Journal: Journal of Adult Protection

Title: Exploring primary care responses to domestic violence and abuse (DVA): operationalisation of a national initiative

Authors:

(1) McGarry J. University of Nottingham, UK (Corresponding author)

Email julie.mcgarry@nottingham.ac.uk

ORCID ID 0000-0002-7629-2447

(2) Hussain, B. University of Nottingham, UK

(3) Watts, K. Kings College London, UK

Abstract

Purpose: In the UK, the Referral to Improve Safety (IRIS) initiative has been developed for use within primary care to support women survivors of domestic violence and abuse (DVA). However, while evaluated nationally, less is known regarding impact of implementation at a local level. The purpose of this study was to explore the effectiveness of IRIS within one locality in the UK.

Design: A qualitative study using interviews/focus groups with primary care teams and women who had experienced DVA in one primary care setting in the UK.

Methods: Interviews with eighteen participants from five professional categories; including General Practitioners, Practice Nurses, Practice Managers, Assistant Practice Managers and Practice Receptionists. Focus group discussion/interview with seven women who had accessed IRIS. Data collection between November 2016 and March 2017.

Findings: Five main themes were identified for professionals: Team role approach to training; Professional confidence; Clear pathway for referral and support; Focused support; Somewhere to meet that is a 'safe haven'. For women the following themes were identified: Longevity of DVA; Lifeline; Face to face talking to someone; Support and understood where I was coming from; A place of safety.

Implications for practice: IRIS played a significant role in helping primary care professionals to respond effectively. For women IRIS was more proactive and holistic than traditional approaches to DVA.

Originality: This study was designed to assess the impact that a local level implementation of the national IRIS initiative had on both providers and users of the service simultaneously. The study identifies that a 'whole team approach' in the primary care setting is critical to the effectiveness of DVA initiatives.

INTRODUCTION AND BACKGROUND

Intimate partner violence (IPV), referred to in the United Kingdom (UK) as domestic violence and abuse (DVA) (Home Office, 2013) is now recognised as a significant global public health, societal and human rights issue (World Health Organisation (WHO), 2018). Global estimates on DVA indicate 35% (1 in 3) of women experience physical and/or sexual violence in their lifetime (WHO, 2017). In the UK it is estimated that 1.3 million women each year have experienced DVA (Office for National Statistics (ONS), 2016). DVA exerts a detrimental impact on the lives and health of all those who experience abuse and this includes wider family members and especially children (Westmarland & Kelly, 2013). The impact of DVA on the physical and psychological wellbeing of those who experience abuse is wide ranging. This includes the immediate physical effects of DVA including physical injury as well as longer term chronic ill health (Bosch et al. 2017). Acute and enduring mental ill-health, substance and alcohol misuse, self-harm and suicide are also more prevalent in this group of individuals (Trevillian et al, 2012). Secondary physiological health issues such as gynaecological, sexual health and gastro-intestinal health problems are also common (Feder et al. 2011). Moreover, the negative health consequences of DVA are not just immediate but may continue in the longer term (Lacey et al. 2013, McGarry et al. 2011).

Those who have experienced DVA may utilise a number of health care settings including the Emergency Department (ED) (Boyle et al. 2006). However, a significant number of those experiencing DVA will present to their General Practitioner (GP) services (Feder et al. 2011). Therefore, individuals working in GP practices, both clinical and wider support staff, are in a key position to identify and effectively support survivors of DVA.

In the UK a number of national policy drivers have highlighted the pivotal role and professional responsibility that health care professionals have in effectively identifying and managing presentations and disclosure of DVA (National Institute of Health and Care Excellence (NICE), 2014, NICE 2016). However, in reality, a number of commentators have highlighted the potential barriers that exist for healthcare professionals in supporting survivors of DVA who access health care services. These include knowledge deficits, lack of professional confidence and organisational time constraints (McGarry & Nairn, 2015, McGarry & Watts, 2016) alongside the limitations of screening in the absence of clear referral pathways (Hegarty & Glasziou, 2011).

To address this deficit, the IRIS (Identification and Referral to Improve Safety) initiative was developed and has since been tested successfully within the primary care setting in the UK (Feder et al. 2011). IRIS is designed to train primary care clinicians and wider members of the team in the identification, response and referral to specialist DVA advocacy support (Malpass, et al. 2014). The development of education and training within primary care has been developed elsewhere, for example the universal screening model in the United States (O'Connor, 2018). However, in addition to education and training IRIS also incorporates the co-location of specialist advocates within the overall model of delivery.

