'Herding cats': the experiences of domestic violence advocates engaging with primary care providers

Medina Johnson from Next Link in Bristol reveals the outcomes of the recent Identification and Referral to Improve Safety trial, set up to engage general practices with domestic violence specialists and advocates.

Engaging health care services in supporting women experiencing domestic violence has been a challenge for domestic violence fora and specialist agencies. Reluctance to talk about domestic violence may be for a variety of reasons: clinicians may feel that domestic violence is not their remit; are not aware of related health issues; fear offending women if they ask about abuse; do not want to open Pandora's Box and then not be able to deal with what comes out of it; domestic violence does not fit with what many see as the traditional medical model of symptom > diagnosis > treatment > cure (even if much of what GPs and nurses do lies outside that model)[1 2].

The Identification and Referral to Improve Safety (IRIS) randomised control trial has been working to engage general practices by providing primary care teams with the information, confidence and skills to ask their female patients about domestic abuse and by creating an easy and clear referral route to a named advocate who is able to meet with patients and provide updates to the referring clinician. The advocate acts as a consultant to the practice team on all issues around domestic abuse.

IRIS used a broad definition of domestic violence, including abuse from family members as well as current or ex-partners and stressing the psychological and emotional dimension in addition to the physical.

Project team

The IRIS project has both an intervention and research team. The intervention team is made up of two advocates from specialist domestic violence support services, their respective managers and a number of clinicians including GPs, a clinical psychologist and a midwife.

IRIS background and summary

IRIS is a cluster randomised trial looking at whether training and support intervention for clinical teams increases the identification of women experiencing domestic violence and

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1 Gremillion DH, Kanof EP. *Overcoming barriers to physician involvement in identifying and referring victims of domestic violence.* Ann Emerg Med. 1996;27:769–773.

2 Sugg NK, Thompson RS, Thompson DC, Maiuro R, Rivara FP. *Domestic violence and primary care. Attitudes, practices, and beliefs.* Arch Fam Med. 1999;8:301–306.

increases their subsequent referral to appropriate domestic violence advocacy agencies. 48 GP practices were recruited across Bristol and Hackney and half were given the training and support. 46 of the 48 practices have now finished the trial and outcome data is being collected and analysed; training is now being offered and delivered to the control practices.

Training

The 24 intervention practices each took part in two, consecutive, two hour training sessions. The sessions were open to all clinicians in the practice. Session one was delivered by the project lead, an experienced GP and researcher, and the domestic violence advocate for each site. Session two was delivered by the clinical psychologist and the domestic violence advocate for each site. Attendance at the sessions varied enormously between practices. Some sessions were attended uniquely by GPs, others by GPs and nurses, others by a whole range of the practice's clinical team including pharmacists, health visitors and midwives. Not all the clinicians who attended the first session were present in the second and vice versa.

Each training session offered a range of information about domestic violence, evidence for the potential role of clinicians in responding safely and effectively, and the opportunity for debate, practicing enquiry and the initial response to disclosure. Various learning methods were used, including practical exercises and role play, as well as more didactic techniques.

A separate one hour training session was offered to reception and administration teams in each practice and delivered by the domestic violence advocate for each site. Engagement with this team proved to be an effective way to work with some practices. Benefits include:

- all staff members having a sense of ownership and involvement in the research as well as an enhanced understanding of and sensitivity to patients;
- administrative staff being able to alert clinicians to concerns if they observe behaviour that concerns them in the waiting room or around making appointments;
- advocates have an easier path into the surgery as they know people on the front desk and those who run the office. This facilitates organising meetings, bookings and access to consulting rooms to meet patients.

