IRIS

Identification & Referral to Improve Safety

COMMISSIONING GUIDANCE

The IRIS solution –
responding to domestic violence
and abuse in general practice

University of Bristol 2011

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COLLABORATION AND THANKS

Without the support and commitment of the following organisations, IRIS would not have been possible. Thank you on behalf of all professionals and patients who have benefitted from IRIS.

This guidance is endorsed by the Royal College of General Practitioners.

IRIS image (cover) from the Theoi Project website,
http://www.theoi.com/Gallery/P21.6B.html
IRIS Athenian red-figure lekythos C5th B.C.,
Museum of Art Rhode Island School of Design

LANGUAGE

Domestic Violence and Abuse (DVA)

This term encompasses all types of abuse, physical, psychological, sexual, financial, social isolation as well as threats. Some survivors describe their experiences as violence, while others use the word abuse. To ensure all survivors and types of abuse are represented, the term DVA is used.

Victim/Survivor

While the terms victim and survivor are both used, some victims do not survive and some survivors do not see themselves as victims.

Gender

The language used refers to victims/survivors as women and perpetrators as men.

The gender bias is discussed fully in Appendix 1.

Contents

Foreword

Attitudes towards domestic violence are changing. We now widely acknowledge the scale of the abuse, the criminality of the violence, and the impact on women and children who are the victims. Most importantly we acknowledge the duty of the statutory agencies to address the problem, rather than just passively deal with the consequences. This is just as well. Domestic violence and abuse has major public health implications, and represents an enormous cost to the NHS.

We know that victims of violence and abuse trust their family doctor and practice staff. We also know that too often, they do not want to disclose information about abuse to these trusted practitioners without gaining "permission" to do so from that practitioner. The paradox is that often practitioners are reluctant to ask because they do not know how to respond, or what referral paths are open to them. IRIS offers a solution, by providing appropriate training for primary care staff and support to their patients.

There are many powerful, coldly logical reasons for the NHS to take seriously the impact of domestic violence and abuse. We can talk about the cost, the public health impact and the social consequence. For me, the strongest case is the moral one - it is wrong and we all should act to address it. IRIS gives us the tools to do this.

Christopher Long
Chief Executive
Humber PCT Cluster

FOREWORD

Domestic violence is a serious and indeed growing problem around the world. It is a violation of human rights as well as a major public health problem. In Britain approximately 15.4 million incidents of domestic violence occur annually - mostly unreported and with many people suffering repeated episodes. It mainly affects women and children but men are not immune either.

Prevention and dealing with domestic violence forms an important component of the strategy of successive governments on tackling Violence Against Women and Children. It was and is recognised that this is not just the province of a single service but involves many different agencies as well as the voluntary sector. It was recognised that the NHS could play an important role but that there was insufficient focus on violence beyond first aid by NHS staff and organisations. A task force was therefore established to make recommendations about the role of the NHS in dealing with violence - particularly against women and children. The report of the taskforce made 23 recommendations. The important ones concerned: raising awareness of staff - particularly first contact staff such as GPs, primary care staff, Emergency department teams, paramedics and people in specialties where domestic violence was common such as obstetrics, psychiatry and child health.; improving education of all health professionals; ensuring that appropriate care pathways exist for victims of violence; and making sure that appropriate services are commissioned. This should all be based on appropriate evidence and a sound epidemiological base. There should also be strong commitment by NHS organisations to work closely with other partners to give a truly multi-professional, multidisciplinary service.

General practice has a key role to play in the health response to DVA. It is the commonest contact point for victims but many episodes of domestic violence go untended in primary care unless primary care clinicians have the awareness and skills to detect DVA and know when to refer patients for specialist support. In addition patients need to be provided with information that increases their safety and improves their health and quality of life. Dealing in a timely fashion with DVA will not only have an effect on the individual but on the whole family with particular impact on children allowing them to grow up and mature in a better environment.

The IRIS project has been an exemplar in terms of producing an effective service for victims of domestic violence and abuse. It has shown without doubt major benefits to the individual and in the longer term is undoubtedly cost-saving. DVA costs the NHS £1.7 billion every year which could be drastically reduced if appropriate investment was made in the IRIS package. We cannot afford not to have it.

The current document gives clear logical guidance on how to commission IRIS to deal with DVA in general practice. It should be taken as a package - there is little point in commissioning one segment of the service if the other parts are not there. It is also worth stressing that although resources may be stretched we should not allow the easy way out - no new services. There is a real urgency about DVA which ruins the lives of tens of thousands of people and their families.

Professor Sir George Alberti
Chair Department of Health Task Force
Chair-elect,
Kings College Hospital NHS Foundation Trust

Executive summary

Domestic violence and abuse (DVA) is an abuse of human rights and a major public health problem with devastating health consequences and enormous costs to the National Health Service (NHS). General practice can play an essential role in responding to and helping to prevent DVA by intervening early, providing treatment and information and referring patients and their children to specialist services. The Equality Act 2010 states that commissioning decisions should be made on equality and diversity, i.e. different services to meet different needs, rather than based on equity, i.e. the same for all.

The close link between DVA, mental and physical ill-health and children's safety and wellbeing, plus the positive results of working in partnership, make it even more important that the NHS recognises and acts upon its responsibilities in this area. General practice, as part of the wider NHS, has a duty to respond to women and child survivors of DVA and to safeguard vulnerable adults and their children. This response can improve public health, improve health outcomes and support a patient-centered service[1] and addresses not only the contemporary health burden but also that of future generations.[2]

GPs' response to women and children, who can be isolated and fearful as a result of their experiences, is critical to their patients' future emotional and physical health. The initial reaction of the person they tell and the follow-up within and beyond the NHS can have a profound effect on their ability to re-establish their life, health and wellbeing.[3]

The majority of specialist DVA support services are based in the third sector and have a strong survivor-led vision and ethos. Dealing with DVA effectively can only be achieved through partnership and collaborative working. It is increasingly acknowledged that initiatives aimed at ending DVA also need to target and engage men as the primary perpetrators of abusive behaviour. The widespread nature of DVA calls for preventative approaches that aim to change attitudes, values and behaviour at the level of the individual, community and professional. In order for general practice to address DVA, providing resource and ongoing support for clinicians is essential for both professionals and patients.

Identification and Referral to Improve Safety (IRIS) is a general practice based DVA training, support and referral programme for primary care staff and provides care pathways for all adult patients living with abuse and their children. IRIS is centred in partnership work between primary care and specialist third sector agencies to deliver essential services and close the historical gap between the two sectors. Ultimately IRIS improves the quality of care for patients experiencing DVA and fulfils the moral, legal and economic case for addressing DVA in general practice.

[1] Department of Health. *Ending Violence Against Women and Children Campaign:* 25 November - 10 December 2010. London: Department of Health; 2010

[2] VicHealth. *The health costs of violence: Measuring the burden of disease caused by intimate partner violence.* State Government Victoria, Australia, Department of Human Services; 2004

[3] Feder G, Long C *et al. Report from the Domestic Violence Subgroup: Responding to Violence Against Women and Children –The role of the NHS*. London. Department of Health; 2010

> Violence against women is never acceptable, never excusable, never tolerable

Ban Ki-Moon,
United Nations Secretary General

1.0 Domestic violence and abuse: The role of health

75% of cases of domestic violence result in physical injury or mental health consequences to women.[9]

As a matter of normal humanitarian principles, core values, social responsibility and its basic mission to make people healthier, the NHS has a critical role to play in relation to violence against women and children[3]

On average two women in England and Wales are killed by a male partner or ex-partner every week.[4]

DVA is an abuse of human rights, a major public health problem with devastating health consequences and enormous costs to the NHS and is a challenge to health care services in the UK and internationally.