IRIS has been shown, through a randomised control trial (RCT), to increase the identification and referral of survivors of DVA within the primary care setting (Feder et al. 2011) and consequently has been commissioned as a service model across several regions within the UK. There have been a number of previous evaluations which have examined the impact of other local 'rollouts' of IRIS in the UK for example Granville, 2014 and Bradbury-Jones & Taylor, 2016. However, evaluation studies to date have not provided an in-depth account from the perspective of GPs and wider members of the practice team regarding their experiences of using IRIS or the in-depth perspectives of both the providers and users of the IRIS intervention simultaneously. The recent UK Government consultation surrounding the Home Office Domestic Abuse Bill provides further impetus for revisiting IRIS within the context of contemporary service provision debates.

AIM

To explore and present an in-depth account of the implementation and impact of the IRIS initiative for both providers and users of the service within one locality in the UK.

METHOD

Study Design

A qualitative research design was utilised and involved semi-structured interviews and focus groups with GP practice teams and women survivors referred into the IRIS service. Data were collected between November 2016 and March 2017.

Sampling

Primary care teams

We used a general practice list which identified practices offering primary care services in the local area from which 55 out of 56 (98%) practices were engaged in the IRIS scheme and were used as the sampling frame for the study. Accuracy of the list was maintained by

the local clinical commissioning group. This practice list was used to contact practice managers, first via e-mail and then by telephone follow-up to organise interviews with possible practice staff participants. Interviews were conducted at the convenience of the participants and venue of their choice. In total 18 participants were interviewed from clinical and non-clinical categories, using stratified purposive sampling across six different general practices engaging in the IRIS scheme. The basis of the stratification was informed by the referral rates to IRIS. Total referrals for each practice were calculated over the preceding 10 months prior to study commencement and practices were categorised by the average referrals made per month into either low, medium and high category. Participants from each practice category were then invited to participate thus providing representation from all types of practice based on referral rates. Participants comprised GPs (n=8), practice nurses (n=4), practice managers/assistant managers (n=2) and receptionists (n=4) with only the practice manager category not being sampled across all categories.

Women who had accessed IRIS

Women who had been referred to IRIS were recruited through a local domestic violence agency who provided support for women referred into the IRIS initiative. To preserve anonymity and safety, women were contacted initially by a member of the specialist agency who were known to the women. In total 7 women agreed to take part in the study. The age range of the women in the study was 23 – 50 years. None of the women were in the relationship at the time of interview. The length of time in their previous relationship ranged from 3 – 20 years. Several women in the study had been in multiple abusive relationships prior to accessing IRIS.

Data collection

Primary care teams

The data were collected through face-to-face individual interviews with primary care team members. The second author (BH) who is an experienced qualitative researcher conducted these interviews. A topic guide was used to inform discussion which included key issues identified from the literature review. With the exception of one participant, all the interviews were digitally audio-recorded and subsequently transcribed verbatim. Written notes were prepared for one interview where the participant did not wish to be recorded. The duration of the interviews ranged between 20-35 minutes.

Women who had accessed IRIS

Data from the women who accessed services was collected through a focus group discussion. A topic guide was used to inform discussion and included experiences of health service responses, disclosure and support through IRIS. The focus groups were facilitated by JM as a female member of the team and with experience of undertaking research with women experiencing DVA. One women was late in attending the focus group, but agreed to be interviewed individually. Time duration for focus group/interview ranged from 35 minutes to one hour. The focus group and the interview were digitally audio-recorded and transcribed verbatim.

Ethical considerations

The project received ethical review from the requisite research ethics committee [EV18082016]. Before starting an interview or focus group, each interviewee was given a participant information sheet to read and decide whether to participate in the study. Participants were assured confidentiality and anonymity of the data in reporting findings. All participants gave written consent to either be interviewed or participate in the focus group and findings have been anonymised.

Data analysis

All data were analysed using the 'framework method' for analysis of qualitative data (Ritchie & Lewis, 2003). This approach is helpful for applied health and social care research. First and second authors analysed the data through a framework thematic analysis approach. This approach involves familiarisation with interview data achieved by listening to recorded tapes of the interviews first, and then repeated readings of the transcripts. This process helped in gaining an overview of the data whilst allowing identification of the main concepts and potential themes from the data.

In the next step called 'indexing or coding ''chunks' of data pertaining to relevant themes were selected. The two authors independently developed two distinctive codebooks and applied these codebooks to five interview transcripts, selecting one from each professional category of the participants. This was followed by an all author discussion and agreement on identified codes/themes.

