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**IDENTIFICATION AND REFERRAL TO IMPROVE SAFETY: LOCAL EVALUATION REPORT FOR
BIRMINGHAM SOUTH AND CENTRAL CCG & BIRMINGHAM CROSS CITY CCG**

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Executive summary

Introduction: Domestic violence and abuse (DVA) is any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. Over 1.2 million women and 750,000 men in England and Wales experience DVA. Because of the prevalence and severity of DVA perpetrated against women it can be considered a gendered issue. The long term health impacts of DVA are such that it is regarded as a significant public health issue. Health professionals – including GPs – are ideally placed to recognise and respond to DVA. However, evidence suggests that they do not always respond effectively.

Background: Identification and Referral to Improve Safety (IRIS) is a DVA training, support and referral programme for GP practices in the UK. IRIS was evaluated in a randomised controlled trial (Feder et al. 2011) and was found to be effective in supporting GPs and practice staff in referring women who have experienced DVA appropriately and therefore improving their safety. IRIS is being implemented nationally and a national evaluation is taking place. IRIS commenced in Birmingham South and Central CCG and Birmingham Cross City CCG in June 2015 and considerable progress has been made since then. Funding was secured for one year initially, for the Advocate Educator (AE) (employed by Birmingham & Solihull Women's Aid). IRIS training for the AE was completed in July 2015 and the first general practice training session was in October 2015. Sixty four referrals have been made. This is a report of a local IRIS evaluation of Birmingham South and Central CCG and Birmingham Cross City CCG - conducted January-March 2016.

Methods: The evaluation draws on a qualitative case study methodology described by Yin (2003). This approach to evaluation uses multiple data sources. Methods were: 1) Email questionnaire responses from the AE; 2) written feedback from IRIS practices; 3) IRIS documentation/archival records; 4) interviews with women referred through IRIS (n=4).

Findings: The findings are positive. IRIS training has improved awareness among general practice staff and this has impacted positively on their practice regarding DVA. Two women interviewed in this evaluation referred to their GP asking about the root causes of their depression. This 'digging deep' is important and may be attributed to GPs' increased understandings about the relationships between poor mental health and DVA. All requests for DVA floating support in Birmingham are dealt with through a single point of access (Birmingham Gateway). Referral rates have increased but the current referral processes pose a challenge in terms of continuity of care. Capacity is also an issue both in terms of AE workload and waiting lists for required support for women being referred through IRIS. There is a gap in communication between GPs and women post-referral that needs to be addressed. Sustainability and future funding are considerable challenges.

Discussion: An important part of the local evaluation was to gauge the impact that IRIS has on the people referred to it. There is little doubt that it makes a significant difference. From the different sources of data collected in the evaluation, particularly the interviews, it is evident that identification and referral do impact on safety and it is crucial that funding is secured for IRIS to continue.

Conclusions and recommendations: There are three principal recommendations: 1. Consider revising the referral processes to an internal system to guarantee continuity of service and sharing of information; 2. The gap in communication between GPs and women post-referral needs to be addressed; 3. Birmingham South and Central CCG and Birmingham Cross City CCG IRIS pilot has made a difference to local women's lives that has been captured qualitatively in this evaluation. It is crucial that funding and support for the programme continues.

‘The IRIS story captures the success of a sound quality improvement intervention, faithfully implemented and locally led’
(The Health Foundation, 2011, p.3).

Introduction

Domestic violence and abuse (DVA) is described by the World Health Organization (WHO) (2013) as the infliction of physical, sexual or mental harm, including coercion or arbitrary deprivation of liberty. The UK Home Office (2013) define domestic violence as ‘Any incident or pattern of incidents of controlling, coercive, threatening behavior, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass but is not limited to: psychological, physical, sexual, financial [or] emotional. It also includes honour based violence, early and forced marriage and female genital mutilation. In the UK, the National Institute for Health and Care Excellence (NICE) (2014) has reported that over 1.2 million women and 750,000 men in England and Wales experience DVA. Population estimates for UK DVA prevalence range from 15%-71% (The Health Foundation 2011).

Both women and men can experience DVA but there are significant differences (in terms of the frequency and the nature of the abuse) between DVA experienced by men and women (Women’s Aid 2016). For example, far more women than men are killed by partners/ex-partners and in 2013/14, this was 46% female homicides compared with 7% male (Office for National Statistics 2015). In her analysis of who does what to whom, Hester (2013) reported that men’s violence tends to create a context of fear and control, which is not the case when women are perpetrators and also, in cases where women are perpetrators, most (62%) have single events recorded compared to the multiple violations associated with male perpetrators. All these issues point to the highly gendered nature of DVA and it is recognised as such in this report.

