The Impact of women Domestic Violence on Health Outcomes in UK.

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Introduction

In the UK, domestic violence (DV) includes violence, emotional abuse, sexual abuse, and coercive control in intimate or family relationships, which often harm in perpetuating cycles (Office for National Statistics, 2024). Physical and emotional trauma, including PTSD, depression, and suicide, remain with the survivor, while chronic conditions, including respiratory illnesses, are also common, to diminish social capital, including intergenerational trauma that advances the development of children to include abuse. Within the framework of trauma-informed care (TIC), DV is viewed with a continuum of care perspective since it will include social services and health care (NHS). With a reported prevalence of 2.3 million adults in England and Wales experiencing DV, it is still grossly underreported (Office for National Statistics, 2024). During the SARS-CoV-2 pandemic, DV exacerbated mental health conditions of women, including 26% of women who died by suicide under mental health services (Turnbull et al., 2025; Keynejad et al., 2025). This scoping review argues the need to integrate TIC, which also involves cross-mapping the health burdens of DV, assessing the responding services, and exploring access gaps. The review will involve ethical survivor-informed research.

Background

Context of DV in the UK

Domestic violence remains a significant issue in the UK, affecting an estimated 2.3 million adults every year in England and Wales, although the true size of the issue may be larger due to underreporting (Office for National Statistics, 2024). The impact of DV is disproportionately acute on women and children, 20% of whom experience exposure that manifests as anxieties and developmental delays (Cleaver, 2025). Carers too are affected, with 33.9% of them reporting histories of DV, which are correlated with common mental disorders. DV also comes with a huge economic cost, estimated at £66 billion every year, due to the expenditure on healthcare and loss in productivity because of DV-related chronic conditions (Carlisle et al., 2024). DV has an intergenerational impact, where DV has been shown to cloud parental relationships and reduce the likelihood of children having good health by 7% and increase the likelihood of having respiratory illness (Jofre-Bonet et al., 2024). Evidence suggests that pregnancy makes individuals more susceptible to DV, and violence during pregnancy is associated with increased risk of miscarriage and preterm birth (Babazadeh et al., 2025). The SARS-CoV-2 pandemic increased the prevalence of 4.6 common mental disorders during the period, which is attributed to increasing intimate partner violence (Keynejad et al., 2025). The adversities that families experience further compound health inequities across generations.

Policies, Legislation, and Guidance

The UK addresses domestic violence legally through the Domestic Abuse Act 2021, which defines domestic violence widely, provides for the introduction of Domestic Abuse Protection Orders, and provides for the banning of cross-examination of abusers in family courts (Di Marco and Rowlands, 2025). The 2014 Care Act enforced inter-agency collaboration for domestic violence by mandating assessments and the safeguarding of carers. The Domestic Violence, Crime and Victims Act 2004, through Statutory Domestic Homicide Reviews, improves ethical engagement with families while encouraging multi-agency learning from fatal incidents. The 1989 Children Act incorporated domestic violence into child protection policy, with reforms that focus on safety and the removal of the presumption of involvement of the parents. Mental health policy is integrated with the NHS, and domestic violence is incorporated as a screening policy under amendments to the Mental Health Act. Trauma-informed care (TIC) policies, which pivot from recognition of trauma to support service recovery and trust building, were developed from 2012 to 2021 (Emsley et al., 2022). These policies combine efforts to reduce the health impact of domestic violence.

Services and Practice

The NHS responses include routine DV screening in primary care to identify physical injuries and assess mental health conditions such as depression, while Child and Young People's Mental Health Services (CYPMHS) respond to intergenerational trauma (Syed et al., 2023). Social care provides advocacy and refuges for safety planning, although support is often delayed due to fragmented services (Keynejad et al., 2025). The more widespread adoption of TIC principles, especially safety and empowerment, has improved provider training and patient outcomes (Emsley et al., 2022). The use of digital health technology, such as virtual therapy apps, has been expanded to improve access after the pandemic and address pre-existing access issues. However, the more than 426 inconsistent outcome measures identified in the literature across studies undermine evaluation and complicate the provision of standardised care (Carlisle et al., 2024). The ethical practices seen in homicide reviews—where survivor voices are integrated to shape services without the risk of further traumatisation—are commendable (Di Marco and Rowlands, 2025). The highlights drawn from these practices emphasise the need for coherent and innovative strategies to respond to DV survivors.