Indexed data were then transferred onto flip charts and organised under themes. We used relevant data 'chunks' and verbatim quotes to highlight main findings related to the research

question and objectives. The final stage was achieved whilst keeping the contextual information in view, data were mapped and interpreted.

FINDINGS

Primary care teams

In total four themes emerged from the data: Team role approach to training; Clear pathway for referral and support; Focused support and Somewhere to meet that is a 'safe haven'. Each theme is presented below.

Theme 1: A team role approach to training

In the present study participants described the way in which the IRIS training, as a collective experience, was understood by the practice staff to be of central importance in terms of engendering a whole team approach to DVA:

I think it was about a couple of years ago [IRIS training], and we undertook whole practice training on two separate occasions and did it as a team. So we did it, all of us did it in the practice (GP5).

The delivery of training to the whole team was further identified as fostering a cohesive approach across all staff in terms of recognition, management and support of women who may present within the practice context:

Well, I think it's a team role really, to be fair, because sometimes, I think the whole team needs to be aware of who these people are. Because if they come to the desk and they're asking for help, the team need to know the background, because the lady at the desk might want to come out, openly say something at the desk, you know, why she needs to see the doctor or what the problem is, because they're too embarrassed and they've got people in the queue behind them (PN1).

The inclusion of all staff – irrespective of whether they provide clinical care or administrative support more broadly within the practice – is arguably central to the success of an initiative of this kind as it is clear that wider practice team members are also likely to encounter

patients attending the practice setting. Moreover, as the following participants highlight, reception staff are often the first point of contact for patients attending practice and knowledge and awareness of DVA may be especially helpful in both recognition and initial response:

I think overall session was really interesting, let's say from my team especially. They all kind of left feeling that they are actually empowered now to recognise (Practice Manager).

Well I just think it's very important [for everyone in the practice to have the IRIS training], like if any patient came to the desk or if somebody was really upset about something – because sometimes they do come and talk to us at the desk. That we would always speak to a GP if we had any concerns about any patient (Receptionist 3).

Within the context of training, a number of GPs and practice staff spoke of how they valued the face to face training sessions as a way of exploring or testing out possible responses to disclosure. It was also clear that face to face training provided an opportunity for reflection on past and possible future presentations. The opportunity for exploration and questioning – around a topic that participants may not be familiar with previously - was also highly valued:

Whereas if you go to a training session it makes you think about it a little bit more, it does. I think everybody should have, if they have training have it again in two or three years' time (Receptionist 3).

As such, those in the study particularly welcomed the opportunity to explore practice situations and scenarios. The exploratory and practical nature of the IRIS programme was particularly highlighted as a positive feature as it provided the opportunity for those undertaking the training to 'learn from each other' – a recognition of the complexity of approaching DVA in practice and the multi-faceted nature of presentations:

I like interaction, interactive ways, because I remember if it's put into interactive way with situations, scenarios and these things, and discussion, open discussions, best to remember things. Because if you have in a group, somebody in a group who have experienced something, a situation that can be shared, then that how we learn. From each other, peer support (PN2).

For a number of the professional participants in the study, the importance of continuing professional development and refresher training was clearly of importance. This was partly in

recognition of the changing landscape of DVA service provision and also in terms of utilising DVA services more specifically for example, updates relating to appropriate local referral pathways:

It's obvious that the problem is there. It's a question of how one addresses it and what services are there and how easily it's possible to make use of those services, so it's more operational things that we would probably need a more update one, yeah (GP 1).

I don't know. I mean it's something you'd hope you'd keep inherent once you've learned something, but it's just a reminder and refresher of it really that would be helpful. I just don't know whether offering regular refresher training courses with the plethora of other things that people are supposed to keep up to date with at the moment would have a great take-up for people who've already done the training, just because of time pressures (GP5).

GPs and staff in the study also spoke of how the targeted training had raised their awareness and deepened their understanding of the more complex presentations of DVA. For example as the following GP highlights in describing presentations often seen by many GPs but which, in the absence of a greater understanding of DVA, may previously have been overlooked:

I think it had quite a big impact on the whole surgery in terms of raising people's awareness of the types of different domestic violence and domestic abuse, with it not just being necessarily physical. That it could be emotional and coercive. And I think the training was very good in the examples it provided, and it the discussion it enabled around it (GP5).

