

UK National Screening Committee (UK NSC)

Screening for intimate partner violence

Date: 26 March 2026

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Aim

To ask the UK National Screening Committee (UK NSC) to make a recommendation, based on the evidence presented in this document, whether screening for intimate partner violence meets the UK NSC criteria for a systematic population screening programme.

Current Recommendation

The 2019 review of screening for intimate partner violence was an evidence summary. Based on the review, the UK NSC did not recommend screening for partner violence. This was because:

- there was a lack of evidence that screening would reduce partner violence or improve health outcomes
- it was not known how effective interventions would be at reducing partner violence or health problems
- there was not enough research to be sure that a test would be accurate enough to be used in a screening programme
- the extent of partner violence within different groups of the UK population was not known

UK NSC 2025 Evidence Map

The aim of the 2025 evidence map was to gauge the volume and type of evidence related to screening for intimate partner violence to support whether the evidence was sufficient to justify commissioning further evidence synthesis work. The following question was addressed:

1. What is the volume and type of evidence on the reported effectiveness of intimate partner violence screening in healthcare settings?

The evidence map highlighted important gaps, including:

- limited evidence for men, LGBTQ+ groups and ethnic minority populations
- a lack of outcome data beyond detection and referral to specialist services

Most studies focused on detection and referral, while key outcomes such as prevention of intimate partner violence, morbidity, mortality, neonatal outcomes, children's wellbeing, and quality of life were not reported. Only one study reported on the reduction of intimate partner violence, and it found no significant impact.

Consultation

A three-month consultation was hosted on the UK NSC website from 26 November 2025 to 18 February 2026. Direct emails were sent to 23 stakeholder organisations and 14 individual subscribers. Annex A contains a list of the 23 stakeholder organisations contacted.

Comments were received from the following 4 stakeholders (see Annex B for comments):

1. Susan Bewley, Emeritus Professor of Obstetrics and Women's Health, XXXX
XXXX
2. Dr Ceryl Teleri Davies, Senior Research Fellow, XXXX XXXX
3. Honey Alma, Policy and Public Affairs Officer, The For Baby's Sake Trust
4. Mark Brooks, Chair, ManKind Initiative

Key points raised in the consultation

The majority of stakeholders agreed that there should be no change to the screening recommendation. Stakeholders highlighted the importance of trauma-informed, person-centred routine enquiry, professional judgement, and trust-based approaches, rather than the introduction of a formalised screening programme. One stakeholder suggested an update to the National Institute for Care and Excellence (NICE) public health guideline.

One stakeholder suggested that the UK NSC should progress with targeted screening and routine enquiry within pregnancy, sexual health and primary care settings, alongside robust support pathways, noting the existence of some evidence that screening could increase identification of IPV. This stakeholder also recommended that the statutory definition of domestic abuse set out in the Domestic Abuse Act (2021) be adopted.

One stakeholder welcomed the UK NSC's recognition of male victims of intimate partner violence and acknowledgement of the relative sparsity of evidence for these populations. Although they agreed that there is not enough evidence to support a population-wide screening programme, they emphasised that professionals should be more alert to possible domestic abuse, including among groups who are often overlooked. They should know the signs, especially coercive and controlling behaviour, and be aware of local support services, using tools like the DASH assessment more consistently.

Response: The UK NSC thanks the stakeholders for their thoughtful and detailed responses to this consultation. The Committee notes that the majority of respondents agreed with the recommendation that there should be no change to the current screening recommendation.

The Committee recognises the importance of trust, safety, trauma-informed practice, and professional judgement in supporting disclosure and access to care. The UK NSC agrees that NICE guidance plays an important role in identifying, preventing, and reducing intimate partner violence; however, responsibility for updating NICE public health guidance is outside the remit of the UK NSC. Information on NICE's process for updating public health guidance is available on the NICE website at this link:

<https://www.nice.org.uk/process/pmg5/chapter/updating-public-health-guidance>

As outlined in the evidence map, the current evidence base for screening remains limited. These limitations were central to the Committee's conclusion that further work on screening for intimate partner violence should not be commissioned at this time.

With regard to terminology, the UK NSC acknowledges the suggestion to adopt the statutory definition of domestic abuse set out in the Domestic Abuse Act (2021). The evidence map uses terminology consistent with the World Health Organization, in which intimate partner violence is recognised as a subcategory of domestic violence and abuse. The Committee's consideration of screening was, therefore, focussed specifically on intimate partner violence and not domestic abuse.