Technical support

The intervention included an electronic pop-up template in the patient's medical record. When a GP or practice nurse entered particular coded symptoms (such as depression, chronic pain or tiredness) the template would appear as a reminder of the links to abuse and to prompt the clinician to ask questions about domestic violence. The pilot HARK template (Humiliate; Afraid; Rape; Kick) aimed to remind clinicians that domestic violence has many facets: emotional, psychological, sexual, physical[3]. The clinicians in the study were trained explicitly that the wording in the template questions was a prompt not to be taken literally e.g. 'kick' to indicate physical violence or 'humiliate' to indicate emotional abuse. However, as the data is being collected some confusion was apparent, for example, 'kick' not selected in the template but free text indicating physical violence (words 'punching' or 'attempted strangulation' used).

Interim trial results

Full results from the trial are not yet available. It is, however, possible to feel positive and hopeful about changes in clinicians' responses to abuse by looking at the numbers of direct referrals received by the two specialist domestic violence advocates. Over 100 referrals were received by each advocate in each site during the 12 month period which began on the completion of training (date of the second training session). Referrals have continued following the end of the active trial in the majority of intervention practices. Nine of the 12 intervention practices in Bristol have so far made referrals after their 12 month trial period ended.

What worked well

Clinicians referred! Victims were identified and continue to be referred. Positive comments and reinforcement from peers has helped to encourage less engaged practitioners on board. A continuation of the project has already been commissioned by the PCT in Bristol.

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3 Sohal H, Eldridge S, Feder GS. *The sensitivity and specificity of four questions (HARK) to identify intimate partner violence: a diagnostic accuracy study in general practice.* BMC Fam Pract 2007; 8(1):49.

'More time in the training could have been spent in helping clinicians to have a better understanding of psychological and physical perspectives of violence and potential risk to patients, in particular understanding the complex nature of choosing to end or leave an abusive relationship. '

> "I would like to say a huge thank you for the work you have done with our practice. There has never been anywhere we felt confident referring victims of domestic violence to before and it has really made a huge difference being able to recommend they contact you (or referring them) and being able to tell them with absolute confidence that they will get a positive, supportive and helpful response. We're all much more willing to ask the questions which might open a can of worms knowing that there's help there if we do - and our patients have benefited enormously."
> GP, Bristol

Having a simple and direct referral route and feedback loop. A simple referral form was created asking for referrer details, safe patient contact details and a brief description of the reason for referral. Clinicians could fax or e-mail this form or ring through the referral to the advocate's mobile phone and on receipt a referral acknowledgement would be sent. The advocate would then provide relevant updates on each case. This included patient progress, onward referral information, closure of work notification and requests for further information.

Collaboration between third sector specialist domestic violence support services and the health service. The involvement of third sector organisations – the nia project[4] and Next Link[5] – offered a different dimension to the care and support available to patients referred to the advocate educator. Different paradigms of care extending beyond medical models were offered; advocates were able to offer a degree of flexibility and uniquely tailored support sometimes lacking in the NHS.

Service user involvement. Service users have taken roles as advisors, collaborators and co-researchers within the trial.

The bringing together of advocate and educator into one role. The advocate educator co-delivered the training to practitioners and was the person who would work with patients they referred. Clinicians have reported feeling reassured that they could refer patients to someone they had met and knew.

Expertise of the lead domestic violence agency. Basing the project in mature agencies that can cope with a developing piece of work and which is able to offer support to women whose needs may differ substantially from the traditional client group for the organisation.

What could have worked better

Managing change and transition. Some clinicians told us, "We support the improvement but don't like the change!" As an intervention, we had put into place a simple referral pathway and believed that having a named advocate would help. These things did help but we hadn't fully considered the psychological processes that clinicians experience around asking their female patients about domestic violence – What if the patients took offence? What if the clinician didn't feel comfortable asking? What if the patient said everything was OK? What if she had been their patient for over 20 years? What if she said 'yes'?

