



Evaluation of the Identification and Referral to Improve Safety (IRIS) Intervention in the West Midlands: A Focus on Health and Deprivation

Short Report

March 2021

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Executive Summary

Introduction

Domestic violence and abuse (DVA) is a serious public health issue. It refers to 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. In the year ending March 2019, an estimated 2.4 million adults aged 16 to 74 years experienced DVA in the last year (1.6 million women and 786,000 men). 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. Evidence has shown that training and clear referral pathways are important in helping them to respond effectively.

Background

Identification and Referral to Improve Safety (IRIS) is a DVA training, support and referral programme for GP practices in the UK. It has been embedded in primary care practice in the UK for several years, coordinated and led by the social enterprise IRISi. National evaluations by IRISi have captured the impacts of the programme and there have been many local evaluations of IRIS across the UK. What has been missing though, is a study that describes the myriad health issues as well as the deprivation profile of IRIS patients.

Evaluation Questions

- 1) What impacts does IRIS have on long term health outcomes as captured in GP and IRIS data in the West Midlands?
- 2) What are the linkages between IRIS as an intervention, deprivation indices and long-term health impacts?
- 3) How do survivors of DVA who have accessed IRIS support, describe its impacts on their health and wellbeing?

Methodology and Methods

The evaluation comprised both quantitative and qualitative strands. It took place between March 2019 and February 2021 in the West Midlands.

Qualitative Phase

Semi-structured telephone interviews were conducted with 21 women who had experiences of DVA and had received IRIS support. Data were analysed thematically. The qualitative findings were reported under seven prominent themes: Life before accessing IRIS support; Driving forces for help-seeking; Experiences of IRIS support; Perceived impacts of IRIS; Recovery as a journey; Looking to the future; Living with the pandemic. Across all themes, women were overwhelmingly supportive of IRIS as an intervention and perceived of its positive impacts on their health and those of their children. Projecting the future, most believed that its impacts would be sustained over time. The women were all interviewed during COVID-19 restrictions and for those who discussed this aspect of service delivery, most had found remote support to be effective. A minority of women reported the potential protective impacts of lock-down on post-separation DVA survivors; an issue that warrants further investigation.

Quantitative Phase

GP records of 294 patients were matched with records from AE (Advocate Educator) i.e. a specialist DVA worker to whom patients are referred) to get a picture of the types of health conditions they suffer from as well as information on lifestyle, pregnancies, abuse and violence currently suffered, historical abuse as well as the support IRIS provided. Postcodes were used to extract a deprivation profile of patients attending each surgery and underscored the socio-economic characteristic of the referred population. A pre and post analysis was also conducted on the presence or absence of conditions before and after IRIS support. The ethnicity of the sample indicated an underrepresentation of White British patients compared to the distribution in the West Midlands and an overrepresentation of ethnic minorities. Descriptive statistics indicated that the patients referred to IRIS had a variety of health conditions (mean 2.78) and 77% belonged to the lowest 5 deciles (with 32% in the lowest 10% of deprivation). Post IRIS record showed a significant drop in the mean number of conditions, though recording issues imply that the change in chronic conditions may not necessarily signify they no longer exist. This nonetheless is consistent with the qualitative findings that indicated a positive association between IRIS and improved health.

Conclusions

The women who took part in the qualitative phase of the evaluation reported that IRIS had impacted positively on their health and moreover, they perceived that these impacts will be long lasting. The quantitative data support the qualitative findings, showing a decrease in a range of recorded conditions post-IRIS. It is important to emphasise however, that for recurring conditions, the absence of the condition being recorded in the post analysis, did not indicate that the condition was no longer present. There were no significant differences in number of prescriptions or number of GP consultations per patient pre and post IRIS. Combined insights from both phases provide important, new insights into the beneficial longer-term impacts of IRIS as regards impacts on health (particularly mental health).

Key Recommendations

- 1) IRIS support impacts positively on the health of women in receipt of the service and it needs to be continued and expanded across the West Midlands.
- 2) Remote support for DVA during the pandemic has been well received. Opportunities need to be taken to learn from emerging evidence as it becomes available regarding the most effective modes of providing IRIS in non-face-to-face settings.
- 3) The evaluation findings indicate that some women considered the restrictive measures of lock-down during COVID-19, to be a protective factor against further abuse. The insight is from a minority of women, so it needs to be interpreted carefully. It is suggested as an area of future research.
- 4) The restrictions of COVID-19 meant that we were unable to conduct a longitudinal qualitative study to capture women's experiences of IRIS. A future longitudinal evaluation would provide important insights.
- 5) Although many GP practices engaged fully in the evaluation, the evaluation team encountered challenges from some, regarding data extraction for the quantitative phase. There are no accountability structures in place to ensure that all stakeholders provide data to an evaluation team when it is necessary for them to do so for the viability of the evaluation. A recommendation is made that participation in service evaluation is an explicit requisite of registering as an IRIS practice and IRISi may take a role in facilitating this action.

"Everyone's aware of antidepressants. Nobody is aware of anti-abuse workers"
Patient quote

Background

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 twelve 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). Moreover, they were 22 times more likely to have a conversation about DVA with their health care professional. Overall, IRIS was found to be an effective intervention and has subsequently been rolled out across primary care services in the UK (and adopted by other countries). It is led by the social enterprise IRISi: <https://irisi.org/about-irisi/>

The IRIS programme entails a full-time Advocate Educator (AE) working with a group of GP practices, based on a worker: patient population ratio. It is aimed at women who are affected by 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 separate training for administration and clinical teams. Reception staff receive one session that lasts for one hour and clinical staff receive two sessions, each lasting two hours. From November 2010 to March 2020, IRIS programmes have:

- Received referrals for 20,544 women
- Fully trained more than 1000 general practices

The result of IRIS programmes is not only better-informed practice, improved responses and support for patients experiencing DVA, but ultimately lives changed and saved (<https://irisi.org/about-irisi/>).

From 2010 to March 2020, 48 localities have commissioned IRIS. Hackney and Bristol were the first sites in 2010. From the West Midlands, Sandwell commissioned IRIS in May 2015, Birmingham October 2015, Solihull 2017, Walsall September 2017, Coventry August 2018, Dudley December 2018. The number of referrals recorded up to 2020 across the West Midlands is circa 2500 (IRISi 2020). In 2016, Bradbury-Jones led on the evaluation of IRIS in two sites in the West Midlands (Birmingham and Sandwell). Aside from the evaluation reports delivered to the funders, the findings relating to the experiences of women who had accessed the programme were reported in a peer reviewed article (Bradbury-Jones et al. 2017). Following the insights from these evaluations, it became apparent that a cross-Midlands evaluation would be useful in providing a fuller picture of IRIS in the region. Moreover, that the evaluation should focus on health and deprivation. Hence the evaluation reported here, that took place between March 2019 and February 2021.

Evaluation Questions

- 1) What impacts does IRIS have on health outcomes as captured in GP and IRIS data in the West Midlands?
- 2) What are the linkages between IRIS as an intervention, deprivation indices and long term health impacts?
- 3) How do survivors of DVA who have accessed IRIS support, describe its impacts on their health and wellbeing?

