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Women's experiences of referral to a domestic violence advocate in UK primary care settings:

a service-user collaborative study

Abstract

Background

Women experiencing domestic violence and abuse (DVA) are more likely to be in touch with health services than any other agency, yet doctors and nurses rarely ask about abuse, often failing to identify signs of DVA in their patients.

Aim

To understand women's experience of disclosure of DVA in primary care settings and subsequent referral to a DVA advocate in the context of a DVA training and support programme for primary care clinicians: Identification and Referral to Improve Safety (IRIS).

Design and setting

A service-user collaborative study using a qualitative study design. Recruitment was from across IRIS trial settings in Bristol and Hackney, London.

Method

Twelve women who had been referred to one of two specialist DVA advocates (based at specialist DVA agencies) were recruited by a GP taking part in IRIS. Women were interviewed by a survivor of DVA and interviews were recorded and transcribed verbatim. Analysis was thematic using constant comparison.

Results

GPs and nurses can play an important role in identifying women experiencing DVA and referring them to DVA specialist agencies. GPs may also have an important role to play in helping women maintain any changes they make as a result of referral to an advocate, by asking about DVA in subsequent consultations.

Conclusion

A short time interval between a primary care referral and initial contact with an advocate was valued by some women. For the initial contact with an advocate to happen as soon as possible after a primary care referral has been made, a close working relationship between primary care and the third sector needs to be cultivated.

Keywords

advocate; domestic abuse and violence; general practice; referral; service user; women's health.

INTRODUCTION

Identification and Referral to Improve Safety (IRIS) is a training and support programme for general practice that aims to improve the response to women experiencing domestic violence and abuse (DVA). The programme trains clinicians in identification, initial response or validation, referral to specialist DVA advocacy, and continuing support.

In a cluster randomised trial the IRIS intervention had a substantial effect on identification of women experiencing DVA and on referral to DVA advocacy.¹ A meta-analysis of qualitative studies found women survivors of DVA see healthcare professionals as potential sources of support.² However, there is still uncertainty about effective responses from clinicians,³ including those working in general practice,⁴ and about how women experience programmes such as IRIS that are designed to improve clinician engagement with DVA.

The aims of this study were to understand women's experiences of disclosure of DVA in general practice settings in the context of the IRIS programme, focusing on women's subsequent referral by their GP or practice nurse to a DVA advocate. The study set out to explore women's experience of the initial contact with an advocate after the GP referral and their views on how important this initial meeting and contact was to any changes that they subsequently reported in attitude and behaviour that improved their

sense of safety. It also aimed to investigate whether it mattered to the women that they had been referred to a DVA advocate by a healthcare professional and what impact, if any, their subsequent contact with their GP or nurse had on any changes they made after seeing the DVA advocate.

METHOD

Study design

A service-user collaborative study using a qualitative study design was conducted. A multidisciplinary team of two DVA advocates, one social scientist, and one DVA specialist clinical psychologist supported a survivor of DVA (KS) to design and deliver a piece of service-user research (service user in this case refers to previous use of domestic violence agencies and services).

Sampling

Women were recruited who had been referred to a domestic violence agency by general practice professionals taking part in a randomised controlled trial testing the IRIS programme. Recruitment took place across the trial sites in Bristol and Hackney. A purposive sampling strategy was adopted to maximise heterogeneity in terms of age, ethnicity, length of DVA, and whether or not women were still with the perpetrator. Twenty women were approached initially in each site by a specialist advocate and told about the study. Thirty-five women

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How this fits in

Women experiencing domestic violence and abuse (DVA) are more likely to consult health services than any other agency, yet doctors and nurses rarely ask about abuse, often failing to identify signs of DVA in patients. This study refutes the view that asking about DVA medicalises a non-medical issue. While previous research has shown that women find referral to a specialist DVA advocate supportive and validating, this study shows for the first time that referral to a DVA advocate has initial and longer-term impacts that are meaningful for women. GPs may have an important role to play in helping women maintain any changes they make as a result of this referral by asking about DVA in subsequent consultations and providing ongoing validation of survivors' experience.

agreed at this stage to be contacted by KS. During the time interval between contact with the DVA advocate and KS arranging an interview, 23 women later declined to take part in the qualitative study because they were either in full-time work or did not want to revisit the past or were unavailable because the advocacy organisation did not have up-to-date contact information or know whether it was safe to contact the women. To protect the safety of potential participants, a specialist DVA advocate known to the woman made initial telephone contact and told women about the study. If women were interested they consented to be contacted and meet with KS, a survivor of DVA, at a designated safe place and time. At this face-to-face meeting women gave full written consent to participate in this study.