There is a well-recognised correlation between DVA and poor health. The health burden of DVA is greater than more commonly accepted public health priorities (such as smoking) and it now ranks

as a top public health concern (Bacchus et al. 2012). Additionally, apart from risk of domestic homicide, DVA is associated with increased rates of suicide among women (Devries et al. 2011). Children who live with DVA are affected in multiple ways (Humphreys et al. 2008). They are far more likely than other children to experience a range of detrimental impacts to their health including post-traumatic stress, depression and behavioural difficulties (Smith et al. 2014). Importantly, they are at elevated risk of being abused themselves (Coordinated Action Against Domestic Abuse 2014). Overall, DVA is a serious issue and one that has direct, negative impacts on the long-term health of all those who experience it.

Domestic violence and abuse in the West Midlands

There is a commitment among statutory organisations and specialist DVA services across the West Midlands (Birmingham, Coventry, Dudley, Sandwell, Solihull, Walsall and Wolverhampton) to address DVA. This is evident in the recent publication of the West Midlands Domestic Violence & Abuse Standards that lay out the requirements across services to tackle the issue. In late 2013, the Birmingham Community Safety Partnership (BCSP) published its needs assessment on domestic violence. Table 1 provides a profile of DVA relevant to Birmingham taken from the report.

Table 1: Prevalence and Impact of DVA in Birmingham

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|---|
| <ul style="list-style-type: none">- There are an estimated 25,000 female victims of DVA each year and between 3 and 6 domestic violence related homicides;- 4.5 per cent of children are exposed to serious DVA each year and in the majority of serious case reviews into child deaths, DVA is a significant factor;- Between 1870 and 3570 men will experience repeated DVA each year, of which an estimated 1500 will be gay or bisexual male victims;- There is no evidence to suggest that DVA is more prevalent in particular communities but black and minority ethnic women may face particular barriers to seeking help;- Women experiencing DVA are 15 times more likely to use alcohol and 9 times more likely to use drugs;- Women with disabilities may be at double the risk of DVA than women without disabilities; |
|---|

- Women who have been subjected to extensive physical and sexual violence are 12 times more likely to spend time as an in-patient on a mental health unit; 4 times more likely to discuss their mental health with a GP and 15 times more likely to have multiple (3+) mental disorders;
- Women and children experiencing DVA are at greatest risk when they try to end a violent relationship and separate from an abuser;
- An estimated third of children living with DVA will have no worse outcomes than the rest of the population but issues of homelessness, parental mental health or substance misuse and deprivation often compound the harm for children;
- DVA is estimated to cost the city's public services £114 million. When combined with the estimated human and emotional costs, this figure increases to £310 million.

The BCSP report highlighted problems within primary care settings regarding practitioners' lacking of understanding about DVA and uncertainty about referral pathways. At the time of the needs analysis in that report, there was no viable DVA pathway and primary care practitioners lacked training and support (BCSP 2013). Since then, Identification and Referral to Improve Safety (IRIS) has been implemented, bringing with it evidence based training, referral and support. This local evaluation captures some of the impacts of IRIS and the difference that it has made to the lives of those experiencing DVA in Birmingham.

Health Professionals' Responses to DVA

Between 6% and 23% of women attending a GP practice will have experienced physical or sexual abuse from their current or previous partner in the past year (The Health Foundation 2011). Some health professionals – including GPs - are competent and confident in dealing with the issue, but many lack confidence (Taylor et al. 2013; Bradbury-Jones et al. 2014). When a woman does disclose DVA the response is habitually inadequate and doctors and nurses are often unaware or appropriate interventions and referral pathways. The IRIS programme was developed in response to this problem. An important issue regarding IRIS is that it is based on sound evidence regarding effectiveness.

IRIS National Programme

IRIS is a DVA training, support and referral programme for GP practices that has been evaluated in a randomised controlled trial (Feder et al. 2011). The trial took place in Hackney (London) and Bristol between 2007 and 2010, funded by The Health Foundation. The aim of the trial was to test the effectiveness of a programme of training and support in primary health care practices to increase identification of women experiencing DVA and their referral to specialist advocacy services. Effectiveness was based on two outcomes: Referral of women to a domestic violence agency providing advocacy; Recording of disclosure of domestic violence in the patient's medical record.

The intervention programme included practice-based training sessions, a prompt in medical records and a clear referral pathway to a named DVA advocate. The advocate was also the person delivering the training and on-going communication/consultancy. Twelve GP practices in each site received the intervention and another 12 practices did not (the control). Women attending intervention practices were six times more likely to be referred to an advocate than women in the control group and three times more likely to have a recorded identification of DVA in their medical record (Feder et al. 2011). IRIS was found to be an effective intervention. Following the trial, The Health Foundation provided two years' further funding to implement IRIS in other areas of the UK. The IRIS programme entails a full-time Advocate Educator (AE) working with up to 25 practices. It is aimed at women who are experiencing DVA from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators. The IRIS training for practices is divided into administration and clinical training. Reception staff receive one session that lasts one hour and clinical staff receive two sessions, each lasting two hours.