Methodology and Methods

In this evaluation, the qualitative phase comprised semi-structured interviews with women (n=21) who had been referred through IRIS. We also undertook a rapid, on-line mini questionnaire of AEs' perceptions of the support that they offer. In the quantitative phase, GP records of 294 patients were matched with records from AE to get a picture of the types of health conditions they suffer from as well as information on lifestyle, pregnancies, abuse and violence currently suffered, historical abuse as well as the support IRIS provided. Postcodes were used to extract a deprivation profile of patients attending each surgery and underscored the socio-economic characteristic of the referred population. A pre and post analysis was also conducted on the presence or absence of conditions before and after IRIS support though it needs to be underlined that for recurring conditions, the absence of the condition being recorded in the post data did not indicate that the condition was no longer present.

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 following review by the University of Birmingham Science, Technology, Engineering and Mathematics Ethical Review Committee (Reference ERN_18-1242). 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. Moreover, we adhered to the recently published five pillars of research practice for research into DVA (Women's Aid 2020a):

- Safety and wellbeing;
- Transparency/accountability;

- Equality, human rights, and social justice;
- Engagement;
- Research ethics.

We were particularly focused on the safety and welfare of the IRIS service users who took part in the evaluation. Consent was sought from them prior to participation. Their physical and emotional safety was 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. The women had all been identified by their AEs as meeting the safety criterion for participation and the direct link between participant and AE provided an important mechanism for support where required. Anonymity and confidentiality were assured and all potentially identifying material has been removed in this report.

Phase 1: Qualitative Phase

Summary of Qualitative Findings

The women who took part in the evaluation were overwhelmingly positive about the support they received. They shared their experiences of the intervention itself and the factors that drove them to seek help. Importantly, regarding the focus of the evaluation, they reported their perceptions of the positive impacts of IRIS on both their physical and emotional well-being. When asked about the actual, or likely longevity of such impacts, almost without exception, the women reported that the impacts were long, rather than short term. This is an important finding. Importantly too, is the perception of mothers, that the positive impacts in turn, influence their children and wider family. From the women's accounts we were able to capture survival and recovery of DVA as a process (a journey), rather than an absolute end. Again, it is important to understand this, when considering perceived health benefits of DVA survivors and how these will necessarily vary, as part of the natural, recovery process. Finally, the interviews were all conducted in the summer 2020 – in the midst of the COVID-19 pandemic. This is vital contextualisation when interpreting the qualitative findings, not least in understanding the specific issues raised by the women as regards surviving DVA in the context of a pandemic.

Sampling and Recruitment

All women were identified through an AE who was familiar with the woman and who was able to assess her safety to participate. All women who were identified as potential participants were provided with a Letter of Invitation and an Information Leaflet. If they were interested, they provided the AE with their contact details and these were sent to the research team. The study information included details of participants' ability to withdraw from the interview at any point or to remove their interviews from the study up to two weeks following interview (no women opted for either of these actions).

Data Collection

Qualitative telephone interviews were conducted with 21 women, all of whom had experiences of DVA and had received IRIS support. The evaluation had been designed originally to engage in face-to-face interviews with women at two time points, but due to Covid-19 and social distancing measures, interviews were conducted virtually and at one point only. The interviews were undertaken with reference to a pre-prepared interview schedule, although this was used reflexively according to the nature of the interaction between interviewer and participant. To protect anonymity, each participant was assigned a code comprising a letter (which denotes the area of residence within the West Midlands) and a numerical identifier. For example, D2 is participant 2 from Dudley and W4, participant 4 from Walsall, etc.

Data Analysis

The transcribed interviews were analysed using the thematic approach described by Braun and Clarke (2006). This is a well-utilised approach in qualitative analysis because of its step-wise, robust approach. Bradbury-Jones undertook the initial analysis and the themes were subsequently discussed and agreed with another member of the team (Zafar).

Sample Characteristics

The ages ranged from 22 to 58 years, with a mean age of 40.6 years. The sample reflected diversity as regards ethnicity and religion. Women self-reported as mostly heterosexual (with two identifying as lesbian). Two women reported as disabled. The findings are presented in a manner that seeks to capture the chronology of women's support from IRIS under the following seven

themes: Life before accessing IRIS support; Driving forces for help-seeking; Experiences of IRIS support; Perceived impacts of IRIS; Recovery as a journey; Looking to the future; Living with the pandemic.

Results: Thematic Findings

Background

“There were times when, I wasn’t even surviving because I wanted to be dead”

To get a sense of the impacts of IRIS, we established a qualitatively-derived baseline, by asking participants about their health and wellbeing prior to accessing IRIS support. All

participants gave an account of significant psychosocial challenges, as shown in the following examples. These reflect the serious impacts of controlling behaviours, isolation and ‘gas lighting’:

B4: I was a shell of a person in comparison to who I actually am. He’d isolated me from my friends, I had no self-worth. My self-esteem was rock bottom. I didn’t even know what self-care was, let alone do any. There were times when, I wasn’t even surviving because I wanted to be dead.

W5: I almost lost emotion, but I also lost the ability to be able to control emotion... I’d feel more anger than I’ve ever noticed I’ve ever felt before... I struggled quite a lot with that and there was a lot of emotions that I was unable to control, almost.

W5: I didn't socialise, I was the complete opposite. I really struggled with a lot of the simpler things in life, and I think it was because I felt shameful.

Participant D2 echoed such experiences of being 'ground down', highlighting also the additional strains of being a parent:

D2: Yeah, I just felt really low like and, to be honest, I think I was just ground down by it all. You know, police intervention, child services, I mean I was a bit embarrassed. You know the last thing you want as a parent is child services - you feel like you've failed a little bit, do you know what I mean?

Driving Forces for Help-Seeking

"I knew I needed to talk to someone I was very, I felt very scared, very vulnerable, I felt I didn't feel safe, I didn't know what was going on, I didn't know what was going to happen"

As part of the interviews, we were keen to learn about prompts to help-seeking and the factors that led women to access IRIS support. In the context of their own DVA experiences, many women explained their reasons:

W8: Things got really bad for me and I needed some support and didn't understand a lot of things. Some things had happened which was really hard for me to understand and I needed the right medication and I needed the right support and help and I think that's when [AE] kind of came in a supported me in my hospital appointments and anything else that I needed really. I was struggling financially and mentally in every aspect, literally, I couldn't function, my day would consume of just literally staying in my room sometimes I would have a panic attack going outside, I couldn't leave the house.

C1: I knew I needed to get it off my chest. I knew I needed to talk to someone I was very, I felt very scared, very vulnerable, I felt I didn't feel safe, I didn't know what was going on, I didn't know what was going to happen, I didn't know... what, what, what the routes were for me, you know. If he went to court, if he didn't go to court. I felt safe knowing they were there, by my side to be my advocate. If you get what I mean?

