Investigating public awareness, prevailing attitudes and perceptions towards domestic violence and abuse: a qualitative study in the United Kingdom

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Abstract

Background

Reported Domestic Violence and Abuse (DVA) cases have increased since the advent of the COVID-19 pandemic and ensuing lockdown. Understanding the general public's view about DVA is vital, as it would help develop targeted interventions and effective public policies to tackle DVA. We investigated public awareness, attitudes and perceptions towards DVA, and explored mechanisms to tackle DVA in the community setting.

Methods

In-depth personal interviews were conducted with 29 participants who responded to study invitations and adverts on social media. A topic guide was used to ensure consistency across the interviews, which were audio-recorded, transcribed and analysed thematically to detect emergent themes concerning DVA.

Results

All respondents were aware of the concept of abuse. Thirty-eight percent declared either having experienced DVA directly or that they knew someone close to being abused. More than half of the respondents were not aware of existing DVA supportive services in the UK. Overarching themes generated from the contextual analysis included contributing factors for DVA, challenges and barriers facing victims and proposals for future interventions.

Conclusions

The public has a broad understanding of the impacts of DVA. Simultaneously, the public fail to recognise specific instances or events in their daily lives. Raising public awareness, particularly in children through the school curriculum, highlighting existing support services and introducing the routine use of short screening tools for DVA in primary care can increase awareness, early identification and effective interventions. Sustained, multi-level community facing interventions are recommended to reduce stigma and fear associated with DVA.

Background

Domestic violence and abuse (DVA) is one of society's 'wicked' problems and violates human rights. It is a common problem and continues to be an issue among families, impacting both the mental and physical health and wellbeing of all who are exposed - perpetrators, victims, and the children who witness the violence (1).

DVA can affect anyone, regardless of age, ethnicity, gender, sexuality, class, lifestyle or geographic location (2, 3). Often people suffering domestic abuse have unnecessary investigations and medications to address a variety of physical and/or mental health symptoms, including chronic pain, and are frequent service attenders (4).

Crime Survey for England and Wales for the year ending March 2020 estimated that 5.5% of adults aged 16 to 74 years (2.3 million) experienced DVA in the last year (5). A study by the Home Office estimated the cost associated with DVA for the year ending on 31st of March 2017 equated to approximately £66 billion (6).

One in seven children and young people under the age of 18 will have lived with DVA at some point in their childhood (7). Witnessing domestic violence can lead children to develop an array of age-dependent negative effects including short and long term cognitive, behavioural and emotional effects, in addition to direct physical consequences including injuries and even death (8, 9). Children exposed to DVA are more likely to either experience or perpetrate DVA as adults (8).

Following the advent of the COVID-19 pandemic, visits to the UK National Domestic Abuse Helpline website increased by 700% in the second quarter of 2020 compared with the first quarter (10). The number of reported cases of DVA has escalated since the COVID-19 outbreak (11) due to lockdown restrictions coupled with financial difficulties, social isolation and victims being forced to stay indoors with the perpetrators (11). Stay-at-home mandates have also amplified pre-existing mental health conditions and psychosomatic distress reactions (11). Usual channels of support were jeopardised by lockdown and social distancing, and those suffering abuse needed to find alternative means of support and safety.

The main reasons why victims face barriers to seeking help include stigma, shame, fear of reprisal, financial implications and perceptions that support may not be available or adequate (3). This is compounded further as some victims do not realise they are experiencing abuse, so there are major concerns that DVA cases in general are especially unrecorded and unreported (12). Victims of DVA are often at different stages in their readiness to disclose their experiences of abuse and may minimise it. Raising awareness of the negative consequences of DVA in the society, would not only help survivors of DVA to openly discuss and encourage receiving support but will also support victims who are suffering in silence to recognise and acknowledge the abuse they are experiencing. The World Health Organization (WHO) encourages the health sector to play a crucial role in prevention (13). Raising awareness about DVA in the community setting can also translate to more victims and perpetrators becoming aware of the help and support they can rely on to tackle this rising problem in society.