Data collection

All the interviews, which lasted between 30 and 90 minutes, were conducted by KS. Interviews used a topic guide, were recorded and transcribed verbatim. The specialist DVA advocate who had made the initial contact remained on the premises during the interview but did not take part in the interview process. Women were asked at the end of the interview if anything they had discussed had triggered distressing thoughts or feelings and/or whether they felt a session with their DVA advocate would be helpful at that time. No women chose to take up this offer of additional support. After the interview, the DVA advocates were also available for a debriefing session with KS in case the interviews had triggered any distressing thoughts or feelings for her.

Data analysis

Data analysis was thematic, using the constant comparison method of noting and coding emerging themes, making comparisons between participants. Each transcript was coded by two members of the research team. The team agreed that a saturation of key themes had been reached after 12 interviews and did not extend recruitment and data collection. The research team met on four occasions to discuss the coded transcripts and cases that refuted any emerging pattern. In the last of these meetings, the themes were organised into a chronological narrative of women's experience of disclosure and the stages of change and readiness to change models were used to inform the analysis and development of analytic categories.⁵

RESULTS

Participants

The age range of women in the sample was 27–81 years. Women had been in an abusive relationship for between 3 months and 60 years before a disclosure in primary care had resulted in a referral to a DVA specialist advocacy organisation. All women had experienced more than one type of abuse. Five women were still with the perpetrator at the time of the interview with KS (Table 1).

Overview of findings

The findings identified a number of themes, including women's experience of DVA and barriers to disclosure of DVA in healthcare settings when clinicians are insufficiently trained and supported to engage. These themes are not reported here, however, as they are already well documented in the literature.⁶ The following themes are reported: the experience of disclosure at the time and its impact in the days, weeks and months to follow; women's experience of initial contact with advocates; the longer-term impacts of advocacy support; the impact of disclosure on subsequent contact with the same doctor or nurse; and what women experiencing DVA want from primary care professionals.

Two types of disclosure of DVA in primary care

All participants described disclosure to a doctor rather than a nurse. This is despite the IRIS programme training both nurses and doctors. The ratio of doctor-led versus nurse-led disclosure in the context of the IRIS programme has been explored elsewhere.⁷ In this study, two types of disclosure were identified from practices that had received

Table 1. Characteristic of participants and their experience of domestic violence and abuse

Site	Age	Marital status	Ethnicity	Number of children	Length of abuse	Type of abuse	With perpetrator
Bristol	48	Cohabiting	White British	1	29 years	Physical, verbal, emotional, financial	Yes
Bristol	27	Separated seeking divorce	Eastern European	0	3 months	Verbal, emotional	No
Bristol	41	Single	White British	1	Unknown	Physical, emotional	No
Bristol	42	Married	White British	1	24 years	Physical, emotional	Yes
Bristol	81	Married	White British	3	60 years	Physical, emotional, verbal	Yes
Bristol	46	Married	White British	1 ^a	6 years	Physical, emotional	Yes
Bristol	57	Widowed ^a	White British	0	Unknown	Physical, sexual, emotional	No
Hackney	49	Married	Black Caribbean	5	26 years	Verbal, emotional, financial	Yes
Hackney	34	Single	Polish	1	7 years	Emotional, financial, physical	No
Hackney	55	Single	White British	3	3 years	Physical, emotional, verbal	No
Hackney	23	Separated	Turkish	1	4 years	Physical, emotional, financial	No
Hackney	>30	Single	Unknown	0	2 years	Physical, emotional, verbal, stalking	No

^aNot by perpetrator.

the IRIS training: clinician-led and woman-led. A woman-led disclosure could occur after many years of DVA:

'She had said "how are you?" and then I just suddenly without looking at her said "I'm ok but I'm in a bad marriage". And I just couldn't look at her and then that's when her face went "oh my!" I know she felt guilty ... I felt for her because she'd known me so long from when my children were little and then seeing me getting ill and having bad moments [mental health problems]. I just felt for her more than myself'. (T1, Hackney)

Prior to this consultation the patient had seen an IRIS poster in the toilet, which prompted her disclosure. The excerpt above shows how she felt that her GP was embarrassed and upset for not 'discovering' the DVA before, while the woman's downcast gaze suggests a sense of shame or embarrassment.