The NHS spends more time dealing with the impact of violence against women and children than almost any other agency and is often the first point of contact for women who have experienced violence.[5] The health service can play an essential role in responding to and helping prevent further DVA by intervening early, providing treatment and information and referring patients to specialist services. The health service is in a unique position to help people who experience DVA to get the support they need.

Perpetrators are patients too and access the NHS. An exploratory study of intimate partner homicides suggests that depression, mental health and suicide risk should be core indicators of high risk perpetrators.[6] Health professionals are therefore well placed to refer perpetrators to appropriate services. Engaging with men requires a balance between communicating that DVA is never justified and providing a non-judgemental approach that signposts support. Men should be engaged by emphasising how they can play a positive role in the health and wellbeing of partners, families, children and communities.

DVA is linked to a host of different health outcomes and is a risk factor for a wide range of both immediate and long-term conditions. The health impacts may show as physical symptoms, injuries, chronic pain, neurological symptoms, gastrointestinal disorders, gynaecological problems and increased cardiovascular risk. The patient may be depressed, self-harm, have post traumatic stress disorder (PTSD), anxiety, insomnia, increased substance use and have thoughts about suicide. Cessation of abuse does not necessarily mean that mental health problems cease as well. The influence of abuse can persist long after the abuse itself has stopped and the more severe the abuse, the greater its impact on physical and mental health. Less well recognised are dental problems and dental neglect (due to dental phobia).

[3] Feder G, Long C *et al. Report from the Domestic Violence Subgroup: Responding to Violence Against Women and Children –The role of the NHS.* London. Department of Health; 2010

[4] Povey D, Editor. Crime in England and Wales 2003/4: Supplementary Volume 1: Homicide and Gun Crime. Home Office Statistical Bulletin No. 02/05. London: Home Office; 2005

[5] Department of Health. *http://www.dh.gov.uk/en/MediaCentre/Pressreleasesarchive/DH_113837* [cited June 2011]

[6] Regan L et al. "If only we'd known": an exploratory study of seven intimate partner homicides in Engleshire. Child & Women Abuse Studies Unit, London Metropolitan University; 2007

DVA can start or escalate in pregnancy with the most serious outcome being the death of the mother or the foetus. It is also associated with low birth weight and premature birth, both of which have subsequent long term health effects. Less recognised are the impacts of unintended pregnancy and the risks for pre-school children.

The Adoption & Children Act 2002 definition of harm; "including, for example, impairment suffered from seeing or hearing the ill treatment of another" strengthens the case for significant harm through DV, or the abuse of another in the household.[7]

If children do not feel safe in their own home this can have many negative physical, emotional and behavioural effects. These include physical health complaints, developmental delays, anxiety, depression, poor school performance, low self-esteem, difficult behaviours and nightmares. DVA may also directly or indirectly cause child mortality.[8] Children can be abused directly, indirectly and may also witness the health consequences that their parents experience.

"Intimate partner violence is all too common, has severe and persistent effects on women's physical and mental health and carries with it an enormous cost in terms of premature death and disability. It is responsible for more ill-health and premature death in women from Victoria under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking. Intimate partner violence warrants attention at least equal to that of many other well-established diseases and risk factors, such as high blood pressure, cholesterol and obesity."[2]

[7] Government. *http://www.legislation.gov.uk/ukpga/2002/38/contents*

[8] Krug E, editor. *World Report on Violence and Health: Volume 1.* Geneva: World Health Organisation; 2002

[9] Department of Health. *Responding to domestic abuse: A handbook for health professionals.* London: Department of Health; 2005

[2] VicHealth. *The health costs of violence: Measuring the burden of disease caused by intimate partner violence.* State Government Victoria, Australia, Department of Human Services; 2004

1.1 DVA: The role of general practice

The GPs' response to women and children who can be isolated and fearful as a result of their experiences is critical to their future wellbeing. The initial reaction of the person they tell and the follow-up within and beyond the NHS can have a profound effect on their ability to re-establish their life, health and wellbeing.[3]

The prevalence of DVA is substantially higher in a general practice population than that found in the wider population.[10] Eighty percent of women in a violent relationship seek help from health services,[11] usually general practice, at least once, and this may be their first or only contact with professionals. There is extensive contact between women and primary care clinicians with 90% of all female patients consulting their GP over a five year period.[12] This contrasts starkly with its virtual invisibility within general practice, where in fact the majority of women experiencing DVA and its associated effects are not identified.

Specialist DVA service providers rarely receive referrals from primary care and historically general practice has been absent from community domestic violence partnerships. If women do disclose DVA to their GP, there is evidence of an inappropriate, poor quality response. Health care professionals are largely unaware of appropriate interventions and have not received effective training. Creating an environment in which patients are more likely to feel safe enough to discuss DVA will make a real difference for men, women and children.

Women report wanting health services and professionals to have a duty to identify and respond to violence against women and girls, and felt it was more appropriate for health professionals to receive mandatory training to meet their needs effectively than it was for criminal justice professionals.[13]

Survivors of DVA trust health care professionals with their disclosures and believe their doctor is one of the few people to whom they can disclose. However many will not disclose abuse without being directly asked. They report wanting to be asked and expect an appropriate response.[14] Clinicians in turn report not knowing how to ask women about DVA, how to respond and where to refer.

The confidential and non-judgemental response offered in general practice is identified as a key inducement for abusive men to make use of this service. In fact GPs emerge as the second most likely source of support accessed by perpetrators after that offered by help-lines where advice can be sought anonymously. Where it is possible to see the same GP at every consultation, the relationship was also seen as one of trust born of familiarity. Even when the GP was not someone they had built a relationship with, they could be valuable in signposting an abusive man to a relevant source of help. As facilitators for help seeking, GPs can reduce the harm and misery experienced by so many patients and families.[15]

[3] Feder G, Long C *et al. Report from the Domestic Violence Subgroup: Responding to Violence Against Women and Children –The role of the NHS*. London. Department of Health; 2010

[10] Hegarty K. What is intimate partner abuse and how common is it? in: Roberts G, Hegarty K, Feder G, editors. *Intimate partner abuse and health professionals: New approaches to domestic violence*. London: Elsevier; 2005

[11] Department of Health, Conference Report: *Domestic violence: A health response: working in a wider partnership*. London: Department of Health; 2000

[12] Wisner CL et al. Intimate partner violence against women: do victims cost health plan's more? *Journal of family practice*. 1999; **48**(6): 439 - 443

[13] Women's National Commission. *A bitter pill to swallow: Report from WNC focus groups to inform the Department of Health Taskforce on the health aspects of Violence Against Women and Girls*. London: Women's National Commission; 2010

[14] Feder GS, Hutson M, Ramsay J, Taket AR. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Arch Intern Med*, 2006; 166(1):22-37.

