survivors and their family.

The National Domestic Abuse Helpline reported a 50% increase in calls compared to pre-COVID-19, along with a 400 % increase in visits to its website [2]. NSPCC helpline received highest number of contacts about DA following lockdown. The escalated cases during the pandemic are mainly due to lockdown restrictions, financial difficulties, social isolation and victims being forced to stay indoors with the perpetrators. Stay-at-home mandates have also amplified pre-existing mental health conditions and psychosomatic distress reactions [3].

There are concerns of increased DA especially unreported cases [4]. Other reasons why victims face barriers to seeking help include stigma/ shame, fear of reprisal, financial implications and perceptions that support may not be available. Few of the victims do not realise they are experiencing abuse.

DA is not straightforward and many clinicians tend to be reticent about asking about abuse directly – don't want to open Pandora's box. Health care professionals have a duty of care and play an important role in identifying and supporting those who experience DA. We could be the victim's first or only contact, providing a lifeline to safety.

Usual channels of support are now jeopardised by lockdown and social distancing and those suffering abuse need to find alternative means of support and safety. Additional challenge during the pandemic is how best to identify, approach and support patients experiencing DA with our "new ways of working" - clinicians dealing with majority of the problems via video, email and telephone consultations. With remote consultations it is hard to assess who is on the other side and many people experiencing DVA may find it difficult to say what is happening to them when they are actually speaking from their home rather than a neutral place like the clinic.

NICE guidance, published in 2016 does not recommend routine screening for or make enquires about DA [5]. People are often at different stages in their readiness to disclose their experiences of abuse and may minimise it. Asking all patients about their experiences of DA routinely during every encounter with the health care professionals, even where there are no indicators of such abuse, would help in early identification of DA and help to tackle the problem before it getting worse. This is good clinical practice.

Routine enquiry would also raise awareness of the negative consequences of DA in the society – further encouraging people to talk about the issues more openly and receive support and combat potential reasons for unreported cases, such as shame, fear, perceptions that support not available or financial implications. Further, it may also raise awareness among perpetrators of DA, who may accept support.

Assessment tools and guidelines are available to help promote the recognition of and outline the support available to people experiencing DA [6,7]. Routine screening for DA improves victim identification in healthcare settings [8]. In a busy clinic we need a short, simple, non-threatening, validated questionnaire to be used as a screening tool. In addition, it would be ideal to have "words" in a screening tool that does not directly ask about violence. Clinicians and patients may find uncomfortable using a tool with direct questions about violence, particularly for cultural reasons.

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The Women Abuse Screening Tool-short (WAST-short) was developed in Canada and is used by family doctors to identify and assess women who are being subjected to emotional and/or physical abuse by their partner (9). It contains the first two questions of the full WAST tool:

1. In general, how would you describe your relationship?
a. No tension b. Some tension c. A lot of tension

2. Do you and your partner work out arguments with...
b. No difficulty b. Some difficulty c. Great difficulty?

If a patient answers 'c' to these two questions, the clinicain can then use the remaining WAST questions [10] or other appropriate questions to elicit more information about their experience of abuse. At the time that the WAST was developed, 100% of clinicians surveyed reported feeling comfortable asking the WAST questions, and 91% of respondents reported feeling comfortable or very comfortable being asked the questions [9,11].

With appropriate training and well-run referral pathways we should Implement DA screening at every patient contact by all health care professionals. This is the way forward to early identification and support of victims, especially with our new ways of remote consultations. The cost of DA is so significant that even marginally effective intervention is cost effective.

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