Methods

Data Collection

Building on Arksey and O'Malley's (2005) approach, this scoping review sought to systematically catalogue the evidence on domestic violence and its impact on health in the UK, providing sufficient breadth in the structured synthesis of the literature. The review utilized several

databases, including PubMed, PubMed Central, PsycINFO, CINAHL, Scopus, UWTSD Library, Sage, and EBSCOhost, using the search strategy "domestic violence" OR "intimate partner violence" AND "health outcomes" AND "UK" AND ("NHS" OR "social care"). The inclusion criteria for the review, to the best of the author's ability, were the identification of primary and secondary peer-reviewed studies focused on the UK and published between the years 2019 and 2025 and in English. Policies, editorials, and conference proceedings were the primary exclusions for the review. From the search, 20 admissible references were identified and reviewed for the study question after title, abstract, and full text screening. From these, 5 studies were identified for primary analysis, inspired by other TIC-focused scoping methods for the protocol design, due to their direct relevance to the health and service data of the UK. Evidence gap mapping informed the breadth of inclusion to capture the underspecified aspects.

Data Analysis

Thematic analysis was conducted according to Braun and Clarke's six-phase process to identify, analyze, and report patterns that emerged from the studies chosen, which included the mental health impact and barriers to the services, to develop a comprehensive understanding of DV outcomes. The first phase of familiarization comprised several readings of the texts. The inductive approach, which aims for themes to emerge from the data rather than assigning themes first, ensures that the approach of the analysis remains aligned to the objectives. Quality appraisal using the Mixed Methods Appraisal Tool (MMAT) for the assessment of the methodological rigor, which included evaluating the appropriateness of sampling strategies, data collection, and integration of findings for mixed-method studies. To deepen the analysis, general TIC methods were modified to increase their relevance to the UK. A scoping study does not permit a meta-analysis, which is typically focused on the statistical synthesis of data. In this case, the study focuses on the breadth.

Ethical Considerations

The ethical performance of this review was based on the treatment of literature concerning survivors, avoiding sensationalism and the potential for re-traumatization. While recognizing the potential for bias—including the possible exclusion of ethnic minorities and LGBTQ+ individuals from the literature on domestic violence—I aimed to extend the analysis on inclusivity and the potential for skewed readings. The ethical considerations on the complexity of working with sensitive data involved the precise and respectful handling of victim-survivor accounts. Any concern for the confidentiality of the participants in the original studies was, of course, met because the analysis was on the aggregated data. Reflexivity was the guiding principle concerning researcher bias to focus on interpretative bias. This is consistent with trauma-informed

research and the need to enhance the empowerment and safety of the research participants in the dissemination of research findings.

Results

Overview of Selected Studies

This scoping review synthesized six peer-reviewed studies that best met the review question and objectives and provided comprehensive accounts of the impact of domestic violence (DV) on health and social care in the UK. These studies (2019–2025), which employ different designs from secondary analyses to meta-reviews and which focus on children and on carers and professionals, are summarized in Table 1. These studies, as a group, describe the impact of DV on the health service response and access to services, with the health service innovations and the barriers that remain. They are framed within the context of the broader literature, which, in the case of DV, is interrelated with mental health issues, particularly with physical and intergenerational impacts. The selection also facilitates the in-depth analysis of each objective by ensuring that two studies are assigned to each objective.

Table 1: Summary of Selected Studies

Author/Year	Study Design	Sample/Setting	Key Methods	Main Findings on Health Outcomes/Services
Allen et al. (2024)	Secondary data analysis (Millennium Cohort Study)	UK parents and children (n=19,000+ households)	Quantitative analysis of SDQ scores and adversity clusters	Parental DV linked to child mental health issues like anxiety, exacerbated by "toxic trio"; intergenerational trauma transmission.
Turnbull et al. (2025)	National observational study	UK women under mental health services (2015–2021)	Quantitative analysis of suicide data	DV history in 26% of suicide cases; elevated PTSD and suicidal behavior risks.
Pell et al. (2025)	Realist evaluation	8 UK primary care sites (Health Pathfinder)	Mixed methods: interviews (n=45), routine data	"Whole health" models improve DV identification and referrals; integrated NHS-social care reduces delays.

