Institution: University of Bristol

Unit of Assessment: UoA2

Title of case study: Reducing domestic violence through 'IRIS', a training and support programme that improves the response of general practice

1. Summary of the impact

Domestic violence (DV) has a devastating public health, clinical and economic impact on women. It is also a major breach of human rights. IRIS (Identification and Referral to Improve Safety), a University of Bristol led randomised controlled trial of a training and support programme to improve the general practice response to DV, demonstrated a substantial increase in identification of victims and their referral to specialist DV services resulting in a subsequent reduction in recurrent abuse and improved quality of life. The programme has now been commissioned by clinical commissioning groups (CCGs) and local authorities in 12 English localities and the training delivered to 122 general practices. The current annual rate of referral of victims of domestic violence from IRIS practices in England to specialist domestic violence agencies is 683 per year, with trial data indicating that at least 600 of these would not have taken place without the IRIS programme. The programme started implementation in Scotland in June 2013.

2. Underpinning research

Contextual information

Domestic violence (DV) against women, a major public health and clinical problem, requires a healthcare response. Historically clinicians in general and GPs in particular have not responded effectively to the needs of patients experiencing DV. Most clinicians have little or no training, fail to identify patients experiencing abuse and are uncertain about further management after disclosure.[1] Women accessing specialist DV advocacy have a reduced recurrence of physical abuse [2], on which rests the claim that increased referral to advocacy can reduce domestic violence and its detrimental effects on health.

Research undertaken

University of Bristol (UoB) research conducted Cochrane [2] and Health Technology Assessment [3] reviews on individual and system (health care setting) level interventions to improve the response to DV. These were the foundation for a cluster randomised controlled trial [4] testing a training and support programme delivered by "advocate-educators" based in third sector DV agencies. Eligible general practices in Bristol and Hackney (London) were randomised to intervention and control groups each of 24 practices. The intervention programme included practice-based training sessions for clinicians and administrative teams, a prompt within the medical record to ask about abuse and a referral pathway to a named DV advocate, who delivered the training and further consultancy.

Key findings

One year after the second training session, advocacy agencies recorded 278 self and direct referrals of patients from intervention practices and 40 from control practices, (adjusted intervention incident rate ratio of 6·6 (95% confidence interval 4·1 to 10·7). Intervention practices recorded 641 disclosures of DV and control practices recorded 236 (intervention rate ratio 3·1, 95% confidence interval 2·2 to 4·3). The trial proved that a training and support programme targeted at primary care staff improves recorded identification of women experiencing domestic violence and referral to specialist DV agencies.

When

The intervention study took place between September 2007 and September 2008 with follow up to September 2009.

Who

UoB researchers led the trial, which was carried out in full collaboration with Queen Mary, University of London (QMUL). A distinctive and pioneering aspect of the trial, which has amplified its impact, was the close collaboration with third sector domestic violence organisations (the 'nia project' and 'Next Link'). These organisations were directly involved in the design of the trial, delivery of the intervention and national implementation of the IRIS model.

Gene Feder (UoB): professor of primary health care – principal investigator

Debbie Sharp (UoB): professor of primary health care – co-investigator
Alison Gregory (UoB): research associate,
Roxane Agnew Davies (Domestic Violence Training Ltd & UoB honorary contract) – co-investigator
Annie Howell (nia and UoB honorary contract): IRIS advocate educator
Medina Johnson (Next Link and UoB honorary contract): IRIS advocate educator
Kim Sales: domestic violence survivor and service user
QMUL co-investigators: Danielle Dunne, Sandra Eldridge, Chris Griffiths, Jean Ramsay

3. References to the research

Grant awarded - Gene Feder; title - Primary care domestic violence trial; sponsor – UoB & QMUL; period of grant: April 2007 to March 2010; value of grant - £428,434; peer reviewed

