NETWORK REPORT

2023 - 2024

IRiS ADViSE IRISi interventions

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ACKNOWLEDGEMENTS

Our gratitude to the IRISi network:

All Clinical Leads, Advocate Educators, Service Managers, Commissioners, and many other professionals and partner organisations involved in the IRIS and ADViSE programmes.

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ACCESSIBILITY STATEMENT

Accessibility is important to IRISi, and we have made proactive steps to embed this into this report. However, we may have missed things. If you require this report in an alternative format, please get in touch with Geisa D'avo geisa.davo@irisi.org and we will endeavour to meet your needs.

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Executive summary

This report provides a detailed analysis of the work of the IRIS and ADViSE programmes during the 2023-24 fiscal year. The IRIS and ADViSE programmes improve healthcare responses to gender-based violence and abuse. The report highlights the work of IRIS and ADViSE teams to support health care professionals to identify patients affected by domestic abuse and sexual violence and refer them for support by specialist VAWG (Violence Against Women and Girls) services.

The IRIS programme, our evidence-based intervention to improve the general practice response to domestic abuse, launched as a commissionable model in 2011 and has grown significantly, supporting nearly 44,000 patients since its inception. Our second intervention, the ADViSE programme, started in 2021. ADVise improves the response of sexual health services to address domestic abuse and sexual violence, and it reached its 1,000-referral milestone during the 2023-24 fiscal year. Despite nationwide funding challenges affecting the commissioning of both health and VAWG services, both programmes demonstrated a positive impact on improving healthcare practices and outcomes for victim-survivors. This summary outlines the key findings and recommendations based on the data presented.

KEY FINDINGS

1 **PROGRAMME GROWTH AND REACH** The network of IRIS and ADViSE programmes continues to grow, with significant geographical spread across the UK. As of March 2024, the IRIS programme has received 43,535 referrals for patients who have experienced domestic abuse, while the ADViSE programme has received 1,051 referrals. The wider impacts of our programmes extend past the number of referrals; we have been able to estimate that least 15,800 women will have been identified and supported as victim-survivors by IRIS-trained general practice staff during 2023-24. The data indicate a steady increase in referrals, especially for the IRIS programme. Despite challenges like funding delays, the programmes have shown a positive trend in referral numbers per site over time. ADViSE, being a newer programme, experienced a slower growth rate. This is expected; the IRIS programme is ten years ahead in terms of uptake and implementation.

2 **CONNECTING SPECIALIST VAWG SERVICES AND HEALTHCARE** In 2023-24, there were over 100 Advocate Educators (AEs) working to deliver the IRIS and ADViSE programmes across the country. These AEs were employed across 38 specialist service partners, and delivered 1,091 training sessions, improving the clinical practice of over 4,600 healthcare professionals to better respond to VAWG. Feedback from these sessions was overwhelmingly positive with reported improvements in knowledge and confidence in addressing DA and SV. Encouragingly, we saw that in the majority of aspects our ADViSE programme reflects the IRIS programme in terms of performance, evidencing that ADViSE is also a high quality, scalable programme.