Powell et al. (2025)	Systems analysis	38 UK professionals in primary/child mental health	Qualitative: thematic analysis of interviews	Fragmented services worsen mental health; need multi-agency coordination for family support.
Carlisle et al. (2025)	Systematic review/meta-analysis	29 UK DSVA intervention studies (n=5,000+)	Meta-analysis of cessation rates/outcomes	Advocacy promotes access but low evidence certainty; links DV to chronic diseases, highlighting inequities.
Wildman et al. (2025)	Cross-sectional survey	UK carers (n=7,000+ from HSE)	Quantitative: adjusted odds ratios for morbidities	DV increases CMD/PTSD in carers; screening obstacles due to silos, with training as promoter.

Physical and Mental Health Conditions Related to Domestic Violence

The review, based on the work of Allen et al. (2024) and Turnbull et al. (2025), identifies various and diverse concrete and abstract health conditions associated with DV. The mental conditions include PTSD, depression, suicidality, and, as noted by Turnbull et al. (2025), suicides of women within mental health services, of which 26% involved DV and chronic hypervigilance. Allen et al. (2024) discusses the child-specific mental health conditions of anxiety and behavioural disorders, from which SDQ scores predict long-term emotional dysregulation. Chronic stress-related consequences, including respiratory illnesses and cardiovascular conditions, are particularly worrying. Intergenerational trauma, which is DV co-occurring with substance abuse disorders, will exacerbate violence-related developmental delay (Syed et al., 2023). Pregnancy-related conditions, including postpartum depression and preterm births, emphasise the need to care about the somatic burdens of DV (Babazadeh et al., 2025). Other research noted a 46% prevalence of CMD during the pandemic, indicating DV during isolation and unrestrained symptom exacerbation (Keynejad et al., 2025). All these conditions need to be incorporated within the UK care framework as holistic provisions.

Current Reactions of NHS and Social Care in Service Delivery

The review examines reactions of the NHS and social care, based mainly on the work of Pell et al. (2025) and Powell et al. (2025). Pell et al. (2025) examines responses of primary care "whole health" and identifies improvements in DV detection due to the presence of on-site advisors and training and improved safety planning. Powell et al. (2025) addresses the issue of fragmentation in child mental health services, where uncoordinated referrals slow down trauma interventions to the family. TIC frameworks are gaining traction, with empowerment in healing approaches shifting to provider education (Chin et al., 2024). Screening in primary care identifies hidden, clinically significant cases, in line with the NHS mental health integration focus (Emsley et al., 2022). Advocacy and social care refuges exist, albeit efficacy is hindered by silos (Carlisle et al., 2024). Post-pandemic, digital innovations provide discreet support to bridge the gaps (Eggleston et al., 2025). These reactions indicate practice improvements, but gaps in metrics result in the inability to standardize (Casingcasing et al., 2025). Overall, services are designed to implement trauma-informed principles in practice to enable recovery.

Promoters and Obstacles in Access to Support for Domestic Violence

The review investigates promoters and obstacles, as outlined by Carlisle et al. (2025) and Wildman et al. (2025) as sources. Advocacy is viewed as a promoter by Carlisle et al. (2025), attaining 58.7% abuse cessation through marginal outreach, especially to underserved populations. Wildman et al. (2025) acknowledges the screening protocols under the Care Act as facilitators for isolation-reducing assessments for carers. Fragmentation, along with other socio-economic barriers, constitutes obstacles (Powell et al., 2025) and amplifies revictimization cycles. These are compounded by low evidence certainty and inconsistent outcomes, which undermine commissioning (Schucan Bird et al., 2025). In reviews, access-ethical challenges are heightened with survivor-centered designs required to mitigate scope (Di Marco and Rowlands, 2025). Digital inequity is an example of gaps which limit the reach of informal supports that are vital for resilience building (Palmieri and Valentine, 2021). Increased service loads during the pandemic surges and Cleaver (2025) outline the gaps that the pandemic surges placed, worsening inequity. Policy improvements are necessary to create pathways for removing these challenges.