[1] Ramsay J, Rutterford C, Gregory A, Dunne D, Eldridge S, Sharp D et al. Domestic violence: knowledge, attitudes, and clinical practice of selected UK primary healthcare clinicians. *Br J Gen Pract* 2012; 62(602):647-655 doi: 10.3399/bjgp12X654623
[2] Ramsay J, Carter Y, Davidson L, Dunne D, Eldridge S, Feder G et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *Cochrane Database Syst Rev* 2009;(3):CD005043. doi: 10.1002/14651858.CD005043.pub2
[3] Feder G, Ramsay J, Dunne D, Rose M, Arsene C, Norman R et al. How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technol Assess* 2009; 13(16):iii-xiii, 1. doi: 10.3310/hta13160
[4] Feder G, Davies RA, Baird K, Dunne D, Eldridge S, Griffiths C et al. Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. *Lancet* 2011; 378(9805):1788-1795. doi: 10.1016/S0140-6736(11)61179-3
[5] Devine A, Spencer A, Eldridge S, Norman R, Feder G. Cost-effectiveness of Identification and Referral to Improve Safety (IRIS), a domestic violence training and support programme for primary care: a modelling study based on a randomised controlled trial. *BMJ Open* 2012; 2(3):e001008. doi: 10.1136/bmjopen-2012-001008
[6] Yeung H, Choudry N, Malpass A, Feder GS. Responding to domestic violence in general practice: a qualitative study on perceptions and experiences. *Int J Fam Med* 2012:960523. doi: 10.1155/2012/ 960523.

4. Details of the impact

Background
IRIS is a landmark trial [4] in the field of domestic violence research, testing a training and support programme, including a referral pathway, designed to improve the response of general practice to women experiencing domestic violence.

Dissemination
The findings were disseminated via presentation at 28 non-academic conferences or meetings to July 2013 (total audience ~ 1200), 9 non-academic publications, and provision of information to national health policy fora, notably the 2009/10 taskforce on health aspects of violence against women and children. The trial findings and cost effectiveness analysis [5], supported through a case study [a] and web-based publicity [b] were presented to meetings of local health care commissioners in conjunction with local third sector organisations

Programme Implementation
Maximising impact was an integral part of the IRIS research programme. Following the success of this trial, 'IRIS – strengthening impact' (IRISimp), an implementation vehicle to mainstream the IRIS model into practices across the country, was created. This two-year programme of work was undertaken in conjunction with and, funded by, the Health Foundation. Beginning in June 2010, it facilitates the commissioning of the IRIS model by primary care trusts and provides advocate educator training. UoB researchers then secured a Department of Health Innovation, Excellence

and Strategic Development Grant to fund further implementation of IRIS in England. A key part of the implementation programme was the translation of the findings of the trial into a commissioning document designed to enable and support the commissioning of the programme by CCGs and local authorities in England [c].

Up to July 2013, 12 localities have commissioned the programme, and 122 practices in 7 localities have received training and started to use the IRIS referral pathway. [d]

Benefits to women
Currently 683 women are being referred annually to IRIS domestic violence advocates in the areas that have implemented the programme. [c] This is estimated to be at least six times the number of referrals occurring in the absence of IRIS. We know from our previous systematic reviews of advocacy interventions [1] [3] that this will result in a reduction of recurrence of domestic violence, improved quality of life and probably improved mental health of these women. The other benefit for patients is a safer and more appropriate response of clinicians to disclosure of domestic violence, a core feature of the IRIS intervention. We have evidence for this impact from interviews with patients who disclosed abuse to their GPs and were referred to an IRIS advocate educator.
For example, here is the account of a woman who spoke to her GP about abuse after seeing an IRIS poster in the waiting room: "I had been experiencing verbal, emotional and financial abuse from my husband for over 26 years. I felt sad, low and unable to cope. The doctor referred me to someone who could help... I don't need to go to the doctor's as much now and have cut down on the tablets I take for depression and sleeplessness. I have slowly got my freedom back and am so happy to be making my own decisions and planning my own way in life. This is not just for me, it's for my children and women like me out there. I feel empowered. I feel proud of me." The patient narratives, as referenced in the corroborative sources, provide further evidence. [e]

Benefits to NHS staff
Intermediate beneficiaries from the widespread implementation of IRIS have been the doctors, nurses and other members of the practice teams in the 122 IRIS practices nationally (Bristol, Hackney, Lambeth, Manchester, Nottingham, Portsmouth, Southampton). IRIS has been commissioned in an additional four areas (South Gloucestershire, Berkshire West, Enfield and Nottingham) and practice training will be delivered in Autumn 2013. From our nested qualitative study [6] we know that the participating clinicians think that the training and support from IRIS allows them to engage with the difficult challenge of domestic violence. The clinician narratives, as referenced in the corroborative sources, provide further evidence. [e]