The Committee notes stakeholders' comments regarding the limited evidence for screening among under-represented populations, including men, and acknowledges the importance of addressing these evidence gaps through further research.

Recommendation

The UK NSC is asked to:

1. Consider the comments received during the consultation and confirm that they are happy with the responses provided.

2. Agree with the following recommendation that due to insufficient volume of evidence, no further evidence synthesis work should be undertaken.
3. Agree that due to there being minimal evidence development since the last two reviews that screening for IPV should be archived and any future requests to examine this topic should be submitted through the UK NSC's open call for topics.

Annex A: List of Organisations Contacted

1. AMIS
2. Association for Improvements in the Maternity Services
3. The British Psychological Society
4. The For Baby's Sake Trust
5. Institute of Health Visiting
6. Institute for Addressing Strangulation
7. Institute of Health Visiting (IHV)
8. ManKind Initiative
9. Refuge
10. Respect
11. Royal College of General Practitioners
12. Royal College of Midwives
13. Royal College of Nursing
14. Royal College of Obstetricians and Gynaecologists
15. Royal College of Paediatrics and Child Health
16. Royal College of Physicians
17. Royal College of Physicians and Surgeons of Glasgow
18. Royal College of Physicians of Edinburgh
19. Royal College of Psychiatrists
20. SafeLives
21. Standing Together against domestic violence
22. Victim Support
23. Women's Aid

Annex B: Consultation Responses

1. **From:** UK National Screening Committee
Sent: Wednesday, December 03, 2025 00:23
To: UK NSC Inbox
Subject: [Partner violence] Comment from a stakeholder

Name: Susan Bewley
Email: XXXX XXXX
Organisation: XXXX XXXX
Role: Emeritus Professor of Obstetrics and Women's Health
Publish submitter's name: True
Publish Organisation name: False

Condition: Partner violence

Thank you for synthesising the evidence. I agree there should be no change to screening recommendations.

However, in view of the rapidly changing nature of technology assisted abuse (whether stalking, sex-texting, pornography inspired high rates of choking and strangulation of young women during sex), it is very important for healthcare practitioners to be up to date.

Partner violence (and other forms of domestic and interpersonal violence) is not a typical or appropriate 'pre-clinical condition' that warrants any kind of "screening" in the first place. It is a complex, non-linear reality in many pregnant women's and other adults lives that definitely endangers their life and health. However, there is no "treatment" that can be applied.

None of this undermines the current, excellent NICE public health guidance about routine enquiry, which may lead to disclosures that can be acted upon (listening, witnessing, documenting, offers of support and referral), having created an enabling environment and relationship of trust.

I wonder if the updating of the NICE PH guideline belongs in the NSC's remit at all? The topic most certainly mustn't be dropped because its difficult and falls between and across crime, social care and healthcare. What would be very helpful if that guideline were to be reviewed would be more information on 'what works' to create trust. For example, there is a recent and very useful reference about what adult survivors of sexual violence (usually an important part of partner violence) say.

PLEASE THINK ABOUT HOW TO UPDATE HEALTH AND SOCIAL CARE ABOUT "WHAT WORKS" IN TRAUMA-INFORMED APPROACHES. These are worth thinking about for staff in stretched services, as well as the patients/ clients.

There is information being gathered from around the world that is applicable in the UK, and to migrants who are here from the 'What works?' programme

SHOULD THE NICE PH GUIDELINE BE UPDATED?

Peeren S, Montgomery E, Sweeney A, Spaducci G, Kaul A, Smeeth D, Oram S. Trauma-informed healthcare from the perspectives of women who have experienced sexual violence in adulthood: a systematic review and meta-ethnography. *BMC Health Serv Res.* 2025 Nov 27. doi: 10.1186/s12913-025-13584-x. Epub ahead of print. PMID: 41310653.

<https://ww2preventvawg.org/>

2. **From:** UK National Screening Committee
Sent: Wednesday, February 04, 2026 16:38
To: UK NSC Inbox
Subject: [Partner violence] Comment from a stakeholder

Name: Dr Ceryl Teleri Davies
Email: XXXX XXXX
Organisation: XXXX XXXX
Role: Senior Research Fellow
Publish submitter's name: True
Publish Organisation name: False

Condition: Partner violence

Consultation Response: Screening for Intimate Partner Violence (IPV)

1. Rationale for Screening Across Healthcare Settings

Screening for intimate partner violence (IPV) should be progressed as a targeted, system-based intervention across multiple healthcare settings, including pregnancy and antenatal care, sexual and reproductive health services, and primary care (including intimate screening). These settings represent key points of routine contact with individuals at increased risk of IPV and provide opportunities for early identification, safe enquiry and referral to support.