The cost of DVA, in both human and economic terms, is so significant that even marginally effective interventions are cost-effective (14). Understanding the general public's knowledge, attitudes and perceptions about DVA is vital, as an awareness about the prevailing societal perceptions about this complex public problem can help guide the development of targeted interventions and the formulation of effective public policies. There appears to be little published research investigating what the general public insights may be to better tackle DVA.

The aim of this study was to understand people's awareness, attitudes and perceptions of contributing factors, barriers to tackling DVA and to explore recommendations for interventions to tackle DVA in the contemporary setting.

Methods

A full description of the method is included in Supplementary File 1. A constructivist qualitative methodological approach involving a semi-structured interview framework was used to address the aims of the study. Potentially eligible participants were contacted via email through community groups in the London Boroughs of Hammersmith & Fulham, Brent and Harrow catchment area, and using adverts on social media. This included all members of the community, provided they fit within the inclusion criteria. The participants provided written informed consent. Semi-structured one-to-one personal interviews with 29 participants were conducted with participants who responded to the study invitation, via telephone, Microsoft Teams or face-to-face in line with social distancing guidelines between 28 July and 8 September 2021. Contextual data gleaned from personal interviews were analysed to detect main and emergent themes concerning DVA. The interviews sought to (1) understand public awareness about the prevalence of DVA in the community since the COVID-19 pandemic, (2) identify people's views and experiences of DVA, including familiarity with contributing factors, (3) explore the perceived barriers and challenges faced by victims of DVA, and (4) identify people's opinions of recommendations of interventions to support and prevent abuse. The research team developed the interview topic guide after defining the research objectives and reviewing relevant literatures, provided as Supplementary File 2. The Consolidated Criteria for Reporting Qualitative Research (COREQ) was used to guide reporting.

Data Analysis

As this is an exploratory study, interview transcripts were coded using a process of open coding by VS in discussion with the research team, followed by the development and clustering of themes in an interpretive process. The basic codes were elaborated into a framework that was continuously refined to reflect all the interviews (Supplementary File 3). The emergent themes were checked against the interview guide and study objectives, resulting in the development of a set of major themes. Co-authors of the study verified the emerging themes and contents. We used the socio-ecological model as a framework (15) to illustrate how the proposed intervention strategies could be used to tackle DVA at the individual, relationship, community and societal levels.

Results

Study Participants

Participants interviewed had varied backgrounds and experiences (Table 1), with an age ranging between 18 and 72 years; nearly a third of respondents (31%) were male, and 69% were female. The vast majority (79.3%) of the respondents had a university degree or higher and the remaining finished high school. The overarching majority was employed either full time (82.7%) or part time (10.3%).

Table 1
Participant characteristics

Age	N	Percentage
18–29	8	27.6%
30–39	6	20.7%
40–49	5	17.2%
50–59	6	20.7%
60–69	3	10.3%
70–79	1	3.4%
Gender		
Female	20	69.0%
Male	9	31.0%
Ethnicity		
White	16	55.2%
Mixed/Multiple ethnic groups	0	0%
Asian/Asian-British	10	34.5%
British Black/African/Caribbean	1	3.4%
Other	2	6.9%
Education		
Did not finish high school	0	0%
High school	6	20.7%
University degree or higher	23	79.3%
Employment		
Employed full time	24	82.7%
Employed part time	3	10.3%
Unemployed	0	0%
Furloughed	0	0%
Retired	0	0%
Student	1	3.4%
Unable to work	1	3.4%

Eleven respondents (37.9%) had either personally experienced DVA (13.8%) or were aware of someone close being abused; three admitted having experienced some form of psychological abuse. All felt emotional and psychological abuses to be easily disguised and overlooked, leaving deep-rooted mental wounds, taking a long time to recover and having enormous bearing on future relationships, as it “continuously chips away” at their mental state and belittles them.

‘… the physical abuse we see is only the tip of the iceberg’ (Male, 50–59)

All participants perceived an increase in the prevalence of DVA since the advent of the COVID-19 pandemic. The majority felt this was due to people not being able to ‘let out’ their frustrations due to forced isolation, reduced social contact, anxieties about the future and the closure of sporting and entertainment venues which could have otherwise relieved stress and diminished occurrences of abuse.

