Identification and Referral to Improve Safety (IRIS)

MANCHESTER IRIS PROGRAMME

Hearing the voices of the IRIS service users

Study Report

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In summary

This in-depth study presents evidence from the Manchester Identification and Referral to Improve Safety (IRIS) service, which began in February 2012 and by February 2014, has received 169 referrals from 16 general practices across Manchester concerning women who have suffered from domestic violence and abuse. The majority of the women interviewed had not disclosed the violence to anyone else prior to speaking to their GP.

The evidence demonstrates positive outcomes for women and children through improved mental health, increased opportunities for training and employment and the ability to begin to take control of their, and their children's, lives. It supports the business proposal to extend the offer of IRIS training and service to GP practices in Manchester, in order to improve the safety and health and wellbeing of all women, men and children in Manchester.

If I had not been asked, I would not have told anyone and who knows what would have happened to me (woman I).

1. ABOUT THIS REPORT

This report captures the experiences of 17 women who accessed the Manchester Identification and Referral to Improve Safety (IRIS) service in Manchester over an 18-month period (between August 2012 and February 2014). The study involved 12 (of 16) General Practices in 3 Clinical Commissioning Groups (CCGs) that had all received the IRIS training.

The report focuses on the voices of the women involved and the impact on their lives of disclosing domestic violence and abuse (DVA) to a General Practitioner (GP) and being referred to a specialist domestic violence service. The report begins with setting the Manchester context for IRIS followed by the methodology and sampling method used. The findings are presented in section 4 under four key themes: accessibility and context, the disclosure process, the referral pathway and the impact on the lives of 17 women affected by DVA. It concludes with a discussion of the key messages and learning that have emerged from this study.

The report will be of interest to senior managers in the Manchester and National IRIS programme in helping them develop and take forward the programme. It

will be useful evidence for local commissioners in CCGs and Manchester City Council (MCC), including Public Health Manchester. The report can inform decisions about commissioning DVA services across MCC and the voluntary and community sector, including the Manchester Safeguarding Children Board. It will also make a contribution to the body of knowledge available on domestic violence and abuse and the effectiveness of the IRIS service in helping women change and have safer lives.

2. REPORT CONTEXT

NHS services have a poor record when it comes to the identification and handling of cases of domestic violence. Women, who represent the majority of cases, may present with physical and mental health problems attributable to violence, often over a sustained period, without ever being asked[1].

The Identification and Referral to Improve Safety (IRIS) programme is an evidence-based programme of training and support in primary health-care practices to increase the identification of women and men experiencing domestic violence and their referral to specialist advocate services.

A cluster random controlled trial in 2011[2] found that a training and support programme targeted at primary care clinicians and administrative staff improved referral to specialist agencies and recorded identification of women experiencing domestic violence.

A recent study[3] of 12 women's experiences of referral to IRIS in two localities found that GPs and nurses can play an important role in identifying women experiencing DVA and referring them to DVA specialist agencies

IRIS is a collaboration between primary care and third sector organisations specialising in DVA. The core areas of the programme are on-going training and education for the clinical team and ancillary staff and an enhanced referral pathway to specialist services. The national IRIS model entails one full time advocate educator (AE) working with 25 practices. Between November 2010 and July 2013, National IRIS has received over 760 referrals from 120 trained general practices in 7 localities nationwide[4]. NHS Manchester is one of the 7 localities that joined the programme.

2.1 Manchester IRIS programme

NHS Manchester joined the programme in February 2012 and in April 2013 the IRIS programme was transferred with Public Health Manchester into Manchester City Council. Public Health Manchester commissioned Manchester Women's Aid (MWA) to host the programme and the IRIS Advocate Educator is part of the Manchester Women's Aid (MWA) team. Funding is currently in place until April 2015.

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[1] The Health Foundation (2011) *Improvements in Practice: the IRIS case study*, The Health Foundation.
[2] Feder G, Davies RA, Baird K et al (2011) Identification and Referral to improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomized controlled trial, *The Lancet: 378, 1788-1795*
[3] Malpass A, Sales K, Johnson M, Howell A et al (2014). Women's experiences of referral to a domestic violence advocate in UK primary care settings, *British Journal of General Practice, March 2014*
[4] Howell A, Johnson M and Harrison S, *IRIS National Report 2013, August 30th 2013.*

The service has been offered to surgeries in areas of Manchester with a range of levels of reporting domestic abuse, including offers to practices that have undergone serious case reviews. The training is co-delivered by a full-time woman Advocate Educator and two local women GPs, who are also members of the steering group. Since February 2012 there have been two Advocate Educators, with the current AE in post since August 2013. 43 training sessions have been delivered since February 2012 in 16 practices.