Evidence indicates that IPV is highly prevalent and associated with significant physical, psychological and social harms, particularly for women and pregnant individuals (World Health Organization, 2021; McManus et al., 2022). While population-wide screening has not yet demonstrated reductions in IPV incidence, consistent evidence shows that screening increases identification, disclosure and referral to specialist services (Feltner et al., 2025). In pregnancy and sexual health settings, screening is particularly important given the links between IPV and adverse maternal, neonatal and reproductive outcomes (Murphy et al., 2001; Jahanfar et al., 2014). Primary care also plays a central role due to continuity of care and established referral pathways, as demonstrated by UK-based interventions such as IRIS (Feder et al., 2011; Sohal et al., 2020).

1. Promoting Routine Enquiry and Supporting Survivors

Screening should be understood as part of a wider approach that promotes asking about abuse in a safe, sensitive and proportionate way, rather than as a single test or standalone intervention. Normalising routine enquiry within appropriate healthcare contexts can reduce stigma, signal that abuse is a legitimate health issue, and create opportunities for disclosure where individuals may not otherwise seek help.

Effective screening should be supported across the system and requires trained staff, clear safeguarding procedures, and access to specialist referral pathways. Evidence shows that when screening is embedded within supported systems – including staff training, clinical leadership and partnership with specialist services – it can improve practitioner confidence, survivor experience and access to support (Miller et al., 2021). Importantly, available evidence does not indicate that screening causes harm, such as increased abuse or distress, when conducted appropriately (Feltner et al., 2025).

1. Cost, Value and Wider System Benefits

From a health economics perspective, the costs of implementing IPV screening are likely to be modest when embedded within existing clinical contacts, particularly compared with the substantial economic burden of domestic abuse. In England and Wales, the estimated economic and social cost of domestic abuse is approximately £66 billion per year, driven largely by physical and emotional harm, lost productivity and healthcare use (Oliver et al., 2019).

While direct evidence on the cost-effectiveness of screening remains limited, screening may generate wider system value through spillover effects. These include reduced crisis presentations, improved mental health outcomes, better safeguarding for children, reduced use of emergency services, and longer-term benefits for employment, housing stability and social care. Early identification and referral may therefore support prevention, cost avoidance and improved outcomes across health, social care and wider public services, even where impacts are not immediately captured in traditional health metrics.

Alignment with UK NSC Criteria and NICE Guidance

The UK National Screening Committee (UK NSC) criteria place strong emphasis on demonstrating clear evidence of benefit, reduction in morbidity or mortality, and an effective treatment pathway following screening. While the current evidence base does not yet meet the threshold for population-wide screening for intimate partner violence (IPV), this should not preclude targeted or context-specific approaches where risk is known to be higher and where safe referral pathways exist.

NICE guidance on domestic violence and abuse (PH50; QS116) supports routine enquiry in selected healthcare settings, including antenatal care, sexual health services and primary care, when delivered by trained staff and supported by clear safeguarding and referral arrangements. This approach recognises the complexity of IPV, the ethical importance of identification, and the limitations of applying traditional screening criteria to social and behavioural harms.

Targeted enquiry within these settings aligns with the spirit of the UK NSC framework by focusing on proportionality, minimising harm, and embedding screening within a wider system response rather than as a standalone test. It

also supports safeguarding duties, equity objectives and prevention priorities, while enabling the generation of UK-specific evidence on outcomes, implementation and value. This approach provides a pragmatic and ethically sound pathway for progressing practice in advance of any future reconsideration of population-level screening recommendations.

1. Conclusion

In light of the high prevalence, under reporting and significant harms associated with IPV, there is a strong case for progressing targeted screening and routine enquiry within pregnancy, sexual health and primary care settings, alongside robust support pathways. Screening should be viewed as an enabling component of a broader system response, rather than judged solely against population screening criteria. Advancing practice in this area would support safeguarding, prevention and equity objectives, while generating the UK-specific evidence needed to assess effectiveness and value more fully over time.

Note on terminology: For UK purposes, I suggest adopting the statutory definition of Domestic Abuse as outlined in the Domestic Abuse Act (2021).