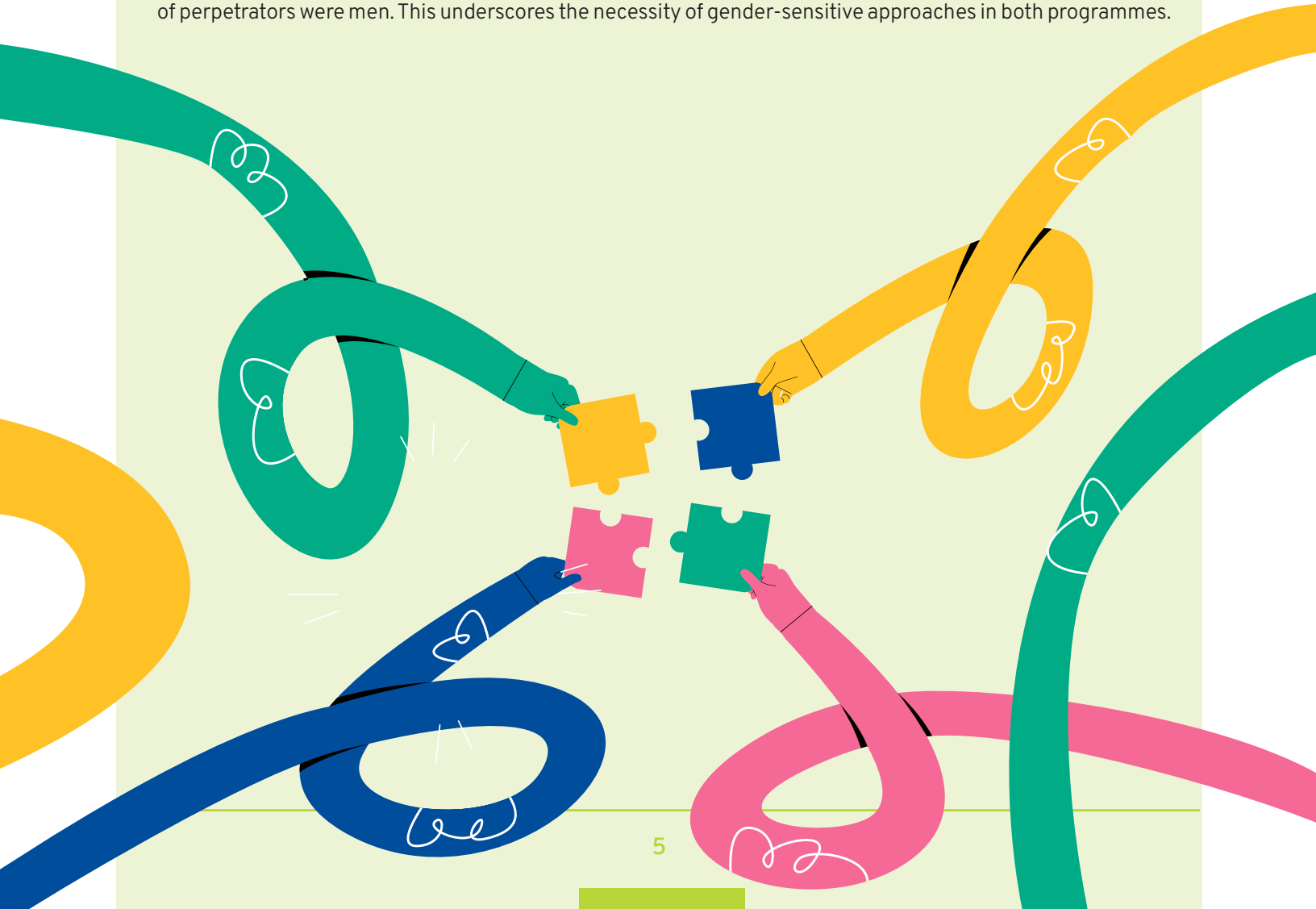
3 **REACHING AN UNMET NEED** IRIS and ADViSE service users are patients who have experienced domestic abuse and/or sexual violence, and who have been identified and referred by a general practice or sexual health clinician. The majority of service users supported by the two programmes had not been able to get support previously for the domestic abuse and/or sexual violence they had experienced. This highlights that IRISi interventions are meeting an unmet need in society. We also see that the two programmes reach different groups of people, and that this difference isn't driven solely by the differences in the referral criteria for the programmes. In particular, a real strength of the ADViSE programme is that it appears to be well-placed to support those from the LGBTQ+ community.

4 FURTHER WORK NEEDED In keeping with IRISi's programmes being evidence based, we have used our data to highlight where further improvements can be made. Our data show that while Black and minoritised victims and survivors are over-represented in referrals, this rate appears to drop amongst the group of patients who engage with support. Without further data analysis, we cannot speculate on the cause. By understanding this further IRISi will be able to ensure that our programmes continue to meet the needs of all people.

5 PREVALENCE OF SEXUAL VIOLENCE We continue to see that those referred to the ADViSE programme have experienced sexual violence (outside of the context of domestic abuse, such as from a stranger, colleague or acquaintance). One in two service users needed support for sexual violence. Our data show us that ADViSE service users are more likely to experience self-harm and suicidal ideation than IRIS service users. The multiple needs of this group are reflected in the complexity of the casework undertaken by Advocate Educators.

6 HOLISTIC SUPPORT Our data highlight that there is a broad range of support sought by survivors of domestic abuse and sexual violence. We see that only a small minority of survivors wish to pursue criminal justice measures, whilst the majority of survivors want emotional support and advice. More than four in ten service users wanted onward referrals to other organisations, highlighting the importance of wide range of services being funded to provide holistic support to survivors.

