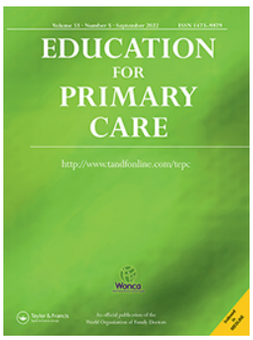

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EVALUATION AND INNOVATIONS

Domestic abuse education in UK GP training schemes: cross-sectional study

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ABSTRACT

Background: Domestic abuse (DA) is a violation of human rights that damages physical and mental health. Healthcare services is the most common agency a woman experiencing DA may present to. DA is part of the GP postgraduate training curriculum in the UK, but we do not know how this is being implemented in registrar training.

Aim: To investigate the implementation of domestic abuse education in GP training schools across the UK.

Design and Setting: Cross-sectional survey of UK postgraduate GP training groups.

Method: Digital surveys were emailed to all UK postgraduate GP training groups. The survey contained quantitative and free-text questions about descriptive features of education provided and self-reported perceptions. The survey was sampled by programme directors (PDs) and trainees. Data was collected and analysed descriptively.

Results: Seventy of the 115 (52%) GP postgraduate training groups responded. 44.2% of the groups did not offer DA education. If available, DA education sessions had different lengths of teaching, facilitators, content and methods. When asked if training was adequate, 47.4% of trainees disagreed and 36.8% strongly disagreed. Throughout the questions, PDs ranked the quality of education higher than trainees. PD's reasons for not providing DA education included lack of time and resources, but also cultural perceptions of DA being a taboo subject and not clinical.

Conclusion: Our survey shows that the provision of DA education in UK postgraduate GP training is absent in almost half the programmes and varies in length, content and quality, with a high proportion of respondents rating it inadequate.

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Domestic abuse; education; primary health care; family practice; general practice

Background

General practice training in the UK typically lasts three to four years with trainees experiencing a combination of clinical training in hospital and general practice surgeries and group education with their peers in Vocational Training Schools (VTS). VTSs deliver training on curriculum topics as specified by the Royal College of GPs (RCGP), which cover a range of specialities and mandatory topics including safeguarding of adults and children. Domestic abuse is listed in the new RCGP curriculum under antenatal care [1] and the Intercollegiate Safeguarding Guidelines [2]. However, educational sessions specifically on domestic abuse are not mandatory. GP VTS schools are run by local GP trainers/programme directors with an interest in education. They are responsible for designing and managing the teaching programme. The independent nature of this local system can lead to a wide variety of teaching across the UK.

In the year ending 1 March 2019, 6 million women in the UK were subject to domestic abuse in the previous 12 months [3]. Domestic abuse is defined as any incident or pattern of incidents of controlling, coercive, threatening behaviour, honour-based violence, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members, regardless of gender or sexuality [4]. Domestic abuse is becoming increasingly recognised as a healthcare issue, with complex physical and mental health consequences [5]. Previous research has found that the lifetime IPV prevalence rate for women presenting to various medical specialities is between 38% and 59% [6]. The most common agency a woman experiencing domestic abuse will present to is healthcare. This places key importance on healthcare professionals being equipped to recognise and respond to domestic abuse.

Education on domestic abuse for healthcare professionals has been found to be diverse with a wide range of approaches. In a scoping review of studies investigating

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education for healthcare professionals where the majority of studies included programmes for physicians, a variety of trainers, methods, content, resources and quantity of teaching was found [7]. In 2001 similar results were found with educational programmes often consisting of single sessions of one to three hours and with deficiencies in programme evaluation [8]. In a systematic review of randomised control trials investigating the effect of domestic violence training, three studies were identified for postgraduate trainees. Following a teaching intervention knowledge was found to be increased but without a change in behaviour for identifying victims of domestic abuse. The review also examined educational interventions for practicing physicians, which found system support interventions, multimedia teaching, small group teaching, and problem-based learning beneficial [9].

This paper reports the current status of GP trainee education in domestic abuse in the UK. In the past two years, the UK has experienced lock downs which have seen the number of calls to domestic abuse helplines rise by 49% [10]. There is a growing recognition of the role of health care, in particular primary care and secondary care, in responding to DA [5,11], this needs to be a consistent and high-quality area of post-graduate training. This study aims to evaluate the current extent of post-graduate GP DA training in the UK.

Objective

To investigate the current quantity and quality of domestic abuse education in GP training schools across the UK.

Methods

This is a cross-sectional study of the UK postgraduate GP training schemes digitally surveyed from October 2019 to February 2020. Training schools were recruited online, via email. Contact details for each VTS school were found on individual training school websites and from deanery websites across the UK. An email explaining the project and inviting the VTS group to participate was sent to the contact email address for each VTS along with a link to the survey itself. To reduce non-response, we sent reminder emails and surveys and also contacted more than one staff member from each VTS group. Emails were sent out from the 28 October 2019, with a second round of emails with reminders on 20 February 2020.

