IRIS: a system level intervention to improve the primary care response to domestic violence

Gene Feder
Responding to intimate partner violence and sexual violence against women

WHO clinical and policy guidelines

World Health Organization

System level programmes
### Recommendations

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<th>31</th>
<th>Health-care providers offering care to women should receive in-service training, ensuring it:</th>
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<td>• enables them to provide first-line support (see recommendations 1 and 10)</td>
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<td>• teaches them appropriate skills, including:</td>
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<td>– when and how to enquire</td>
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<td>– the best way to respond to women (refer to sections 2 Identification and care for survivors of intimate partner violence and 3, Clinical care for survivors of sexual assault)</td>
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<td>– how to conduct forensic evidence collection where appropriate</td>
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<td>• addresses:</td>
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<td>– basic knowledge about violence, including laws that are relevant to victims of intimate partner violence and sexual violence</td>
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<td>– <strong>knowledge of existing services</strong> that may offer support to survivors of intimate partner violence and sexual violence (this could be in the form of a directory of community services)</td>
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<td><strong>34</strong></td>
<td>Care for women experiencing intimate partner violence and sexual assault should, as much as possible, be <strong>integrated</strong> into existing health services rather than as a stand-alone service (see minimum level of requirements, box 1, p. 19).</td>
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<td><strong>35</strong></td>
<td>A country needs multiple models of care for survivors of intimate partner violence and sexual assault, for different levels of the health system. However, priority should be given to providing training and service delivery at the <strong>primary level of care.</strong></td>
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How do we engage primary health care services?

Identification and Referral to Improve Safety
IRIS intervention and causal pathway

- Training and support
- Referral pathways including safeguarding children and adults
- Medical record prompts
- Recording and flagging system
- Advocate educator
- Practice champion
IRIS model

Training and support + referral pathways including safeguarding children and adults + Medical record prompts + Recording and flagging system + Advocate educator + Practice champion

IRIS REFERRAL

DISCLOSURE
Your female patient discloses to you that she is currently experiencing or has experienced domestic violence

Is she (and any children) in immediate danger?

YES

IMMEDIATE ACTION
Offer to help her contact the DART and/or National Domestic Violence Helpline: 0808 2000 247

NO

Does she have children?

YES

Are they at risk?

YES

Discuss with health visitor

NO

Refer to your FCT's child protection procedures

RESPOND
* listen * believe * not alone * help available * safety

OR

REFER
To Medina Johnson specialist domestic violence Advocate Educator: 07912 476 011
Or email referral form:
medina.johnson@theclinkhousing.co.uk
Or fax referral form: 0117 929 3290
If she is unavailable leave a message and establish a safe way for your patient to be contacted and explain contact will be made within the week

RECORD
* Hark + and notes * Safe documentation * Explain why recording information

SIGNPOST
Give IRIS leaflet
Next Link: 0117 925 0580
IRIS model

Training and support
+ referral pathways including safeguarding children and adults
+ Medical record prompts
+ Recording and flagging system
+ Advocate educator
+ Practice champion

specialist domestic violence service
link to local domestic violence fora and coordinated community response
IRIS model

Training and support
+ referral pathways including safeguarding children and adults
+ Medical record prompts
+ Recording and flagging system
+ Advocate educator
+ Practice champion

Health education material
+ Clinical enquiry
+ Validation
+ Documentation
+ Immediate risk check and safety assessment
IRIS model

Training and support
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Health education material
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+ Immediate risk check and safety assessment

Domestic Violence Aware Practice
If you are a woman being hurt by someone you know or you are afraid of someone at home, you can talk to doctors, nurses and other staff working here, in private.

You can also call the next link domestic abuse services on: 0117 925 0680
OR the 24 hour National Domestic Violence Helpline on: freephone 0808 200 0247

If you are a man who is a victim of domestic violence contact the Men's Advice Line on: 0808 801 0327
If you have been violent or are worried about your own behaviour, call Respect on: 0845 122 8609

Bristol Primary Care Trust
IRIS model

Training and support
+ referral pathways including safeguarding children and adults
+ Medical record prompts
+ Recording and flagging system
+ Advocate educator
+ Practice champion

Health education material
+ Clinical enquiry
+ Validation
+ Documentation
+ Immediate risk check and safety assessment

Identification + Referral

Advocacy
Emotional & Practical support

Less abuse
Improved quality of life
+ mental health

Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse (Review)

The Cochrane Collaboration®
Does IRIS work?