Between February 2012 when the project began and the end of February 2014, there have been a total of **169 referrals** to the specialist domestic violence service from **14 General Practices.**

2.2 Meeting local strategic priorities

The IRIS programme is relevant to key policy developments in Manchester City Council and partners and meets a number of local strategic priorities.

The council is responsible for promoting and protecting the health and wellbeing of people in the city through working in a number of partnerships. It also provides specialist public health advice to primary care services: for example GPs and community health professionals.

The priority areas of work in the three Manchester NHS Clinical Commissioning Groups over the next five years is a greater focus on primary and secondary prevention, working with Public Health Manchester and Manchester City Council to develop population based interventions that prevent ill health and focus resources on those with the highest needs.

Manchester Health and Wellbeing Board[5] include in its strategic priorities a need to turn round the lives of troubled families, improve people's mental health and wellbeing and bring people into employment and lead productive lives. There is evidence in this report that IRIS is addressing these priorities.

Manchester Safeguarding Children Board (MSCB) Business Plan[6] has two objectives, which are particularly relevant to this report. Objective 3 aims to maintain and publish a performance and quality assurance framework for safeguarding as a key indicator of the effectiveness of safeguarding services. In particular, it plans to include the experience and views of service users in this framework. Objective 5.1 gives a commitment to maintain a number of active

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5 http://www.manchesterpartnership.org.uk/info/6/health_and_wellbeing_board/42/strategic_priorities

6 Board Business Plan for April 2013 –March 2015.

work streams in key safeguarding risk areas such as domestic abuse.

The MSCB also commits to quality assure and 'challenge' the implementation of Manchester City Council's Early Help Strategy[7], to ensure it is proportionate and is being accessed appropriately by agencies working with vulnerable children and families.

Manchester's Early Help Strategy is particularly relevant to IRIS; the strategy encompasses the three main priorities of the Manchester Safeguarding Children Board, one of which is tackling the root cause of dependency through a whole family approach and enabling more families to achieve economic independence. There is evidence in this report that some of the women helped by IRIS have moved from receiving benefits to employment, education and training opportunities.

The report now looks at the methodology used in this study before presenting the findings.

[7] Manchester City Council Early help Strategy: Children, Young People and Families 2013-2015

3. METHODOLOGY

The aim of this study was to capture the experiences of women using the IRIS service in Manchester. In particular we were interested in their experiences of disclosure at the General Practice, their referral process to specialist services and the resulting impact on their lives.

We planned to recruit a sample of 15-20 people from 16 participating practices in Manchester. The final sample was 17 women[8] from 12 practices across the 3 Manchester Clinical Commissioning Groups. Their ages ranged between 19 to 52 years[9], one woman was pregnant and one woman had a mild learning disability.

16 of the 17 women had disclosed to a female GP[10]. All the women had been seen by the Advocate Educator (AE) and none of the women were living with the perpetrator at the time of the interviews. 11 women were still in touch with the AE, 6 cases were closed and all the women were referred to other agencies. A full sampling matrix is shown below.

Characteristics of participants and their experience of domestic violence and abuse

Code	Ethnic Group	Marital status	Children	Immi status	income	Length of abuse	Type of abuse	Living with perp	Referral After training
A	White British	Single	No	Citizen	ESA	10y	Emotional Verbal Financial Physical	No	8 days
B	Black African Somali	Separated	Yes	Citizen	JSA	20y	Emotional Verbal Financial Physical	No	8 days
C	White British	Separated	Yes	Citizen	JSA	Not known	Emotional, verbal, physical	No	14 months
D	Asian Pakistani	Separated	Yes	Visa – limited leave	JSA-ESA	4y	Emotional, verbal, physical, isolation	No	14 months
E	Black African Zimbabwe	Single	No	Visa - sponsored	JSA	1y	Emotional, verbal, financial, physical	No	Same day
F	Mixed race White/ Caribbean	Single	Yes	Citizen	ESA	2y + Historic	Emotional, verbal, physical, sexual	No	12 months