There is a national IRIS team who provide support, guidance and a ‘train the trainers’ programme to enable implementation of IRIS nationally. They are also involved with the evaluation of IRIS at national level. The IRIS national report of 2014 (an update is due in 2016) reported that between 2010 and July 2014, IRIS had received over 1566 referrals and trained 301 general practices in 13 localities nationwide (Howell, Johnson & Harrison 2014). The report indicated that the longest running IRIS sites were performing well and the newest were showing great promise. There is no reason to believe that this trend does not continue.

Evaluation questions

- 1) How has IRIS been implemented to fit with local context and needs?
- 2) What are the opportunities and challenges associated with IRIS as stated by the providers of the service (AE and general practice staff) locally?
- 3) What impact has IRIS had on the perceived wellbeing and safety of women referred through the service?

Methodology and methods

Other parts of the UK have used varying approaches to their IRIS evaluations. For example, the evaluation of NHS Mansfield and Ashfield Clinical Commissioning Group focused on GP staff regarding their knowledge and awareness of DVA and appropriate support services (Hinsliff-Smith 2015). The Manchester IRIS programme focused on the experiences of women using the IRIS service and 17 women were interviewed (Granville 2014). Drawing inspiration from these previous local evaluations of IRIS, we opted for a hybrid approach that privileged the experiences of women, while gathering information from other sources - such as GP practices and the AE. We felt that this would provide the fullest picture within the limited timeframe.

The evaluation draws on a qualitative case study methodology described by Yin, which is an approach to inquiry that follows ‘a rigorous methodological path’ (Yin 2014, p.3). Case study

focuses on people and programmes, each one being similar to other programmes, but unique in many ways. In a case study approach, evaluators and researchers are interested in ‘uniqueness and commonality’ (Stake 1995, p.1). So in this evaluation, we were interested in how the core programme of IRIS as detailed in the commissioning information (the commonality) has been implemented to meet the unique needs of the local context and services (uniqueness).

Data collection

A case study approach to evaluation uses multiple data sources (Baxter & Jack 2008). Data for this evaluation were: 1) Email questionnaire responses from AE (Appendix 1); 2) Written feedback from IRIS practices; 3) IRIS documentation and archival records; 4) Interviews with women referred through IRIS (n=4).

Access and recruitment of the women who had been referred to IRIS was through the AE. The AE identified potential participants from the database, selecting only those who were considered safe and well. The AE contacted them, provided information about the evaluation and gained consent for the main evaluator (CB-J) to make contact via a safe telephone number. On making initial contact, CB-J explained again the purpose of the evaluation. For those who agreed to be interviewed, a place convenient and safe for the participant was arranged. Of the four women who took part, one opted for the interview to take place at the GP surgery because this was a familiar setting and three asked for the interview to take place over the phone. Interviews were based around the questions and discussion points in the interview guide (Appendix 2). All interviews were audio recorded with the woman’s consent.

Data analysis

Data analysis was undertaken using a thematic approach guided by the approach of Braun and Clark (2006). The specifics varied according to the sources of data, but essentially, all data were analysed inductively initially and then mapped deductively to the evaluation aims.

Ethical issues

Although this was a service evaluation rather than a research study, the University of Birmingham as the evaluators' employer required ethical approval to be in place prior to data collection. This was granted on 8th March 2016 following review by the University of Birmingham Science, Technology, Engineering and Mathematics Ethical Review Committee (Reference ERN_15-1698).

Working on the ethical principle of 'do no harm', the fundamental basis of this evaluation was to protect all those who contributed from potential harm. This was particularly the case for the users of the IRIS service who took part. Consent was sought from them prior to participation (Appendix 3). Their physical and emotional safety were critical and at any point of recruitment and/or data collection if there were indicators of risk (such as the presence of a partner), contact was deferred or terminated. Anonymity and confidentiality were assured (See appendices 2 & 3) and all potentially identifying material has been removed in this report. The exception to this is with data from the AE. Although not named in the report ('AE' is used instead), the person is identifiable. They did however provide the information willingly and with full knowledge of their potential identifiability.

Findings

Findings are presented with reference to the research questions. A considerable amount of information for the first section is taken directly from communication with the AE.

How has IRIS has been implemented in Birmingham South and Central CCG and Birmingham Cross City CCG to fit with local context and needs

IRIS commenced in Birmingham South and Central CCG and Birmingham Cross City CCG as recently as June 2015 and considerable progress has been made since then. Funding was secured for one year initially for the AE (employed by Birmingham & Solihull Women's Aid (BSWA) to work with 25 practices across two CCGs). IRIS is delivered locally the same way as set out by IRIS nationally, whereby the AE delivers both the training for practice staff and the advocacy service for

patients at the practices. This model was used so that the AE could build a working relationship with the practice staff resulting in:

- increased trust and confidence in the AE and specialist DV service, thereby increasing likelihood of referring habits;
- effective communication/feedback between BSWA and practices regarding patients.

