Institution: University of Bristol		
Unit of Assessment: 2) Public Health, Health Services and Primary Care		
Title of case study: Changing policy and practice to improve support for women experiencing domestic violence and abuse in England and Wales		
Period when the underpinning research was undertaken: 2007 - 2019		
Details of staff conducting the underpinning research from the submitting unit:		
Name(s):	**Role(s) (e.g. job title):**	**Period(s) employed by submitting HEI:**
Gene Feder	Professor of Primary Care	2008 - present
Alison Gregory	Research Fellow	2007 - present
Alice Malpass	Senior Research Fellow	2003 - present
Debbie Sharp	Professor of Primary Heath Care	1994 - present
Period when the claimed impact occurred: 1st August 2013 **–** 2020		
Is this case study continued from a case study submitted in 2014? No		

1. Summary of the impact

University of Bristol (UoB) led the development, trialling and implementation of the IRIS (Identification and Referral to Improve Safety) programme across 46 areas of England and Wales, including training in over 1000 general practices. This programme, evaluated through a research collaboration between UoB and Queen Mary, University of London, has supported over 20,000 women patients in England and Wales to reduce their exposure to violence and improve their mental health and quality of life. The IRIS programme is cited and recommended by UK Home Office and Welsh Government policy and strategy, as well as NICE health guidance and standards. IRIS has also been used as an exemplar to inform initiatives in Palestine, Brazil, Nepal and Sri Lanka, as well as informing global World Health Organisation guidelines.

2. Underpinning research

Domestic violence and abuse (DVA) against women, a major public health and clinical problem, requires a healthcare response. Historically, clinicians in general and GPs in particular have not responded effectively to the needs of patients experiencing DVA. Most clinicians have little or no training, fail to identify patients experiencing abuse and are uncertain about further management after disclosure.

In 2007/2008, the University of Bristol (UoB), in collaboration with Queen Mary, University of London (QMUL) and funded by The Health Foundation [i], led a cluster randomised controlled trial [1], evaluating a training and support programme delivered by 'advocate-educators' based in third sector DVA agencies. A total of 48 eligible general practices in Bristol and Hackney (London) were randomised to intervention or control groups. The intervention programme included practice-based training sessions for clinicians and administrative teams, a prompt within the electronic medical record to ask about abuse, and a referral pathway to a named DVA advocate (who also delivered the training and further consultancy to the practices). The latter was undertaken because advocacy support to survivors of DVA reduces their risk of further abuse and improves mental health outcomes.

One year after the second training session (2009), advocacy agencies recorded 278 self and direct referrals of patients from intervention practices and 40 from control practices (intervention incident rate ratio 6·6, 95% confidence interval 4·1 to 10·7) [1]. Intervention practices recorded 641 disclosures of DVA and control practices recorded 236 (intervention

rate ratio 3·1, 95% confidence interval 2·2 to 4·3) [1]. The trial established that a training and support programme targeted at primary care staff improves recorded identification of women experiencing domestic violence and referral to specialist domestic violence (DV) agencies. Linked research included a cost-effectiveness study of the trial intervention [2], a qualitative study of the experiences of survivors of DVA receiving IRIS support [3], an interrupted time series of the service implementation and sustainability of the IRIS programme in north London [4], and a further cost-effectiveness analysis of post-trial NHS implementation [5]. The national cost-effectiveness study, carried out in collaboration with University College London, found that the IRIS model has retained its cost-effectiveness in translation from trial intervention to a widely commissioned national programme [5]. Moreover, the interrupted time series analysis showed that when an area decommissions IRIS, referrals fall sharply [4].