Impact on national policy
The trial findings were made available pre-publication to the Department of Health taskforce on the health aspects of violence against women and children [f] and they were a key source of evidence on training of health care professionals. The IRIS model was cited as an exemplar alongside the recommendation about training of staff (recommendation 3, p. 31) and was highlighted as a case example in the commissioning guidance, [g] (p.58) based on the report. Draft NICE guidelines have a specific training and support recommendation for primary care based explicitly on IRIS (p.21). [h] The 2012 Welsh Assembly Government White Paper [i] specifies IRIS as an effective primary care training model (pp.48-49) and this will be the basis of implementation of IRIS in Wales. Twelve IRIS advocate educators have been trained in Scotland. They are delivering the IRIS practice training and referral pathway in three Health Boards.[j] IRIS implementation has been part of the recommendations of Home Office Domestic Homicide Reviews [k].

Impact on international policy
The landmark 2013 WHO publication 'Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines' drew heavily on the research of the UoB team in framing their approach and in making recommendations about the training of healthcare providers with specific citation of the IRIS model (p.33). [l]

Economic impact
With the current number of IRIS practices, the annual societal cost saving is estimated to be greater than £1m annually. This estimate is based upon the results of the cost-effectiveness model developed from the trial outcomes [5]. This modelling indicated that implementation of the IRIS programme is cost-effective as judged by NICE criteria, generates societal cost savings and is likely to reduce NHS costs.

Impact on national DV screening policy
Broader UK government policy on domestic violence has been deeply influenced by the outputs of the UoB domestic violence research programme. In particular the systematic reviews that underpinned the IRIS study helped forestall the implementation of ineffective domestic violence screening/routine enquiry in health care settings in England, as reflected in the DH taskforce report [d] and in the UK national screening committee recommendations. [m] The National Screening Committee has adopted the definition of domestic violence developed by Feder.

5. Sources to corroborate the impact

[a] Case study from the Health Foundation website http://www.health.org.uk/publications/identification-and-referral-to-improve-safety/

[b] Web pages on the Health Foundation website developed to disseminate findings of the trial, including interviews with intervention and trial team members http://www.health.org.uk/areas-of-work/programmes/engaging-with-quality-in-primary-care/related-projects/primary-care-domestic-violence-programme-iris/

[c] This document describes the components of the IRIS programme in the format of a commissioning specification, including a budget and deliverables. It is used both by domestic violence service providers to pitch to commissioners and by commissioning groups http://www.irisdomesticviolence.org.uk/holding/IRIS_Commissioning_Guidance.pdf

[d] Report on localities that have commissioned IRIS: number of practices, clinicians and administrative staff trained, referrals made to IRIS advocate educators

[e] IRIS website that includes narrative evidence from patients and clinicians http://www.irisdomesticviolence.org.uk/iris/patient-quotes/

[f] Main report of DH taskforce on health aspects of violence against women and children that includes IRIS as exemplar http://www.health.org.uk/media_manager/public/75/external-publications/Responding-to-violence-against-women-and-children%E2%80%93the-role-of-the-NHS.pdf

[g] DH Commissioning guide on domestic violence that cites IRIS as model programme https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215635/dh_125938.pdf

[h] NICE public health draft guidance: Domestic violence and abuse: how social care, health services and those they work with can identify, prevent and reduce domestic violence and abuse – makes recommendation about integrated training and referral programme for primary care based on IRIS model http://www.nice.org.uk/nicemedia/live/12116/64783/64783.pdf

[i] Welsh Government white paper Consultation on legislation to end violence against women, domestic abuse and sexual violence that cites IRIS model http://wales.gov.uk/docs/dsjlg/consultation/121126taskfingrouprepen.pdf

[j] Statement from Katie Cosgrove, Gender-based Violence Programme Manager, NHS Health Scotland that evidences implementation of IRIS in Scotland

[k] Home Office Domestic Homicide Review recommending IRIS implementation (pages 4&5) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/259547/Domestic_homicide_review_-_lessons_learned.pdf

[l] WHO guidelines on health care response to intimate partner violence that make recommendations on training of health care professionals partly based on IRIS http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf

[m] Draft expert review informing National Screening Committee decision on domestic violence screening that is largely based on Feder's HTA review http://www.screening.nhs.uk/domesticviolence DRAFT_Domestic_Violence_Adults_17_05_13.pdf