One participant recalled the supportive actions of her GP that had helped her to realise the abusive nature of her relationship (that subsequently led to a referral to IRIS):

D7: I told the doctor, and I just explained the situation, how it was at home, because how I was living with him. And it was the doctor who diagnosed it as coercive control and I thought, that's weird because he said, "has he ever hit you, physically?" and I said, "No." But he was nasty with us, me and my daughter... and it weren't 'till my doctor sort of listened, and then I realised it [was abuse].

One particular issue highlighted by participant B4, was the importance of accessibility of services. As she explained, removal of potential barriers was instrumental in her accessing IRIS support:

B4: Once I knew that it was only down the road, for example – there was lots of things that helped me make that decision, so the fact that it was local, that I could do it, it was term time only, they had child care... so in a way... it got to the point that I couldn't not go! Because there were no barriers, you know? So, all the barriers that, you know, would stop me from going were sorted out.

Experiences of IRIS Support

"She's just sat there and allowed me to speak, allowed me to cry, allowed me to express. And she's given me all... support and advice"

Given the focus of the evaluation, it was inevitable that we would hear a great deal from the women about the IRIS support that they had received. Although such experiences have been captured in previous evaluations

and in the review of programmes conducted by IRISi, we present here some of the salient points illuminated in this evaluation. Most women talked of the specific support offered by their AE:

D6: She's just sat there and allowed me to speak, allowed me to cry, allowed me to express. And she's given me all... support and advice.

S1: She phoned me, literally every week I was being supported. She sent me e-mails, you know. I mean even when my Mum died I phoned her up at eight o'clock in the morning and I says, "I can't cope, I can't do this," and she was really good,

she phoned me straight back. I've managed to get counselling as well because they said they don't want me going backwards. It was... it was brilliant to be honest with you.

B5: I think because she was, she'd done counselling before and she really understands how my brain works. And, she was, after, even after the first session I had, I was realising stuff that I'd not even realised, you know, sunk in before. But it was also, she's been supporting me with not just the whole domestic side of things, you know. It's just given him more control and she was very good with you know, just speaking to me about that because I felt that I'd lost all control... She give me all the right help at that time so I think it was a really good outcome, if I didn't, I don't know which place I would be in if I didn't meet [AE] I probably would have been in a lot of worst place.

In the excerpt from participant B5 above, the issue of gaining control is discussed. This resonated with the accounts of so many women. IRIS support allowed women to understand the nature of their abuse from a more objective viewpoint, which is important in mitigating the effects of 'gas lighting':

D2: Yeah, it was really good, because I think when you're in a domestic violence situation and you're clouded by a lot of factors, it's kind of, you know, someone shedding that bit of light on it for you so you kind of look at it in a different way, if that makes sense?

Many women talked of the importance of being listened to, and as illustrated in the quotes below, the essential act of validation:

B4: And I think it's very important that you are validated by professionals. Not that other women can't validate you, that's also important. But I think that it's really, really important that you can get to an understanding yourself that what was done to you was wrong, and that you're in no way responsible for it.

W5: And I think, I just needed that validation I think, and to believe myself. Because there was lot of things that I didn't say out loud, there was a lot of things that I didn't act on, because if I said it out loud it was real. I think saying it out loud and

realising it's real is one of the most important things because otherwise it just gets hidden away and ignored.

We have already reported on the importance of accessibility. Our sample was predominantly made up of women for whom English was their first language. Crucially though, we learned of the support available to non-English speaking participants that facilitated their access and utilisation of IRIS support:

B1: She [AE] told me, “don’t worry if you can’t speak English, just call me and if you can’t speak, just ring and say “call me”. She said she would call back with an interpreter. I would message her “call me” and she would call back with an interpreter who could speak Urdu. For example, I would call in the evening, even though I know that the office is closed in the evenings, she would text back saying she will call in the morning. Then without fail I would receive a call from her. So that’s why I say that even my soul prays for her. I received a lot of help from [AE].

Finally in relation to experiences of IRIS support, many participants talked of continuity and the important perception of longevity in its availability, as illustrated in this example:

B3: It does always feel like there’s always that open door opportunity. So rather than going back to the doctor to get the re-referral again, because I’ve got someone who’s available to me, I can drop that text message and then the ball can start rolling again. So, what I’d say is you don’t ever feel alone in the process.

Perceived Impacts of IRIS

“My diabetes, well, that is much, much better and my physical health, I’m getting fitter, I’m walking more, I’m exercising more. I’m taking care of me.”

In this section we highlight the impacts of IRIS support of women’s perceptions of health, particularly their psychological and emotional well-being. First, we present two quotes that show the impacts of IRIS on shaping women’s

understandings not only of the abuse itself, but on awareness of psychological help as opposed to prescription of antidepressants and what happens post-referral (which is often a barrier to help-seeking):

D6: I think to be honest with you in that aspect, it's... everyone's aware of antidepressants. Nobody is aware of anti-abuse workers. Forget the antidepressants, no one is aware that we have support workers out there who can do a lot better than those antidepressants can.

One woman was keen to point out the issue of consent and control as regards what happens post-referral:

B5: Especially with IRIS and Women's Aid and I think for me... GPs don't automatically get in touch with the police. I didn't realise this... It doesn't go further without your consent, and I didn't know that.

The positive impacts of IRIS were evident in all participants' accounts and women expressed this in multiple ways. A prominent theme was increased confidence and self-esteem:

B1: Today I can stand on my own feet because before this I was not even allowed out. When I used to go out I used to tremble and get very scared. I can do everything myself now and do everything for my kids and do not have a problem doing it. I have no problems.

B3: In terms of my confidence and self-belief, me realising that actually it's not me – it's not me that's the problem it was him and his behaviours. And because of how they... they obviously listen, I've had lots, I've had a few face-to-face sessions with them, with [AE] and because you've got that person, she can connect with you in the sense that she understands the traits of the typical abuse, she'll give examples and then you relate to them as well and then you'll give your examples. I probably wouldn't be here today if I hadn't had all the support provided by Women's Aid.

S1: I've slowly started to, sort of, understand my anxiety, I know when I'm getting into a situation and I'm... I can see the signs, I'm starting to recognise the signs of anxiety, or I'm feeling low or stressed, you know.

For other women, the impacts related to physical health, mobility and improvements in self-reported eating disorders as illustrated in the following accounts:

D1: My diabetes, well, that is much, much better and my physical health, I'm getting fitter, I'm walking more, I'm exercising more. I'm taking more care of me.

That's the thing, I never took care of me and now I am. So, it's had a massive, massive impact on every aspect of my health.

W6: Well, I was in a wheelchair... and now, the wheelchair is there if I needed, but I'm— I'm trying to make... Let me start again! I push myself to go down for a walk to the garden.

D1: You know my Mum and Dad... IRIS has had such a positive effect because they can see the improvement in me, and as parents, I know how much they worried about me and my partner, you know, constantly worrying about me and my partner. So, obviously that's improved, and they're happy that I'm losing weight I'm not binge eating so much. So, you know, well, to be honest, it's had a big effect on all of us.

In most of the interviews (where it seemed appropriate), we asked women to assess their sense of self-esteem before and after IRIS, based on a virtual Likert scale of 0 relating to extremely poor and 10, extremely high. Table 2 reflects some of their responses to this qualitative self-rating. As shown in these eight reflections, the perceived impacts of IRIS were considerable.