A key facet of the training for professionals in the study centred on a heightened awareness of possible presentations of DVA in primary care, as noted above, beyond the more well documented or obvious signs. GPs in the study for example spoke of 'taking a step back and look at the whole picture' as a result of the undertaking the IRIS training. As GPs are often the main point of contact for many survivors of DVA, recognition of the significance of repeated visits and possible signs of DVA is central to effective identification:

So repeated visits to the doctor for minor illnesses, psychological symptoms, physical injuries that are not easily explained, you know, those sort of things. But it was just, it was more of, the training was more just to remind us of these facts I suppose. We probably knew them already, but it was just it brings it back, brings it to the front of your mind to bear in mind when you see these patients (GP 3)

And [training] it's just encouraging you to take a step back and look at the whole picture. So it just reminds us to do that. And some specific clues to consider, you know, do they always, are they always ever here, do they always come with their partner who seems to talk for them and they sit there very quietly and passively, things like that. So it's those sort of clues that they've reminded us to think about (GP4).

Finally, in this theme GPs and practice staff described how the IRIS initiative as a whole and the presence of the advocate educator (AE) had facilitated a greater confidence in identifying and effectively supporting women survivors of DVA:

It's obviously raised awareness of the issues of domestic violence, and because there is a resource out there to help people I think it enables us to feel more confident about raising those issues with patients and exploring them more (GP5).

Theme 2: Clear pathway for referral and support

Directly linked to GPs professional confidence as noted in the previous theme, participants also spoke of how IRIS and the provision of a clear referral pathway and particularly the presence of a named individual (AE) had increased their awareness of DVA and provided a straightforward means of direct referral. This was also directly linked to notions of time for example, as noted by one GP how previously asking about DVA might incur 'opening a can of worms':

Before that [IRIS], no, not really. I don't think I would have asked before. Unless they volunteered, it wouldn't have occurred to me to ask, I would think.

[Interviewer] why not?

Why not before? I don't know. It's just a hassle. You open a can of worms and then you end up having to phone and this and that. At least now I know what the procedure is, what the pathway is (GP6).

The importance of IRIS in terms of providing a clearly defined referral pathway was highlighted throughout the interviews and it was clear that the ability to 'hand over' the direct responsibility for support – and the essence of time that AEs brought to the encounter - rather than attempting to engage in often difficult and sensitive conversations within a time limited appointment was also clear:

The gap that IRIS has filled in is more that we having identified it, you now have a place you can, you know, a person or a service you can pass on the care to (GP 1).

By having the [IRIS] service it means that we're more confident in looking for the problem, and therefore exploring it because we're confident we've got somewhere to refer patients onto that can support them, rather than opening a can of worms that feels difficult to deal with in a 10 minute GP consultation (GP5).

Moreover, as with many well documented professional accounts of possible barriers to action in responding to DVA, those in the present study also spoke of the importance of clear referral pathways and correspondingly the reduction in the time consuming actions associated with the referral process:

And also they're linked to the pathway. It's straightforward. It's on a form. We just fill the form in and talk to them and fill the form in and the secretaries just deal with the rest. It's faxed over. It's simple. You don't have to be on the phone for a long time, which makes a difference (GP6).

Theme 3: Focused support

During the study GPs and practice staff spoke of the importance of continuity of support that IRIS offered in terms of referring women to the service and personal continuity of the AE that was available beyond the initial point of contact:

*It was more [before IRIS] the greater challenge was what service would be available and periodically send them to the women's centre or to the other psychological therapies available. So IRIS was a good addition to more focused care for them…Well it [IRIS] filled in the gap and give them a one-to-one and some continuity and then incorporating or including the IRIS worker in the introductory consultation here because one of the problems often is they don't want to see somebody they don't know. So having somebody here and the person comes and sees them here so that you know those sort of things have made it more accessible for somebody that domestic violence…(*GP 1).

As well as personal continuity of support, it was also clear that a key component of the IRIS initiative focused towards the structural continuity of the service support that GPs felt that IRIS was able to provide:

I probably didn't recognise it [DVA] as well as I do now. I would refer people to other services like the Women's Aid, the separate different Women's Aid, the police, or would often not know where to refer them, so I could be sympathetic to them but not really know how to help them. So this has made it very simple that they [IRIS] can [support] (GP3).

…the actual IRIS thing just made it a bit more, well, I don't know what way to put it really. I suppose it's – I don't know how to say it. It put more systems in place really, didn't it, the IRIS project; whereas before some of the domestic violence support was a bit higgledy-piggledy; whereas at least with IRIS you know exactly where to go to, if that makes sense (PN 1).