Digital surveys were sent to UK GP training schools aiming to recruit programme directors and staff responsible for education within each scheme and GP trainees. Educational staff eligible to take part included programme directors – responsible for arranging and delivering teaching and are often a working GP; other suitable members of staff included training school managers and deans involved with education. Eligible GP trainees included all years of training from year 1–4.

One hundred and twenty-four GP training schools exist across the UK, grouped into sixteen deaneries. We aimed to contact all of these individual GP schools. The majority of these were individual groups, however for Northern Ireland and the North Eastern and North Western areas of England it was difficult to find individual VTS group contact details, hence regional offices were contacted and asked to forward the survey to each VTS group. After an extensive search and enquiries, nine of these school's contact details could not be found. Hence, one hundred and fifteen GP training schools were contacted.

Data collection was performed using Google Forms software, which allows the survey to be designed, sent, and received on the platform. Data collected included the respondent's job role and training school that they worked for, as well as the main survey questions detailed below. The survey had fifteen questions. There are no validated tools or surveys designed for asking about domestic abuse education, hence we designed this survey *de novo*. The survey covered three key areas: the training content and delivery, quantity, and opinions on the quality of the education.

The survey questionnaire is included as an online appendix.

Survey responses were downloaded to Microsoft Excel. The quantitative data were descriptively analysed, and free-text question responses were thematically analysed. Comments were categorised into basic themes, with inductive codes derived and applied to each appropriate comment. These codes were grouped into subthemes and then into overarching themes.

Findings

We had responses from 70 of the 115 (52%) VTS groups to which we sent the survey. In the UK, there are 16 deaneries, from England and Wales we had 92% coverage of deaneries (n = 12). No responses were received from VTS groups in Northern Ireland, Scotland, Defence, and Peninsula deaneries.

We analysed the respondent job title, of which 70% were from programme directors and staff involved with education (n = 49) and 30% were from GP trainees (n = 21).

Presence of domestic abuse training

Question 4 of the survey asked if there is a formal educational session on domestic abuse in the VTS scheme. Forty per cent of VTS schools did have a formal educational session (n = 28), however 44.2% did not (n = 31). Of the respondents 7.1% were unsure if one existed (n = 5), and a further 8.6% said that it was part of a safeguarding training session, but not an independent session (n = 6).

Description of domestic abuse teaching

From the VTS groups that did report having an education session 6.7% offered a whole-day session (n = 2), 43.8% provided half a day (n = 14), and 31.6% provided 2 hours (n = 12). The minimum session length was 1 hour. Domestic abuse educational training was offered most commonly in the third year of GP training 69.6% (n = 16).

The type of educational methods to deliver the session was predominantly small group 34.1% (n = 14) and workshop style teaching 31.7% (n = 13). 19.5% also gave lectures (n = 8). Educational films and patient experience were not used.

Education was delivered by professionals from a safeguarding team in 24.1% of sessions (n = 13), local domestic abuse services 25.9% (n = 14), programme directors 11.1% (n = 6), GP with a special interest 3.7% (n = 2), and unspecified expert 1.9% (n = 1). Self-directed learning and learning with peers made up 5.5% (n = 3) and 7.4% (n = 4), respectively. 9.3% received training from a multi-professional team-a mix of local services and clinicians (n = 5).

When asked about what topics are covered in the teaching, 31% (n = 18) of respondents said that all of the subjects listed in the question were covered. In the remaining 69% (n = 40) the most common topics included were identification of domestic abuse 20% (n = 8), sources of support 17.5% (n = 7), management of DA 15% (n = 6) and risk factors 12.5% (n = 5). This group also said epidemiology, mental and physical health consequences, LGBTQ+ issues, and male victims of domestic abuse were not included in any training.

Quality of teaching

Responses to these questions are reported in two groups: programme director/educational staff and GP trainees.

When asked about the amount of the teaching provided, programme directors and educational staff ranked the amount about right 40.4% (n = 17) and not enough 52.4% (n = 22). Trainees ranked this lower scoring about right 16.7% (n = 3), not enough 50% (n = 9) and 33.3% poor (n = 6).

On quality of the education PDs and educational staff responded positively with 14.2% very high (n = 5), 57.1% high (n = 20), and 25.7% neither high nor low (n = 9). Trainees did not rank the quality as high as PDs and staff, with none scoring training as very high quality, 33.3% high quality (n = 4), 25% neither high nor low (n = 3), 25% low (n = 3), and 16.7% very low (n = 2).

When PDs and educational staff were asked if they thought the training was adequate 5% strongly agreed (n = 2), 35% agreed (n = 14), 32.5% neither agreed or disagreed (n = 13), 17.5% disagreed (n = 7), and 10% strongly disagreed (n = 4). Trainees predominantly rated this low with 47.4% disagreeing (n = 9) and 36.8% strongly disagreeing (n = 7).

In questions 12–14 results were more negatively skewed for GP trainees than programme directors and educational staff.

Future plans

If domestic abuse education was not already provided PD and educational staff were asked if there were plans to introduce it 14.6% responded yes (n = 6), 12.2% no (n = 5), and 73.2% were unsure (n = 30).