[8] Even though the programme is open to men and women suffering abuse the programme has only engaged women to date.
[9] The ages of the women have been removed for confidentiality purposes
[10] One woman had also disclosed to a male GP as well as a female GP

G	Other UAE	Divorced	Yes	Citizen	JSA-Employ -JSA	18 mons	Emotional, verbal, physical,	No	11 months
H	Asian Pakistani	Divorced	No	Citizen	JSA	3y	Emotional, verbal, Arranged marriage	No	4 days
I	Other Ski Lanka	Separated	No		JSA	20y		No	1 month
J	Black Caribbean	Single	Yes	Citizen	JSA	4y + historic	Emotional, verbal, financial, physical, sexual	No	1 month
K	White British	Separated	No	Citizen	Employ	6y	Emotional verbal, financial, physical	No	8 months
L	White British	Single	Yes	Citizen	Unknown	3y + historic	Emotional, verbal, Financial, physical, sexual	No	7 months
M	White British	Separated	Yes	Citizen	JSA	3y	Emotional, verbal, physical	No	5 weeks
N	White British	Divorced	Yes	Citizen	ESA	15y	Emotional, verbal, physical,	No	16 months
O	Asian Pakistani	Separated	Yes	Citizen	ESA	9y	Emotional verbal, financial, physical	No	1 month
P	Asian Pakistani	Single	No	Citizen	Unknown	Historic	Unknown Forced marriage	No	6 months
Q	White British	Married	Yes	Citizen	Employed	9y	Emotional, verbal, physical	No	3 weeks

3.1 Recruitment

The method of recruitment was through the Advocate Educator as a trusted source and the sampling process was agreed with the independent researcher. Where it was safe to do so women were contacted initially by text to ask if they would participate, and if they agreed, an appointment was made for the interview. An information sheet and consent form were available for further information. The AE gave the researcher basic demographic details of each participant to ease the process of interview.

The women were clearly told that the purpose of the interview was about their experiences at the surgery and follow on referral to the Advocate, rather than a detailed discussion about their abuse. This proved reassuring to the women, and along with their relationship with the AE, ensured a high return of women willing

to be interviewed. It is also probable that women who are no longer living with the perpetrator feel safer and more able to discuss their experiences.

3.2 Method

A semi-structured interview was carried out (topic guide in Appendix 1) with each individual woman. In one case a Mental Health worker was also present. Three of the interviews were face to face and 14 by telephone. The telephone method was chosen because it can be less threatening than face-to-face meetings for vulnerable people. It also allowed a higher volume of interviews to be carried out within a limited budget. The three face-to-face interviews allowed the researcher to develop some of the emerging themes in more depth, and to have a clearer understanding of the practice context in which the programme was operating.

Based on the ethical principle that research should do no harm, a plan was agreed with the Advocate Educator for any women who needed follow up support after telling their stories.

A thematic analysis was applied to the interview data, using the aims of the study as a framework. Section 4 looks at the findings.

4. FINDINGS

This section presents the findings of the study under four main areas:

1. The accessibility and context in which the Manchester IRIS project is set
2. The interaction between the women and the doctor when disclosure occurs
3. The referral pathway to specialist DVA services
4. The impact on the lives of the women who disclosed

4.1 Accessibility and context

The women in this study viewed the GP surgery as part of the local community. It was a familiar and accessible place where they felt safe, particularly when they were vulnerable and anxious. They did not feel they needed to explain the reasons they were attending the surgery to family or other people who may see them, as people assumed they had health issues. One woman explained:

> *It just looks as though I am coming to the doctors, more private. If I went to a Women's Aid building people would know I had problems, I don't want that (woman H).*

Many of the women explained that when they visited the surgery they knew where to come and this reduced some of their anxieties. In addition, all the women in this study met the AE at the surgery that referred them. If they had been initially referred to DVA services outside their immediate vicinity they may not have met the Advocate, as finding a new location was too daunting when they were already struggling with their confidence. One woman who was new to the area said:

> *We (AE) met at the doctors. I knew where it was. If she had said meet at another place that would have been a problem, as I don't know anywhere, where anything is; it was here and I knew where to come (Woman H).*

The women in this study who had fled from abusive relationships and moved to Manchester from other areas, registered with a GP even if they did not engage with other local services. Several of these women also requested appointments with women doctors when they registered, which may account for why the participants disclosed to more women doctors. After 10 years of abuse, one woman came to Manchester from another area:

> *I went to register with a new GP and asked for an appointment with a woman doctor. I knew I needed something (Woman K).*

Another woman had fled to Manchester for safety:

I was in a new city and I went to register at the doctors to renew my medication (Woman D).