- cluster randomised controlled trial
- 1 year follow up
- 48 general practices in Bristol and Hackney
primary care responded

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

Gina Feder, Rosanna Agnew-Brooks, Kathleen Brand, Danielle Brown, Sandra Eddey, Lisa Griffiths, Alison Gregory, Annick Howell, Medina Johnson, Jean Marmion, Clare Ridgwell, Debbie Stone

Summary

Background: Most clinicians have no training about domestic violence, lack information about women experiencing abuse, and are uncertain about management after disclosure. We tested the effectiveness of a programme of training and support in primary health-care practices to increase identification of women experiencing domestic violence and their referral to specialist advocacy services.

Methods: In this cluster randomised controlled trial, we selected general practices in two urban primary care trusts, Hackney (London) and Bristol, UK. Practices in which investigators from this trial were employed or those who did not use electronic records were excluded. Practices were stratified by proportion of female doctors, postgraduate training status, number of patients registered, and percentage of practice population on low incomes. Within every practice, we randomised practices with a computer minimisation programme with a random component to intervention or control groups. The intervention programme included practice-based training sessions, a prompt within the medical record to ask about abuse, and a referral pathway to a named domestic violence advocate, who also delivered the training and provided consultancy. The primary outcome was recorded referral of patients to domestic violence advocacy services. The primary secondary outcome was recorded identification of domestic violence in the electronic medical records of the general practice. Poisson regression analyses accounting for clustering were done for all practices receiving the intervention. Practice staff and research associates were not masked and patients were not aware they were part of a study. This study is registered at Current Controlled Trials, ISRCTN71401786.

Findings: We randomised 51 (62%) of 84 eligible general practices in Hackney and Bristol. Of these, 24 received a training and support programme, 24 did not receive the programme, and three dropped out before the trial started. 1 year after the second training session, the 24 intervention practices recorded 228 referrals of patients to advocacy and the 24 control practices recorded 12 referrals (adjusted intervention rate ratio 22.1 [95% CI 11.5–42.4]). Intervention practices recorded 441 disclosures of domestic violence and control practices recorded 2.96 (adjusted intervention rate ratio 3.1 [95% CI 2.3–4.5]). No adverse events were recorded.

Interpretation: A training and support programme targeting primary care clinicians and administrative staff improved referral to specialist domestic violence agencies and recorded identification of women experiencing domestic violence. Our findings reduce the uncertainty about the benefits of training and support interventions in primary care settings for domestic violence and show that screening of women patients for domestic violence is not a necessary condition for improved identification and referral to advocacy services.

Funding: Health Foundation.

Introduction: Domestic violence is a threat to many women's physical and emotional health.1 It involves: some people harming others; women who experience more violence than men; and violence perpetuated by partners. A severe breach of human rights, with profound consequences, particularly for women who, compared with men, experience more emotional violence, more severe physical violence, and are less able to protect themselves from their partners.2 The lifetime population prevalence of physical and sexual violence varies internationally from 10% to 79% and is consistently higher in women seeking health care, including primary care.3

Domestic violence damages health.4 Survivors have chronic health problems including gynaecological disorders,5 chronic pain,6 neurological symptoms,7 gastrointestinal disorders,8 and self-reported heart disease.9 The most prevalent effect on women's mental health, including depression, anxiety, suicide ideation, and substance misuse.10,11 Health-care services, particularly primary care, can be a survivor's first or only point of contact with professionals and can be the first step towards abuse victims being heard and supported.12 The magnitude of the health consequences of domestic violence contrasts...
(very) cost-effective

- NHS cost savings of £1.07 per woman per year, equivalent to UK £3155 per practice per year
- societal cost savings of £37/woman/year
- 78% of model replications under a willingness to pay threshold of £20,000/QALY
translation into practice

- **IRISimp**: ongoing project to facilitate commissioning of the programme, train advocate educators and monitor outcomes

- commissioned in 12 English localities, piloted Scotland and being considered in Wales
messages from IRIS

- training of clinical teams must be combined with referral pathways to specialist DV advocacy/services
- training should be delivered by DV specialists in combination with clinical peers
- periodic feedback to clinical teams and reinforcement needed
for more information

http://www.irisdomesticviolence.org.uk

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