Free-text feedback

This summarises the themes and categories from the free-text data from the question 'If domestic abuse education is not provided can you think of a reason why?'. Time pressures, full curriculum, lack of resources, as well as expectations of trainees to study the topic in their own time were used frequently to explain lack of teaching by programme directors. GP trainees frequently commented that they thought education was not provided as there was a belief that it was covered in safeguarding training.

Notably, one programme director commented:

'Don't tend to pick topics like that, more often purely clinical topics eg. Ophthalmology'

Discussion

This study shows the variability and inconsistency in domestic abuse education provided by UK GP training schools, despite being listed as an educational objective in

the GP training curriculum. Only 40% of VTS schools provided DA education, compared to 44.2% who did not have any domestic abuse educational sessions available for trainees, with the remainder of respondents either unsure or saying that they believed the education was provided in safeguarding training. Free-text comments gave a valuable insight into why DA education uptake is low, including lack of time, resources, lack of demand, and believing it to be a topic the students should cover independently. One interesting comment described domestic abuse as a taboo subject, and a further indicated they only focussed on clinical subjects. These comments indicate some hesitancy in teaching on domestic abuse, a subject that can be challenging and includes considering health in a social context.

Responses to questions on the description of DA education showed great variability in time provided for sessions, ranging from 1 day to 1 hour, with the majority of sessions being either a half day or 2 hours. While there was a high proportion of teaching led by local DA services and safeguarding teams, educators who could be considered experts in the topic, there were still trainees receiving peer-to-peer education or having to do self-directed learning which in a complex socio-medical topic may be difficult to achieve. Commonly key topics such as identification of DA and management were covered in education provided. However, medical issues such as physical and mental health implications of DA, which are commonly seen by GPs, and diverse subjects such as LGBTQIA+ and male victims were omitted from teaching.

Overall the quality of teaching provided was rated high by respondents, but the provision of education was rated low, with respondents rating time allocated to teaching and range of topics poor. The division of responses between those responsible for the teaching and those receiving the teaching was interesting. Trainees consistently reported the amount, quality and adequacy of teaching as lower than programme directors and staff. Given the lack of provision for domestic abuse education, it is surprising that those who did not provide domestic abuse education indicated that they were not planning on introducing it or were unsure.

The high proportion of senior respondents, predominantly programme directors, show that the answers to the questionnaire were given by staff with supervisory responsibility for the educational programme in their VTS group, able to give an overview of the education they provide as well as plans for change in the future. A high proportion of deaneries in England responded.

The detail contained in the questionnaire gave a detailed overview of domestic abuse education in each VTS group that responded, providing a description of time, subject, educators and teaching methods. The self-rated quality assessment provided a comparison of perceived quality across VTS groups. In addition, the free-text comments allowed respondents to give an indication of the reasoning behind responses, which provided insight into the problems that programme directors and staff organising education may face.

Whilst we had a good response from deanery in England and Wales, we lacked responses from Northern Ireland and Scotland. Overall, the individual VTS group response rate was limited. One possible reason for non-response may be not wanting to admit that their VTS group does not have DA education, this is known as social desirability bias in which participants may under-report or hide 'bad' behaviour [12]. Non-response may also indicate a lack of interest in the topic. This was found in a 2004 study that found that the chances of co-operating in a survey are 40% higher for topics of interest to the individual [13]. Further evidence of reporting bias was found in our results with notable differences in the ranking of the amount, quality and adequacy of teaching between staff and trainees.

Conclusion

This study is consistent with others that have evaluated domestic abuse education in postgraduate training in the UK and internationally. A 2018 scoping review of studies on postgraduate DA education found variability in teaching with a range of content, facilitators, and methods [7]. Improvements in knowledge and practice have been shown in domestic abuse education for qualified GPs in the UK. A study comparing DA training and systems support with direct access to specialist services with a single educational session to qualified GPs found that referral rate and new codes for DA increased in the former group [14]. Evidence that benefits can be found in qualified practitioners could be translated to postgraduate training, and potentially medical schools.

Our results are important in giving an overview of the state of domestic abuse education in the UK for GP trainees. They indicate variability and paucity in domestic abuse teaching. By investigating what is lacking in education, changes can be made to start educational sessions or improve those that already exist. There is a clear need for education on this topic and it is essential given the prevalence of DA and the frequency of presentations in general practice. We recommend that all VTS groups should have access to training on domestic abuse, not just in the context of safeguarding, but also on enquiring

about domestic abuse, responding to patients experiencing DA, and managing physical, mental and social health implications. NICE recommends that clinicians should receive domestic abuse training as part of their pre-qualifying curriculum delivered in partnership with local DA services [15]. Good-quality educational resources on DA for use by GP trainees and educational facilitators need to be developed, and could be adapted from existing training provided for GPs, for example, in the Iris programme [16]. Multiple opportunities for training could be provided in the format of group work, case-based discussions, survivor-led experiences, lectures and online work, provided by GP champions, survivors, local DA services and charities.

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