[15] Stanley N, Fell B, Miller P, Thomson G, Watson J. *Strength to Change: Men's Talk: Research to inform Hull's social marketing initiative on domestic violence*. Preston: University of Lancashire; 2009.

"When my GP asked, I felt that I was believed, that what was happening was affecting my health"

IRIS service user

The reality in general practice

In east London general practice waiting rooms 41% of women had ever experienced physical violence from a partner or former partner. In total 74% of women had experienced some form of controlling behaviour by their partner and 46% had been threatened. Physical violence from a partner or former partner had been experienced by 17% women within the previous 12 months and 35% had ever felt afraid of their current or former partner. However, only 15% of women had any reference to violence in their medical record.[16]

[16] Richardson J et al. Identifying domestic violence: cross sectional study in primary care. *BMJ* 2002; **324**(7332): 274 - 278

1.2 DVA: The costs to health

The cost of DVA to the health service is £1.7 billion per year with the major costs being to GPs and hospitals.

This does not include mental health costs, estimated at an additional £176 million.[17]

There are three main elements in the cost of GP services: the consultation itself; prescriptions consequent to the consultation; travel and opportunity costs to the patient. Survivors who are subject to forms of wounding that involve sustaining serious or slight injuries make an average of three visits more to a GP than an average person.[18]

On average, survivors of abuse experience more operative surgery, more visits by and to doctors, more hospital stays, more visits to pharmacies and more mental health consultations over their lifetime than non-victims. Women who have depression, PTSD or are suicidal as a result of DVA have approximately twice the level of usage of general medical services and between three and eight times the level of usage of mental health services.[19] They are admitted to hospital more often than are non-abused women and are issued more prescriptions.

The impact over time of different types of abuse and of multiple episodes of abuse appears to be cumulative. Given the long-term impact of violence on women's health, women who have suffered abuse are more likely to be long-term users of health services, thereby increasing health care costs. A substantial amount of NHS resources goes into services for victims of violence.

[17] Walby S. *The cost of domestic violence: Update 2009*. Lancaster: Lancaster University; 2009

[18] Walby S, Allen J. Home Office Research Study 276. *Domestic violence, sexual assault and stalking: findings from the British Crime Survey.* London, Home Office, Research, development and statistics directorate; 2004

[19] Ulrich Y et al. Medical care utilization patterns in women with diagnosed domestic violence. *AM. J. Prev Med* 2003; **24**(1): 9-15

2.0 Strategic relevance

The way the NHS responds to women and children with experiences of DVA is a test of how well it is living up to the values and principles it set for itself in the NHS Constitution. An NHS that "provides a comprehensive service...." which "has a duty to each and every individual that it serves and must respect their human rights" and which numbers "compassion" and "respect and dignity" among its values must be a service that takes seriously the needs of women and children experiencing violence and abuse.[20]

- Primary Care Organisations (PCOs) have a statutory duty to work with other local agencies to reduce crime under the **Crime and Disorder Act** (1998).

- **The Department of Health** advises general practice to consider regular in-house training and its benefit to the whole team; to establish links with named specialist workers at local domestic violence services; to flag health records; to consider the links between DVA and pregnancy; to be aware of the risks to children; to seek support for new initiatives at a strategic level.

- **The Royal College of General Practitioners** has identified domestic violence as one of its four new clinical priorities for 2011-2013.

- Articles III and VIII of **The Human Rights Act** (1998) require statutory services to act to prevent, or protect against, violent treatment, especially to provide safety to vulnerable people. The Act enables individuals to claim their human rights around autonomy, liberty, dignity and security.

- Under the **Children Act** (1998) health services have a legal duty to safeguard children from harm. The **Adoption and Children Act** 2002 extended the legal definition of harming children to include "harm suffered by seeing or hearing ill treatment of others, especially in the home".

- **'No Secrets'**, the Department of Health safeguarding vulnerable adults document, states that everyone has the right: to live his or her life free from fear, violence or harm; to be protected from harm or abuse; to live an independent lifestyle and the right to make choices, some of which may involve a degree of risk.

- **The Equality Act** (2010) streamlines and strengthens anti-discrimination legislation and incorporates the existing gender equality duty. Public authorities are required to recognise that men and women are not always starting from the same place and at times have different needs. Evidence shows that for female survivors to feel physically and emotionally safe they need access to women only specific services.

- **Domestic violence homicide reviews** recommend the need to develop and expand core training to address the dangers of culturalisation and victim blame in general practice.

- The report from the **Health Taskforce Violence Against Women and Girls (VAWG) subgroup** (2009) states that when interacting with patients NHS staff should have, and apply, a clear understanding of risk factors for violence and abuse and of the consequences for health and wellbeing of violence and abuse.

- The Coalition Government is committed to implementing the national VAWG action plan. The involvement of health is fundamental.

- The **NHS Operating Framework 2010/11** states that NHS commissioners will continue to work as a member of the Community Safety Partnership to identify and share information effectively in order to support local action on reducing violence crime - especially serious youth violence, including knife crime, and violence against women and children.

- Under Section 9 of the **Domestic Violence Crime and Victims Act 2004** there is an expectation that local areas undertake a multi-agency review following a domestic violence homicide. This also introduces a duty for every person or body establishing or participating in the review to have regard to the statutory guidance.

[20] Department of Health. The NHS Constitution: the NHS belongs to us all [internet] 2010. Available from: *http://www.dh.gov.uk/en/Healthcare/NHSConstitution/index.htm*

3.0 The IRIS Model

"The advocate educator is a fantastic ambassador for the organisation. It has provided an opportunity to reach women who may never have engaged with our or other violence against women services and to provide them with an opportunity to improve their safety and the quality of their lives."
Manager, DVA agency

IRIS is a general practice-based domestic violence training, support and referral programme for primary care staff. It is a targeted intervention for female patients aged 16 and above experiencing current or former DVA from a partner, ex-partner or adult family member. IRIS provides care pathways for all patients living with abuse as well as information and signposting for male victims and for perpetrators.

The model rests on one full-time advocate educator working with 25 practices. The advocate educator is a specialist DVA worker who is linked to the practices and based in a local specialist DVA service. The advocate educator provides training to the practice teams and acts as an ongoing consultant as well as the person to whom they directly refer patients for expert advocacy. The advocate educator works in partnership with a local clinical lead to deliver the model.

The model is centered in partnership work, with primary care and specialist third sector agencies coming together to deliver services and promote work across the historical gap.

Based on 25 practices,

220 primary care clinicians trained and supported

150 administration and reception staff trained and supported

250 direct referrals to advocate educator

(over the 12 month trial period)

General practices receive:

- In house DVA training for the whole practice team
  - Clinical team training - Two training sessions, each lasting two hours, are delivered. Session one is run by the advocate educator and the clinical lead and session two solely by the advocate educator. Content focuses on how to recognise DVA and how to respond, how to refer and how to record disclosures. The model promotes clinical enquiry, recognition of risk indicators, safety planning and holistic care for all patients including children, perpetrators and male victims.
  - Reception/administrative team training - One training session lasting for an hour is delivered by the advocate educator. The training focuses on understanding DVA, responding to patients, resource provision, confidentiality and safety.
  - Refresher training and additional sessions for new staff are available to all practices.