Discussion

Physical and Mental Health Conditions Related to Domestic Violence

From the results, the various forms of domestic violence (DV) mentioned in the integrated overview of the reports correlate with objective one, working with a myriad of definitions in the physical and mental health domains. Core studies highlight depression and PTSD and show mental health services attributing DV to 26% of suicides (Turnbull et al., 2025), whilst Allen et al. (2024) show parental exposure to DV and child anxiety. Stress-induced chronic and exacerbated

respiratory problems are alongside preterm births (Jofre-Bonet et al., 2024; Babazadeh et al., 2025). Other studies describe the intergenerational transmission of developmental harm, where 20% of children in the UK face severe dysfunctional bonding (Cleaver, 2025). The prevalence of 2.3 million cases annually is a significant claim to the increased risks of CMD in the pandemic (Keynejad et al., 2025). Family adversities amplify the presentation of DV in deteriorating health (Syed et al., 2023). These findings capture the aggravating combination of mental and physical load placed on the carer and the increased odds of chronic mental disorder (Wildman et al., 2025). These myriad links manifest the morbidity DV will attribute; crude recognition of DV is needed in UK codes and frameworks.

Evaluation of NHS and Social Care Service Delivery Responses

The review identified advancements alongside gaps in NHS and social care responses to DV. According to Pell et al. (2025), “whole health” models are improvements in identification due to integrated advisors, whereas Powell et al. (2025) points out the lack of integration and the hold-up of support in child mental health. TIC frameworks expand provider education by enhancing safety and empowerment (Chin et al., 2024; Palmieri and Valentine, 2021). Policy advancements in TI frameworks, starting in 2012, support asymmetrical adoption of primary care screening (Emsley et al., 2022). Advocacy interventions lead to the cessation of abuse and are associated with improved, albeit poorly defined, outcomes (Carlisle et al., 2025; Carlisle et al., 2024). TIC principles are incorporated in digital trauma recovery interventions (Eggleston et al., 2025; Casingcasing et al., 2025). Ethics discourse around homicide reviews ensures survivor-centered responses (Di Marco and Rowlands, 2025). In summary, such responses illustrate the development of trauma-informed approaches and the siloed nature of the NHS and social care as a hindrance for integrated provision.

Promoters and Obstacles in Access to Support

The results identify facilitative promoters like advocacy, screening, and access, while barriers like fragmentation impede support. Advocacy that leads to support abuse reduction. (Carlisle et al. 2025). Carer assessments under the Care Act are what Wildman et al. (2025) advocate. Informal social supports help to integrate and mitigate the gaps that limit evidence isolation. Schucan Bird et al. (2025). Across the pandemic, socioeconomic barriers and inequities surged over pent-up demand that overloaded services (Keynejad et al., 2025). Complex ethical issues on the research and practice side relate to not retraumatizing the subject (Di Marco and Rowlands, 2025). Digital tools that access gaps and promote and bridge discrete uses are more common (Eggleston et al., 2025). Family and intergenerational delay tasks aimed at children and parents are exclusionary (Allen et al., 2024; Powell et al., 2025). When prevalence is the trend, underreporting

is the key barrier to access, with 2.3 million (Office for National Statistics, 2024). Dynamic balancing in the area of equity proportionate support requires systemic and targeted gaps to enhance access.

Strengths and Limitations of the Evidence

The strengths identified in the evidence base are high-quality and UK-specific data, robust methodologies such as meta-analyses that inform on the outcomes of DV, and the information that is given by the core studies (Carlisle et al., 2025). The complexity that has been injected into synthesis by the underlying studies is significant with the input of perspective obtained during cohort studies and professional evaluation (Allen et al., 2024; Powell et al., 2025). It is also informed by extensive research and national statistics that give grounds to prevalence assertions (Office for National Statistics, 2024). The drawbacks in this instance are the large proportion of low-certainty evidence, which is mainly caused by biases and variable metrics that limit the possibilities of generalizability (Carlisle et al., 2024). The absence of digital aspects, particularly in tech-enabled TIC, is a severe missing ingredient that constrains the assessment of modern service propositions (Eggleston et al., 2025; Casingcasing et al., 2025). Complexities of surviving constituents can be overlooked, and ethics are rudely addressed (Di Marco and Rowlands, 2025). Vulnerable populations like ethnic minorities during pregnancy are unrecognized (Babazadeh et al., 2025). Intergenerational data is powerful but does not have the required longitudinal richness to follow the long term (Jofre-Bonet et al., 2024; Cleaver, 2025). The identified gaps require more rigorous and inclusive research.