The GP surgery created the initial conditions for the interaction between the GP and the patient to take place. This encounter is discussed in the next section.

4.2 The Disclosure Experience

The previous study[11] of women's experiences of disclosure describes two types of disclosure: clinician-led and woman-led, with women-led disclosures more unusual; most of the women had disclosed only when asked. All disclosures occurred with the doctor rather than a nurse, despite the IRIS programme training both doctors and nurses at the practices.

All the women in the Manchester study disclosed to a doctor, rather than a nurse. 16 disclosures were to women doctors and one to a male GP although in that case there had been a previous disclosure to a woman partner in the practice, prior to referral to the AE.

Our findings revealed a less clear distinction between woman-led and clinician-led disclosure. Three women recalled directly being asked by the doctor, but the remaining 14 women spoke more about the conditions and triggers present that enabled them to tell the doctor about their abuse.

The women who remembered being asked by the doctor described their experiences and demonstrated how important the doctor's reaction was. One woman who had been abused over a 20-year period saw a GP she had not previously seen and who spoke to her in her first language. The woman recalls that the doctor asked if she had any problems at home. She continued:

I could then tell her (GP) and it was easier to talk about in my own language. I would never have told anyone if I hadn't been asked (Woman I)

This finding is particularly interesting because the woman had disclosed to two different groups of professionals in the past but felt her disclosure was ignored and she was never referred to any DVA services. She was treated for the results of the abuse rather than the cause, and potentially, this made it more unlikely that she would disclose abuse to other professionals in the future.

Two women had visited the doctor for repeat medication and had not intended to talk about the abuse. However, when the doctor enquired why they needed

[11] Malpass A, Sales K, Johnson M, Howell A et al (2014). Women's experiences of referral to a domestic violence advocate in UK primary care settings, *British Journal of General Practice, March 2014*

medication they disclosed. One woman who had been abused by her partner for 10 years and never told anybody explained:

> *I went to the doctor when I moved to Manchester to renew my medication. The doctor asked me why I was on medication and I told her a little about the abuse. The more I felt comfortable, the more I opened up and could talk. She made me feel relaxed (Woman A)*

She continued:

> *I felt confident that she (GP) was taking me seriously; you let so much out (Woman A)*

When she next saw the GP, the GP told her about a new service for people who had been abused (IRIS) and within two days she saw the AE.

Another woman who had been abused by her partner and now lived alone with her son in a new area went to her GP on the advice of a family member. The family did not know of the abuse but were concerned that she was so tearful and depressed. The woman recalled telling the doctor that she felt unwell and had headaches. She continued:

> *She (the doctor) asked me: 'Why are you stressed? What has happened? Can you tell me about your problem? What did he do to you?' (Woman G)*

The woman said that she would not have disclosed if the doctor had not made the links to abuse. She had been involved with other services prior to disclosure (not DVA related), and found the doctor's approach different, making her think in a different way about herself.

Another woman, who had lived with a violent partner for 3 years, had been asked by previous doctors at the surgery about abuse but had always denied it. She went on:

> *It is difficult when you are asked straight out, because you are scared of the consequences of speaking out. Then I saw a doctor I had seen occasionally and broke down. She was 'just different', really friendly, acted as though she really cared, listened and helped me talk about it (Woman M).*

She is now seeing the Advocate Educator for support and help with legal matters.

The important finding from this study is that the women would not have disclosed abuse if the doctor had not shown empathy and understanding. It was the reaction of the doctor and the establishment of trust that facilitated disclosure. In this study, speaking about the abuse was unrelated to how long

the woman had known the doctor; it was the receptive conditions present in the exchange. One woman explained:

> *It was the doctor's reaction when I spoke. If she hadn't believed me or not had some empathy, I wouldn't have bothered; nothing else would have happened and I wouldn't have developed it (Woman A).*

None of the women in this study were prompted by leaflets or posters in the surgery to raise the matter of their abuse with the GP.