"I can't tell you how grateful I am for all your support through this... I do not know who I would have turned to without you. I have learned a lot. Thanks!"
IRIS practice manager

All participants complete a pre- and post-training questionnaire which measures ability to enquire, respond, refer and record DVA and to plan safety. The feedback indicates knowledge and competencies before and after training. Each training session for receptionists/administrators is evaluated to measure participant understanding of DVA and issues of data handling, confidentiality and safety.

At each practice a lead professional is identified to be the IRIS practice champion. This person is the main point of contact for the advocate educator and receives a further session of training to enable them to be the practice DVA lead. The practice champion can be any member of the practice team and is not limited to one professional.

"She (GP) made it clear that she was available to talk. I did not feel pressurised into making any decisions and wasn't just offered medication."

IRIS service user

- Ongoing support and consultancy
  This is provided by the advocate educator who will attend practice meetings quarterly to discuss all aspects of the programme. The advocate educator is available to support the entire practice and individual professionals on a day to day basis by phone, email and when in the practice.
- An electronic prompt in the medical record
  This in the form of a pop-up called HARKS. HARKS is a mnemonic for Humiliate, Afraid, Rape, Kick and Safety and is linked to health symptoms of DVA. HARKS is:
  - A practical reminder to clinicians to ask about DVA
  - A flagging system noting HARK+ on the patient record when there is a positive disclosure of DVA
  - A safety tool instructing clinicians to assess immediate risk

HARKS is installed centrally via the practice's existing electronic medical record system. The template and protocol is already available in EMIS LV and Synergy systems.

"Encouraging myself that I can do this… I feel empowered…I feel proud of me …thank you for believing in me"
IRIS service user

"Just asked my first patient re domestic abuse. She was fine and was glad I asked."
IRIS GP

- Outcome data
  - HARKS - quarterly searches are carried out by the practice (or centrally) with the support of the advocate educator and provide feedback on:
    - recorded identification of DVA in the patient record.
    - recorded safety check in the patient record.
  - Referral - number of direct referrals received by the advocate educator and number of self referrals received by the specialist DVA agency. The clinical discipline and practice name are recorded.
  - Client - includes demographic information, monitoring data, self defined data (e.g. substance use, mental health) and case details (e.g. type of abuse, perpetrator)
  - Advocacy - this includes
    - frequency of contact, e.g. two meetings
    - type of support, e.g. access to refuge
  - Service-user - patients are invited to complete an outcome and satisfaction form detailing perceived safety, confidence, knowledge of available support services and ongoing use of primary care services.

- Resources
  - IRIS 'DVA aware practice' posters and cards to put up in the practice and to give to patients. Resources can be translated and re-formatted to meet the need of the local patient population.
  - Training folder - electronic and hard copies of training slides and IRIS DVA handbook
  - Referral forms - a simple form that can be faxed or emailed directly to the advocate educator. This includes safe contact information for the patient.
  - Care pathways for female survivors, male survivors and perpetrators. These include guidance for use in emergencies and where there are child protection concerns.

- Named contact for patient referrals: the advocate educator

  Patients who are experiencing, or who have experienced, any type of domestic violence and abuse, see Appendix 1, historic or current, can be referred to the advocate educator. Practice staff can refer by phone, fax or email. The advocate educator provides patients with emotional and practical support, carries out risk assessments and safety plans, advocates on behalf of the patient as appropriate and responds to specific needs around culture, language and diversity. Ultimately the advocate educator empowers the client to make informed choices.

  Referring clinicians receive regular updates from the advocate educator including information about the support their patient is receiving and information about any other services to which they have been referred. The advocate educator encourages updates from the referring clinician as appropriate and this sharing of information enables monitoring of risk and safety planning.

- Clinical lead

  A local clinician is identified to be the local IRIS champion. They are responsible for co-delivering training and offering peer support for clinical colleagues in each practice. They work closely with the advocate educator.

"Thanks so much. I saw her shortly after and she felt so supported and understood. Really moving. One of those special moments in general practice when you feel that there is proper support out there for those most needing it. Fab"

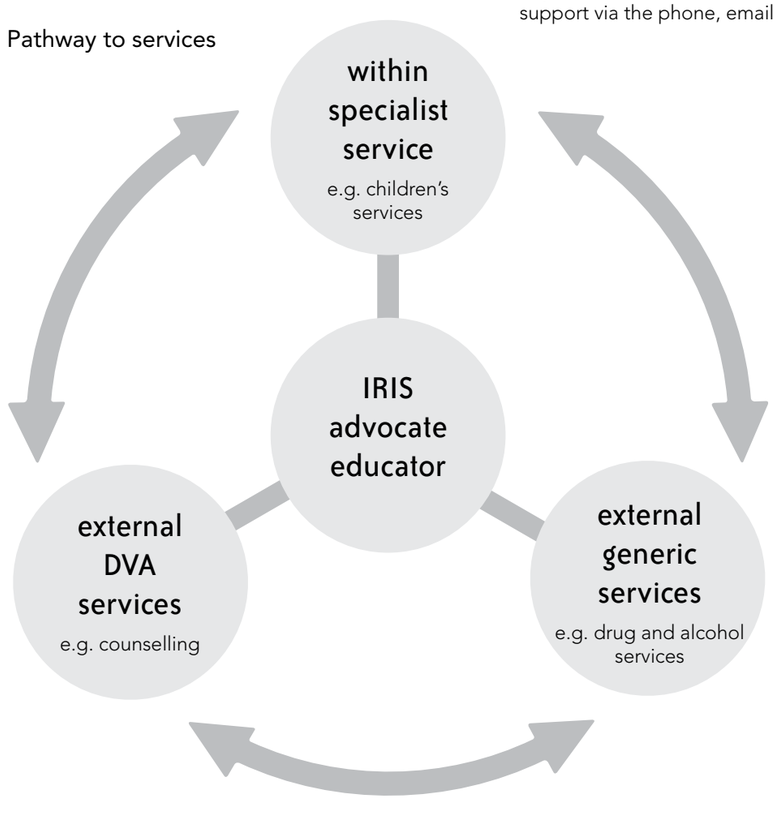
IRIS GP

- Patient access to specialist support
  The advocate educator can also refer or signpost patients to other services if appropriate. Referrals are made:
  - within the specialist service where the advocate educator is based
  - to external DVA services, including specialist services
  - to external generic services