Perhaps unsurprisingly, freedom from control and gas lighting were reported by most women as being powerful impacts of IRIS:

W6: I started reading books because he wouldn't let me read books and, do you know what I mean? So, I haven't stopped reading, but now I've got eye-ache. It's the only trouble now, I get pain in my eyes.

W5: Yeah, I'll say that if I'd stayed the way I was, I wouldn't have been able to have a relationship with anybody, friends, family, or relationship, I wouldn't have been able to have, I wouldn't have been able to sustain a relationship at all.

S4: You know, I feel, I'm beginning to feel freer than I ever felt, I'm not looking over my shoulder as much (although I am looking over my shoulder), but it's definitely not the way I did it before when it first happened.

S3: I feel like I'm gaining everything back – I look back now, and I think: I should have done it sooner. I think it completely changes you, I think it makes you tougher.

Table 1: Participants' perceptions of their self-esteem before and after IRIS support

Before IRIS	Following IRIS support
I'd scale it as one. W8	Now probably about a four.
I was zero. I didn't know what would happen to me or my children and I was really terrified. I was stressed that there was no one to support me. B1	After meeting [AE] I would say 10. I received support and help from [AE] and my stress levels are lower.
Oh, oh, I'd say it would have been even maybe a zero, I would say a one. W4	A good seven or eight.
Probably a zero. D6	I would probably say about... six and half to seven. Because I know that there is plenty more that I can progress at the moment.
I would say a zero. D4	I'm like an eight. I feel like, I feel like I... I don't mean to sound big headed; but I'm an eight! <i>Interviewer:</i> And do you think you could get to ten? <i>Participant:</i> Yeah, when I get my, my kids back, I'll be, I'll be eleven.
Before IRIS very weak, very weak inside... I guess I was kind of, maybe... I don't know maybe a four/ five... D5	IRIS kind of opens your eyes and with the help from IRIS... I feel like I'm definitely ten plus now, definitely.
Well, I would definitely say one to two. D1	And I would say seven to eight now. I could say because I do have times where I've actually just come out to the bit of a bout of depression and anxiety and that.
I'd probably say three. D2	I'd probably say now, I'm probably a...mmm... eight.

Recovery as a Journey

"I haven't come to the end of my journey in terms of dealing with what happened to me, but I'm a lot further forward than I would have been..."

In spite of the evident positive impacts, it is important to recognise that recovery from abuse is a process. It does not occur on a linear time-line and it is one that takes considerable time. Several participants captured this in their

narratives, many using the word 'journey' to refer to their own recovery (such as B4):

B4: I haven't come to the end of my journey in terms of dealing with what happened to me, but I'm a lot further forward than I would have been, had I not been able to get outside support. It's taken a long time for me to recognise and understand that my mission in life is to be the best version of me.

As the following three accounts demonstrate, even on a trajectory of recovery, there are periods of 'down days' (D6), 'worries' (D2) and 'difficult times' (D1). This accounts for why sometimes receiving support means that women may need more help from their GP initially, rather than less, as part of the recovery process. The importance is in the trajectory towards healing:

D6: I mean, don't get me wrong, I do still have my down days, and I've had moments where I've been on the antidepressants but then I put my children first and think, well if I'm teaching my children that they need to battle to succeed in their life, me as being their role model and being on antidepressants – what am I actually teaching them? I'm totally going against my own teachings.

D2: I think my outlook is completely different and I can actually say that I'm happy. Don't get me wrong, I have my worries and... about the future, you know, it is daunting being a single parent, you know, it is hard work but I do have good support network and my boys are really happy, you know, because I'm happy they're happy you know?

D1: To be honest, I honestly don't think, if it wasn't for [AE], I don't think I'd be in here now. I mean, I'm not saying I don't have, my difficult times.

Looking to the Future: "Where do you see yourself in about a year's time?"

“I’ve got my life back on track and I’m feeling a lot better about myself.”

In this evaluation we were keen to capture the impacts of IRIS over time. Time constraints meant that we did not conduct a longitudinal study. Instead, we endeavoured to capture

women’s self-perceptions pre-IRIS support (as already reported). To get a sense of a continued journey, where appropriate, we took the opportunity to ask participants to consider the future. The following excerpts are participants’ responses to the following question: Where do you see yourself in about a year’s time?

B3: I think it’s just the point that you have to accept that they can’t control your life for any longer than you need to. And I refuse to because life is far too short and I think especially with the current climate that we’re in at the moment, it makes you realise what is important and you can’t dwell on the past any more you have to look to the future. And that’s what I want to do, you know.

D6: I am on a mission. There’s like, there’s like, about twenty things going on all at the same time, so, I’m on a solid mission.

D2: I mean I’ve enrolled into college to start in September... So, you know, I’ve got my goals, in place, where I want to get to. You know I want to study, I want to further my career, I want a secure future for my children.

D6: I’ve got my life back on track and I’m feeling a lot better about myself.

These quotes show how, as a process of recovery, the impacts of receiving IRIS support are still to be experienced. This points to the longer-term impacts of IRIS support, albeit from a subjective and hypothetical viewpoint.

[Living with DVA in a Pandemic](#)

“Obviously now, us being lockdown for COVID, I’ve still for [AE] calling me and being there for you, and saying ‘you alright? How’s things?’ And she knows, sometimes you just need someone to talk to that’s not in the family.”

When the evaluation began, the global pandemic of COVID-19 had not arisen, but by the time we conducted the qualitative interviews, the UK was in the midst of the first national lockdown (and hence the need for remote methods of interviewing the women).

Although not forming a core part of the evaluation, we are able to report on some of the insights gained in relation to IRIS in the context of COVID-19. In response to the pandemic, the prompt adaptation of domestic violence services to remote working, rather than face-to-face support was required. For some women, the shift in mode of delivery of services was regarded as troublesome:

B4: When the pandemic started everything was a bit changed with everything, I wasn’t able to go back to the GP and have face-to-face consultations or to get the right medication.

Interview: Right, so the pandemic and the lockdown has impacted even on your GP visits?

Participant: Yeah, yeah, it has.

W8: I did get some help from somebody and it was a therapy on the phone but I wasn’t really comfortable talking to someone I’ve never seen and spoken to and, so I wasn’t really getting anywhere with that so I had a few sessions and I wasn’t really responding to that and then they kind of had to let me go kind of thing.

For one woman, the pandemic had a negative impact on her ability to access services (although in the following example, as part of IRIS support, the AE was mitigating such impacts):

B1: Actually, what I am in the most need of is to learn English. [AE] helped to find a course for me for English classes. I was going to be enrolled on it but when I was provided a date to attend the country went into lockdown because of the pandemic of COVID-19. I was told that due to COVID-19 everyone is working from home and nothing is open. So I am unable to learn to speak English and make my life a little easier. [AE] is trying and as soon as something is available, she will inform me.

For most women who talked about the pandemic, the service responses were regarded as effective, efficient and supportive, as illustrated in the following quotes:

D5: Obviously now, us being lockdown for COVID, I've still for [AE], calling me and being there for you, and saying "you alright? How's things?" and she knows, sometimes you just need someone to talk to that's not in the family.