Challenging the medical model of symptom-diagnosis-treatment-cure. Domestic violence and abuse can be compared to a chronic condition where clinicians are supporting the patient and encouraging self management. The difference with patients experiencing domestic violence is that the perpetrator is in the background undoing and sabotaging all the good work being attempted by the clinician and patient. In retrospect, more explanation and discussion of the role of the abuser could have been encouraged during the training sessions

Provision of information. More time in the training could have been spent in helping clinicians to have a better understanding of psychological and physical perspectives of violence and potential risk to patients, in particular understanding the complex nature of choosing to end or leave an abusive relationship.

Disengaged practices. In both trial sites there have been two practices where engagement has been poor. These practices were struggling with staffing and organisational issues and this affected other aspects of their performance, such as engagement with IRIS. In

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4 www.niaproject.info
5 www.nextlinkhousing.co.uk/index.htm

addition, practice variability within politics, communication and morale would appear to be reflected in their engagement with IRIS.

Factors negatively affecting practices include:

- an overwhelmed or no practice manager;
- a planned or recent change in practice site;
- few or no practice meetings;
- an unwillingness to believe that the patients at the practice could be affected by domestic violence. This could have been because of a misconception that domestic violence only occurs in certain areas and to certain people;
- a disbelief of the statistical and research evidence of the high numbers of women affected by and experiencing domestic violence; this was associated with low level identification and a high threshold for asking women.

Practice champions (PCs). We would reconsider how we recruited our PCs. In some practices this has worked well but in others, our main contact is a clinician other than the PC. On reflection, there could have been a named contact for materials and contacts at the beginning of IRIS, with PCs invited on board later in the day when there was evidence of commitment. It is possible in some practices that reception team members could have been PCs. Sometimes a poorly engaged PC became a bottleneck to engaging other clinicians in the practice team.

Having the two training sessions closer together. The aim was to deliver both of the training sessions within four weeks of each other to keep up the momentum of the project. In practice this was not often possible due to competing priorities at the practices.

Take home messages

Our main take home messages to date include:

- *Work with nurses.* Nurses as well as GPs need to be part of the intervention team and take an active role in the training and promotion of the project in order to secure better involvement from nurses at a practice level. A consideration could be to offer separate training for the nurse team.

- *Feed back to referring clinicians.* Provide prompt and regular updates to referring clinicians: acknowledge referral, provide update when contact has been made with patient, provide a final update when an onward referral is made or when support via IRIS ends. This appeared to promote clinician confidence in the IRIS referral process and therefore encourage more referrals.

- *Customise the computer template.* A standard template to be provided to all practices but which needs to be modified on a practice by practice basis to suit individual requirements.

- *Work collaboratively.* Try to encourage domestic violence service providers to connect with those responsible for domestic violence in the PCT to commission this type of collaborative training and support model for practices.

- *Work flexibly.* Be prepared for the profile of some women being referred from the practice to be outside that most commonly seen by the domestic violence agency. This necessitates a flexible, open response from the domestic violence agency to be prepared to work with women experiencing the long term emotional effects of abuse rather than only those in acute crisis.

- *Find a domestic violence champion.* Find a GP ally in the PCT or local university's general practice or primary care unit.

Where next?

The emerging results from the IRIS trial suggest that it is possible to change the behaviour of primary care clinicians in regard to supporting women experiencing domestic violence. The provision of training, electronic prompts, support materials and a simple, direct referral route to a named advocate appear to have created a positive formula to address the reluctance many clinicians have felt around addressing issues of domestic violence and abuse with their patients. Work is also underway to develop a commissioning model with the view of extending IRIS to PCTs across the country. The challenge of finding local champions, fund holders and third sector partners continues.

MEDINA JOHNSON
IRIS (Identification & Referral to Improve Safety) Advocate Educator
Next Link Domestic Abuse Services, Bristol
medina.johnson@nextlinkhousing.co.uk

With thanks to the rest of the IRIS team:
Roxane Agnew Davies
Kathleen Baird
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"Thanks so much. I saw her shortly after [your meeting with her] and she felt so supported and understood. Really moving. One of those special moments in [being a] GP when you feel that there is proper support out there for those most needing it. Fab."
GP, Hackney