Three overarching themes were generated from the contextual analysis: (1) contributing factors to DVA, (2) challenges facing the victims, and (3) proposals for future interventions (Table 2) a fuller description of the themes and resultant framework are included in the Supplementary File 3. From the respondents' feedback, we identified three categories of proposed interventions to support victims and perpetrators of DVA: (a) raising public awareness, (b) enhancing provision of support services and, (c) education and training throughout the life course.

Table 2
Overarching themes

Categories	Subcategories	Thematic framework
Contributing Factors	· Victims	1. Experience
	· Perpetrators	2. Personality types
		3. Feelings & Beliefs
		4. Sociocultural aspects
		5. Religious beliefs
		6. Circumstances
		7. Finance
		8. Children & other dependents
		9. Substance abuse
		10. Vulnerable/ ill-health
Challenges Facing Victims	· Barriers to seeking support	11. Social conditioning
	· Societal beliefs	12. Cultural/religious constraints
	· Individual attitudes & behaviours	13. Circumstances
	· Prevailing legal /policy framework	14. Perceptions
	· Practicalities & logistics	15. Fear
	· Support mechanisms	16. Physical & mental vulnerability
		17. Disability
		18. Lack of education & training
		19. Lack of awareness
		20. Lack of accessible support
		21. Limited communication
		22. Children & other dependents
		23. Lack of tools to identify 'hidden abuse'
Proposed Interventions	· Raising Awareness	24. Improve public awareness
	· Education & Training	25. Improve self-awareness & holistic wellbeing
	· Reducing stigma	26. Promote social support & break social silence
	· Routine signposting to screening tools for DVA	27. Raise awareness in school curriculum
	· Guidance & mobilization of support services	28. Workforce training
		29. Support from family & friends
		30. Housing/shelter
		31. Financial assistance
		32. Legal support
		33. Counselling
		34. Improved communication
		35. Accessible support services
		36. Screening/ better tools to help identify 'hidden abuse'

1. CONTRIBUTING FACTORS TO DVA

Reasons why victims continue to experience DVA

Cultural and religious beliefs were stated as central contributing factors. Some victims may not be aware that they are experiencing the abuse.

'It's what happens in every household – so it's normal' (Female, 30–39)

A few participants identified that in certain cultures, male dominance hierarchy is the 'social norm' and accepted widely, which supported violence as a means of conflict resolution. These gender norms have an impact on women's roles and access to resources and influence the extent of personal involvement in decision-making at all levels.

Respondents lamented that victims often suffered in silence and may not come forward because they feared a lack of anonymity, of the unknown and a lack of trust in the system.

'I feel I will be looked down by others - especially as a male victim, [because] as a man you shouldn't be abused' (Female, 18–29)

Participants were mindful that anyone could be exposed to abuse. Poverty was linked with domestic abuse as both a cause and a consequence. One participant stated that DVA may be syndemic with affluence and therefore also present in wealthy or 'powerful' families, but this tends to be easily ignored and to remain unquestioned.

Reasons why perpetrators abuse victims

Participants acknowledged any kind of abuse is unacceptable and unjustifiable. Nevertheless, they indicated perpetrators are compelled to commit abuse due to certain personality traits such as a lack of self-confidence, and/or mental illnesses. Others suggest it might be related to a desire to gain control, or that DVA may stem from a lack of marital/relationship satisfaction or financial worries, especially with job loss and associated substance misuse. It follows that whereas stress at the workplace or home environment may cause an inflammatory response in a relationship, and subsequently DVA, the 'perpetrator as victim' standpoint is not justifiable. Few voiced that some abusers are ignorant of their actions, and that such demeanour is established as 'the norm' by the children and young adults, who in turn may carry on the behaviour.

2. CHALLENGES FACING THE VICTIMS

Sociocultural and religious constraints played a substantial part. Other factors included stigma, fear of repercussion, shame, embarrassment, not wanting to be judged, considering DVA as a private matter, lack of support from family/friends, fear of loneliness, lack of alternative housing or lack of job skills. Victims may feel guilty, give excuses, blame themselves for the abuse, experience feelings of powerlessness or feeling that they have no choice or being "forced" to stay for the sake of their children who "need a father". Some feel safer and that it is more convenient to stay with the perpetrator because the abuser provides the monetary assistance, financial security or the necessary amenities for the couple to care for their dependents. Participants also expressed the victim's unawareness of undergoing abuse or accessibility of support services as a considerable reason for not seeking support.