References

- Feder, G., Davies, R.A., Baird, K., Dunne, D., Eldridge, S., Griffiths, C., Gregory, A., Howell, A., Johnson, M., Ramsay, J. and Rutterford, C. (2011) Identification and referral to improve safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: A cluster randomised controlled trial. *The Lancet*, 378(9805), pp.1788–1795.
- Feltner, C., Peat, C., Asher, G.N., Wright, S., Vaughan, J., Middleton, J.C. and Jonas, D.E. (2025) Screening for intimate partner violence and caregiver abuse of older or vulnerable adults: A systematic review. *JAMA*, 334(4), pp.339–355.
- Jahanfar, S., Howard, L.M. and Medley, N. (2014) Interventions for preventing or reducing domestic violence against pregnant women. *Cochrane Database of Systematic Reviews*, 11, CD009414.
- McManus, S., Walby, S., Barbosa, E.C., Appleby, L., Brugha, T. and Bebbington, P. (2022) Intimate partner violence, suicidality and self-harm in England. *The Lancet Psychiatry*, 9(7), pp.574–583.
- Miller, C.J., Adjognon, O.L., Brady, J.E., Dichter, M.E. and Iverson, K.M. (2021) Screening for intimate partner violence in healthcare settings: An implementation-oriented systematic review. *Implementation Research and Practice*, 2.
- Oliver, R., Alexander, B., Roe, S. and Wlasny, M. (2019) The economic and social costs of domestic abuse. Home Office Research Report 107.
- Sohal, A.H., Feder, G., Boomla, K., Dowrick, A., Hooper, R., Howell, A., Johnson, M. and Eldridge, S. (2020) Improving the healthcare response to domestic violence and abuse in UK primary care. *BMC Medicine*, 18, 48.

3. **From:** UK National Screening Committee
Sent: Tuesday, February 17, 2026 13:30
To: UK NSC Inbox
Subject: [Partner violence] Comment from a stakeholder

Name: Honey Alma
Email: XXXX XXXX
Organisation: The For Baby's Sake Trust
Role: Policy and Public Affairs Officer
Publish submitter's name: True
Publish Organisation name: True

Condition: Partner violence

Screening for Intimate Partner Violence for the UK National Screening Committee

The For Baby's Sake Trust, February 2026

We welcome the government's commitment to improving the healthcare response to domestic abuse. Intimate partner violence (IPV) is a significant public health issue, and healthcare professionals are often the first or only point of contact for many people experiencing abuse. Universal recognition of domestic abuse across all health settings is therefore essential. We strongly support the principle that all patients – of every gender, sexuality, and background – should be met with sensitivity, awareness, and the opportunity to disclose safely. Normalising conversations about relationships and wellbeing can help reduce stigma and create the conditions in which people feel able to speak about abuse.

However, while we support the aim of increasing identification and support, we do not believe that a highly formalised, mandatory screening programme is the right approach for the UK at this time. A trauma-informed, person-centred model of routine inquiry, grounded in trust and professional judgement, is more likely to create the safety required for meaningful disclosure.

The evidence base for universal screening remains limited

Current routine enquiry practices in UK healthcare – including in maternity services – are driven more by practice guidance than by a strong evidence base. The consultation's evidence review does not include important UK-based research, such as the ongoing RIVA study led by King's College London, which is evaluating healthcare-based Independent Domestic Violence Advisors (IDVAs) in maternity settings. Early learning from this work, and from the wider literature on health-based IDVA programmes, suggests that having access to specialist domestic abuse expertise within clinical teams can increase staff confidence and improve identification, particularly when clinicians feel supported to respond safely and appropriately.

At the same time, it is important to recognise that IDVA models, while valuable for many, are not the only or necessarily the most appropriate form of specialist provision in every context. Some IDVA roles are closely tied to criminal justice pathways, and a model that implicitly channels victim-survivors towards reporting as the primary or expected route to safety does not reflect the realities or preferences of every individual. We therefore encourage a broader, trauma-informed approach that prioritises therapeutic, whole-family support and recognises the diverse ways people seek safety and change. Strengthening specialist training, reflective practice, and access to skilled workers is essential, but this does not need to be limited to IDVA roles. A more flexible ecosystem of specialist support – one that includes but is not defined by carceral pathways – is better aligned with a person-centred model of routine inquiry.

The UK National Screening Committee’s own evidence mapping exercises have twice concluded that the evidence for universal IPV screening is insufficient to justify changes to current recommendations. Significant gaps remain, including the lack of evidence on the effects of screening on men, LGBTQ+ people, and minoritised ethnic groups; the limited research in underrepresented healthcare settings such as mental health services; and the absence of robust evaluations of outcomes beyond detection and referral. The NSC also emphasises the need for UK-specific research rather than reliance on US-based studies, which may not translate well to the UK’s health system or population. These gaps make it difficult to justify a shift to a formalised screening model.