7 GENDER-BASED VIOLENCE Gender continues to play a significant role in the experiences of abuse. Even with the introduction of the ADViSE programme which supports all genders, we continue to see disproportionately high numbers of women accessing the services. The data also show that in 2023-24, 92% of perpetrators were men. This underscores the necessity of gender-sensitive approaches in both programmes.



SUMMARY OF KEY RECOMMENDATIONS

By following these recommendations, those with decision making power across government (national, devolved and local), the health system and the VAWG sector, can continue to strengthen the impact of both the IRIS and ADViSE programmes, providing vital support to victim-survivors and improving the healthcare response to domestic abuse and sexual violence.

1 **DOMESTIC ABUSE AND SEXUAL VIOLENCE MUST BE RECOGNISED AS HEALTH ISSUES** VAWG must be addressed by the health system at every level as a health issue and government departments and bodies should work alongside the specialist VAWG sector to achieve this. Adequate and sustainable funding must be provided by central government to enable this to happen.

2 **EXPANSION OF THE IRIS AND ADVISE PROGRAMMES** Local health commissioners should commission effective, evidence-based interventions to improve the health response to domestic abuse and sexual violence and award longer contracts for this work to be undertaken. Expanding the programmes to cover more geographical areas would help reduce the current postcode lottery, ensuring that more survivors can access the necessary support. The success of the IRIS programme's scalability provides strong evidence that ADViSE could also scale successfully. Currently commissioned areas need secure, multi-year funding at safe levels. Funding gaps lead to disruptions in service delivery, impacting referral numbers and healthcare professionals' confidence in making referrals. Regular reviews of and potential increases in funding should be prioritised to ensure the retention of delivery teams and uninterrupted programme delivery to best support the responses to VAWG within our health system.

3 **ENHANCED DATA COLLECTION** IRISi should work with its network to refine its programme and training materials and to improve its data collection in order to provide more nuanced analyses in the future. Improvements in data collection processes, particularly around the recording of healthcare connections, are crucial for better understanding the full impact of the programmes. Structural updates to the IRISi database would enable more comprehensive tracking of training attendances, referrals, and ongoing connections between specialist VAWG services and health care services.

4 **EVIDENCE LED TAILORING OF PROGRAMMES** IRISi will further monitor differences between the IRIS and the ADViSE data and adapt the ADViSE programme accordingly. This will include reviewing training materials for healthcare staff and reviewing what practice development will enable Advocate Educators to better be able to support victim-survivors.

IRISi's interventions:

Bridging the gap between healthcare and the specialist Domestic Abuse and Violence Against Women and Girls sector

IRIS TRAINING

4,522 general practice staff completed their initial IRIS training.

Estimated reach

Across England and Wales, we estimate that 1.5 million women who have experienced domestic abuse are now able to access the IRIS Programme via their general practice.

We estimate that GPs identified & supported at least 15,800 victim survivors as a result of their IRIS training.

Bridging the gap between health and the specialist DA & VAWG Sector

- IRIS and ADViSE partner organisations **worked with over 1,000 GP practices/sexual health clinics** to improve their response to DA and SV.
- This is not one-off training; relationships are maintained - nearly **200 follow up training sessions** were delivered for healthcare professionals.

PARTNERSHIP WORK WITH SPECIALIST DOMESTIC ABUSE SERVICES

Over **100 advocate educators** from **38 specialist** partners supported clinicians and service users across the country.

Advocate educator

"Our role is twofold: we provide training to clinicians and support service users throughout their journey. Delivering training and hearing the diverse experiences and insights from participants is one of my favourite aspects of being an AE."

SUPPORT FOR VICTIM-SURVIVORS

- Support is patient-led and tailored to individual needs.
- It could be one-off advice, or advocacy and support for several months.
- The most common areas AEs supported service users with were ongoing emotional support and advice & information.

ADViSE TRAINING

121 sexual health clinic staff completed their initial ADViSE training.

Clinician trained by IRISi

"Having personal experience of being in an abusive relationship, this really resonated with me. Very informative and well presented".

In total, there were **7,234** referrals to IRIS and ADViSE programmes, comprised of **6,626** referrals made to IRIS advocates and **608** made to ADViSE advocates.