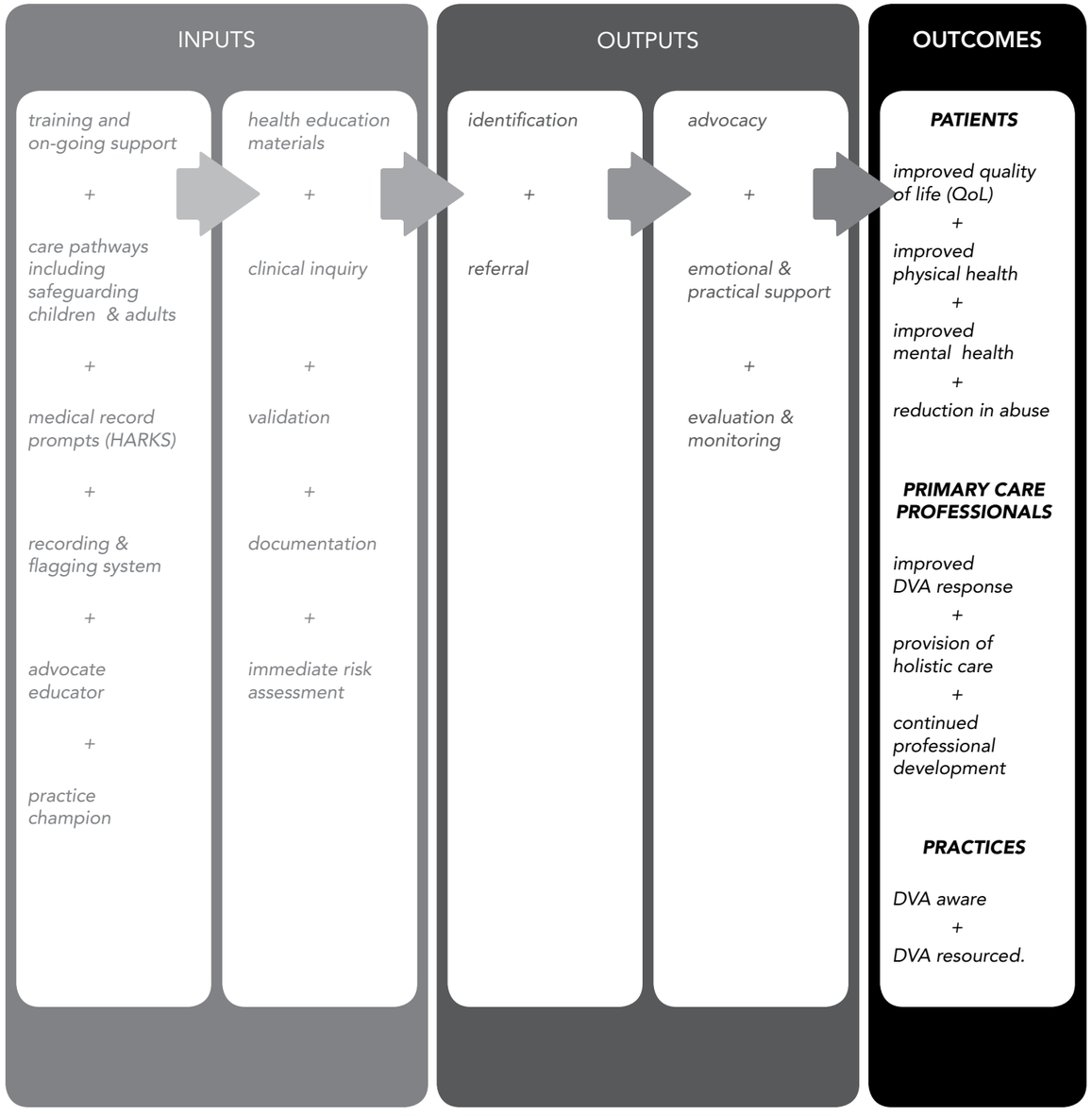
- Steering group
  A group is set up to monitor and guide the ongoing implementation and development of IRIS. It is suggested that this comprises the advocate educator, a manager within the specialist service, a service user, the local IRIS clinical lead and a representative from PCO/Clinical Commissioning Group (CCG).

- National network
  The national IRIS team provide facilitated network days to local IRIS teams as well as mentoring and support via the phone, email and the IRIS website.

Pathway to services



The IRIS model

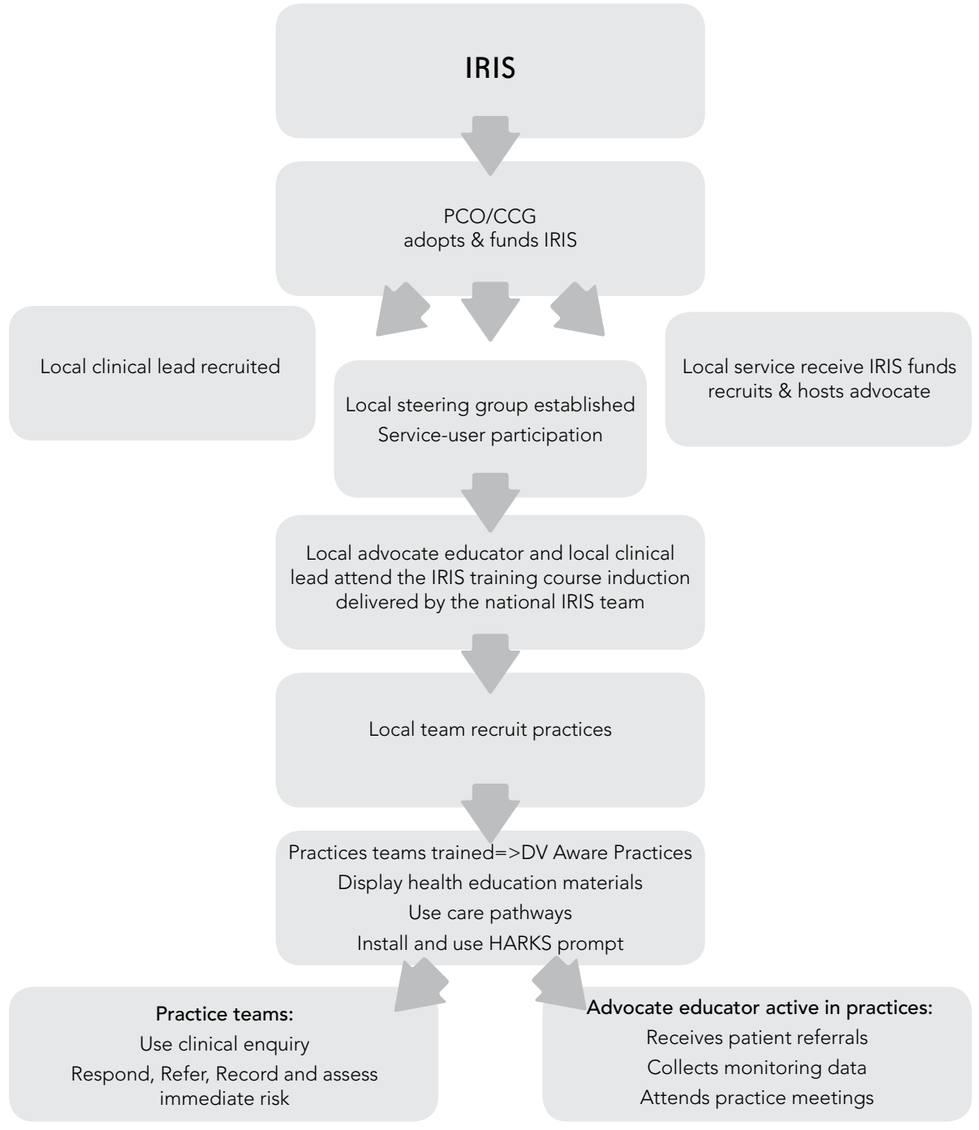


4.0 IRIS costs

The PCO/CCG funds approximately £65,000 for IRIS. The main costs include advocate educator salary (and on costs), clinical lead salary and resources.