Theme 4: Somewhere to meet that is a 'safe haven'

Finally, the physical presence and co-location of IRIS and AEs within general practice was viewed as crucial in terms of enabling women to access support in a safe environment. One participant for example referred to the practice as a 'safe haven' in the sense of a place to meet that was more readily accessible to survivors. This final theme is developed further by the women we interviewed in the following section:

…if you refer to IRIS then IRIS can contact the woman or they can meet the woman here, which is a little bit of a safe haven away from the violence or away from the perpetrator. So they [IRIS support] can often get in that way to help the woman (PN1).

We've been able to facilitate people having meetings with [advocate] and the IRIS team in the surgery, because often if somebody's in a controlling relationship they're still allowed to go to the doctor. So they've actually been coming to the doctor's surgery, but not to see the doctor, to see the IRIS worker instead (GP4).

<u>Women who had accessed IRIS</u>

For the focus group/interview five main themes were identified: Longevity of DVA; Lifeline; Face to face talking to someone; Support and understood where I was coming from and A place of safety.

Theme 1: Longevity of DVA

In the present study it was striking that all the women we spoke to had experienced DVA for a significant length of time before actively being recognised as such. It was also clear that while women who had accessed IRIS recently had been identified during encounters with

health care professionals - through participating GP practices - potential signs of DVA and/or opportunities for disclosure may also have been missed in the absence of the IRIS initiative:

I've been in numerous ones [abusive relationships]. Then something happened [recently]. It was to do with sex and I had to go to the doctor for some help and she knew that certain things couldn't have happened just on their own (Participant 3).

I've suffered more or less 10 years, and they never had that kind of support and help. It was never done through the doctors. But this time it's been done, it's brilliant (Participant 4).

It was also evident that historically while the women had been in contact with a range of health services, including general practice, their experiences had until relatively recently remained largely hidden:

It was a six-year relationship when I reached the end of it. And I think I was a very good actress. Again, I went in with a hell of a lot of bruising. It was quite substantial over a period of six months, you know. And I kind of never alluded to anything that anything was wrong and so nobody really picked up on things. Now I've read my medical records and I remember I'd had bruising one month and I'd go in for help with depression the following month and get more pills, but nobody would have checked the bruising because I'd hide it so well (Participant 2).

For the women in the study it was clear that the level of abuse was such that they were, at the time of referral to IRIS, experiencing a significant and serious episode of poor mental health and wellbeing. The value of the AE in terms of continuity and support was identified as central to women's experiences of IRIS:

I was literally at rock bottom to where I nearly took my life. So since I've been with [AE] she's helped me so much. And from where I was then to where I am I feel like a completely different person (Participant 4).

Theme 2: Lifeline

For the women in the study IRIS had provided what they described as a 'lifeline' for their particular situation at a given time. Moreover, as described in more detail below, the location and connection between the GP practice and AE resulted in the service being easily accessible – this was a pivotal point in terms of access to support for the women in the study:

I'm glad that obviously working with the doctor, stuff like that, so they can point out to people this is the help you can get and stuff like that. So I think it was fantastic (Participant 6).

I wasn't aware of how Women's Aid or how IRIS worked with the GPs, so when they actually did it was a lifeline that was just needed basically (Participant 7).

Building on the theme as a whole, the women attending the focus group and interview described how they would not have been able to contact women's services themselves for example, fear of being found out or discovered by the perpetrator. This in itself was arguably a major asset of IRIS:

It's having the courage to do that. I don't think courage is something you have when you're in that kind of relationship (Participant 2).

(Contacting women's services) No, I wouldn't have dared no (Participant 7).

Not ringing off my own back I wouldn't have done no (Participant 5).

Theme 3: 'Face to face talking to someone'

During the focus group and interview women were asked about their experiences of previous contact with DVA services. However, it was clear that women either were not aware of the existence of women's services or if they were, did not feel comfortable engaging with a telephone-based service. When explored further the women's reluctance to use a helpline service was because they felt that they needed to 'see' the person, in other words the IRIS AE, in order to be able to trust them with their disclosure:

And then you're at a point where you think, and they ring you up on the phone and that's not what you want. I want to be face to face talking to someone (Participant 6).

And I didn't want to tell anybody anything, you don't know who it is and things, so you think well I'm not going to bother (Participant 7).

Theme 4: Support and 'understood where I was coming from'

For the women in the study, telling their stories was obviously very difficult and they had spent considerable personal time in a position where they were unable to disclose their experiences and as such the availability of the AE and the relationship that they were able to

form with one person was invaluable. This was especially important as women did not feel that they then needed to repeatedly tell their experiences to multiple agencies and professionals as illustrated in the quote below:

So when I was coming here and I was seeing that one person, so I didn't have to go through it all again, because it was. But when I was talking to [AE] and going through it with her, she understood where I was coming from. It was only her that I was seeing every time I was here, and not everybody else (Participant 7).