B5: I think it's really helpful to have someone who rings you regularly to check up on you. I think it's so important, especially you know, if you're in that situation and COVID makes it twice as difficult. You know, and it's a terrifying thought to think if I was in one of those relationships in my past in COVID... It's... because I mean women were worried that they couldn't leave because of COVID rules, and obviously that's not the case. And thankfully the government made that very clear, thankfully.

A surprising finding from the evaluation is held in the final excerpt that alludes to the perceived protective nature of the pandemic. Highlighting, perhaps paradoxically, how lockdown and social isolation may have provided a safe haven for some women post-separation:

W4: When COVID wasn't happening if [AE] said "right, come and meet me at the GP," I would have to rely on like, you know my partner or, you know, a friend to drop me down... COVID has actually helped me loads like, even though loads of people have like, unfortunately, developed mental health because of it. With me, the fact that people are stuck in their homes helped me, because I actually I went out for walks with my daughter. I felt safe.

Phase 2: Quantitative Phase Methodology

Data Collection

Data were collected from GP surgeries and IRIS support agencies: Black Country Women's Aid (BCWA), Birmingham and Solihull Women's Aid (BSWA) and Country Haven Women's Aid (CHWA) across the West Midlands: Coventry, Dudley, Walsall, Sandwell, West Birmingham, Birmingham and Solihull. The data collected per patient comprised of variables pertaining to socio-

demographic, lifestyle, prescriptions, consultations, pregnancies, health conditions, mental health, abuse and violence suffered as well as the referral to IRIS and support and the nature of support provided.

Study Criteria

Criteria - Surgeries:

- Only IRIS trained surgeries would be included in the evaluation where those surgeries have referred patients to IRIS for support.

Criteria – Patients Included:

- All referrals and ≥ 18 years only including self-referrals and re-referrals.

Study Period

At least 6 months of time for post IRIS data was required to collect sufficient information on health conditions post IRIS intervention compared to pre.

Only 44 surgeries (out of 156) across the West Midlands responded with data collected from 294 patients.

Demographic, lifestyle, pregnancies, abuse and violence suffered, historical abuse, IRIS support provided were variables used in data analysis for all patients. The pre and post model was only used on data pertaining to health conditions, prescriptions and consultations to see if there were statistically significant changes, with the caveat that for chronic conditions an absence does not necessarily indicate an absence of the condition.

Phase 2 Quantitative Results

Descriptive Statistics and Pre and Post Analysis for West Midlands

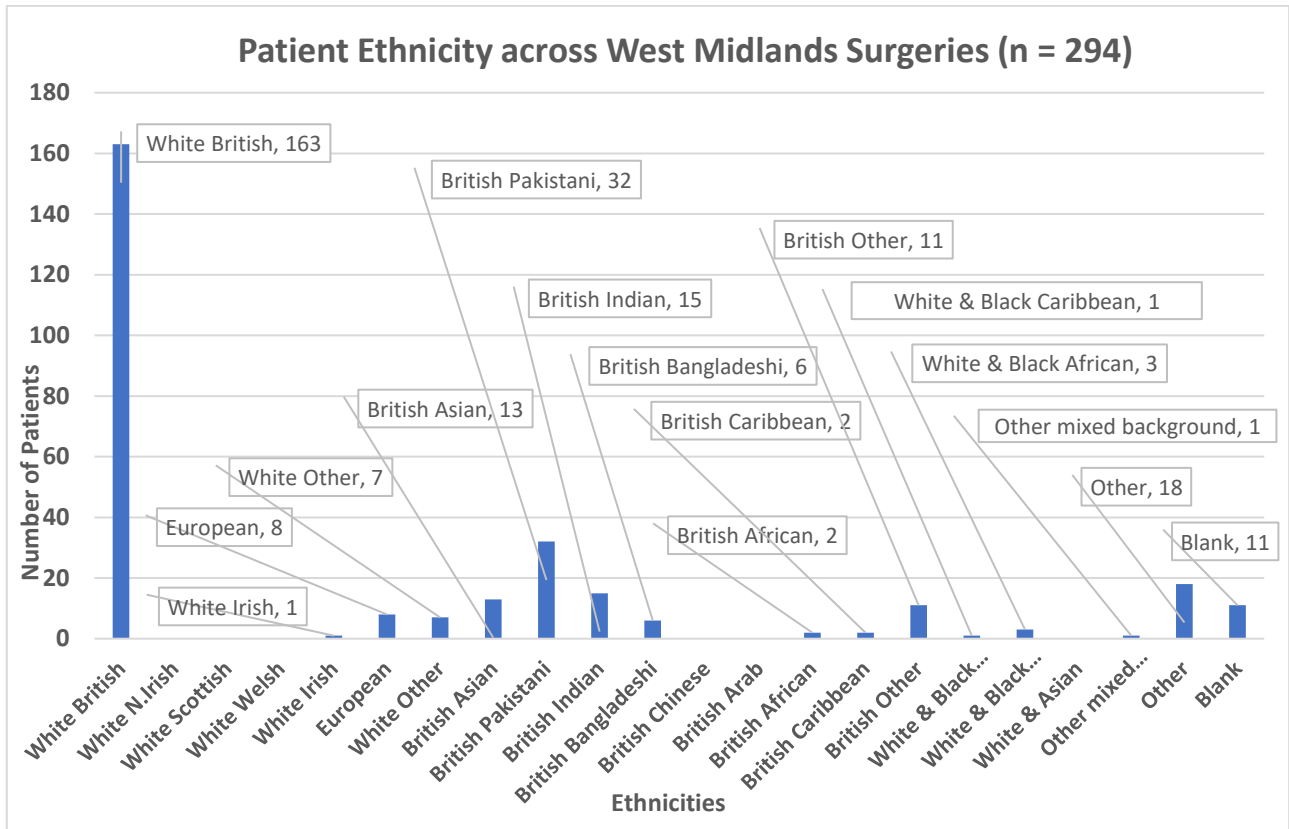
Outlined are the overall results on ethnicity and deprivation across the surgeries in the West Midlands, as per Graphs 1 and 2. Graph 1 shows the ethnic backgrounds of patients attending surgeries across the West Midlands. The majority of patients (55%) were of White British background, whilst the next highest in percentage were of British Pakistani (11%). While they

constitute a majority in the sample, compared to the ethnicity distribution of White British in West Midlands (roughly 79% according to the last census, see