4.1 Steps to IRIS implementation

The role of the IRIS Implementation Leads is to support the PCO or CCG to develop and implement the IRIS model locally, as shown in diagram below. The model requires local health funding to support a local specialist service to deliver IRIS. Year 1 costs are approximately £50,000. The costing template for year 1 and subsequent years is in Appendix 3.



5.0 Benefits

"By becoming more aware of the signs and symptoms that suggest abuse – long term anxiety and depression, repeat visits to the surgery for minor symptoms, unexplained gynaecological problems – I became much more aware of patients who were living with abuse and the negative impact that this was having on their health outcomes. The penny drops and you realise the exact scale and extent of the problem amongst your patient population."

IRIS GP

IRIS provides a unique opportunity for primary care clinicians and their patients to talk about DVA. General practice can play an essential role in preventing and responding to DVA by intervening early, providing treatment and information, and referring women on to specialist services. The way in which a primary care clinician approaches DVA with a patient can make an immense difference to that person's life and the lives of affected children.

Ultimately the whole programme is to the benefit of patients, practices and practice teams. It:

- improves safety, quality of life and wellbeing for patients and their children, see Appendix 4.
- reduces the recurrence of DVA.
- fulfils patient need for dignity and respect, private examination, good communication, pain control and involvement in decision making.[21] Women value services that take a proactive role in identifying, responding to and preventing violence against women.
- provides a preventative solution so that patients do not need to reach critical risk levels in order to get help.[13]
- provides access to advocacy which benefits victims and survivors of DVA with "survivors showing improvement in abuse, mental health and quality of life".[22]
- works flexibly and responsively to patient need. IRIS advocacy works at a client's pace, provides tailored, practical and emotional support and is grounded in empowering patients to make informed choices.[23] This includes offering patients access to multiple services to improve safety.[24] This type of support developed in response to survivor consultations and best practice guidance.
- offers patients access to specialist services that they identify as safe and effective.

[21] Page B. *Making the most of the patient survey.* Ipsos-MORI; 2004. Available at: www.ipsos-mori.com/Assets/Docs/SRI-%20Health-%20Presentation%20by%20Ben%20Page-%20HSJ%20Conf%2030%2006%2010.pdf

[13] Women's National Commission. *A bitter pill to swallow: Report from WNC focus groups to inform the Department of Health Taskforce on the health aspects of Violence Against Women and Girls.* London: Women's National Commission; 2010

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[23] Parmar A et al. *Tackling Domestic Violence: providing advocacy and support to survivors of domestic violence:* Home Office Development and Practice Report 34. London: Home Office; 2005

[24] Howarth E *et al. Safety in numbers: A Multi-site Evaluation of Independent Domestic Violence Advisor Services.* CAADA; 2009

"...the only doctor who ever asked...I was just so relieved that somebody just said something. And he gave me the box of tissues and I just sat and cried...and he said, tell me when you're ready, he said, there is somebody out there to help me. I'm not on my own. And if I want help, it's there and not to be ashamed of it. Which I was, really ashamed of it and he said, you're not on your own. We can get you this help. And he did. He really did."

IRIS service-user

SUPPORT CHART
Type of support provided by the advocate educator

data for 173 women (women accessed more than one type of advocacy support)

5.0 Benefits of IRIS continued

"Since the training we have been able to pick up more cases and have been able to help women who had previously been unable to talk about their abuse. We are also more able to assess risk for the women and their children."

IRIS GP

"IRIS remains one of the most significant studies that we have taken part in and one that has influenced our clinical practices the most."

IRIS GP

IRIS

- develops DVA aware practices with fully informed, resourced and equipped practice teams, see Appendix 5.
- provides integrated pathways that offer the most health gain and reduce health inequalities.
- saves general practice and the wider NHS time and resources, see Appendix 4. [19] [18]
- provides holistic care thus achieving better patient outcomes in terms of improved quality of life, physical and mental health and wellbeing.
- provides a cost effective domestic violence and abuse intervention in general practice.[25]
- operates in line with existing Department of Health guidance, the engagement cycle. IRIS is informed by patient involvement and works with local partners.
- fulfils all general practice duties, including safeguarding vulnerable adults and children as highlighted in section 2 of this document, Strategic Relevance.

[19] Ulrich Y et al. Medical care utilization patterns in women with diagnosed domestic violence. *AM. J. Prev Med* 2003; **24**(1): 9-15

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Appendix 1
Domestic Violence & Abuse

Domestic Violence and Abuse (DVA) is a common breach of human rights. It affects individuals and has far-reaching consequences for families, children, communities and society as a whole. The extent of the problem is shocking and intolerable.

"Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality."
This includes issues of concern to black and minority ethnic communities such as so called crimes of honour, forced marriage and female genital mutilation.[26]

DVA is the systematic use of power and control. It includes emotional and psychological abuse, physical abuse, sexual violence, stalking and harassment, intimidation and humiliation, manipulation, threatening behaviour, financial control, isolation and entrapment. The context of fear is an important element in the understanding of domestic violence as a pattern of coercive control.

[26] Home Office. *http://rds.homeoffice.gov.uk/rds/violencewomen.html*

[18] Walby S, Allen J. Home Office Research Study 276. *Domestic violence, sexual assault and stalking: findings from the British Crime Survey.* London, Home Office, Research, development and statistics directorate; 2004

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DVA and gender

89% of victims of the most severe ongoing violence are women (i.e. four incidents or more).[18]

In 4 out of 5 incidents of DVA the offender is male.[27]

25% of women have experienced domestic violence.[18]

54% of female murder victims aged 16 or over were killed by their partner, ex-partner or lover; in contrast, 5% of male victims aged 16 or over were murdered by their partner, ex-partner or lover.[28]

Violence against any person is unacceptable, whatever gender, age, race or social background, but domestic violence has a disproportionate effect on women and children. Women experience domestic violence, sexual abuse, and forced marriage to a far greater extent than men and it is essential to recognise that men and women have different needs. Men can also be victims of DVA and it is important that the suffering of all victims is taken seriously and that support and help is available when needed.

DVA and children

DVA is a major indicator of risk to children and young people. Department of Health figures indicate that nearly three quarters of children on the 'at risk' register live in households where domestic violence occurs (being on the at risk register is now known as being subject to a child protection plan).[29] In addition 75% of DVA incidents are witnessed by children.[30]

Children's responses to the trauma of witnessing DVA may vary according to a multitude of factors including but not limited to age, race, sex and stage of development. With support, children can make sense of what is happening and do not have to be scarred permanently by their experiences.

DVA and Black, Asian, Minority Ethnic and Refugee (BAMER) women

Although there are similarities across all abusive relationships, many BAMER survivors are unable to access language or culturally appropriate services within a context that recognises and addresses their specific needs around social identity, discrimination and inequality. BAMER women identify general practice among the top three agencies to contact for help and support at the point of leaving the abuse.

BAMER women are likely to stay in abusive situations for longer before seeking help, are more likely to experience abuse from multiple perpetrators, are more prone to ongoing violence from extended family members and pressure from the wider community after they leave an abusive situation and often experience higher levels of isolation and marginalisation.

