The impact of IRIS: from research trial to commissioned programme

Professor Gene Feder, Anna K. Taylor and Medina Johnson investigate the impact IRIS (Identification and Referral to Improve Safety) has had on survivors of domestic abuse and its future as part of the NHS response.

Introduction

IRIS (Identification and Referral to Improve Safety) is a general practice-based domestic violence and abuse (DVA) training support and referral programme. It stems from a collaboration between primary care and third sector organisations specialising in DVA. An advocate-educator (AE) based in a local specialist DVA service is linked to general practices and works in partnership with a local clinical lead (CL) to deliver the IRIS training to practice members including the whole clinical team and ancillary staff. The AE is patient-led, offering emotional and practical support such as time and space for the woman to speak about her experiences, support to access housing and legal support, as well as referrals to Multi Agency Risk Assessment Conferences (MARACs) and other specialist services. A comprehensive risk assessment is done during the first contact and a safety plan agreed. The AE also collects patient and practice data, and provides case updates to primary care professionals. In terms of education, the AE measures performance, provides training for the practice team and is the main source of information and materials. The CL works in partnership with the AE, provides training and promotes awareness of the experiences and needs of women with experience of DVA.

The programme is aimed at primary care clinicians and administrative staff and involves education and training within the practice, a pop-up prompt on the medical record system to ask about abuse when certain diagnoses are entered, care pathways, and an enhanced referral pathway to specialist domestic violence services (see Johnson, SAFE Winter 2010, and Feder et al, SAFE Winter 2012). The programme is aimed at women with experience of DVA from a current partner, an ex partner or an adult family member, and it also provides information and signposting for male victims and for perpetrators of DVA.

IRIS was evaluated in a cluster randomised controlled trial of 48 practices across Bristol and the London Borough of Hackney. Two outcomes were measured: referral of women to a domestic violence agency providing advocacy, and recording of disclosure of domestic violence in the patient's medical record. Women attending the intervention practices were 22.1 times more likely than those attending the control practices to have a discussion with their clinician about a referral to a DVA advocate, which resulted in them being six times more likely to be referred to the AE. Women attending the intervention practices were also 3.1 times more likely to have a recorded identification of DVA in their medical records. It is evident from these results that there are major benefits from support and training interventions within primary care. IRIS was also shown to be a cost-effective intervention[1,2]. This paper will discuss the progress and impact made by the IRIS programme, including the

response to the model by the patient and general practice community, successes and failures in implementation, and future plans to develop IRIS further.

The impact of IRIS

The original trial was funded by the Health Foundation, which provided two years continuation funding, post-trial, to enable the development of commissioning guidance, a 'train the trainer' programme and to support the commissioning of the first IRIS projects nationwide. Subsequent funding, on a three year sliding scale, has been received from the Department of Health's Innovation, Excellence and Strategic Development Fund. IRIS is commissioned and running in 26 areas of England as at October 2015, and two in Wales. Discussions are ongoing with a further eight areas and enquiries from new areas come in weekly. Five areas of Scotland use IRIS-type models, but do not systematically report referral data to the national team.

Benefits to women

The number of referrals has increased over time, with 805 referrals made between July 2013 and July 2014 from the 13 localities[3]. This is estimated to be at least six times the number of referrals occurring in the absence of IRIS. Previous systematic reviews of advocacy interventions[4,5] indicate that this will result in a reduction of recurrence of domestic violence, probably improved quality of life and possibly improved mental health of these women. The next IRIS national report from the 23 longest running localities will be available in 2016.

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. Women appreciated that GPs recognised that their home life affected their health, and that referral to the AE was an option for them when they felt able to take this up. Patients were contacted by the AE, and follow-up was agreed as it suited the patient.

We have evidence for the positive impact of IRIS from interviews with patients who disclosed abuse to their GPs and were referred to an IRIS AE.

> "I had been experiencing verbal, emotional and financial abuse from my husband for over 26 years. I felt sad, low and unable to cope. The doctor referred me to someone who could help... I don't need to go to the doctor's as much now and have cut down on the tablets I take for depression and sleeplessness. I have slowly got my freedom back and am so happy to be making my own decisions and planning my own way in life. This is not just for me, it's for my children and women like me out there. I feel empowered. I feel proud of me."
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> **The patient narratives, as referenced in the corroborative sources, provide further evidence[6,7].**

Women were often relieved at being able to disclose to their GP, felt hopeful, and felt that their disclosure enabled them to ask for further help. They also described being able to let go some of their shame and self-blame. In terms of their interaction with their AE, they felt accepted and understood. The empathetic encounter helped them to realise they had choices and that a future without DVA was possible[6].

Benefits to NHS staff

Intermediate beneficiaries from the widespread implementation of IRIS have been the doctors, nurses and other members of both the clinical and ancillary teams in the IRIS practices nationally. The nested qualitative study[8] showed that the participating clinicians felt that the training and support from IRIS allowed them to engage with the difficult challenge of domestic violence.

> "A complete revelation. By becoming more aware of the signs and symptoms that suggest abuse – long-term anxiety and depression, repeat visits to the surgery for minor symptoms, unexplained gynaecological problems - I became much more aware of patients who were living with abuse and the negative impact that this was having on their health outcomes. The penny drops and you realise the exact scale and extent of the problem amongst your patient population."
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> (IRIS Clinician Quotes[9])

GPs appreciated that IRIS is a programme that is evidence-based, is replicable, and makes significant improvements to women suffering from DVA. IRIS also encourages better record-keeping, which is a benefit for the practice itself.