3. PROPOSALS FOR FUTURE INTERVENTIONS

Respondents considered what type of interventions or initiatives could be implemented to support victims and perpetrators. Whereas the majority acknowledged that perpetrators could themselves be considered as victims of previous DVA, they did not feel that perpetrators are likely to be remorseful for treating their 'loved ones' improperly. Hence, they emphasized the importance of interventions to support both parties, with a specific emphasis on children.

(a) Raising public awareness of DVA and accessible support

Most attributed public awareness to news and social media. Posters displayed in public toilets, including waiting rooms in GP surgeries were considered beneficial in raising awareness, whereas campaigns targeting specific at-risk groups were welcomed. Those participants who experienced DVA had supportive relatives, and hence felt better able to 'cope and get on with life'. More than half (52%) of respondents interviewed reported not knowing what services, helplines or resources they could rely on should they experience DVA. They highlighted a need for more publicity and awareness of support services like safe spaces, helplines, organisations and charities to be more visible and accessible to the public. Participants felt that such information should be advertised widely in various languages to address the UK's multi-ethnic population, including the use of visual infographics to communicate salient points.

(b) Enhancing provision of supportive services

Alternative accommodation such as 'emergency hotels or safe space' was recommended by all as a means of immediate support for victims. Anonymous helplines and online chats at all hours of the day were welcomed. Few mentioned having access to free counselling services, and a 'safe social house' with psychologists and social workers as a step forward in tackling abuse. Financial assistance, provision of childcare and housing were advocated as an optimistic step towards motivating victims to seek support. Mental health issues were recognised as a central contributing factor for both victims and perpetrators. Investing resources in this avenue were advocated by many to unravel the inherent issues relating to DVA. All felt that familiarity with the pathways, having quick access and speedy response from support services would encourage victims to pursue help.

(c) Education and Training

All participants stressed the importance of preventative measures through the life course, which can be implemented in the school setting and across the general population. Such measures should help support early identification of DVA, disclosure of abuse and support perpetrators as well as survivors of abuse.

Schools

All participants emphasized that schools could be an ideal place to educate children about DVA and what support mechanisms are in place to tackle this rising problem of society, especially if education is tailored appropriately to the age group (such as interactive play for primary school children). Teachers should also have better training and attentiveness to identify and support children who are exposed to DVA. A majority felt it should be the schools' responsibility rather than the parents to teach children about DVA as it would help provide more consistent guidance and advice. This approach was encouraged as it unquestionably circumvents any differences in cultural perspectives at home and further cultivates better awareness of DVA in the long-term.

'Children learn their behaviour by watching their parents; we need an external and internal source to educate children; hence a united learning that recognises the unacceptable behaviour' (Female, 40–49)

General population

Participants felt no single or 'one-size fits all' strategy could combat the myriad of reasons contributing to the problem. Widespread publicity would capture the attention of the general population.

Being vigilant and responsible in supporting the victims in the community should be the prime aim in dealing with such a diverse, sensitive and preventable problem. Theatre and dance companies could collaborate in a creative way reaching out to people, raising social consciousness around DVA and supporting survivors to express their experience. This could create a safe space for victims to reveal the challenges they have faced and celebrate their endurance with the audience.

Early identification

Routine touchpoints with healthcare professionals (HCPs) in the NHS and social care settings were considered ideal opportunities to identify abuse, and this assumption was also confirmed by the HCPs interviewed. Most respondents recognised screening as an effective means for early identification of victims. However, a few (mostly GPs) highlighted time constraints as the main barrier for the widescale implementation of DVA screening during routine consultations. All participants welcomed the idea of key workers including postal service, delivery drivers and shop keepers becoming proficient in DVA awareness and referral pathways should they encounter a victim who needed assistance.

'Victims will come forward if people are willing to listen to their stories' (Female, 18–29)

Disclosure of abuse and support

The emphasis was primarily around unlearning the learnt behaviour, for both the victims and perpetrators.

Victims

Education on attitudes and behaviour to avoid re-victimisation was highlighted by majority of the participants.