Women with insecure immigration status or no recourse to public funds will also experience additional barriers to seeking help and support. They are often coerced into remaining in an abusive relationship or face destitution. In fact, findings show that BAMER women across all age groups are likely to experience depression, a sleeping disorder and panic and anxiety attacks. There is a higher incidence of self harm and suicide amongst young Asian women experiencing DVA.[31]

BAMER children are likely to experience a range of problems, the most common are related to schooling, a lack of interest or enjoyment in activities, aggression or anger towards adults and peers, eating disorders, being withdrawn or unable to make friends and sleep disorders.

DVA and diversity

DVA does not discriminate and happens in all groups and sections of society. It can happen to anyone regardless of race, gender, disability, age, culture, mental health, religion, socio-economic level, or sexual orientation. All of these may have an additional impact on the way DVA is experienced, dealt with and responded to.

Women from diverse groups and their children often face additional barriers and further oppression from society as a whole. Disabled women, for example, are at higher risk of sexual violence, are less likely to escape and more likely to be isolated.[32]

Physical barriers, racism or homophobia are examples of discrimination that make it even more difficult for women to seek help and support. It is important to approach each case without assumptions and prejudice.

Health care professionals are well placed to spot cases of abuse among their older patients. However, research has highlighted a general tendency for health care professionals to overlook domestic violence as a potential issue for older women.[33]

DVA and perpetrators

It is increasingly acknowledged that initiatives aimed at ending DVA also need to target and engage men as the primary perpetrators of abusive behaviour. The widespread nature of DVA calls for preventative approaches that aim to change attitudes, values and behaviour at the level of the individual, community and professional.

When one relationship ends most perpetrators have other relationships creating new victims. One of the most common requests from survivors is for someone to work with their partner, to help him change and keep them safe from his violence.

DVA perpetrator programmes are well placed to assist agencies to fulfil their statutory duties by working with men who are applying for child contact as well as those who may be a danger to their children or to the child's mother.

[31] Mouji A. *A Matter of Life and death: A right to exist - a paper looking at the eradication of specialist services to BAMER women and children fleeing violence*. London: imkaan; 2008

[32] Hague G *et al. Making the links: disabled women and domestic violence*. Women's Aid Federation England; 2008

[33] McGarry J. Exploring relationships between older people and nurses at home. Nursing Times, 2008; **104**(28): 32-33

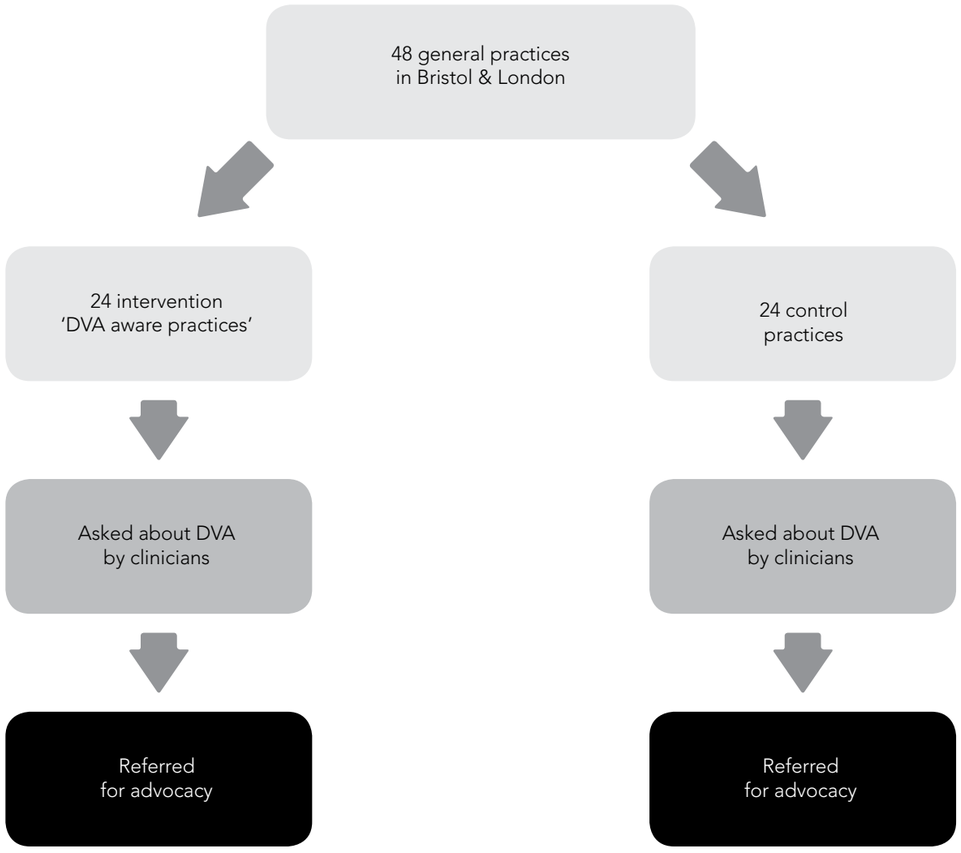
Appendix 2
IRIS Randomised Controlled Trial (RCT)

IRIS is the first European randomised controlled trial of an intervention to improve the health care response to DVA. It aimed to determine the cost-effectiveness of a general practice based DVA training and support programme and measure two outcomes:

- Referral of women to a domestic violence agency providing advocacy
- Recording of disclosure of domestic violence in the patient's medical record

The trial took place in Bristol and Hackney in 48 practices during 2007-10. Twelve practices in each site were allocated to the intervention part of the trial and twelve in each site were in the control part. The intervention practices received the IRIS model while the control practices did not.

IRIS trial design



Appendix 3
IRIS (Identification & Referral to Improve Safety) Costing Template

The costing template and budget information are currently being revised and updated. The correct version will be added once complete.

If you require immediate financial information please contact Medina Johnson or Lizzie Birch on the numbers shown on page 29.

March 2015

October 2012

Appendix 4
Case study - IRIS patient outcomes

Catherine is a 49 year old black Caribbean woman. She is disabled and has four adult children.

Catherine was referred to the IRIS programme through her 'domestic violence aware' general practice (all practice staff received IRIS training and on-going support). The IRIS poster was on display in the practice and having seen this poster Catherine spoke to her doctor about domestic abuse. The doctor made a direct referral to the IRIS advocate-educator and Catherine met with the advocate-educator at the surgery and spoke about her ongoing experiences of abuse. Her husband verbally, emotionally and financially abuses Catherine and this has been happening for over 26 years. During the first meeting Catherine described feeling sad, low and said she felt unable to cope.

Catherine was registered at her practice for over 16 years and had never spoken to anyone about the abuse she was experiencing. She had previously been unable to access specialist domestic violence support and it was unsafe for her to visit other services. Catherine's case would also not fit easily into the categories of risk relevant to other local domestic violence services, such as medium and high risk of repeated abuse. Without the IRIS programme, Catherine would not have been able to access support or information about her situation. As the general practice was part of the IRIS programme Catherine was able to easily and safely arrange appointments and meet with the advocate-educator at the practice. The advocate-educator provided a range of practical support, giving information and options for Catherine to consider. The advocate educator also provided consistent emotional support, including key messages around Catherine's disclosures and always discussed the safety of Catherine and her children.