A few women went to the doctor's with an intention to tell them about the abuse. Two women went to the doctor with physical injuries, and another had been involved with the police. Women who had held their abuse secret for years felt they had to say something and the doctor was seen as the most likely professional that they could talk to safely. One woman said:

> *It was good telling a doctor because they are professional and she knows what she is doing (Woman E).*

Another woman who had been seeing the doctor for a little while explained why she told the doctor about the abuse, rather than other clinical staff:

> *I think it is because they sort of know you, you get used to seeing them and they know a little bit about you (Woman H)*

One woman with a history of previous abuse was feeling so bad that she felt she had to say something to the doctor: *'I just blurted it all out' (Woman L).* She recalled how gradually the doctor helped her to piece it all together and she was then referred to the AE.

Evidence from other research and within this study suggests that the response of the doctor was key to improving the women's health and wellbeing. One woman with a long history of abuse from a partner, who she still has contact with, explained that she had never told anyone about the abuse because she did not see it as a problem. She had been seeing the doctor for sometime with anxiety and depression and then nine months ago she told the doctor what had happened:

> *I had been seeing the doctor for sometime, she was very understanding, empathetic and her body language…so I was able to open up' (Woman Q).*

The women in the Manchester study did not expect the doctor to be an expert on DVA and to be able to solve all their problems. But they did value the referral by a trusted source to specialist services.

The referral pathway is discussed in the next section.

4.3 The referral pathway to specialist DVA services

The Identification and Referral to Improve Safety (IRIS) model entails two main, inter-related elements. One is the training of clinical teams and ancillary staff in General Practice to enable women to disclose domestic violence and abuse (DVA); the other is an enhanced referral pathway to specialist DVA services. Initially, the clinical staff refers the woman to an Advocate Educator (AE) who supports and facilitates the women to access other specialist services.

Five of the women in this study had used specialist DVA services before. The remaining 12 had not because either they did not know about the services, did not identify their own abuse or were too worried about the response they may receive. For example:

> *I wouldn't have known what other services there were. I tried online but that didn't work; it was not for me (Woman H)*
>
> *I did not seek help from Women's Aid because you don't really know what will happen if you do ring the numbers. It is out of your hands (Woman M)*

In the Manchester study, the first step from the trusted doctor source to another service was a critical transition for the abused woman and one that depended on the GP's explanation of what would happen next. All the women in this study were seen at the surgery they had attended and all but one was contacted directly by the AE.

The explanation given to the women about the advocate services was consistent across the study. The AE was most commonly described as someone who understands about domestic violence and could help them. For example:

> *The GP explained the service as being part of Women's Aid. (AE) had more experiences and insights into DV than she (the doctor) had and she could help me go to other services (Woman D).*
>
> *The GP explained the service well. He said that it would be safe and confidential and that (AE) saw women in a similar situation. It was a very simple and straightforward explanation (Woman P).*
>
> *Would you like to see someone who knows about DV and can help you? (Woman I)*

A woman who was suffering from family abuse was surprised at being referred to the AE:

She told me about (AE) who could help with DV issues. I was surprised, as I had not thought of this as DV as I thought that was only with partners. I did not know anything about DV services (Woman J)

Many of the doctors reassured the women about the skills and attributes of the AE, which were important to women who have lost confidence and found it difficult to talk about abuse. For example:

There is this lady who can help you, she is really nice (Woman H).

She offered the AE to talk to me; she said she is really, really good and there are many ways she can help you. If you like her, you can continue but you have the right to say no (woman G).

Another doctor described the AE as a *'lovely woman'*.

A significant finding from this study was the importance of the Advocate contacting the victim, rather than the woman being given a number to call herself. All the referrals were contacted by the AE except one and the woman explained the difficulty of that:

The GP wrote the number down and said 'give her (AE) a call'. I put it off for a week. I didn't know what to say and felt very anxious (Woman H).

This finding may be more significant in this study because the majority when they disclosed were not with the perpetrator. However, having had the courage to talk about their abuse to one professional, they were still anxious about contacting other services. They all appreciated the phone call from the AE.