'We need to identify the teachable moments when victims are receptive to receiving information; this is the time to share facts' (Male, 50–59)

Ensuring that anonymity is maintained was identified by many as a way of improving victims seeking help, potentially giving a new identity. Participants highlighted those children who witness abuse including overhearing or observing the abuse, or those who directly experience the abuse, can also be considered as being exposed to DVA. There was a clarion call from respondents that child victims need a supportive parent/adult to get through this ordeal. As abuse is a learned behaviour, focus should be on children to stop evolving victims or perpetrators.

Perpetrators

Participants established that abusers will not willingly talk about their conduct, even if they are aware of the distress they are causing their victims. Hence, having helplines and receiving assistance without being criminalised would be a productive step.

The majority felt that perpetrators are victims themselves and might be unaware of their behaviour; this could be related to their upbringing in a violent environment. Few felt a level of empathy should be given as most abuses come from unresolved trauma and if appropriate therapy was given to the abuser, they would gain insights to reshape their morals and live more fulfilling lives.

Finding the trigger factor might be a helpful way to support perpetrators. They should be offered counselling and/or rehabilitation. The majority felt that sending the abuser to prison may not solve the matter in terms of behavioural change. Education was emphasized to be vital in stopping repeat offences or being victims themselves. However, a few participants felt strongly this should be in addition to the prison sentence as this will deter others from committing such crimes.

Discussion

To the authors' knowledge, this is the first study in the UK that explored public attitudes and perceptions concerning DVA and the use of a short screening tool in primary care and in the community setting. Due to the sensitive and qualitative nature of the study, the findings may not be representative of the UK population, but they provide useful insights into personal experiences from a small cross-section of respondents.

Our study showed that all respondents were aware of the concept of abuse, reflecting that their awareness of DVA may have increased somewhat due to the broad publicity it has received during the first national lockdown following the advent of COVID-19. Remarkably, a third of respondents reported having been exposed to or experienced some form of abuse. But the lack of public recognition attributed to normalisation or social silence with its associated fear, stigma and 'lack of trust in the system' at local and national levels was emphasised as a reason for non-disclosure. That only half of the participants in the study were aware of existing support services in the UK was consistent with previously published research confirming that DVA cases are vastly unreported (12). Feedback from respondents also echoed the findings of a recent NHS survey which showed that two in five people were not sure or did not know where to get help after being abused, and more than half of people did not ultimately seek help following their experiences of abuse (16). DVA organisations including The Survivors Trust and politicians are also attentive that many victims and survivors are unaware of the specialist support available to them and how to access it (16). This shows that the abuse recorded is only the 'tip of the iceberg', largely because most victims may not access support for what some individuals deem to be a 'private matter'. Many of the interventions proposed by the respondents have already been implemented in the UK, reinforcing the significance of

simultaneously raising public awareness and improving the visibility of accessible support mechanisms for both victims and perpetrators. A new campaign launched in February 2022, coinciding with the first day of UK's Sexual Abuse and Sexual Violence Awareness Week, aims to raise awareness of the centres and support available in England to those experiencing sexual assault, abuse or rape, including those not knowing who or where to turn to (16). This is an important step to help raise public awareness of DVA and is the largest such campaign in the UK since the advent of COVID-19.

In our analysis, we used the socio-ecological model as a framework (15) to illustrate how the respondents' recommended prevention strategies could be used to tackle DVA in our society (Table 3). This approach sheds light on how dynamic interactions across multiple domains ranging from individual risk factors to broad social factors could contribute towards the risk and protective elements for DVA (8). It also highlights how preventive interventions can be developed to work across four distinct levels; individual, relationship, community and societal.