Implications for Practice and Future Directions

Implications indicate that integrated models of whole health concentrate on the effects of DV, such as regular screening of patients by the NHS and training in TIC to enhance detection (Pell et al., 2025; Chin et al., 2024). Multi-agency coordination of social care should be used to reduce the presence of fragmentation by facilitating families and carers (Powell et al., 2025; Wildman et al., 2025). Digital innovations can eliminate access gaps in cases where TIC is introduced to facilitate secure and equal covert remedies (Eggleston et al., 2025). Policy enhancements that are grounded in the law should normalize and harmonize unequal actions as well as favor metrics. (Emsley et al., 2022; Schucan Bird et al., 2025). Guidelines in pregnancy and child services should be provided that address the possible intergenerational problems (Babazadeh et al., 2025; Syed et al., 2023). To minimize suicides, DV history should be screened and integrated within the mental health services (Turnbull et al., 2025). To address the unavailability of evidence on social supports, future studies should evaluate the digital TIC model (Casingcasing et al., 2025). These

recommendations result in trauma-informed practices in the UK that are collaborative to enhance survivor outcomes.

Conclusion and Recommendations

Future Research Recommendations

To improve the accessibility of digital trauma-informed care (TIC) applications for domestic violence (DV) survivors, developing digital trauma-informed care (TIC) applications for domestic violence (DV) survivors, especially the ones proposed by Eggleston et al. (2025), should be the focus of future research. Longitudinal studies on the intergenerational health impact and on child mental health and deterioration (Allen et al., 2024; Jofre-Bonet et al., 2024) and on the mental health impacts of exposure to domestic violence should be prioritized. These studies should focus on and measure the long-term impacts of advocacy, which recorded 58.7% abuse cessation, as this would respond to the low evidence certainty highlighted by Carlisle et al. (2025). Moreover, research on social networks, as highlighted by Schucan Bird et al. (2025), is also crucial to ensure representative data and include under-represented populations. For example, social networks should include the informal supports of social workers and ethnic minorities (Wildman et al., 2025; Babazadeh et al., 2025). This will incorporate evidence to inform and influence digital evidence and innovations policy and practice.

Policy Recommendations

For the standardization of trauma-informed care within the NHS to progress, policy development should incorporate a national program, as Emsley et al. (2022) advocate, that embeds trauma-informed practices and principles of care safety. Strategies should include the implementation of routine DV screenings within primary care to address the 2.3 million (2024) reported cases from the Office for National Statistics and integrate mental health frameworks for DV-linked (Turnbull et al., 2025) suicide prevention. The Domestic Abuse Act 2021 is a good start; however, policy needs to require the provision of and a consistent approach to outcome measures to promote intervention evaluation, as Carlisle et al. (2024) propose. Di Marco and Rowlands (2025) state ethical guidelines suggest the use of survivor data, especially for homicide reviews, should be a compassionate best practice. This focus on standardization will bolster the NHS's resilience, Babazadeh et al. (2025) support, for pregnancy-related care and for addressing inequities during the COVID-19 pandemic (Keynejad et al., 2025) to promote an integrated system of care.

UK Practice Recommendations

The coordination of primary and child mental health services in the UK practice will further reduce the fragmentation noted by Powell et al. (2025) so that services remain accessible for families enduring DV. In Pell et al.'s (2025) "whole health" model, multi-agency protocols provided systems

for efficient referrals and safety planning, positively impacting children subjected to developmental harms (Cleaver, 2025). Di Marco and Rowlands (2025) suggest training activities need to include the ethics of service delivery to ensure re-traumatization is not an outcome, particularly for carers with heightened risks of CMD (Wildman et al., 2025). Advocacy by Carlisle et al. (2025) should be used for routine screening in social care and incorporated under the Care Act 2014. Digital TIC tools proposed by Eggleston et al. (2025) will ensure tools for screening are accessible. Practices proposed here, and strengthened with informal support mapping (Schucan Bird et al., 2025), will provide survivors with empowerment, addressing the TIC framework to reduce the physical and psychological impacts.

Conclusion

This scoping review confirms the significant mental and physical impacts of domestic violence (DV), including PTSD, chronic illnesses, and intergenerational trauma, on 2.3 million adults in the UK each year. The review question— “What are the health and social care outcomes for people living in the UK who have experienced DV?”—is answered by examining documented health conditions, service reactions such as the “whole health” model, and the dynamics of service access. The objectives of detailing the health impacts, assessing the NHS and social care responses, and examining access to support were achieved and documented, despite the rationalization and promises in TIC diffusion. The limitations of high-quality data on DV burdens include well-catalogued evidence of digital exclusion and low evidence certainty. Integrated model, DV research, and DV ethical practice instructional suggestions are pathways to effectively address DV burdens.

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