She (AE) got in touch with me. I wouldn't have done it myself. I still struggle to ring and ask for things (Woman K)

As discussed in 4.1, meeting at a familiar place eased the first meeting with the AE for many of the women. One woman explained:

AE rang quickly. I saw her at the surgery, which was an advantage because people think you have an appointment with the doctor. It (the surgery) is also familiar and you do not have to find a new place (Woman M).

Another said:

(*AE) made contact 2 days later. We met at the surgery. It felt a safe place (Woman D).*

Meeting the Advocate Educator

The first meeting with the AE was significant for giving the women the support they needed and signposting them to other specialist services. The right skills and attributes of the AE were important in continuing the early trust that the women had developed with their doctor.

The approach and style of the advocate allowed the women to relax, talk about their abuse and accept help from other services. The women felt the AE took them seriously, believed their stories and did not judge them. One woman who had hidden her abuse put it this way:

> *I was nervous on the first visit but when I met (AE), she was smiling and happy which gave me confidence and I was able to open up (Woman J).*

Many of the women described the AE as someone who really cares, and how she had put them at their ease so they could talk about how they felt. A few of the women spoke of telling the AE experiences that they had never told anyone else. One woman with a history of abuse said:

> *I feel really comfortable talking to her; I have told her more than I have ever told anyone else (Woman L).*

Another woman who hid her abuse for 10 years described her contact with the AE:

> *(AE) has been brilliant, I won't be where I am now without her support (Woman K).*

One woman explained the value of having someone who is not a friend, as you can't tell friends about the abuse, but someone who did not judge you and understands why you may behave in certain ways.

Many of the women who are abused have complex issues to disentangle. These women in the Manchester study felt less overwhelmed by their problems because the advocate took a person-centred, step-by-step approach to finding solutions. She was able to support each woman by bringing some planning and structure to the many problems they were facing. For example:

> *She (AE) helped me plan and prepare for a job interview (Woman P)*

> *She (AE) really helped me, talked about my experience and found ways to help me. She has helped me set goals, help plan (Woman E)*

> *We set goals, to concentrate on one thing as a time that I need to do. It made me less stressed (Woman H).*

The women in the Manchester study did not discuss their on-going relationship with the GP following referral. The important issue appeared to be that a trusted source, the GP, had referred them to a specialist who was now helping them deal with their abuse.

The final part of this section looks at the impact on women's lives after the initial disclosure and referral to DVA services.

4.4 The impact on the lives of the women who disclosed

The IRIS model of disclosure to a doctor and follow on support from a specialist Advocate Educator has impacted on the lives of the women interviewed for this study and shows positive changes for themselves, their children and the wider community.

The majority of abused women in this study have a long journey back to a fulfilling life, but the impact of IRIS indicates that things are changing for them in a positive way. Some of the changes may appear small but for the women themselves they are vital steps to rebuilding their lives and to become full citizens again.

Increased agency

The abused women in this study had experienced long periods of time when they did not feel in control of their own lives, some for as long as 20 years. The intervention of IRIS gave them the power to begin taking action and they recognised that this sense of agency gave them the right to a better life where they felt safe. Many of the women spoke of getting their life back, being able to do things for the first time and feeling safer. One woman who had suffered abuse for 10 years said:

> *I have got the beginning of a life; I am not scared to go out now (Woman K).*

Another woman abused by a family member told us:

> *She (family member) has no right to do it. I am now focusing on myself, I have never done that before and it is the best way (Woman J).*

Another woman with two children who was also pregnant said:

> *'I am at the very beginning of taking control of my life' (Woman M)*

Increased confidence and raised self worth are important first steps in building agency and enabling these women to change their lives. They all talked about feeling more confident since they had been believed and more able to make

decisions and move forward in their lives. They also acknowledged the right to feel safe, both for themselves and their children. One woman who was abused physically and emotionally by her partner explained:

> *I have the confidence now to do something; I have increased confidence because someone actually believed me. I saw a solicitor to get him removed and he has no contact with the children (Woman C).*

Women were less scared and felt more able to speak out. One woman was now applying for a divorce and custody of her small son. She acknowledged:

> *I feel more positive, some days are difficult, but I need to face facts and let go (Woman B).*

One woman who disclosed whilst she was still with her abusive partner, is now living alone and feels confident to tell her husband to leave her alone if he calls at the house or she meets him in the street. Another woman with three children who was abused for 9 years and fled recently to Manchester says that since disclosing and receiving support from the AE:

> *I handle things better now with the children (Woman O).*

Improved mental health

Abused women are nearly four times more likely to experience depression or anxiety disorders than other women[12]. One-third of all female suicide attempts and half of those by Black and Ethnic Minority women can be attributed to past or current experiences of domestic violence. In addition, children who live with domestic violence are at increased risk of behavioural problems and emotional trauma, and mental health difficulties in adult life.[13] In this study, 12 of the 17 women reported mental health issues (2 were unknown) and 11 of the 17 women had children.