Three Clinical Leads (CLs) are also involved in the project – two GPs and the DVA lead at the Birmingham CCGs. The GPs were offered the role as they have expertise in safeguarding. All CLs attended training by the national IRIS team along with the AE staff from BSWA. The CLs are involved because:

- They have clinical expertise and can deliver this perspective in training;
- They can inspire/encourage their peers to implement this new way of working;
- They can be ambassadors for IRIS when in contact with colleagues across their networks.

IRIS training for the AE was completed in July 2015 and the first general practice training session was in October 2015. The training programme is arranged thus: AE and a clinical lead deliver Clinical Session One; AE delivers Clinical Session Two alone; AE delivers Reception Session alone. At the time of preparing this evaluation report, only three practices are yet to receive their first clinical training session. This is excellent progress. Table 2 shows the training profile as of March 2016.

Table 2: Profile of practice training

CCG	Session 1	Session 2	Reception
Cross City (13 practices)	12	6	9
South Central (12 practices)	10	3	6
Total (out of 25)	22	9	15

All requests for DVA floating support in Birmingham are dealt with through a single point of access at Birmingham city Council called the Birmingham Gateway. They allocate referrals to several organisations who are all commissioned to deliver DVA floating support. Regarding the

model of advocacy, the AE sees patients at the practice if safe and convenient, for at least one face to face appointment where emotional support is provided and the woman's needs and risk is assessed. Interpreters are used when women are not able to speak English. If the woman has practical needs around housing/benefits/safety etc., a referral will be via the made via Birmingham Gateway. Where there are no practical needs, continual emotional support has been provided by telephone and in follow up appointments by the AE. To date, eighty five referrals have been made, with figures 1 and 2 showing the overall demographic regarding ethnicity and age.