Theme 5: A place of safety

For both women and as identified in the previous section the professionals, the location of the meetings with the AEs was of central importance in terms of personal safety and perhaps centrally, enabling women to access a service in a familiar physical environment where they themselves felt safe. This facet of IRIS and the importance of co-location as a means to meet in a place of relative safety is arguably what sets IRIS apart from other referral based initiatives:

Both times I've met [IRIS AE] at the GP surgery, but what was nice though it wasn't like she wasn't looking at her watch and there was no time limit. It took me about two hours to truly come out, and she was just there listening and not like rushing me out of the door, and just to have that sympathetic ear was just so nice when you're burdened with so much for so long. And you can't even tell your friends or your family or anything what's going on because they'd think are you mad. But she just sat there and just let me ramble on and I just felt so relieved afterwards. I really was (Participant 6).

She [IRIS AE] makes me feel safe, that I'm not alone and that there's always options. Because my confidence is low and I get a lot of anxiety coming out of the house. I've started now I can come to the women's centre on my own, which is really good (Participant 3).

DISCUSSION

To our knowledge, this is the first study to provide an in-depth exploration of the views of both providers (including wider practice staff) and users of the IRIS service simultaneously within the context of a local 'roll out' of the IRIS initiative. There are clear indications of areas that can inform future practice and policy development which could enhance these positive perspectives identified in the data in the future for all parties involved.

This exploration of the IRIS initiative in one locality in the UK demonstrates the positive impact and success of IRIS both GPs and professionals working in the GP practices and for women who access these services. The significance of the co-location of IRIS cannot be underestimated and may be described as encompassing four main components; accessibility for women; clear referral process for GPs and those working in GP practices; raised awareness of IRIS through the implementation of 'face to face' training and visibility. A similar approach of co-location of specialist workers alongside targeted education and support has also been found to be effective in other contexts (McGarry & Watts, 2016).

As such, all four elements fit together to form the whole to secure the success of the IRIS initiative (Feder et al. 2011). As noted in the wider literature, training alone, while valuable in raising awareness is not in itself a panacea for effective recognition of DVA (Malpass et al. 2014) and in the absence of an identified 'named' and visible individual arguably is not adequate or effective in supporting recognition, support and referral of women who have experienced abuse (McGarry & Nairn, 2015). SafeLives (2016) in the recent evaluation of the THEMIS Project which examined the effectiveness of AE within UK emergency departments also highlight this point in that "*it could appear tempting for overstretched services to invest in training rather than incurring the cost of employing domestic abuse professionals…however this would not be an effective or cost effective alternative"* (p53). The rationale and support for this statement in the context of the present study is outlined below.

The visibility of a named IRIS AE was key to IRIS in the present study and was the result of recommendations from the original trial (Feder et al 2011). In this qualitative study the visibility of the AE in the practice setting was viewed by both GPs and practice staff interviewed as extremely important in terms of 'keeping DVA on the radar' and reminding them of the need to monitor and refer when appropriate. The approachability and accessibility of the AE was also important in terms of acting as a freely available source of information and advice to staff of all grades. The founding tenant when IRIS was introduced was to promote ease of referral by GPs and has been described as a key asset in terms of 'knowing who and where to refer to' (Hegarty and Galzieu 2011). The contact by the AEs as providers of the initial training and then continuity of their support in the context of referrals enables a good working relationship to be built with both clinical and non-clinical staff at the practices. The insight provided by undertaking this study from both a service user and provider perspective has highlighted this and adds to the evidence base.

The quality of the relationship between the women and the AEs was pivotal for referred women. For example, 'knowing who to trust' was a huge issue for women and as such the scope to build trust through a sustained relationship with the AE was key for women who had often kept their abuse 'hidden' for many years. The development of the supportive relationship with the AE also meant that women 'did not have to keep telling [their] story' to numerous different professionals and the potential for re-traumatisation, this reinforces earlier findings by Cerulli et al. (2012). It was also clear from women interviewed in this study, that consciously seeking out help was not something that they felt able to do by themselves – central to this were issues of confidence and the personal 'energy' required to do so. Where women in the present study had accessed services previously, they had not sustained the contact and supports findings from Malpass et al (2014) that referral approaches were key to the effectiveness of the support provided. This is a really important point and highlights that the provision of information by itself, again while helpful to many women, often does not bridge the gap between identification and action further reiterated by the findings of the review by Zaher et al (2014) within an international context. Therefore, the system of direct referral to IRIS via the GP alongside the location of meetings between the AE and women was again a fundamental part of the success of this initiative. Furthermore, from a purely practical perspective, the physical location of meetings enabled women to access support in familiar surroundings in relative safety. Moreover, as Kelly, et al. (2016) describes, recognition is just the first stage of a longer journey for women who have or are experiencing DVA and continuity of support – as articulated by the women in the present study beyond initial referral - is central in enabling women to navigate their way through services for example, social care, housing and the criminal justice system.