A distinctive and pioneering aspect of the trial was the close collaboration with third sector domestic violence organisations (Nia and Next Link), which were directly involved in the trial design, intervention delivery and national implementation. Following the success of the IRIS trial the team created *IRIS – strengthening impact* (IRISimp), an implementation vehicle to roll-out the IRIS model into general practices across the country. This two-year programme of work was undertaken in conjunction with and funded by the Health Foundation [ii]. It facilitated the commissioning of the IRIS model by CCGs and local authorities and funded the advocate educator training. A Department of Health Innovation, Excellence and Strategic Development Grant [iii] supported further implementation of IRIS in England. In 2017, with support from an ESRC impact accelerator award [iv] a social enterprise, IRISi, was created to facilitate further national scaling up of the general practice IRIS intervention and implementation of IRIS-related research. The latter included IRIS ADVISE [6] – an adaption of IRIS for sexual health settings that has been evaluated in east London and Bristol [v].

3. References to the research

[1] **Feder G,** Davies RA, Baird K, Dunne D, Eldridge S, Griffiths C, **Gregory A,** Howell A, Johnson M, Ramsay J, Rutterford C, **Sharp D.** (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. DOI:10.1016/S0140-6736(11)61179-3

[2] Devine A, Spencer A, Eldridge S, Norman R, **Feder G.** (2012). Cost-effectiveness of Identification and Referral to Improve Safety (IRIS), a domestic violence training and support programme for primary care: a modelling study based on a randomised controlled trial. *BMJ Open,* 2(3): e001008. DOI:10.1136/bmjopen-2012-001008

[3] **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): 151-158. DOI:10.3399/bjgp14X677527

[4] Sohal AH, **Feder G,** Boomla K, Dowrick A, Hooper R, Howell A, Johnson M, Lewis N, Robinson C, Eldridge S, Griffiths C. (2020). Improving the healthcare response to domestic violence and abuse in UK primary care: interrupted time series evaluation of a system-level training and support programme. *BMC Medicine,* 18(1): 48. DOI:10.1186/s12916-020-1506-3

[5] Barbosa EC, Verhoef TI, Morris S, Solmi F, Johnson M, Sohal A, El-Shogri F, Dowrick S, Ronalds C, Griffiths C, Eldridge S, Lewis NV, Devine A, Spencer A, **Feder G.** (2018). Cost-effectiveness of a domestic violence and abuse training and support programme in primary care in the real world: updated modelling based on an MRC phase IV observational pragmatic implementation study. *BMJ Open,* 8(8): e021256. DOI:10.1136/bmjopen-2017-021256

[6] Sohal AH, Pathak N, Blake S, Apea V, Berry J, Bailey J, Griffiths C**, Feder G**. (2018). Improving the healthcare response to domestic violence and abuse in sexual health clinics: feasibility study of a training, support and referral intervention. *Sex Transm Infect*. 94(2): 83-87. DOI:10.1136/sextrans-2016-052866

Key funding:

[i] **Feder G**. Identification and referral to improve safety (IRIS), The Health Foundation + Department of Health, 2007 – 2010, GBP388,434 + 40,000 Primary care domestic violence trial

[ii] **Feder G**. IRIS – strengthening impact (IRISimp), The Health Foundation, 2010 – 2013, GBP184,074

[iii] **Feder G.** IRIS implementation, Department of Health Innovation, Excellence and Strategic Development Grant, 2013-14, GBP173,226

[iv] **Feder G** IRISi Ltd – Social Enterprise Set Up, 2017, ESRC Impact Acceleration Account and Support, GBP15,000

[v] **Feder G** Evaluation of IRIS implementation in sexual health settings, Elizabeth Blackwell Institute, GBP50,886

4. Details of the impact

IRIS was a landmark trial [1] in DVA research, evaluating a training and support programme, including a referral pathway, designed to improve the response of general practice to women experiencing domestic violence. It had an initial impact on national policy and service implementation in the two years after its publication in 2011. Here we focus on its impact post-August 2013.