"This is the first service I have been involved with that makes me feel seen, heard, understood and supported. I very much appreciate the help given to me and will always be grateful"

Service User

Glossary

ADViSE **A**ssessing for **D**omestic **V**iolence in **S**exual health **E**nvironments. The ADViSE programme supports sexual health clinicians to identify and respond to patients affected by both domestic & sexual violence and abuse. In addition, the programme facilitates onwards referral for the victim-survivor to specialist services.

Advocate Educator (AE) The integral member of a local IRIS/ADViSE team. The AE delivers training and ongoing support to healthcare staff. Additionally, they support those who have been identified as victim-survivors and who wish to receive onwards specialist support.

Clinical Lead (CL) A local practising clinician who is a key member of a local IRIS/ADViSE team. The CL champions the programme amongst clinical peers and uses their contacts to engage healthcare settings with the programme. They also co-deliver training with the AE.

Clinical Staff The staff within a healthcare setting who directly treat patients or deliver patient care. This includes roles such as nurses, doctors, sexual health practitioners.

Domestic Abuse (DA) Domestic abuse encompasses various forms of abusive behaviour that occur within a domestic or family context. It includes physical, emotional, psychological, sexual, or financial abuse between intimate partners or family members. Due to changes in language over time, some of IRISi's older literature may also use the term DVA (domestic violence and abuse) and DV (domestic violence).

Domestic Abuse and Sexual Violence (DASV) This term combines domestic violence and sexual violence to emphasise the interconnectedness of these forms of abuse within intimate relationships or family settings.

Ethnicity A term that refers to the social and cultural characteristics, backgrounds or experiences shared by a group of people. This could be based on their culture, family background, identity or physical appearance. Ethnicity is self-defined.

Gender and Sex IRISi recognises that there is a changing landscape in relation to data capture around gender and sex. This report has taken a trans-inclusive approach and will categorise people by the gender they state they are. Where any data sources used only refer to male/female the original source's language is mimicked in the text for the purpose of clarity. For analysis purposes, 'female' has been taken to mean woman/girl & 'male' to mean man/boy. This method is to allow comparisons to be made to other datasets and is not reflective of an essentialist approach to gender.

Gender based violence (GBV) Gender-Based Violence refers to an act perpetrated against someone against their will as a result of unequal power relationships perpetuated by gender norms. IRISi uses the term gender-based violence in recognition of this. GBV may take the form of emotional and psychological abuse, physical abuse, sexual violence and abuse, stalking and harassment, intimidation and humiliation, manipulation, threatening behaviour, financial control, coercion, isolation and entrapment, forced marriage, 'honour'-based violence, human trafficking, modern slavery, and FGM.

IRISi's programmes including training, materials and other guides, and these are rooted in the understanding that those exposed to violence and abuse throughout their lives are likely to experience long term impacts. This is particularly true for women and girls. We understand that the above acts of violence and abuse are perpetrated as a result of harmful gender norms, no matter who is subjected to them. The majority of GBV is perpetrated against women and girls, though many men, boys and those with gender-fluid identities also experience it.

Healthcare staff Includes both clinical and non-clinical staff that work within a health care setting.

IRIS **I**dentification and **R**eferral to **I**mprove **S**afety. The IRIS programme is an evidence based domestic violence and abuse training, support and referral programme developed to improve the general practice response to domestic abuse.

IRISi IRISi is a not-for-profit social enterprise established to improve the healthcare response to gender-based violence. IRISi works to sustain and expand the IRIS and ADViSE programmes, and to collaborate with researchers to develop other evidence-based gender-based violence health interventions into commissionable models.

IRISi Network The IRISi network refers to IRISi and the specialist services involved in delivering the IRIS and ADViSE programmes across different sites. This report also refers to the IRIS network and ADViSE network specifically.

Non-clinical staff The staff within a healthcare setting that provide administrative and operational support to facilitate patient care. This includes roles such as receptionists, administrators, managers.

Patient Someone who has received healthcare support. A patient may be referred to the IRIS/ADViSE programme.

Programme Shorthand for the IRIS and ADViSE programmes.

Referral A referral is made regarding a patient from healthcare staff to Advocate Educators in local specialist services. A patient may be referred more than once and may or may not go on to receive the service (e.g. their circumstances may change, or they may no longer want the support). A patient in a participating IRIS practice/ADViSE sexual health clinic may also self-refer into the programme.