Implications for research and practice

As highlighted earlier DVA is a complex and 'cross cutting' phenomena. Whilst we have evidence of the effectiveness of differing approaches to tackling DVA we did not have strong evidence about the experiences of those providing and accessing services in the same location, this study addresses this. This study provides an insight into the experiences of not just women accessing and receiving the referrals but the health professionals and support staff making those referrals. The findings indicate additional areas that should be considered by policy makers and local commissioners of the placing and skill mix of staff working in the primary care settings in order to tackle DVA effectively. This research supports the colocation of placing the advocate within the primary care setting and the advocate role being used as a conduit between NHS and voluntary services. This colocation model has been evaluated in another area of the same city by the authors of this paper but in the context of supporting social services with similar positive outcomes (McGarry & Watts,

2016). This movement towards integrated services is key in addressing this complex issue and alternative models need to be considered as a way forward in enhancing the care for vulnerable women generally. Future research needs to focus on the complexity of the interaction between health professionals and women presenting with DVA and how this can be tailored to meet individual needs whilst acknowledging the challenges faced by increasingly busy primary care practitioners. Implications of this research indicate the benefit of the IRIS approach but the sustainability due to financial pressure may see this become unsustainable. There is a need to develop and evaluate robustly new approaches that can provide a strong rationale of the benefits and impacts these services have for both professionals and women alike. Future research should focus on clear indicators to capture the true benefits of services rather than just prevalence of the problem.

Strengths and Limitations

It is acknowledged that this was a small-scale study and as such, there are limits to the generalisability of the conclusions drawn. This arguably does not detract from the powerful voices of those who have accessed IRIS within the study locality and who agreed to take part in the study. It is also acknowledged that there are a number of challenges and ethical considerations when researching within sensitive fields of enquiry such as DVA. However, the study does provide a detailed and in-depth account of the IRIS initiative as experienced by both professionals and women who accessed the service. This itself provides a new perspective in terms of dual perspectives within one location of care delivery. The rich data collected in this study identifies key aspects of good practice that could be adapted by other professions in differing settings to enhance the care provided to these women.

AUTHOR CONTRIBUTIONS

JM and KW designed the project and analysed the data with input from BH. JM and KW supervised data collection and drafted the paper with input from BH. BH interviewed professional staff participants. JM facilitated focus group interviews with women who were using IRIS. All authors have agreed on the final version.

ACKNOWLEDGEMENTS

We would like to thank all the participants for taking part in the study and for sharing their experiences.

CONFLICT OF INTEREST

The authors do not have any conflict of interest.

FUNDING INFORMATION

This research received funding (locally anonymised) and the funders were not involved in the study design, data collection, data analysis, decision to publish, or the preparation of the manuscript.

REFERENCES

Bosch, J., Weaver, T. L., Arnold, L. D., & Clark, E. M. (2017). The Impact of Intimate Partner Violence on Women's Physical Health: Findings From the Missouri Behavioral Risk Factor Surveillance System. *Journal of Interpersonal Violence*, 32(22), 3402–3419. https://doi.org/10.1177/0886260515599162

Boyle, A., Jones, P., & Lloyd, S. (2006). The association between domestic violence and self- harm in emergency medicine patients. *Emergency Medicine Journal* 23(8): 604-607.

Bradbury-Jones, C., & Taylor, J. (2016). *Identification and Referral to Improve Safety: Local Evaluation Report for Birmingham South and Central CCG and Birmingham Cross City CCG.* University of Birmingham UK. Retrieved from http://violencepreventionalliance.org/wp-content/uploads/2016/05/Birmingham-IRIS-Evaluation-report-2016.pdf

Cerulli C, Poleshuck E, Raimondi C, Veale S, Chin N. (2012) "What Fresh Hell Is This?" Victims of Intimate Partner Violence Describe Their Experiences of Abuse, Pain, and Depression. *Journal of Family Violence.* 27(8): 773-781

Feder, G., Davies, R. A., Baird, K., Dunne, D., Eldridge, S., Griffiths, C., Ramsay, J. (2011). 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* 378(9805): 1788-1795.