There was some initial resistance around the length of the training (two 2-hour sessions). Previous clinician training was shorter, focusing on

information giving rather than introducing practical skills and the AE role, but the feedback from the trial and the training courses has been consistently positive. However, the training courses have evolved naturally based on feedback to ensure that pre-course reading provides a good foundation and that training focuses more on practical work and meets specific needs of a local area. Nevertheless, practices joining the IRIS programme often request shorter sessions, sometimes quoting the total clinician time that the training involves, which in large practices is over 100 hours.

Economic impact

Cost-effectiveness estimates are based upon the results of the cost-effectiveness model developed from the trial outcomes[2]. 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. With the number of IRIS practices at 301 as of June 2014 (and an average 3155 women per practice), the annual NHS cost saving is almost £1m annually. The societal saving is in excess of £35m per year (based on a societal saving of £37 per woman per year).

Impact on national and international policy

Broader UK government policy on domestic violence has been deeply influenced by the outputs of the University of Bristol Domestic Violence and Health research group. In particular the systematic reviews that underpinned the IRIS study helped forestall the implementation of ineffective domestic violence screening/routine enquiry in health care settings in England, as reflected in the Department of Health taskforce report and in the UK National Screening Committee recommendations[10,11]. The National Screening Committee has adopted the definition of domestic violence developed by Feder.

The trial findings were made available pre-publication to the Department of Health taskforce on the health aspects of violence against women and children and they were a key source of evidence on training of health care professionals[10]. The IRIS programme was cited as an exemplar alongside the recommendation about training of staff and was highlighted as a case example in the commissioning guidance based on the report. NICE guidelines have a specific training and support recommendation for primary care based explicitly on IRIS[12]. The 2012 Welsh Assembly Government White Paper specified IRIS as an effective primary care training model[13] (pp.48-49) and this will be the basis of implementation of IRIS in Wales. IRIS implementation has been part of the recommendations of Home Office Domestic Homicide Reviews[14]. The Ministry of Justice accepts an IRIS referral from a health professional as evidence to prove a woman qualifies for Legal Aid.

The landmark 2013 WHO publication 'Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines' drew heavily on the research of the University of Bristol team in framing their approach and in making recommendations about the training of healthcare providers with specific citation of the IRIS model[15]. IRIS was also cited in the 2013 Annual Report of the Chief Medical Officer as a safe and appropriate response to a disclosure of domestic violence[16].

Challenges to implementation

Despite goodwill towards the IRIS model and support from clinicians and patients, there have been some challenges to successful implementation of the programme. The imposition of austerity through budget cuts in local authorities and clinical commissioning groups (CCGs) can prevent the initial setup of the programme, and getting support from commissioners and key stakeholders is a challenge to the national IRIS team and local DVA services.

Occasionally, commissioners have wanted to only implement parts of the IRIS model to save money, but this has been consistently resisted as there is no evidence for the benefits of partial implementation, which could be both a waste of money for the area and affect the reputation of IRIS. Additionally, recruiting staff and coordinating suitable dates for training can be difficult, and sustaining these staff is also not easy due to the short contracts that they often have. IRIS can be commissioned initially for as short a period as 12 months, which is also challenging in terms of demonstrating concrete outcomes.

There has only been one area where implementation failed completely, which was due to a variety of factors. The original commissioner's contract ended, the new commissioner was not interested in supporting the programme, and the CL was not able to drive the model locally. Phone conference and support from the national team were not enough to recover IRIS in that area so it was decided that it was inappropriate to continue.

Sustainability and the future

Currently, the ability to provide training and support is outstripped by the demand for IRIS and its exponential growth. The programme requires more national infrastructure to continue growing at this rate.

IRIS implementation is nationally supported by the Department of Health until 2016, but the programme is locally commissioned. In order to be self-sustaining, it will be necessary to generate money from implementation of IRIS in new areas. Locally, the model is commissioned in short-term contracts, so it is crucial to constantly demonstrate improvements in terms of patient experience and safety, and clinician knowledge, attitudes and beliefs about DVA. This is done through data collection and case studies, as well as an updating of the IRIS cost-effectiveness model and its application to local data.

Once implemented, the programme is embedded successfully due to the involvement of engaged and enthusiastic AEs and CLs delivering ongoing training and mentoring. However, if the AE leaves there is a gap in the service and GPs may not want to refer their patient to someone they do not know and trust.

There are a number of options to ensure the sustainability of IRIS nationally, including the development of a self-sustaining business model not dependent on grants, possibly in the form of a social enterprise.

Conclusions

IRIS has successfully transitioned from a research study in two localities to a nationally supported programme, bridging the historical gap between primary care and the domestic violence sector. The next step is to ensure a sustainable national framework for the continuing commissioning of the programme at local level.

IRIS has already contributed to the support available for women experiencing domestic violence, enabling positive long-term effects on health and potentially saving lives, and has provided crucial support for the healthcare professionals who care for these women.

To find out more about IRIS: http://www.irisdomesticviolence.org.uk/iris/ or email Medina Johnson (medina.johnson@nextlinkhousing.co.uk)

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Notes

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