Service User A service user describes anyone who has accessed either the IRIS or ADViSE programme. Access means that the service user has received some kind of support from their Advocate Educator.
The term 'closed' in relation to a service user indicates someone who has finished their support from the AE. Service users may access the programme again at another point if they wish.

Sexual Violence We use the Rape Crisis definition of sexual violence. This is "*any kind of sexual activity or act (including online) that was unwanted or involved one or more of the following:*

- *pressure*
- *manipulation*
- *bullying*
- *intimidation*
- *threats*
- *deception*
- *force*

In other words, any kind of sexual activity or act that took place without consent. There are lots of different types of sexual violence, including child sexual abuse, rape and sexual assault." [i]

Site A defined geographical area in which the IRIS/ADViSE programme is delivered, e.g. 'Bristol' or 'Hackney.'

Specialist service (or partner service) IRIS and ADViSE operate on the same model, where IRISi establishes a partnership with a local VAWG specialist provider. This partner organisation takes on the responsibility of embedding an IRIS/ADViSE Advocate Educator within the healthcare setting. The AE's role includes delivering training for healthcare professionals, providing support to referred patients & ongoing guidance for healthcare settings.

Violence Against Women and Girls (VAWG) Violence Against Women and Girls. VAWG is a term used to describe various forms of gender-based violence that predominantly affect women and girls. It includes domestic abuse, sexual violence, human trafficking, and other forms of violence rooted in gender inequality.

Victim-Survivor This report predominantly uses the term 'victim-survivor' to reflect that either term may be used, depending on the context, although the term 'survivor' is preferred in recognition of the strength and resilience of those who have experienced domestic abuse and/or sexual violence.

Foreword

Lucy Downes
Director of Programmes and Partnership

2023-24 has been a period of growth and development for IRISi and for our network of IRIS and ADViSE sites. It has also been a period of maturation for IRISi, bringing clarity to and articulation of our goals, with the publication of our three-year strategy 2023 – 2026.

Since our flagship intervention, the IRIS programme for general practice, became available to commission in 2011, our network has grown from just two areas to 55 sites delivering our programmes at the time of writing. Across that time period, IRISi was established in 2017, and we launched our second programme, ADViSE designed for sexual health settings, in 2021 as well as working with a range of academic partners on piloting interventions in other healthcare settings. As our network has grown, so too has our ambition and indeed our scope to promote and improve the healthcare response to gender-based violence. This is reflected in our decision to publish two dovetailed reports this year, one on impact and the other on the work achieved across our network.

Our **impact report** highlights IRISi's growing work at a national level, seeking to influence policy and legislation so that gender-based violence is consistently recognised and addressed as a healthcare issue.[ii] As we have explored in this network report, we estimate that around 1.5 million women across England and Wales have access to the IRIS programme at present. Far fewer have access to ADViSE. While justifiably proud of our achievements and the dedication of the network of partner organisations delivering our programmes, this is not enough. Working alongside other second tier organisations in our sector we are striving for domestic abuse and sexual violence to be prioritised in our health system right across the UK, so that every patient who would benefit can access our effective and cost-effective interventions.

> **"IRISi is seeking to amplify the voices of our partners at a national level, using our platform to lobby for the kind of sustainable long-term funding needed to truly implement the recent progress in policy and legislation around domestic abuse and health."**

We recognise that the strength of our impact rests upon our network of like-minded partners who share our vision and values and who deliver our programmes to drive sustained change in their local areas. Our partners are frontline specialist domestic abuse and sexual violence agencies, nearly all of whom are independent third sector organisations providing vital services across their local areas and operating in an increasingly challenging funding landscape. There have been notable and welcome policy and legislation developments in the last few years, particularly in England, giving Integrated Care Boards (ICBs) statutory responsibilities to address domestic abuse and sexual violence, but this

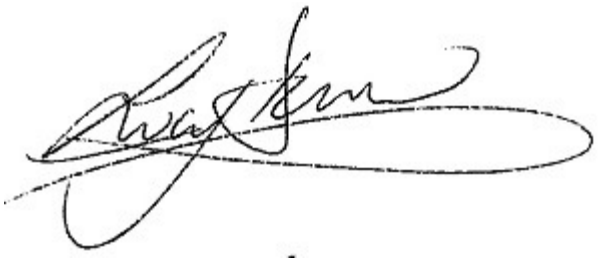
[2] For example, Domestic Abuse Act 2021; VAWG Strategy 2021; Health and Care Act 2022; Police, Crime, Sentencing and Courts Act 2022; Women's Health Strategy 2022; Victim and Prisoners Act 2024.

has been accompanied by funding cuts and slashed budgets. [2] IRISi is seeking to amplify the voices of our partners at a national level, using our platform to lobby for the kind of sustainable long-term funding needed to truly implement the recent progress in policy and legislation around domestic abuse and health.