Benefits to women and practitioners

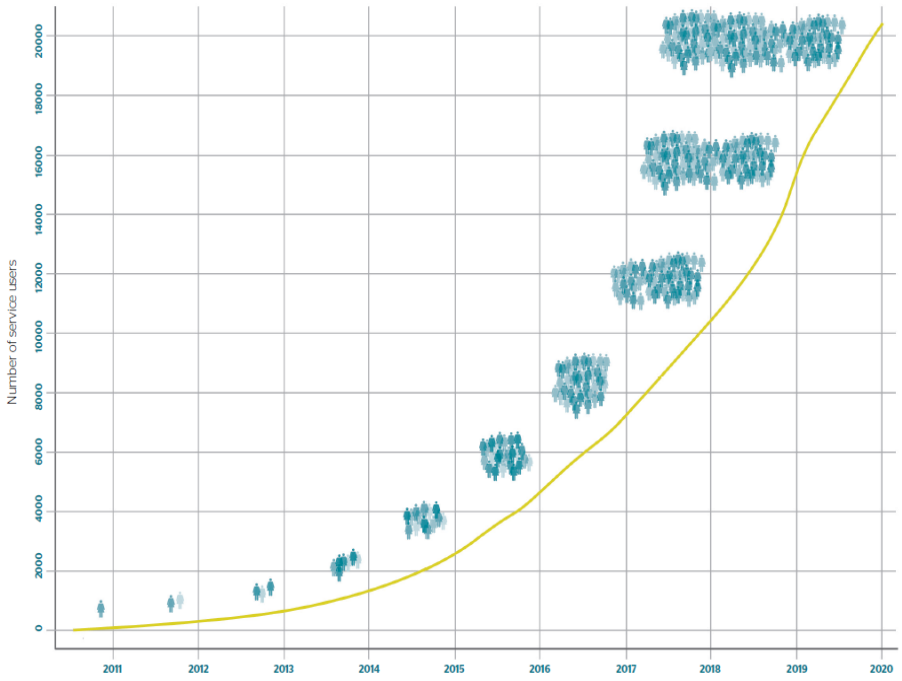

Figure 1 - Cumulative total referrals to IRIS from across England, Wales and Northern Ireland (2011 – 2020) [A].

Up to March 2020, 48 localities in England and Wales have commissioned the IRIS programme; 1,036 practices have been trained and over 20,544 women (Figure 1) referred from these practices to DV services [A]. The other benefit for patients is a safer and more appropriate response of clinicians to disclosure of domestic violence, a core feature of the IRIS intervention.

We have evidence for this impact from feedback from patients who disclosed abuse to their GPs and were referred to an IRIS advocate educator [A (p.12)] and evidence of the sustained effectiveness of the IRIS model from an interrupted time series study of IRIS implementation in north London [5].

A total of 302 general practices received training during April 2019 – March 2020, with 265 clinical training sessions, 157 for reception staff, and 132 refresher courses. IRIS reaches an older demographic of women who we know are less well represented in specialist DVA services. It is a positive feature of IRIS being able to reach an otherwise invisible groups of survivors.

In response to the COVID-19 pandemic, IRIS moved from a fully face-to-face to a fully virtual programme, including webinar versions of all training packages. As a result, all IRIS Advocate Educators have been able to continue supporting patients during the pandemic. National data shows an initial reduction in referral cases (March-April 2020) followed by a renewed increase in referrals (May-June 2020). IRIS has been able to collect feedback on their support from 1,500 women. 98% were pleased to have been referred to an Advocate Educator. In response to other questions, more than 80% said they felt safer, more confident, more able to cope, and optimistic about the future. For example: *"I was unaware of what types of abuse I have been going through and it has opened my eyes for a better and brighter future for my unborn child and myself. Thank you for everything it has been appreciated".* [A]

Furthermore, IRIS ADVISE – an adaption of IRIS for sexual health settings – has been piloted in east London and Bristol [6]. It is now being commissioned in Manchester [Bi] and commissioners in other areas have expressed an interest.