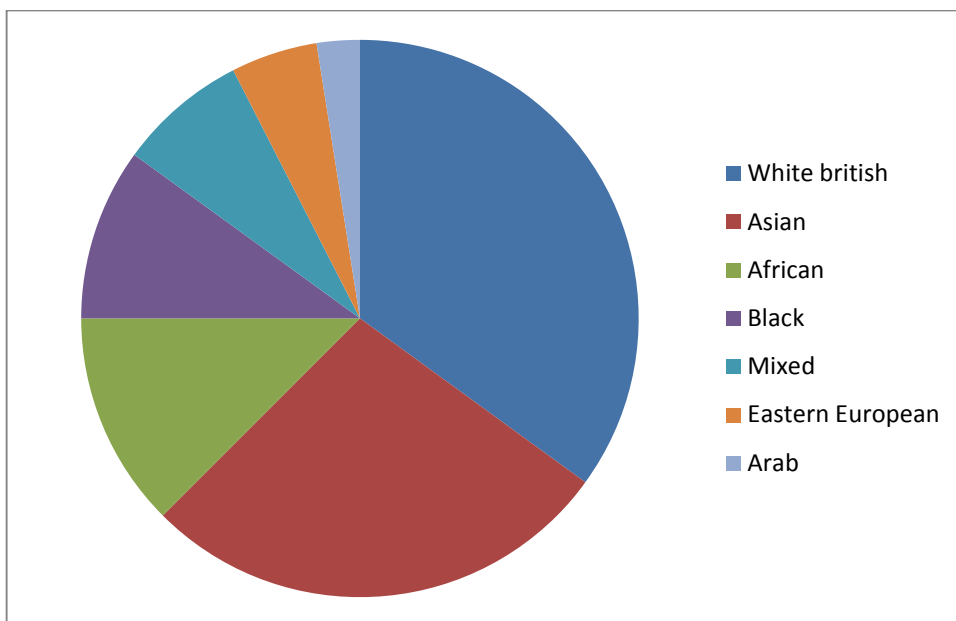


Figure 1: Demographic data regarding ethnicity

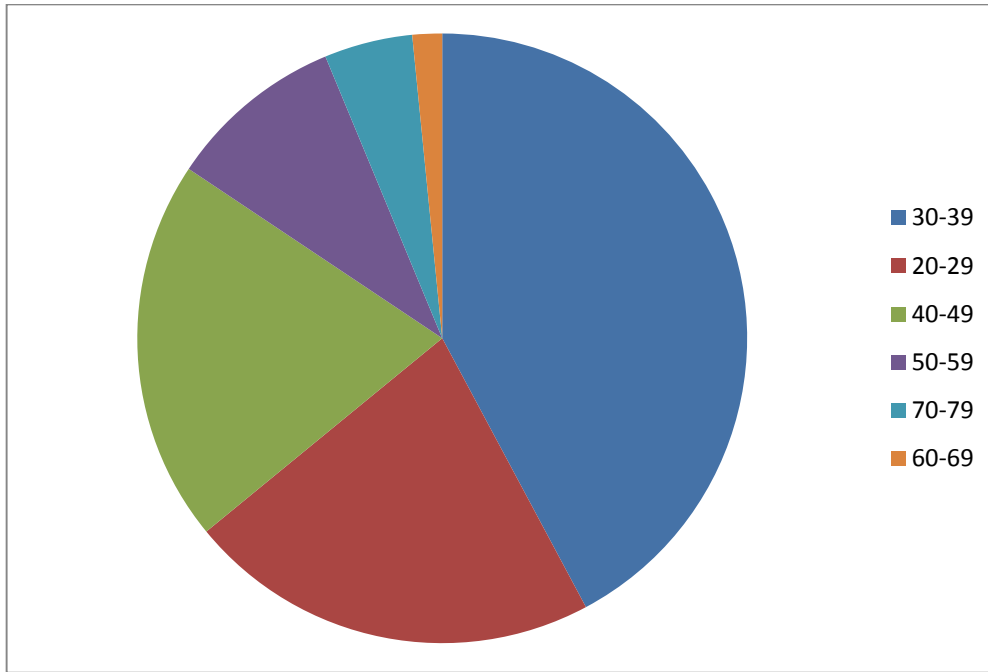


Figure 2: Demographic data regarding age

Overall the Birmingham South and Central CCG and Birmingham Cross City CCG model of implementation shows considerably commonality with the national programme.

The opportunities and challenges associated with IRIS as stated by the providers of the service locally

Findings in this section are derived from the questionnaires with the AE for Birmingham South and Central CCG and Birmingham Cross City CCG (Appendix 1) and participating general practices (Appendix 4). In the following quotes, the abbreviations AE and GP are used. Findings are presented under opportunities and challenges. Data from the post-training questionnaires are also used. These are from clinical and reception staff.

Opportunities

There is perception that IRIS training has improved awareness among practitioners and that this has impacted positively on their practice regarding DVA:

Feedback on training has been positive... and practice teams are gaining a greater understanding of DV and how best to respond to their patients, which will benefit many people in the long term (AE).

It was a really great session and it was great to hear the different resources and agencies that we can utilise, especially your services (BSWA) and having a name to

a face always aids us to give the patient confidence to confide in you if we can say that we actually know you (IRIS practice clinical staff).

I just wanted to say how much everyone benefited from the training today. They said you were a brilliant trainer and you have really given them the confidence to ask questions and refer (IRIS practice clinical staff).

I just wanted to take this opportunity to tell you how very; very grateful we are for all your support. The IRIS training was absolutely fantastic and led to real and immediate benefits... We have had great feedback from patients who feel they are being taken seriously and listened to. I think you are doing a great job (GP1).

The IRIS training is delivered to all staff in a practice and this is important in raising levels of awareness about DVA among 'front line' staff. Reception staff have one hour training, which is less than clinical staff, but nevertheless it is important. The following excerpts show the benefit of their inclusion within the training programme:

Even our admin team on reception are spotting signs of suspected DV patients in the waiting room e.g. talking on their phone to their partner in fear... (GP1).

Training was really helpful and I learned a lot more about DV (IRIS practice reception staff).

Many thanks for the training today, it was really interesting and worthwhile (IRIS practice reception staff).

A perceived benefit among the staff who work towards implementing and delivering the programme, is its impact on referral and safety:

[Many] women have been offered a DVA service that they are unlikely to have considered/been aware of/been able to access if it hadn't have been for their GP (or in some cases nurse/midwife) asking them about DVA and then referring on to the AE. This is a massive increase in accessibility, as BSWA historically have rarely receive referrals from GPs (AE).

I have referred two women into IRIS. The referral process is straight forward and I have always found the advice and feedback about patients from the IRIS advocate prompt and helpful. It is really useful having a named contact that I can direct patients to and that they can be seen in a familiar environment. I think it is a fantastic service. One patient felt talking to [AE] was a real eye opener and she has since started to seek greater family support in dealing with her current difficult living situation (GP 1).

I found the referral process simple and easy to use once the form was embedded into the practice system. I was really impressed by the speed with which you got in touch with patients I referred, it has given me a lot of confidence in the service. It is

important to know that the service is reliable for patients. For me, practical advice on how to arrange meetings with people with no safe phone number was very helpful. Meeting you personally at the training was also very helpful because now I know that I can confidently seek advice if I just need to talk something through and I can say to my patients that I have met you and know who you are (GP 2).

It is evident from GPs and the AE responses that IRIS training impacts positively on responses to DVA and referral. One GP wrote a lengthy response to the email questionnaire, citing a case example where IRIS has made a difference to her awareness of DVA and subsequent responses. This is presented in Appendix 5 and illustrates well the difference that IRIS training makes. There are however some challenges.