In a clinician-led disclosure, sensitivity to a woman's sense of apprehension is very helpful:

'I just cried. I was just so relieved that somebody, somebody just said something. And he gave me the box of tissues and I just sat and cried and cried and cried. And he said "tell me when you're ready". And he was just the nicest person to me ever ... and I poured it all out and that's when he said about [the advocate], he said "would you

like me to put you in contact with somebody who can help you?" And he's holding my hand all the way through this. And I said "I'd be really grateful" and he said "it's a wonderful service" and he told me all about it and said "I'll get you a referral".' (T9, Bristol)

Immediate responses to disclosure

Women-led disclosures were unusual and most women in the sample had only disclosed DVA when asked by their doctor. GPs need to be prepared for the reactions women may experience in the consultation immediately following a disclosure. As the following extract shows, the immediate impact of a disclosure in a primary care setting can raise a mixture of conflicting feelings:

'It made me frightened actually because it made it more real and I think if I don't think about it and if I don't talk about it then it's not happening ... I felt frightened. I just felt frightened because I didn't think that the problems that I have at home are domestic violence. I really didn't ... it's so difficult to see myself in that position ... because I see people [at work in the refuge] with their faces hanging off and that's never happened to me. He's pushed me a couple of times but never really hit me ... bullying and God, controlling. He [the GP] put the label on which gave me a bit of a shock

but it also made me feel supported'. (T11, Bristol)

Often this paradoxical response to the initial disclosure was related to a dissociation with the identity of being a victim of DVA. The dissociation mapped on to different internal barriers to disclosure. For example, some women were in survival mode, on automatic pilot and not stopping to think or identify as someone experiencing DVA as a way to manage their sense of safety; while other women felt so ashamed and saw the abuse as their fault that they did not identify with being a victim of DVA. For these women the initial enquiry by their GP could be experienced as a shock:

'He [the GP] put the label on which gave me a bit of a shock ... I didn't think that the problems that I have at home are domestic violence. I really didn't'. (T11, Bristol)

Or a relief:

'It just takes the weight off you. [Laughs] Because I didn't have to find all the words to say'. (T5, Hackney)

Or a challenge that 'pushed' the women towards getting help:

'I just needed that push from my GP to do it [get some help]. Because I wouldn't have done it'. (T9, Bristol)

Despite experiencing either an initial sense of shock, relief, or challenge, the GP-led disclosure was, with the passage of time, often welcomed:

'I was thinking no, I can't do this because it will cause more trouble, more problems. He will get angry if he finds out. And I really didn't, I wouldn't do it, I couldn't do it ... looking back I am really grateful the GP made this decision for me'. (T2, Hackney)

Other women experienced a sense of hopefulness, ease, and calm after the initial disclosure:

'Oh it was brilliant. I came out. I felt I was walking on a cloud. It was just so nice [after] 24 years. I just felt calmer and at ease'. (T9, Bristol)

However, as the initial disclosure often triggered conflicting feelings, on leaving the GP surgery women's sense of risk could either increase or decrease, associated with fear or hopefulness, respectively:

'It did make me feel weird going home ... when you've opened that door. If it falls out when he's there, you know then I'm, well, God, I don't know what he'd do'. (T11, Bristol)

Despite these complexities in women's responses to the initial disclosure, for most women this was the moment they described as the starting point for a shift in their readiness to make changes in their lives, albeit surrounded still by uncertainty:

'I didn't feel so ashamed because I was hiding this secret'. (T9, Bristol)

Disclosure to a GP had allowed women to let go of some of their sense of shame and self-blame and for some women, it was the moment they could see the first glimmers of hope:

'I felt inspired when I went back [home] that there is hope for me. That there is somebody who cares for me'. (T9, Bristol)

Women's experience of initial contact with advocates

Women reported that the GP information on what to expect from the referral was often vague, limited, and in some cases inaccurate. Despite this, all women described the initial contact with the advocate as a 'turning point' in their journey from 'someone hiding a shameful secret' to being a 'survivor'. The pivotal nature of the referral in the women's journey was reinforced by the first contact with the advocate following on very quickly (in most cases) after the GP referral.

Five initial impacts of contact with DVA advocate

Five important impacts were described as a consequence of the initial contact with the advocate. The first impact was emotional. Women felt the advocate responded to them with unconditional acceptance, with no agenda to change or mould their decisions in any particular direction and this was powerful:

'She [the advocate] really understood, the main thing was she listened to me, I didn't feel she was judging me'. (T9, Bristol)

For many women experiencing DVA, simply being heard for the first time, without any agenda or goals for change, is an important first step.