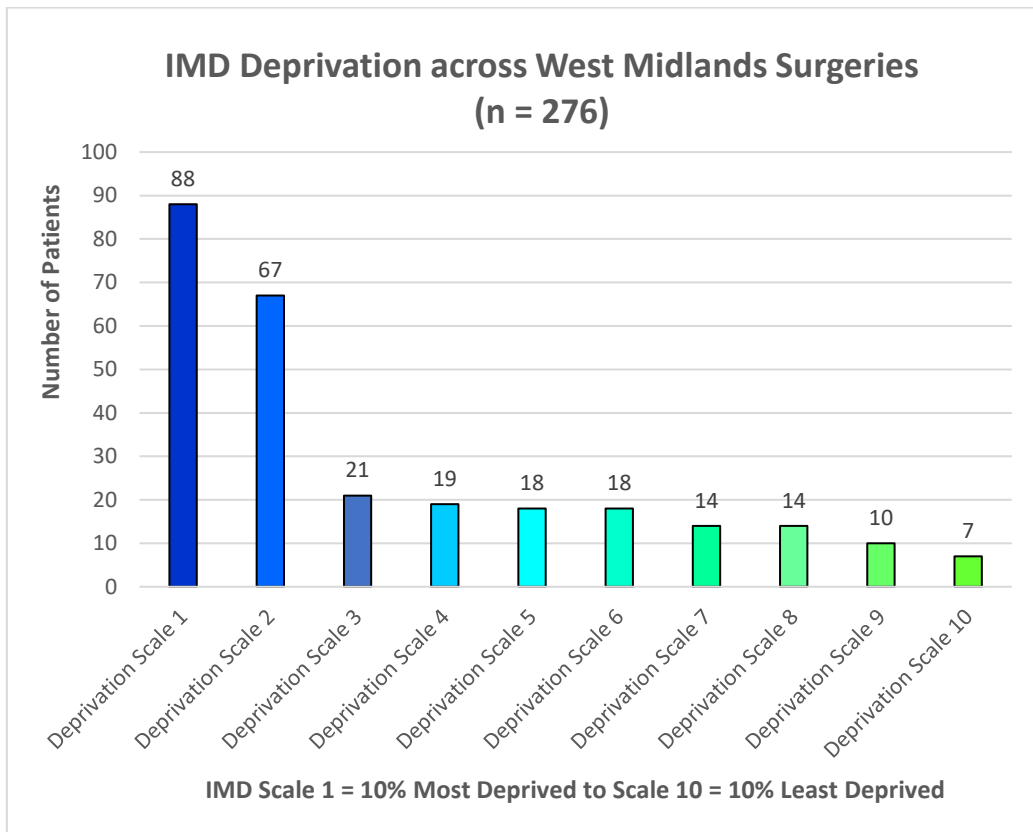
<https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityandnationalidentityinenglandandwales/2012-12-11#:~:text=The%20West%20Midlands%20had%20a,British%20at%2079.2%20per%20cent>) this

indicated an underrepresentation of White British and an overrepresentation of other ethnic groups in our sample of patients.

Graph 1: Demographic background of patients attending surgeries across the West Midlands



Graph 2: Deprivation profile of patients attending surgeries across the West Midlands

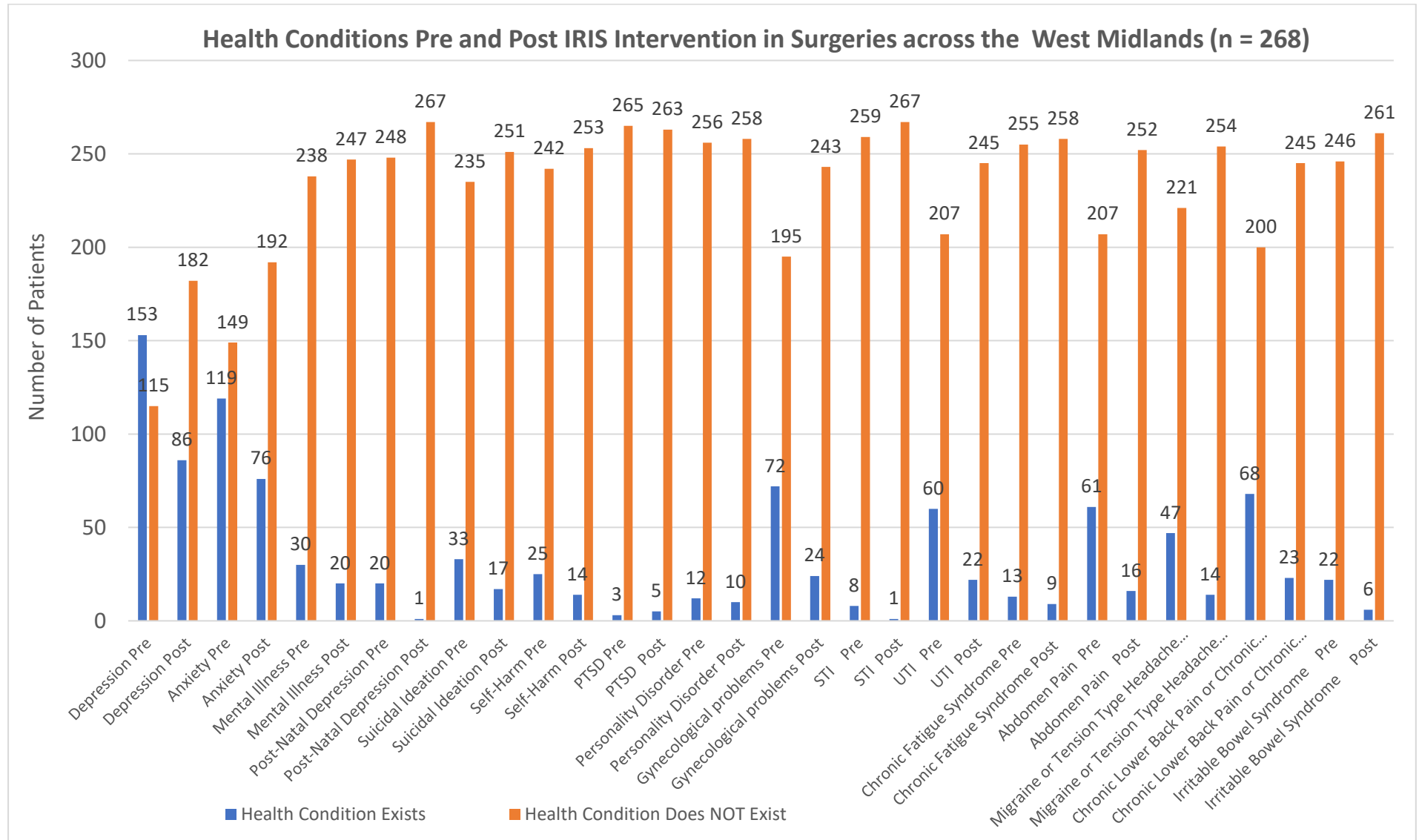


Deprivation: The Index of Multiple Deprivation, commonly known as the IMD was used as this is the official measure of relative deprivation for small areas in England. The deprivation distribution

in Graph 2 indicates the number of patients (32%) who fall in 10% of the most deprived decile. This decile forms England's most deprived areas. The next highest percentage of patients (24%) fall in the 20% of the most deprived decile. The results indicate that collectively 77% of patients who attend surgeries across the West Midlands live in the most deprived areas, which is represented by decile scales of 1 to 5. The rest (23%) live in the least deprived areas of England represented by decile scales of 6 to 10.

Health conditions: Graph 3 shows the existence of health conditions present either before any IRIS intervention or after IRIS intervention amongst those patients who were referred to IRIS across the surgeries in West Midlands.