Challenges

Although referral rates have increased, the current referral processes pose a challenge in terms of continuity of care:

While the process of referring is clear and easy, the challenge is that I can't guarantee to women that they will be supported by a BSWA caseworker, so it's complicated to explain to women, especially when I'm already having to explain that I am just a first point of contact and they won't be able to get on-going support from me. It would be better to be able to refer internally and guarantee continuity of service and easy sharing of information that woman has already disclosed to BSWA (AE).

Capacity is also an issue both in terms of AE workload and waiting lists for required support for women being referred through IRIS:

There are times when Birmingham lacks capacity in casework, as just before Christmas when there was a significant waiting list at Gateway for floating Support (AE).

The capacity of the AE is stretched. This limited capacity and the unpredictability of referrals makes it hard to judge whether it's possible/fair for the AE to offer on-going emotional support to women who don't have high risk levels or practical needs... this is something that could be looked at in more detail (AE).

Another important challenge is the short term nature of funding. This has implications for relationships with practices and convincing them of the value of investing time in IRIS. This concern was expressed by the AE:

Short term funding is a challenge... GPs have fed back their frustration that projects like this get set up then end very quickly and this is a barrier to them investing their time in training... it can take several months to get a practice fully set up. Then there is more that needs to be done to maintain and develop the working relationship with practices – provide feedback on longer term outcomes, attend practice meetings to keep IRIS on the agenda, offer top up training etc. (AE).

The concern offered by the AE was echoed by a GP from one of the IRIS practices, who wanted feedback about women who had been referred:

It would be helpful to have feedback from you about individual referrals in a way that can be easily incorporated into the practice system in the patient's notes. I'm not sure what would be the best way of doing this but perhaps as an attachment to an email to the practice email address, with the email marked FAO the IRIS coordinator within the practice? I'm always a bit concerned about emails directly to individual doctor's as someone might be away or off sick, or just have full inbox and then the information might get missed. I haven't seen any of the patients I referred again yet, so have not had any feedback as yet from individual patients (GP2).

The impact of IRIS on the perceived wellbeing and safety of women referred through the service

Data in this part of the evaluation are based on evaluation interviews with women. Seven women were invited to participate in the evaluation interviews, but only four agreed to take part. Demographic data were collected from participants (including age and ethnicity) but the decision has been made to omit these details from the report to protect anonymity. Key messages from the women were about safety, support and empowerment.

Women felt both safer and happier after the IRIS intervention as the following accounts demonstrate:

She (GP) is the one who contacted women's aid, I don't know how she did it, but she did it and she said someone from women's aid will call you. AE called another lady ...She was my case worker. She was the one who helped. When I said I wanted to leave she was the one who took me to the house and waited for me to get my things while my husband was out. She waited for me in the car...then she took me to somewhere safe...

Interviewer: Does your husband know where you are now?

Participant: No. No... I am very happy with it [IRIS]. I am very pleased because I was in a domestic abuse environment and they helped me to move from that place. I am pleased.

I called the GP and she told me I could get help, so I went to the clinic. The GP made the referral. AE called me and we met at the health centre. So I got a lot of information that I needed because I was going through the services for the first time because I am not from Britain and so I got advice from AE about the services so that I could use them in the future. So I know for the future and I was learning about what to do if it happened again. I just needed to know what to do in an emergency so I felt safer knowing there is help

AE has been really helpful. I just let everything out that I wanted to talk about. She said that she was there for me if I wanted to talk.

Interviewer: Now that you have moved away from your husband how are you? How is your health?

Participant: I am feeling fine, I am much better. My medication is changed.

Interviewer: It is decreased?

Participant: Yes, it is decreased.

Referral does not always equate to a woman leaving her relationship, but IRIS provides a perception of safety for those women who stay in a relationship:

Participant: Things are better now and my husband is getting help too. He is booked on courses.

Interviewer: So he is getting help too?

Participant: Yes.

Interviewer: Are you still with your husband?

Participant: Yes, but I know what to do if it happens again - how to be safe. I know that all I have to do is contact Women's Aid and there is someone there to help. I don't have to be scared.

Women participants also felt empowered, that they were not being judged and that decisions were in their hands. This was important to the women and they appreciated it:

So I received a call from AE and I met her at the surgery...It was good for me to see her there because we were sitting in private. It was only the two of us. I explained my situation to her.

After seeing AE a few times I must say she made me look at myself in a different way, in that I have rights like anyone else... now I can say that I'm not putting up with this because I have someone on my side, so in a sense I feel a lot better in how I deal with it.

One woman shared her experiences the day following a physical assault from her partner:

I ran down to my GP surgery and explained my situation... The GP asked me everything that happened and she asked me did I want to take things further and I said 'yes'. AE came out to see me. To be honest she gave me all the information. She gave me all the choices. She gave me options as well and said you don't have to

go ahead with anything. I was really happy with her to be honest. She was really helpful. She listened to me and gave me advice and I am really pleased with her.