A second impact was realising, often for the first time, that they had choices:

'It suddenly became a reality and it became easier to handle ... she gave me all these lists of options ... I hadn't thought about those things ... it suddenly seemed to be more concrete, more possible and easier'. (T11, Bristol)

The third impact was realising, again for the first time, that the problem was the perpetrator's and not their fault:

'He was making me feel there was something wrong with me. I was blaming myself for everything that happened ... the conversation with her [the advocate] changed absolutely everything. Because she made me realise there's nothing wrong with me, it's him'. (T2, Hackney)

The fourth impact was experiencing an empathetic and motivational encounter. The combination of these two qualities together was important for the women, because the motivation was not linked to an externally applied goal of action, but matched where the woman felt her readiness to change was at that time:

'When she [the advocate] speaks you can understand it's from inside her ... sometimes I can't even talk to my mum or sister but I understand from her [the advocate's] voice she wants to help me out, she wants to make me get stronger and she wants me to do the right thing for me, when I'm ready'. (T4, Hackney)

The fifth impact was realising that a different sort of life (without DVA) was possible:

[After thinking] This is it then, this is it. Nobody cares, nobody's asked, it wasn't until I seen [the advocate] I knew something was happening. Something positive and I thought "well I'm going to be alright now"'. (T9, Bristol).

Many women described the initial contact with the advocate as the first time that they had a sense of hope and were able to see that a different future, one without DVA, was possible.

Longer-term impacts of referrals to advocates

The women in this study identified a range of behavioural changes that were

meaningful for them that they attributed to their encounters with advocates as a result of GP referral. Some of these changes were shifts in attitudes. Other changes were actions towards increasing their sense of safety and self-efficacy. For example, one woman described how the advocacy work had helped her face difficult memories and move on:

'It [advocacy] brings back all the memories that you try to push to the back of your head. It's good because then it's gone'. (T5, Hackney)

Another woman described a new sense of hopefulness for the future:

'I feel like I've got a future ... I've sat numeracy tests and literacy tests. I'm doing my numeracy college starts tomorrow. And then my nursing course starts in September. I'm so excited! Finally things are turning a corner!' (T8, Bristol)

Some women took actions, such as no longer accepting abuse from the perpetrator:

'I don't take no abuse off him no more' (T3, Hackney)

It should be noted that none of these actions involved decisions to leave the perpetrator, yet each woman identified these as meaningful changes that made them feel safer and gave them a greater sense of self-efficacy.

Impact of disclosure on subsequent GP behaviour: maintenance of change

Of those women that mentioned further consultations with their GP after the initial disclosure and referral, only one woman mentioned a negative experience, in which the GP did not enquire or ask about the DVA situation. Six women reported changes in their GP's behaviour that were helpful in maintaining any shifts they had made in their emotional, attitudinal or behavioural stance in relation to DVA. For example, one woman described the importance of her GP asking about DVA at subsequent consultations:

'I went back about my legs, because my legs were swollen. And he, first of all he caught hold of my hand and he said, "How's things going?" I said, "Oh really well thank you." I said, "I've had a meeting with [advocate]." And I said, "It's going really well." And he said, "Oh, I'm so pleased." But he was

Box 1. What women want from their GP regarding domestic violence and abuse

- Advocacy available via the general practice
- GP to ask regularly how things are at home
- GP to ask regularly about domestic violence and abuse (DVA) when women consult with low mood or anxiety
- GP to ask about DVA when women present with visible injuries (bruises/cuts/broken teeth/broken bones)
- GP to receive training on how to approach DVA issues
- Posters and leaflets in waiting rooms
- More avenues put in place for women to get referrals or make connections with an advocate

genuinely interested ... and I felt that from him ... I really did. And he remembered. Because I didn't go down to talk to him about that. I went down about my legs. But that was the first thing he asked.' (T4, Bristol)

What women experiencing DVA want from primary care clinicians

When women were asked what they wanted from primary care clinicians they were very clear. They saw the GP's role as being one of referral and signposting rather than advising specific actions. Women also wanted GP practices to display information about the type of advocacy support and referrals available via posters and leaflets in the waiting rooms and toilets (Box 1). This would inform women what help was possible through disclosure to their GP and potentially encourage women-led disclosures.

DISCUSSION

Summary

This is the first study to look at women's experiences of referral to specialist domestic violence services from a UK primary healthcare setting. GPs and nurses can play an important role in identifying women experiencing DVA and referring them to DVA specialist agencies. GPs may also have an important role to play in helping women maintain any changes they make as a result of referral to an advocate, by asking about DVA in subsequent consultations.