Graph 3: Existence of health conditions before and after IRIS Intervention in surgeries across the West Midlands



Pre and post analysis: This was followed by a pre and post analysis of health conditions as a crude measure of whether patients had less health complaints post IRIS, showing that there is significant difference in the health conditions before and after treatment.

Similar data were collected for prescriptions and number of consultations. The results show that for mental health prescriptions; anti-depressants, anxiolytics, anti-psychotic medication, are all higher post IRIS but lower in consultations post IRIS. The increase in prescriptions accompanied by a fall in consultations may occur for a number of reasons. A possibility is that the mental health medications are provided as monthly prescriptions which indicate better patient compliance with collecting medication post IRIS while the need to consult with the GP (which is not a requirement to pick up repeat prescription) falls as they have less unmet health needs. In fact, at time of IRIS referral, mental health prescriptions were also issued which would show up as an increased number of prescriptions post IRIS. A similar trend is seen for opioids, birth control and UTIs. A test of significance of difference in means shows that there is no significant difference in the number of prescriptions issued or consultations attended before and after treatment.

Overall Evaluation Findings

The quantitative phase of the evaluation showed a significant drop in the mean number of conditions post-IRIS as recorded on GP records. We have placed a caveat on interpreting these results because the change in chronic conditions may not necessarily signify that they no longer exist. However, the evaluation findings do indicate a positive impact of IRIS on many conditions, as presented in the results. For example, depression, anxiety, mental illness, post-natal depression, suicidal ideation and self-harm, all showed a significant drop following IRIS. Pre-IRIS, 57% (n=153) of the sample had depression recorded, and 44% (n=119) had anxiety recorded. These are consistent with rates recorded nationally, with 59.1% of women referred to IRIS experiencing mental ill health, mainly depression and/or anxiety (IRISi 2020). This is reassuring suggesting our sample was representative of the women referred to IRIS. Invaluable insights from the evaluation though, show that post-IRIS, depression and anxiety were recorded at 32% (n=86) and 28% (n=76) respectively. The quantitative results show similar positive impacts across a range of health conditions (including non-chronic ones) and these are all consistent with the qualitative findings

that indicated a positive association between IRIS and perceived improved health among the women who participated.

The evaluation findings regarding health impacts are important when considering the broader DVA literature. The long-term impacts of DVA on women's physical and mental health are well established (Dillon *et al.*, 2013). Chronic health problems can result both directly and indirectly from exposure to DVA, with consequences ranging from injury-related health problems (for example, damage to sight and hearing) to issues arising from exposure to prolonged stress (for example, chronic pain syndromes) (WHO & Pan American Health Organization, 2013). Women who experience DVA are also at an increased risk of various lasting adverse mental health outcomes, including depression, anxiety and post-traumatic stress disorder (Ferrari *et al.*, 2016). In a US-based longitudinal study, Zlotnick and colleagues (2006) found that women who experienced DVA continued to experience long-term mental health problems regardless of whether or not they remained in an abusive relationship. Furthermore, evidence suggests that the relationship between DVA and psychological ill-health is bidirectional (that is, women who experience mental health difficulties are at greater risk of DVA, and vice versa) (Devries *et al.*, 2013). With this broader context in mind, the impacts of IRIS reported in this evaluation report are important.

Women who took part in the qualitative phase were overwhelmingly supportive of IRIS and its impacts, as already discussed. Almost all participating women emphasised the importance of retaining the intervention so that it can continue to provide support to DVA survivors. These findings concur with national IRIS data (IRISi 2020), where feedback from more than 1500 service users showed that:

- The majority feeling safer, more confident and able to cope;
- 81% agreed/strongly agreed that they felt optimistic about the future;
- 70% agreed/strongly agreed that they accessed the GP or practice nurse less following IRIS intervention.

The qualitative findings provide evidence for the value that women place in having the input of a skilled person to support them. All women who took part in the evaluation had received AE support for either emotional support and/or advice. This aligns with national IRIS data, where data

from 20,262 service users showed a range of support offered by AEs, with emotional support (45%) and advice and information (37%) being the most commonly accessed. Multiple forms of support were received by 65% – this is two out of every three women, with 98% of women pleased to be referred to an AE (IRISi 2020). Our evaluation findings regarding perceived benefits of AE support, reinforce data from the national evaluation.

Identification and referral responses that lead to support from that AE are contingent on health professionals being aware of the nuanced indicators of DVA and who know the referral pathways. This is the *raison d'être* of IRIS. Up-skilling the healthcare workforce in relation to recognition and response to DVA is crucial and is an issue that has gained prominence in literature over recent years. Despite the fact that women experiencing DVA are frequent users of mainstream health services (Hegarty *et al.*, 2013), health professionals' responses to disclosures of DVA remain inconsistent. In a UK-based qualitative study, Keeling and Fisher (2015) found that while some women reported receiving appropriate support following a disclosure of abuse, others described experiencing dismissal and renunciation from health professionals. Similarly, Ramsay *et al.* (2012) found that primary care clinicians in the UK felt ill-prepared to enquire about and respond to DVA, with many reporting insufficient previous training as a contributing factor. With these contextual issues in mind, the evaluation highlights the importance of receiving DVA support from a suitably prepared GP (or other member of the practice team), who is the catalyst for referral and safety planning.

We have referred to the impacts of COVID-19 on the evaluation and consider it for discussion here, with reference to some emerging literature and research. National measures implemented in response to the COVID-19 pandemic have presented challenges both to those experiencing DVA and UK support services (Chandan *et al.*, 2020). Emerging evidence suggests that lockdown restrictions have resulted in worsening abuse for women – particularly those living with their abuser (Women's Aid, 2020b). This has been attributed to reduced access to support networks, increased susceptibility to control tactics as a result of isolation, and heightened household stress resulting from financial instability (Roesch *et al.*, 2020). Additionally, the pandemic has resulted in an exacerbation of many pre-existing structural inequalities that disproportionately affect women, including income inequality and unequal sharing of household and childcare responsibilities (Andrew *et al.*, 2020). It is noteworthy here though, that in the qualitative evaluation findings,

eight of the women who took part told us that the restrictive measures of lockdown during COVID-19 held a protective factor against further abuse. It is important to emphasise though, that the women had exited the relationship and were no longer with the perpetrator. Lockdown meant that they were 'locked-away' from their perpetrator as opposed to 'locked-in'. This provides a new angle on understanding the safety of DVA survivors post-separation and is an area that warrants further research. It needs to be contextualised though, in terms of the undoubted negative impacts on many DVA survivors who have experienced new episodes or exacerbated abuse at this time.

Most DVA support services are now operating remotely, using online platforms or telephone support, in order to reduce the risks associated with face-to-face contact. It is useful to present here the key responses of IRISi in relation to the pandemic (see the following for further details: <https://irisi.org/all-resources/covid-19-guidance-and-advice/> <https://irisi.org/wp-content/uploads/2020/09/Adaptations-to-IRIS-During-COVID-19-3.pdf>

In response to COVID-19 IRISi have:

- Developed and issued a number of guidance papers;
- Developed webinar versions of all training;
- Supported IRIS sites to adapt their training and delivery of IRIS.