Granville, G. (2014). *Identification and Referral to Improve Safety (IRIS) MANCHESTER IRIS PROGRAMME, Hearing the voices of the IRIS service users.* Study Report. Retrieved from http://www.gilliangranville.com/wp-content/uploads/IRIS-service-users-study-April-2014-Report2.pdf

Hegarty K & Glasziou P. (2011). Tackling domestic violence: is increasing referral enough. *Lancet*, 378, 1760-2. doi:10.1016/S0140-6736(11)61386-X

Kelly, L., Sharp, N., Klein, R. (2016) *Finding the costs of Freedom: How women and children Rebuild their Lives after Domestic Abuse* Retrieved from http://solacewomensaid.org/wp-content/uploads/2014/06/SWA-Finding-Costs-of-Freedom-Report.pdf

Lacey, K. K., McPherson, M. D., Samuel, P. S., Powell Sears, K., & Head, D. (2013). The impact of different types of intimate partner violence on the mental and physical health of women in different ethnic groups. *Journal of Interpersonal Violence* 28(2): 359-385.

Malpass, A., Sales, K., Johnson, M., Howell, A., Agnew-Davies, R., & Feder, G. (2014). Women's experiences of referral to a domestic violence advocate in UK primary care settings: a service-user collaborative study. *British Journal of General Practice* 64(620): e151-e158.

McGarry J and Watts K (2016) *Strengthening Interventions to Reduce Domestic Violence and Abuse (STRIDE).* Final Report, June 2016 University of Nottingham and Kings College London Retrieved from https://www.nottingham.ac.uk/research/groups/mhw/documents/stride-summary-2016.pdf

McGarry, J., & Nairn, S. (2015). An exploration of the perceptions of emergency department nursing staff towards the role of a domestic abuse nurse specialist: a qualitative study. *International Journal of Emergency Nursing* 23(2): 65-70.

McGarry, J., Simpson, C. and Hinsliff-Smith, K. (2011) The impact of domestic abuse on the health of older women: a review of the literature *Health and Social Care in the Community* 19(1): 3-14

NICE (2014). *Domestic violence and abuse: how services can respond effectively* Retrieved from https://www.nice.org.uk/advice/lgb20

NICE. (2016). *Domestic violence and abuse: Quality standard* [QS116]. Retrieved from https://www.nice.org.uk/guidance/qs116

O'Connor, Tara. (2018) *Implementing a Universal Education Approach to Intimate Partner Violence in a Patient Centered Medical Home.* Scholar Archive. 4039.https://digitalcommons.ohsu.edu/etd/4039

Office for National Statistics. (2016). *Domestic abuse, sexual assault and stalking.* Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/yearendingmarch2016/domesticabusesexualassaultandstalking.

Ritchie, J., & Spencer, L. (2002). Qualitative data analysis for applied policy research. *In* Huberman, A M, and Matthew B. Miles. *The Qualitative Researcher's Companion*. Thousand Oaks, CA: Sage Publications Print.

SafeLives (2016) *A Cry for Health: Why we must invest In Domestic Abuse Services in Hospitals.* Retrieved from

http://www.safelives.org.uk/sites/default/files/resources/SAFJ4993_Themis_report_WEBcorrect.pdf

Trevillion K, Oram S, Feder G, Howard LM (2012) Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. *PLoS ONE* 7(12): e51740. https://doi.org/10.1371/journal.pone.0051740

United Kingdom Home Office. (2013). *Domestic violence and abuse.* Retrieved from https://www.gov.uk/guidance/domestic-violence-and-abuse.

Westmarland, N., & Kelly, L. (2013). Why Extending Measurements of 'Success' in Domestic Violence Perpetrator Programmes Matters for Social Work. *British Journal of Social Work:* 43(6) 1092-1110

World Health Organisation (WHO). (2016) *Global plan of action to strengthen the role of the health system within a national multi-sectoral response to address interpersonal violence, in particular against women and girls, and against children.* Retrieved from http://www.who.int/reproductivehealth/publications/violence/global-plan-of-action/en/

World Health Organisation (WHO). (2017). *Violence against women.* Retrieved from http://www.who.int/mediacentre/factsheets/fs239/en/

Zaher, E, Keogh K, Ratnapalan S (2014) Effect of domestic violence training: Systematic review of randomised controlled trials. *Canadian Family Physician* 60(7) 618-624