Impact on national policy

In 2013, IRIS was cited in the Home Office's *Domestic Homicide Reviews – Common Themes Identified as Lessons to be Learned* [C], as a way to improve local provision. The 2014 NICE DVA guidelines [Di] had a specific training and support recommendation for primary care, based explicitly on IRIS and directly informing a NICE DVA quality standard [Dii]. In 2016, the UK Home Office's refreshed Violence Against Women and Girls Strategy (2016-2020) endorsed IRIS as a key part of the strategy and included the programme in its action plan [E]. IRIS was recommended for local adoption by the government's National Statement of Expectations (NSE) for Violence Against Women and Girls Services and the IRIS programme was promoted in the Home Office's *Modern Crime Prevention Strategy* [F (p.13)]. In Wales, IRIS was similarly endorsed as an innovative approach for early intervention in the National Strategy on Violence against Women, Domestic Abuse and Sexual Violence (2016-2021) [G]. IRIS has recently been cited in the MOPAC (Mayor's Office for Policing And Crime) Violence Against Women and Girls strategy: *The London Tackling Violence Against Women and Girls Strategy 2018-2021* [H], as an example of good work within the health sector (Greater London Authority, 2018). The UK INCADVA (Inter-Collegiate and Agency Domestic Violence Abuse) forum's June 2020 evidence submission to Parliament pressed for uniform national implementation of the IRIS programme within the statutory instruments of the UK's Domestic Abuse Bill [J].

Benefits to NHS staff

Intermediate beneficiaries from the widespread implementation of IRIS have been the doctors, nurses and other members of the practice teams in the 1,036 IRIS practices in England and Wales. Feedback from general practice teams (20,000 individuals) [A (p.13)] following training shows an increase in participant knowledge and described the session as *'invaluable and*

addressed a real hole in our learning'. Nineteen out of twenty clinicians would recommend IRIS training to a colleague. Following IRIS training, GP reception teams reported that their confidence to deal with and respond appropriately to patients experiencing DVA rose from 4.2 to 8.3/10. [A]

Impact on international policy

The landmark 2013 World Health Organisation publication titled *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines* [I] drew heavily on UoB's research [1]. Specifically, this research helped frame their approach, and in making recommendations about the training of healthcare providers there was specific citation of the IRIS model [I (p.33)]. IRIS has been the basis of two European projects and is now informing interventions in an NIHR Global Health Group (Healthcare responding to violence and abuse, HERA) in Palestine, Brazil, Nepal and Sri Lanka, including wider country-specific implementation (e.g. implementation in Sao Paulo) [Bii].

Economic impact

Based on the results of our cost-effectiveness modelling [2] which has been updated using our non-trial data [5], we estimate the annual societal cost saving associated with IRIS is greater than GBP2,400,000. This modelling indicated that implementation of the IRIS programme is cost-effective as judged by NICE criteria, generates societal cost savings and is likely to reduce NHS costs. This estimated cost saving is conservative, as it does not include benefits to children exposed to DVA.

5. Sources to corroborate the impact

[A] IRIS (2020). IRIS Identification & Referral to Improve Safety

[B] i) Greater Manchester Health & Social Care Partnership (2020). Supporting Letter – Consultant in Public Health
ii) São Paulo Municipal Health Secretariat (2020). Supporting Letter - Technical Director

[C] Home Office (Nov 2013). Domestic homicide reviews: Common themes identified as lessons to be learned *IRIS recommended for local and national approach (p.4-5).*

[D] i) NICE (2014). Public health guideline [PH50]: Domestic violence and abuse: multi-agency working. *IRIS economic model is the basis for recommendation 16.*
ii) NICE (2016). Quality standard [QS116]: Domestic violence and abuse

[E] HM Government (2019). Ending Violence against Women and Girls 2016 - 2020, *(pp.21, 27, 53).*

[F] Home Office (2016). Modern Crime Prevention Strategy, *(p.13).*

[G] Welsh Government (2016). National Strategy on Violence against Women, Domestic Abuse and Sexual Violence – 2016 - 2021 *(p.23).*

[H] Greater London Authority (2018). A Safer City for Women and Girls The London Tackling Violence Against Women and Girls Strategy 2018-2021 *(p.32-33).*

[I] WHO (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines *(cites [1]).*

[J] Domestic Abuse Bill (2019-21). Written evidence submitted by the INCADVA (Inter-Collegiate and Agency Domestic Violence Abuse) Forum (DAB57)