While many women have reported positive experiences of remote DVA services (including the women who participated in this evaluation), others have highlighted the challenges of arranging appointments remotely or receiving slower-than-usual responses from professionals (Women's Aid, 2020b). Furthermore, as Bradbury-Jones and Isham (2020) note, many women experiencing abuse do not have (safe) access to the technology required to utilise remote services. On the other hand, recent strong evidence from Canada (Ford-Gilboe *et al.*, 2020) illustrates that online DVA interventions can result in sustained benefits for women in a variety of contexts. Women in both tailored and non-tailored groups of this randomised controlled trial demonstrated improvements in their symptoms of depression and PTSD over time. Moreover, the study's diverse sample (including women from a variety of socioeconomic backgrounds, cultural groups and living situations, and with varying experiences of abuse) suggests that such interventions are suitable to

meeting complex needs. Given the diversity of respondents who took part in the qualitative phase of the evaluation, this is important contextual information.

Limitations of the Evaluation

Almost one year of the evaluation took place in the context of a global pandemic. Moreover, this coincided with data collection for both the qualitative and quantitative phases. While the evaluation team took measures to mitigate the impacts of social distancing and remote working, the evaluation was impacted, particularly regarding adherence to the original scope and timeline. This needs to be taken into account when reading the evaluation report and its recommendations.

As regards the qualitative phase, interviews were conducted with women who were identified and recruited via the AE from whom they had received support. While this assisted with recruitment numbers, and provided a crucial support mechanism for the women, it is likely to have introduced an inherent selection bias. Interviews with women in the qualitative phase were converted to on-line, rather than face-to-face. In some interviews, this may have compromised the richness of data generated.

There are a number of limitations of the quantitative analysis mainly caused by difficulties of obtaining data:

- There is a possibility that the set of patients is non representative of those who were referred to IRIS as out of 1798 patients eligible for the evaluation, data on only 294 were returned even though we were able to sample across practices across a number of boroughs/councils.
- It was not possible to obtain a control group to compare to the treatment group.
- The pre and post analysis must be treated with caution particularly for chronic conditions as absence in the post data does not imply that the problem has necessarily disappeared.

These limitations notwithstanding the quantitative analysis indicates that the sample has higher than average levels of deprivation and often faces complex health problem, particularly mental health. While we do not read too much into the post data on mental health it is encouraging to find that even non chronic conditions (e.g. UTI and STI) show a reduction post IRIS. These are in

line with the problems arising from deprivation captured in the qualitative analysis and are consistent with the themes of how IRIS has helped them as brought out in the interviews.

The 8-step process that was implemented in relation to data collection in the quantitative phase, involved complex negotiations on how data could be safely and appropriately shared, which caused significant delays in data collection and analysis. Agreeing how to share data and the variables to be used created further delays were caused by the restrictive measures put in place nationally in response to COVID-19. Some surgeries did not respond and other surgeries shelved participation in the evaluation at the start of the lockdown in preparation for UK health delivery and priorities during the pandemic. Additionally, some GP surgeries requested payment for conducting the evaluation for which there was no budget which significantly affected the rate of return. The problems with data capture suggest that some changes in accountability structures may be needed, as under the present governance structure, GPs participating in IRIS have no obligation to participate in the evaluation. Many see the data collection as onerous and along with other stakeholders continue to have concerns around patient privacy even though research for statistical analysis remains explicitly covered under GDPR.

Overall, the quantitative data are limited by the fact that it is not possible to distinguish from the data whether many chronic conditions (e.g. forms of mental ill health) have improved over time. Further, the unavailability of data from a suitable control group makes any kind of causal inference difficult. The evaluation team were reliant of GP practice staff and AEs to complete the data collection sheets. This occurred at a time of immense pressure on primary care and DVA service provision, as they adjusted to the demands of the pandemic. The evaluation team acknowledge the immense efforts of our colleagues who despite the challenges, provided the required data. We accept that its quality and quantity may in some instances have been impacted due to unavoidable competing demands.

Conclusions

The evaluation drew on both qualitative and quantitative approaches and the combined insights have captured a hitherto un-reported analysis of the impacts of IRIS on health, coupled with analyses of deprivation. Women who took part in the qualitative phase reported that IRIS had impacted positively on their health and moreover, they perceived that such impacts will be long

lasting. The quantitative results support the qualitative findings, showing a decline in multiple health conditions recorded by GPs recorded post-IRIS, in comparison to pre-IRIS. These results need to be interpreted cautiously given the complexities in both reporting and recording of any long term conditions.

The inherent challenges and limitations with the quantitative phase have led us to emphasise the qualitative findings and to place the voice of survivors as central to the evaluation. They provided many insights that support existing, national data regarding the perceived benefits and impacts of IRIS. Novel insights are provided that highlight the perceived longer-term impacts of IRIS as perceived by women themselves, who are in a position to speak with authority regarding how IRIS has impacted positively on their health and well-being and crucially, how this will continue in the longer-term.

Recommendations

- 1) IRIS support impacts positively on the health of women in receipt of the service and it needs to be continued and expanded across the West Midlands.
- 2) Remote support for DVA during the pandemic has been well received. Opportunities need to be taken to learn from emerging evidence as it becomes available regarding the most effective modes of providing IRIS in non-face-to-face settings.
- 3) The evaluation findings indicate that some women considered the restrictive measures of lock-down during COVID-19, to be a protective factor against further abuse. The insight is from a minority of women, so it needs to be interpreted carefully. It is suggested as an area of future research.
- 4) The restrictions of COVID-19 meant that we were unable to conduct a longitudinal qualitative study to capture women's experiences of IRIS. A future longitudinal evaluation would provide important insights.
- 5) Although many GP practices engaged fully in the evaluation, the evaluation team encountered challenges from some, regarding data extraction for the quantitative phase. There are no accountability structures in place to ensure that all stakeholders provide data to an evaluation team when it is necessary for them to do so for the viability of the evaluation. A recommendation is made that participation in service evaluation is an explicit requisite of registering as an IRIS practice and IRISi may take a role in facilitating this action.

Acknowledgments

We would like to express our gratitude to the IRIS AEs who helped with the patients and participant identification and for providing the information required throughout this evaluation: Jennifer Lumsden-Gordon and her team: Toni Jones, Jayne Element, Randip Gakhal, Eleanor Chew, Chloe Best, Jas Adkins; and Sarah Alexander and her team especially Andrea Davis; and Haley Lenton.

Thanks are extended to the CCGs leads for providing help and support required to link with GPs, in particular Marie Kelly, Natalie Solomon for helping with deprivation, and a special thank you to Andrew Colson for being our support throughout the evaluation. Thanks also to the GP surgery staff who provided data and liaised frequently throughout the evaluation, in spite of the pressures of the pandemic and lockdown. Finally, huge thanks to the women participants who provided us with impactful information about their IRIS journey.

“ I honestly think that if it wasn't for [AE], I don't think I'd be in here now.”

Patient quote

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