It was clear from all four women interviewed, that information, support and a non-judgemental attitude from the AE are powerful means of promoting women's empowerment:

I am very satisfied because I know my rights. I was very happy to have AE as a helper because she understood and I got a lot of information about the services. I had a very fruitful first meeting and I didn't need to contact her again.

There were a couple of examples given where GPs had tuned into mental health issues and used this as a lever for asking about DVA:

I went to my GP and I explained my problems to her because I was experiencing domestic violence with my husband and I was depressed and stuff and on antidepressants and so my GP asked what was leading to my depression and I told her everything. She told me if I needed help they could call women's aid and they called up women's aid and made an appointment for me to see AE.

When I came to see the doctor I said that I wanted to come off the antidepressants and she said did I need some help and that she can refer me.

One participant however was disappointed that her GP did not follow up with her:

My GP should have contacted me to see if everything was alright and to be honest I'm not really happy... I would have liked them to contact me, even to ring me up to see how things are going on. How things are at home. They don't know what's going on with me, so I'm not very happy to be honest.

Although this was a singular observation, it was clearly important to this participant. It is clear from the women we spoke to that they are largely satisfied with IRIS and that it is working well in Birmingham South and Central. The AE was perceived as very supportive whilst also offering practical help and the women all derived a sense of being safer because of her intervention. Women's Aid also received very positive comments. All of the women felt empowered by the process, feeling that they were in control and given choices about their own lives. Whilst not all chose to leave a violent home, they nonetheless felt better equipped to deal with the future.

Discussion

The Health Foundation (2011) reported that NHS services have a notably poor record when it comes to identification and handling of DVA. This evaluation canvassed the perspectives of general practice staff and it has shown that the IRIS programme has helped build confidence for GP's and NHS staff to deal with DVA. Since October 2015, 76 women in Birmingham South and Central have been offered a DVA service that they are unlikely to have accessed had it not been for their GP. Two women interviewed in this evaluation referred to their GP asking about the root causes of their depression. This 'digging deep' is important and may be attributed to GPs' increased understandings about the relationships between poor mental health and DVA. This is positive progress because studies have found that GPs are sometimes quick to prescribe antidepressants without enquiring about abuse as a potential associated factor (Taylor et al. 2013). Overall, most women who we talked with for the purpose of the evaluation were positive about their GP's responses and handling of the disclosure event. However, one woman did report that she had expected some follow up from her GP post-referral – a point to be discussed later.

Behind every referral is 'a woman being provided with validation of her experiences and a safe space to articulate what is happening to her' (Howell, Johnson & Harrison 2014, p. 2).

Pivotal to women's positive experience in this evaluation is the advocate who provides this validation and serves as the linchpin for women's safety and wellbeing. Empowerment is important for women who have experienced DVA (Bradbury-Jones et al. 2016). Many have been stripped of all control and have borne the brunt of another's controlling behaviours. So an important finding in this evaluation is the sense of control and empowerment that women experience as part of the IRIS programme. The AE is instrumental in this and is a very important person in women's lives.

An important part of the local evaluation was to gauge the impact that IRIS has on the people referred to it. There is little doubt that it makes a significant difference. From the different sources

of data collected in the evaluation, particularly the interviews, it is evident that identification and referral do impact on safety. Whether still with the perpetrator, or having fled to a safer place, women told us that they felt safer as a result of being referred to the IRIS programme. In the evaluation of the Manchester IRIS programme, Granville (2014) reported positive outcomes for women and children through improved mental health and improved control over their lives. These findings concur with those of our evaluation.

There were some issues and challenges identified within this evaluation – all of which can be addressed. The first relates to the referral model via Birmingham Gateway. The challenge is that the AE cannot guarantee to women that they will be supported by a BSWA caseworker. There are times when there is lack of capacity in the AE casework and at points there has been a significant waiting list at Gateway for floating Support. This will become more of a challenge as referrals increase. The AE herself suggested that it may be better to refer internally and guarantee continuity of service and easy sharing of information. This is proposed as a recommendation. It is noteworthy however, that none of the women reported lack of continuity as a problem.

The second issue is concerned with post-referral communication. One GP had no information on what had happened to the woman she had referred and she wanted to know the outcome. One of the women we spoke to in the evaluation told us that she wanted follow up from her GP. She had expected the GP to make contact following the referral. A suggestion then, is to consider ways to address the gap in communication so that GPs and women have some communication post-referral.

The third challenge relates to short term funding. The AE cautioned that it is not easy for her to get longer term outcomes to feedback to GPs in order to increase their drive to ask women about DVA.

This local evaluation may help in part, but longer term funding is required to assist with embedding the service and demonstrating its sustainability.

Limitations

A limitation of this evaluation is the small number of women interviewed. We had hoped to speak with seven women and although they were all contacted, only four agreed. However, for the sake of ethical practice and respect for choice, we veered on the side of caution in our recruiting. This may be reflected in the number of women who took part, but we were still able to elicit some rich insights into their experiences of IRIS.