The advocate-educator worked with Catherine for 12 months. For the first two months this involved an appointment once every two weeks. The next two months involved an appointment once every month and for the last eight months an appointment once every two months (each approximately an hour in length).

In total the advocate-educator met with Catherine for ten support sessions. Catherine set the frequency of the appointments which contributed to her increasing empowerment in taking decisions about her life. Additional support included a total of approximately five phone-calls and a monthly text.

Catherine remains with her husband and over the 12 month period of support she reports many positive changes in her life;

- Going out on her own and leaving the house at least once every day
- Meeting with a friend/family member each week
- Opening her own bank account
- Setting career goals
- Taking a holiday to visit family
- Having her own time and time with her children
- Beginning a degree
- Getting "my freedom back" and "making my own decisions and planning my own way in life"

Catherine feels empowered to make decisions for herself and her family, increasing her safety and breaking the cycle of abuse. Catherine reports the feeling of "having her life back" and "feels stronger to cope", she feels less anxious and states she is happy and has self belief. Catherine also states that she visits her GP less frequently than before.

Catherine's doctor states that since identifying domestic abuse it is as if "a light switch has been turned on". Dr Smith reports improved health and emotional wellbeing and many positive changes including increased independence, confidence, self esteem, achievement of personal goals and "moving incredibly from strength to strength". Catherine's visits to the surgery have reduced by two thirds. Within the 12 months prior to accessing support Catherine visited her doctor once per month and during the 12 months that Catherine has been receiving support through IRIS she has visited her doctor once every 3 months (once a quarter). Dr Smith reported that as Catherine has a long-term chronic condition (linked to her experience of domestic abuse) she would expect to see Catherine once a quarter. Catherine has also largely reduced her use of medication for both depression and sleeplessness.

Since engaging with IRIS the doctor feels that the practice is better resourced to help Catherine manage her health and that she is getting the support she needs.

In Catherine's words "Encouraging myself that I can do this.....I feel empowered.....I feel proud of me.....thank you for believing in me".

The names of the service user and doctor have both been changed.

Appendix 5
Case study - clinician experience

Dr Trish McQuoney is a senior partner at Air Balloon Surgery in Bristol, a large practice serving over 12,000 patients in the central working class district of St George.

The Surgery embraces innovation and since 1996 has received funding as a National Research and Development General Practice. Three years ago, Air Balloon Surgery was invited to take part in a research project developed by the University of Bristol called IRIS (Identification and Referral to Improve Safety of women experiencing domestic violence). The cluster randomized control trial tested the effectiveness of a training and support programme which helps GP surgeries identify and refer patients who are experiencing abuse.

Trish was keen to support the research after working with patients who were living with domestic abuse throughout her career. "We've all come across domestic abuse in our general practice work and hospital work prior to that, so I thought the programme sounded interesting" she says. "But I was also slightly sceptical about the amount of time that the training would take, especially as I felt that we already knew about the issues involved. The entire staff team received training at the same time - from receptionists to GPs - so we needed to close down the main functions of the Surgery for an afternoon in order for this to happen."

Despite her initial concern, Trish and her staff team found the training to be extremely useful. The staff were educated to look out for the signs and symptoms which suggest that a patient might be living with domestic abuse. They were also encouraged to find ways of 'asking the question', using role and scenario play. "This was a new approach for us, and like many people we were understandably worried that patients would be upset if we asked them, or would find it intrusive," she affirms. "But the IRIS research team provided plenty of evidence to show that when relevant, patients welcome being asked. This helped our confidence enormously."

Once the team had been trained up, a referral system and very simple care pathway was put in place to ensure that disclosing patients were referred to a specialist IRIS advocate educator at Next Link, a local specialist domestic abuse service. Male patients who disclosed abuse were also supported and referred to specialist services. "I believe that in addition to the training, the robust referral system played a key role in making this project a success," she says. "Without this we wouldn't have had the right support in place to be able to positively encourage patients to disclose." Following feedback from the GP practices that were involved in the trial, a new programme for local male perpetrators is also in the process of being set up.

Having been a partner at the surgery for 23 years, Trish thought she knew her patients well. She had treated generations of families from the local area, including children who had grown up to have families of their own. But she describes the whole project as "a complete revelation. By becoming more aware of the signs and symptoms that suggest abuse - long term anxiety and depression, repeat visits to the surgery for minor symptoms, unexplained gynaecological problems - I became much more aware of patients who were living with abuse and the negative impact that this was having on their health outcomes. The penny drops and you realise the exact scale and extent of the problem amongst your patient population."

Trish has since identified and referred many women for support. "I've been amazed by some of the disclosures that have occurred," she says. "For example, I'd known one of the patients who disclosed to me for 21 years. In that entire time I had no idea that she was living with a very controlling and psychologically abusive husband, and that this abuse played a key role in her health problems. I've also had women in their sixties and seventies disclose. These women have put up with it for so long, but when offered the right support they are capable of making really brave decisions and changing their lives for the better."

As well as adult victims, Trish has also referred a number of teenage girls. "Often these girls present with low self esteem and depression, and they may not be aware that they're in an abusive relationship as the abuse might not be physical; perhaps their boyfriend is continuously checking up on them by checking their mobile phone calls or messages, or their ex is using Facebook to stalk and psychologically abuse them. In these instances, it can help to have a family GP, a professional that they have known and trusted since childhood, to provide support and refer them to appropriate services, whether that's counselling or a local specialist service."

The IRIS trial found a substantial difference in identification and referral of women experiencing abuse between the 24 intervention and 24 control practices in Bristol and London. Full results will be published before the end of the year.

Victim referrals have increased dramatically at Air Balloon Surgery since the staff got involved in the trial. For Trish, the programme has been an overwhelmingly positive experience. "I'm now convinced that Violence against Women and Children is a major public health problem with long term consequences for women and their families," she says. "As an experienced GP, the whole project has been nothing short of transformational."

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ADDITIONAL MATERIALS CONSULTED:

CAADA. *Saving lives, saving money: MARACs and high risk domestic abuse.* CAADA, 2010

Ellsberg M, Jansen HA, Heise L, Watts CH, Garcia-Moreno C. Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *Lancet* 2008; **371**(9619): 1165 - 1172

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Povey D, editor. *Home Office Statistical Bulletin: Crime in England and Wales 2003/2004.* Home Office, 2004

Women's Aid. *Commissioning Domestic Violence Services: a quick guide*. Women's Aid, 2009

ADDITIONAL LINKS:

Refuge. http://www.refuge.org.uk/

Royal College of General Practitioners. http://www.rcgp.org.uk/

Women's Aid. http://www.womensaid.org.uk/

"I have slowly got my freedom back and am so happy to be making my own decisions, planning my own way in life. This is not just for me, it's for my children and women like me out there."

IRIS service user

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"The clinicians have found the support, advice and service provided by the IRIS advocate educator invaluable"
IRIS practice manager

"I'm now convinced that Violence against Women and Children is a major public health problem with long term consequences for women and their families. As an experienced GP, the whole project has been nothing short of transformational."

IRIS GP