There was evidence in this study that the IRIS intervention improved mental health in the participants. At least 3 women had reduced antidepressant medication and were sleeping better. The majority of the women spoke of feeling more positive, enjoying each day and feeling less depressed. The women also told of new friendships and reduced isolation from the local community. This often related to increased confidence and self worth as well as feeling safer and more secure. For example:

> *I now live and enjoy today (Woman Q).*

[12] Goldings J (1999) meta-analysis, Intimate Partner Violence as a risk Factor for Mental Disorders: A Meta-Analysis, *Journal of Family Violence, 14, 2, 99 -132.*
[13] Source: http://www.womensaid.org.uk/

I was a sad person, but telling (AE) has made me more open and I have made more friends (Woman E).

One woman who was abused for 20 years and suffered from severe mental illness, says her mental health is improving:

My mental health is improving, the stress is reduced and for the last two weeks I have slept well and not heard voices (Woman I).

Another with a long history of abuse and mental health issues had been supported by the AE and had begun attending group therapy. She explained the change for her:

I am moving on, leaving stuff behind me. Since going to the women's group I do not have so many flashbacks to what happened (Woman N)

A woman with a long history of current and historic abuse told us:

(I want to) sort out my mental health, have my daughter off the at-risk register and get on with my life. It is a shambles but people are around helping me now (Woman F)

There was some evidence of less contact with the GP due to a range of anxiety symptoms since referral to specialist DVA services. One woman said:

I now have less contact with the GP. I am not so scared because there is someone (AE) there (Woman M).

Two women spoke of being suicidal and having wanted to take their own lives; they believed they would not still be alive if it hadn't been for the IRIS intervention. They now could see a future without violence and although many recognised that this would take time, they had hope and could see an end to their lives of violence.

Increased employment and training opportunities

Lack of confidence and self worth, partner control and feeling unsafe and vulnerable prevented women finding employment; in this study of 17 abused women, 13 were on state benefits and 2 were employed (2 were unknown). There is evidence in this study that women wanted to reduce their dependency on the state and find meaningful employment.

During the time of this study one woman has found employment. She had been receiving benefits since fleeing the family home 5 years ago and at the interview she explained:

Before I felt lost all the time, I did not know what I was going to do. Now I want to work (Woman H)

Shortly afterwards she found employment.

One woman found a new job as a result of support from the AE, and another had recently changed jobs. She had suffered family abuse for over 10 years:

I am more confident now, moving ahead. I now have a new job (Woman P).

Many of the women aspired to improve their employment opportunities through taking college courses. They recognised that their increased confidence was helping them to find employment:

I have more confidence now. I talk to people and have lots of friends. Before I had none. I am happy now, doing a range of courses to lead to a job (Woman I).

Before I felt bad about myself and depressed but now I think about a good future. I am starting a college course and want to look for a job (Woman G)

I want to improve my communication skills, which I had lost, and to go on courses and find a job (Woman O).

Vision for the future

As a result of the IRIS programme, all the women in this study, at various levels, had hopes for the future. They wanted peace and security in order to live healthy, fulfilling lives for themselves and their children. One woman hoped that her child would no longer be on the at risk register; some wanted to travel, have good jobs and have better relationships with their children and families. They all felt they had started on that journey.

5. DICUSSION: KEY MESSAGES AND LEARNING

The combination of disclosure to a receptive GP and referral to a specialist service at the surgery resulted in positive changes to the lives of the 17 women in this study. They all increased their confidence and self worth in order to start to build a better future for themselves and their children. There is evidence from these women's experiences of improved mental health and wellbeing and increased opportunities for employment.

The reception and response of the GP, both verbally and, most importantly, in body language, was crucial to whether the women disclosed abuse to the doctor during the consultation. The warmth and empathy shown by the doctor, whether in asking the question or in being open to listen and not judge, were significant factors in making the space for disclosure. The length of time that the woman had known the doctor did not appear relevant.