The limited timeframe associated with IRIS local evaluations has been identified by other evaluators as a challenge (Hinsliff-Smith 2015). We too found that the timeframe in which to undertake the evaluation (three months) was tight, and this is reflected in the scope of the evaluation. We have had to select what we considered to be the most meaningful forms of data that would fit within the timeframe. In this we wanted to include the experiences of women and the perspectives of the AE, along with email communication from GPs. It would have been useful to collect quantitative data on training and referrals but these can be the focus of subsequent evaluations. It is relatively recently that IRIS has been implemented locally and therefore measuring long term outcomes is impossible. As discussed, this poses a problem in terms of demonstrating commitment and worth to all involved, for example GPs. Again, longer term impacts can be captured in future evaluations at local and national levels.

Conclusion and recommendations

The findings of this evaluation are positive and Birmingham South and Central have had considerable success with their implementation of the IRIS pilot programme. There are three key recommendations:

1. Consider revising the referral processes to an internal system to guarantee continuity of service and sharing of information.
2. Consider ways to address the gap in communication so that GPs and women have communication post-referral.
3. Birmingham South and Central CCG and Birmingham Cross City CCG IRIS pilot has made a difference to local women's lives that has been captured qualitatively in this evaluation. It is crucial that funding and support for the programme continues.

To conclude, findings of this evaluation indicate that IRIS has impacted positively on the safety and wellbeing of women in Birmingham South and Central CCG and Birmingham Cross City CCG.

The closing remarks are testimony to its perceived success locally:

Well done [AE]. Well done IRIS and the whole team. I think you are and will continue to make a big difference to our patients and communities in an area that has for too long been neglected at a huge cost to our society (GP).

The pilot has been really successful because it's been implemented well and is receiving high numbers of referrals. We have also learned a great deal during the set up and are in an excellent position to roll out IRIS further (AE).

If you speak to [AE] say thanks very much for her help and say thank you very much for her support (woman interviewee).

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Appendix 1: Email questionnaire for AE

1. Please describe how you have implemented the IRIS programme within Birmingham South and Central. How is it organised? Why is it done this way?
2. What do you consider to be the main benefits of having implemented the IRIS programme?
3. What are the main challenges or threats facing you as an IRIS pilot site?
4. What is the key message that you would like to highlight within the IRIS evaluation report?

Appendix 2: Interview guide for women



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Identification and Referral to Improve Safety (IRIS): Service Evaluation

1. Introduction and demographic information (if appropriate)

2. Experience of disclosing DVA

What happened?

What led up to that point?

What happened afterwards?

Have you ever been asked before?

What was good and bad about the experience?

3. Experience of referral

Were you referred to one of the advocate educators (AE)?

If so, where? What happened?

What was good and bad about the experience?

4. Experience of safety planning

What happened following the disclosure?

How did the referral through the IRIS programme impact on your safety (and any children)?

Impact on sense of freedom?

Impact on health of woman (and children)

What has changed for you as a result of the IRIS programme?

What has been good and bad about the experience?

5. Overall feedback on IRIS experience

Is there anything you would have liked done differently regarding your referral through the IRIS programme??

What advice would you give to other women who may be thinking about disclosing their experiences of domestic abuse to a GP?

Is there anything else that you would like to tell me?

6. Close, debrief and safety. Assurance of anonymity and confidentiality.

Thank you very much for talking to me!

Appendix 4: Email questionnaire for general practices

We are currently evaluating the implementation of IRIS (Identification and Referral to Improve Safety) in Birmingham so far, and as one of the first referring clinicians we are very keen to get your feedback.

Please respond to the questions below if you can, ideally by Thursday 24th March. Any insight is really valuable and will help us develop the project to its full potential – Thank you

How have you found the referral process to the IRIS advocate, and the subsequent feedback/communication regarding patients?

How have you found the support provided to you by the advocate and clinical leads to implement IRIS in your practice?

Do you have any feedback about the impact IRIS has had on any of your patients?

Feedback given may be included in the evaluation report but anything included would be done so anonymously.

Appendix 5: GP case example

The following day [after the IRIS training] I saw a pregnant lady who thought her bump wasn't looking big enough although she was only about 12 weeks pregnant. I checked her physically and reassured her and normally would have left it that as I know she tends to get over anxious. But due to your training I was reminded to ask her how everything was going at home especially as she had a toddler at home and the difficulties of early pregnancy. [The IRIS training] mentioned the domestic violence in pregnant patients and also in women who frequently attend for seemingly insignificant matters. This alerted me to ask about support at home and she disclosed to me how controlling her husband was being which led me to refer her to you. I don't think I would normally have even considered it in a busy GP surgery if it hadn't been for your recent training to raise awareness of this very important topic.