Table 3
Socio-ecologic grouping of proposed interventions to tackle DVA in the community setting

Level	Example intervention	Scale /reach
Individual	• Personal empowerment	Small (Micro); Home setting
	• Self-referral/ Online referral	
	• Counselling (medical, psychological, legal)	
	• Coping strategies when abused	
Relationship	• Friendships/ community support	Mid-level (Meso); Education, community & workplace settings
	• Individual social responsibility in the community	
	• Mentoring	
	• Teaching/ skill-building programs	
	• Rehabilitation	
Community	• Use of screening tools for early identification	
	• Increase visibility of existing support services	
	• School curriculum	
	• Education and training initiatives	
	• Workplace support	
	• Online resources. Free helplines	
	• Awareness raising campaigns	
	• Police protection orders & prosecution service	
Societal	• Promoting social norms	Large (Macro); culture based
	• Policies and legal framework to support victims	
	• Funding, charities, supportive services including safe space	
	• Advocacy	

As there can be no 'one size fits all' approach to tackling DVA, the socio-ecological lens reinforces the importance of developing a comprehensive approach in which actions at each level of the social ecology synergise with interventions implemented at other levels (15). Multi-level programs are most effective in changing behaviour, but there is consensus that any such interventions need to be funded and sustained for several years to make any real impact on the actual cases of DVA.

At the individual level, raising awareness educates and influences people to change their attitudes, behaviours and beliefs, thus helping to shift public opinion and sway the political will of decision-makers (17). At the relationship and community level, public education campaigns focussing on the individual's social responsibility in the community may also help change some of the prevailing and largely unhelpful societal attitudes towards DVA such as victim-blaming, silence, tolerance, stigma and inhibition, and could make a substantial contribution to preventing abuse (18).

Social support leads to positive mental health outcomes, improved quality of life and more willingness to seek formal support and physical safety (14, 19). Having open dialogues about the detrimental health consequences of abuse in society, coupled with more awareness about appropriate referral pathways and linkage with local support services, including helplines might motivate survivors to pursue support. This mobilization could also prompt support networks to encourage those who are ignorant or inhibited due to social silence to come forward. By breaking this 'deafening code of silence' and reducing social tolerance and inhibition, individuals, health systems and society can take the necessary steps towards the challenge of 'melting the iceberg' of DVA. This could also help raise awareness among perpetrators who may become more accepting of receiving support (20).

Assessment tools and guidelines are available to help promote the recognition of and outline the support available to people experiencing DVA (21, 22). In healthcare settings, routine DVA screening improves victim identification (20) and can play a key mechanism in reaching and supporting the victims, particularly those who may not engage with other services. Examples of brief screening tools for DVA include the Woman Abuse Screening Tool (WAST),

WAST-Short, and Hurt-Insult-Threaten-Scream (HITS) etc (23–25). HCPs have a crucial role in tackling DVA, especially when utilising rapid assessment tools to identify abuse, when signposting to suitable services or when helping promote the recognition of and outline the support available to victims (22, 26). The National Institute for Clinical Excellence (NICE) in England does not currently recommend the use of validated tools for routine screening (27).

About 8.6% (2.94 million) of the total working age population in the UK are employed by health and social care (H&SC) organisations (Table 4). The H&SC workforce routinely engages with the vast majority of the UK population on an annual basis (i.e. during touchpoints with a HCP, GP, or specialists in secondary care, or allied health professionals for reablement or social care). This makes the H&SC ideally suited to raise awareness and screen for DVA using short validated tools. The provision of on-going training and support to the H&SC workforce is necessary to improve the professional's confidence in the identification, guidance and referral of victims to the existing DVA support services. In spite of current NICE recommendations, it is crucial to increase access to effective screening tools so that it is easier for HCPs to assist victims in disclosing information about DVA so that the root cause could be addressed. As screening plays a central role in the early identification of DVA, particularly unreported and easily hidden abuse (e.g., psychological, financial, coercive and controlling behaviour), we recommend that the routine use of validated screening tools for DVA be considered by community and NHS primary care services to promote the timely identification of victims for signposting and referral to appropriate support services.

Table 4
percentage of UK workforce who work in health & social care

Population	Total (million)	% of total UK population	% Total working age population
Total UK population (30)	67.0	100%	NA
Working age population (16–65 yrs.) (31)	34.4	51.3%	100%
NHS workforce (32)	1.40	2.0%	4.1%
Social Care workforce (33)	1.54	2.2%	4.5%
Total health & social care workforce	**2.94**	**4.2%**	**8.6%**

The routine screening for DVA during H&SC touchpoints should also be supported by structured education and training in the school setting. Most respondents proposed that a DVA awareness exercise should ideally be integrated into the school curriculum, and to feature as part of the education workforce induction and mandatory training, but this is unlikely to happen at scale without the support from policymakers. Entertainment venues also have a momentous role in educating the community, via creative interaction and by providing a safe place for victims to seek help.