The surgery premises were known to the women in their local community, and felt a place of safety due to their familiarity and confidential environment. This reduced their anxieties and helped the women to disclose and later to engage with specialist services.

In keeping with findings from a previous study[14], the women did not expect the doctor to be an expert in DVA. They saw the GP's role as helping them access services that could support them in addressing their issues. The doctor was seen as a trusted source that could channel them towards specialist advice and support.

There is some evidence to suggest that because the doctors had a clear referral pathway, and they knew the Advocate Educator personally through the training sessions, this encouraged disclosure and appropriate referral. This is supported by evidence from another Manchester service, which showed that referrals from midwives to specialist DVA services increased dramatically when the advocate was known to the midwives and worked in the antenatal clinic[15]. More evidence on the relationship between the GP and the AE would be useful.

The skills and attributes of the AE were essential for reaching the outcomes described in this study. The women appreciated the friendly, open style of the AE and trust was quickly built, which is remarkable for women who have lost trust in themselves and others. Many were overwhelmed by their problems and the

[14] Malpass A, Sales K, Johnson M, Howell A et al (2014). Women's experiences of referral to a domestic violence advocate in UK primary care settings, *British Journal of General Practice, March 2014*

[15] Granville G and Bridge S (2010) *PATHway Project: An Independent Domestic Violence Advisory service at St Mary's Maternity Hospital, Manchester: Independent Evaluation,* NHS Manchester

AE's approach of taking one small step at a time, dealing with one issue at a time, was instrumental in building the women's confidence and bringing about real change.

The partnership between the NHS and voluntary sector is evident in this study. The disclosure to a GP opened the gateway to a range of specialist statutory and voluntary sector organisations.

The evidence from this report could contribute towards some cost benefit analysis of the service.

In Summary:

This in-depth study presents evidence from the Manchester Identification and Referral to Improve Safety (IRIS) service, which began in February 2012 and by February 2014, has received 169 referrals from 16 general practices across Manchester concerning women who have suffered from domestic violence and abuse. The majority of the women interviewed had not disclosed the violence to anyone else prior to speaking to their GP.

The evidence demonstrates positive outcomes for women and children through improved mental health, increased opportunities for training and employment and the ability to begin to take control of their, and their children's, lives. It supports the business proposal to extend the offer of IRIS training and service to GP practices in Manchester, in order to improve the safety and health and wellbeing of all women, men and children in Manchester.

APPENDIX 1: IRIS Service User Interview topic guide

- One-one interviews – phone or face to face
- Narrative style with question areas and prompts
- 30-40 minutes
- Introduce myself and check they have seen the information sheet
- Check consent
- Check confidentiality

1. Introduction

Could you tell me a little about yourself? If appropriate - Where in Manchester are you from? Include information on family, children etc. plus age, ethnicity and disability

2. Can you tell be what it was like to be asked about domestic violence and abuse at the doctors surgery?

- Were you surprised?
- Who asked – doctor or nurse? Did it make a difference to be asked by a health professional, and if so why?
- How long/ well have you known the health professional who asked you? Did that make a difference and if so, why?
- How did that make you feel?
- Did you see the information in the surgery and ask the doctor yourself?
- Was there anything about the practice setting/ environment that helped or hindered you?

3. Have you ever been asked before? Was this the first time?

- Did you feel able to ask questions of the doctor or health professional?
- Did you expect to get help?
- Have you ever told anyone else about the abuse?

- Would you have sought help from other services if you had not been asked by the GP? If not, why not?

4. Engagement Impact - Did you see Catherine or Saj, the advocate educators?

- If so, where? What happened?
- If not, why not?
- If you hadn't been asked (by the GP) would you have used the service?
- If you did use it, how did the doctor or nurse explain the service offered by the AE?
- If the GP had given you a phone number for another service would you have used it? (Women's Aid, IDVA, police). If not, why not?

5. Is there anything you would have liked done differently at the surgery?

6. What has changed for you as a result of being asked/ asked about domestic abuse by a health professional at the surgery? ***Most significant change***

- Feel safer, more in control, feel it is your right to be safe
- Would you encourage other women to speak to their doctor or nurse

7. What is your ONE hope for the future?

Thank you very much for talking to me