Strengths and limitations

A strength of this study is its service-user collaborative study design, which ensures the service user perspective is included from the early design of a study through to data collection and writing up. However, a potential limitation of this design is that all the interviews were conducted by KS; as a survivor of DVA and service user

of DVA services, KS brought with her a particular perspective as an interviewer and a particular style of interviewing that is distinct from what a professional qualitative researcher may bring. The methodological and ethical issues surrounding the choice to work collaboratively with a service user are discussed in a separate article.⁸

This study has several limitations; while saturation in key themes was reached during analysis, the study's sample size was small. However, the small sample size does reflect in part the caution used during recruitment not to put any woman at risk and the intention to protect the safety of potential participants (by not contacting women if the advocacy organisation was not sure if it was safe to do so). Although the sample size is small, the sampling strategy enabled a good range of women across two sites to be recruited (in terms of ethnicity and number of years of abuse prior to disclosure).

Another limitation is that it cannot be presumed that these findings are applicable to all abused women in primary care settings, as interviews were only conducted with women whose GP practice had undergone the IRIS training as part of a trial evaluating that intervention.

Comparison with existing literature

Why referral in primary care context matters. The view that asking about DVA in some way 'medicalises what is a non-medical issue'⁹ is not supported by the findings. Women valued disclosure in a GP setting that resulted in referral to a DVA advocate. This study found that referral to a DVA advocate has both initial and longer-term impacts that are meaningful for women. This supports the key role of healthcare professionals, particularly in primary care, in asking about DVA, supporting a woman when she discloses, and offering referral to advocacy.^{2,6} There is a growing recognition in the UK¹⁰ and internationally¹¹ that doctors need to help patients to access specialist domestic violence services, not least because 'a physician may be the only healthcare professional a [DVA survivor] sees and all physicians see [DVA survivor]'.¹²

Referral, power and decision making.

The findings showed that some women 'need that push from their GP' to make contact with a DVA advocate. This finding raises questions about shared decision making in the context of DVA and particularly how male GPs should skilfully manage the accentuated power

imbalance in a consultation with a female survivor of DVA. More research on both these questions is needed. DVA impacts a person's psychological and emotional wellbeing, including their confidence, self-esteem, assertiveness, and ability to make decisions.¹² Research recommends that clinicians in primary care should offer a referral to a DVA advocate 'even if the woman declines the referral, she will know that her clinician is not ambivalent about discussing what is happening to her, and she may choose to be referred at another time'.¹³ Research in other healthcare settings, such as mental health services, has shown that lack of referral pathways is a major barrier to providing effective support, and the importance of patients receiving information about DVA services at the time of disclosure.⁹ The findings show then the importance of offering a referral while 'respecting the autonomy and choices of each [woman]' to accept the referral or not, 'may gradually enable victims to empower themselves and ultimately move themselves to safety'.¹²

Increasing women-led disclosures. Women wanted DVA advocacy to be made more visible and accessible in primary care settings. Researchers have similarly reported that primary care practices have a role to play in encouraging spontaneous disclosures (referred to here as 'women-led' disclosures) by having telephone numbers for national and local services displayed on posters in waiting rooms, leaflets at reception and cards in the toilets.¹³ Sohal *et al*¹³ also endorsed an

important feature of the IRIS Programme: posters stating 'Domestic Violence Aware Practice' with the aim of engendering trust and increasing women's confidence in disclosing DVA to GPs or practice nurses without being asked first.

Implications for research and practice

Women value contact with an advocate following on quickly after the GP referral. In the IRIS intervention this was possible by having a named advocate from a local DVA service liaising with each practice. This created an explicit care pathway between primary care clinicians and specialist DVA services, particularly advocacy, provided by the third sector.

The findings are consistent with research that shows women hope GPs will help them access specialist DVA advocacy or support.^{14,15} Current research already recommends that asking about DVA for the first time and validating a survivor's experience should not be separated,^{12,16} as 'validation' from a healthcare professional can provide relief and comfort, and start the wheels turning towards change.⁸ An important implication for practice that can be drawn from these findings is that GPs may have a role to play in helping women maintain any changes they make as a result of referral to an advocate, by asking about DVA in subsequent consultations, providing ongoing validation. More research on this follow-up period and the role of GPs in validation after disclosure is needed; as has been suggested, 'validation may, in fact, be the most important ingredient in the GP's response'.¹²

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Competing interests

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