'Everyone has a role in ending domestic abuse; together we can create a society that no longer tolerates abuse' (Female, 18–29)

Serious case review findings show that death or serious harm might have been prevented if H&SC professionals had acted upon their concerns or sought more information (28). This makes the case for more pervasive use of short DVA screening tools (e.g., WAST-Short), and those multiple strategies to tackle DVA throughout the life course are needed with consistent funding and support from policymakers.

Raising public awareness, enhanced education and training of people from all walks of life and throughout the life course coupled to the routine utilisation of screening tools for early identification of DVA can help tackle this "wicked" problem of society. Collaborative efforts from every layer of society and organisations including schools, communities, workplaces, healthcare settings, law enforcement bodies and politicians are required to keep DVA 'relevant' via public awareness campaigns to affect a positive change in social attitudes and the visibility of support services.

Limitations of this study

Our interview-based study provided insights into the public's knowledge, attitudes and perceptions about DVA following the advent of the COVID-19 pandemic. In qualitative studies, the pragmatic sample size is often considered sufficient when saturation of themes is nearly accomplished (29). We feel our data was sufficient in this respect. We acknowledge that additional interviews may have resulted in the identification of other emergent themes, particularly with respect to considering the perspective of perpetrators and not just individuals who may have suffered abuse. Inevitably, the study sample included some selection bias, such that only those with an interest or who experienced DVA, or those who were in employment or educated participated in the interview, but the breadth of contextual data we explored was adequate given the sensitive nature of the topic. A larger study with a more diverse cross-section of British society is indicated, including data collection from policy makers and commissioners of wellbeing support services.

Conclusions

To our knowledge, this is the first study in the UK that explored public attitudes and perceptions concerning DVA in the community setting since the advent of COVID-19. Sustained, multi-level community-facing interventions need to be implemented and targeted at individuals from all walks of life and throughout the life course to change the social climate and break the code of silence on DVA, and continue to bring this issue into the public light. If we are serious about tackling the issues of DVA with a view to improve prevention, NICE may consider recommending the routine use of a rapid screening tool for DVA which could be administered by H&SC professionals during the millions of contacts per year. The health and social care workforce represent nearly 10% of the total UK working age population and may help with early identification and supporting of survivors of DVA. The use of rapid screening tools in H&SC, inclusion of DVA education in educational setting and the sustained funding of multi-level interventions can help introduce new values, thinking processes and relationship skills that are incompatible with abuse.

Abbreviations

DVA	Domestic Violence & Abuse
NHS	National Health Service
COVID-19	Coronavirus Disease 2019
NICE	The National Institute for Clinical Excellence
GP	General Practice
WHO	World Health Organisation
WAST	Women Abuse Screening Tool
WAST-short	Women Abuse Screening Tool-short
UK	United Kingdom
eSurvey	Electronic Survey
COREQ	Consolidated Criteria for Reporting Qualitative Research
HCPs	Healthcare Professionals
HITS	Hurt-Insult-Threaten-Scream
H&SC	Health and Social Care

Declarations

Ethics approval and consent to participate

The study was reviewed by Imperial College Research Ethics Committee who approved the study (ICREC #21IC6721). No incentives were offered to volunteers.

Written consent to enter the study was sought from each participant only after a full explanation of the study was given, documentation was offered, and time allowed for consideration. The right of the participant to refuse to participate without giving reasons was respected. All participants were free to withdraw at any time and without giving reasons. The interviews were transcribed with the principle of anonymity in mind and transcriptions were not outsourced, therefore no confidentiality agreements were required.

Consent to publish

Consent for publication was sought from all participants in the study through an electronic consent form. Participants were notified on the plans for publication, and were reminded that all their data was pseudonymised.

Availability of data and Materials

The datasets analysed during the current study are not publicly available to protect the privacy of participants but are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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- SupplementaryFile1Methods.pdf
- SupplementaryFile2CribSheet.pdf
- Supplementaryfile3Preliminarycodes.pdf