Trauma-informed, person-centred practice is more effective than rigid screening

Evidence and lived experience consistently show that disclosures of abuse occur when individuals feel safe, respected, and in control of the interaction. A rigid screening protocol risks undermining these conditions by prioritising process over trauma-informed relationship-building. The barriers to disclosure for victim-survivors, for those using abusive behaviours, and for witnesses are complex and well-documented, including in resources created by The For Baby’s Sake Trust. These barriers cannot be overcome by a tick-box approach.

A trauma-informed model of routine inquiry allows clinicians to tailor conversations to the individual, to use their professional judgement, and to respond in ways that are sensitive to the person’s history and needs. This approach aligns with NICE guidance, which emphasises asking about domestic abuse in a way that is supportive, integrated into wider safeguarding practice, and grounded in an understanding of trauma. It also reflects the operational realities described in NHS presentations and professional guidance, which show that staff often struggle with rigid screening expectations but feel more confident when supported to ask about abuse in a flexible, relational way.

The impact of IPV on children underscores the need for early, sensitive intervention

Recent research using ALSPAC data demonstrates that sustained exposure to IPV significantly harms children’s socio-emotional and cognitive development between ages 0 and 4, with maternal mental health acting as a major channel for these effects. Interventions that support parent–child interactions and maternal mental health can help mitigate harm, but the most important factor is that the abuse stops as early as possible. This reinforces the need for healthcare professionals to recognise IPV, but it also highlights the importance of doing so in a way that builds trust rather than risks retraumatisation. A relational, trauma-informed approach is more likely to achieve this than a formalised screening protocol.

Our recommendation

We support universal recognition of domestic abuse as a health issue and believe that healthcare professionals should feel confident and supported to ask about it with all patients. However, we do not support the introduction of a formalised universal screening programme at this time. Instead, we recommend strengthening trauma-informed, person-centred routine inquiry across the health system; investing in specialist domestic abuse roles for adults and for children; and prioritising high-quality UK research that evaluates not only identification rates but also meaningful outcomes such as safety, wellbeing, and prevention of further harm. Additionally, this training and learning should be available for all health professionals as part of their qualifying programmes and ongoing CPD.

A compassionate, relational approach – rather than a procedural one – is far more likely to create the conditions in which people feel safe to disclose abuse and access the support they need. Crucially, relational inquiry is also better able to adapt to the diversity of patients’ backgrounds, identities, and experiences. Given the significant gaps in the evidence base around screening for men, LGBTQ+ people, ethnic minority communities, and other minoritised groups, a flexible, trauma-informed model is more responsive to the realities of people’s lives than a rigid screening protocol. It allows clinicians to meet individuals where they are, to recognise the cultural and structural factors that shape disclosure, and to build trust in ways that standardised screening tools cannot.

4. **From:** UK National Screening Committee
Sent: Wednesday, February 18, 2026 20:51
To: UK NSC Inbox
Subject: [Partner violence] Comment from a stakeholder

Name: Mark Brooks
Email: XXXX XXXX
Organisation: ManKind Initiative
Role: Chair
Publish submitter's name: True
Publish Organisation name: True

Condition: Partner violence

We at the ManKind Initiative, a charity supporting male victims of domestic abuse, fully agree with the conclusions of the NSC with respect to NOT extending screening until more evidence is available.

We are grateful to the NSC for ensuring that there was full recognition of male (including GBT+ men) in the review – including the sparsity of information and research.

We have incidentally formally requested that the NIHR produce a research fund on male victims of domestic abuse (there currently is one for female victims) which would help.

Lastly, we recommend that in its formal response, that the NSC, makes the point that whilst screening is not currently appropriate, professionals in the health and social care system (including GPs and social services) should; enhance their levels of professional inquiry including to under-represented victims such as men and LGBT+ people, know who their local domestic abuse support agencies are, and, better understand the signs of domestic abuse – especially coercive and controlling behaviour. Greater use of the DASH assessment would be good too.

It may be worthy of note that the ONS has produced updated and more accurate data on all victims of domestic abuse including IPV – which do have breakdowns for sex and other Protected Characteristics:

<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabuseprevalenceandtrendsenlandandwales/yearendingmarch2025>

Thank you also for including us in the consultation.

All the best

Mark Brooks
Chair