This network report provides analysis of the data from the network of sites and partners delivering our evidence-based programmes, IRIS and ADViSE. It offers depth and detail about the life-changing and life-saving work undertaken by Advocate Educators and Clinical Leads who work tirelessly to improve clinical practice around the healthcare response to domestic abuse and sexual violence. It focuses on the key activities undertaken by the IRIS and ADViSE teams; establishing connections with general practices and sexual health clinics (by IRIS and ADViSE teams respectively), delivering specialist training sessions, and providing advocacy and support to patients who are victim-survivors. This report also analyses the outcomes of this work; increasing connections between specialist domestic abuse services and healthcare settings, improving healthcare professionals' confidence, knowledge and skills to identify and respond to domestic abuse and sexual violence, increasing the number of identifications of patients affected by DA and SV, increasing the number of referrals for patients for specialist support, and improving the health and well-being, safety and quality of life for victim-survivors. In addition, this report also contextualises what has been achieved to date by exploring the spread of the IRIS programme nationally.

> **"This network report offers depth and detail about the life-changing and life-saving work undertaken by Advocate Educators and Clinical Leads who work tirelessly to improve clinical practice around the healthcare response to domestic abuse and sexual violence."**

As you will see on reading this report, there is much to celebrate! Since the launch of the first IRIS sites in 2011 nearly 44,000 patients have been referred into IRIS and ADViSE programmes. Furthermore, our analysis shows that nearly two thirds of patients had not sought support or been able to access it elsewhere. We know that our programmes, and our partnerships with all those delivering our programmes right across the network, make a real difference to improving the healthcare response to gender-based violence and a real difference to the health, wellbeing, safety and lives of survivors.



Introduction

This report presents the work of the IRISi network for the 2023-24 fiscal year. It complements our Impact Report and provides detail on the reach and effectiveness of the IRIS and ADViSE programmes. The information we report here is the result of the dedication of our network of Advocate Educators, Clinical Leads and healthcare professionals working together to identify, refer and support victim-survivors of domestic and sexual abuse and violence.

After introducing IRISi and our IRIS and ADViSE programmes and presenting our methodology for this report, we move into the main part of the report. Each of these chapters follows a similar structure: a presentation of the data followed by a discussion section at the end. Chapter One provides an overview of the IRISi network, detailing its geographic spread and estimating its reach. Chapter Two then looks at the initial training sessions that were delivered in 2023-24, both for clinical and non-clinical staff. It covers the method of delivery, the job titles of attendees and feedback about the impact and training itself. Chapter Three starts by presenting an estimate on the number of identifications of DA made by clinicians in 2023-24. We then go on to explore the referral numbers, looking back retrospectively to make year-on-year comparisons. Chapters Four and Five cover the profile of victim-survivors referred to the programmes, looking at their demographics and health needs. These chapters make comparisons between IRIS and ADViSE, and we also take this opportunity to highlight comparisons between the data of those referred to the programmes and that of service users whose engagement with the programmes has ended. Chapter Six looks at service user's experiences of abuse and who their perpetrators were. Chapter Seven explores the support provided to service users and the outcome of that support. Lastly, Chapter Eight then presents the ongoing work Advocate Educators do to build and maintain connections between healthcare services and specialised VAWG services. We conclude this report with a list of recommendations that stem from our analysis.

ABOUT IRISI

IRISi is a social enterprise dedicated to developing and implementing evidence-based, cost-effective programmes that improve the healthcare response to Gender-Based Violence (GBV). We bridge the gap between specialist services and healthcare professionals, and our programmes provide specialist support for victims and survivors of domestic abuse and sexual violence. We provide expert advice and consultancy in the field of GBV and health, whilst scaling our evidence-based commissionable programmes across the country. We also collaborate with academic colleagues to develop innovative, evidence-based solutions, providing expertise at the health-GBV intersection, and we work alongside sector colleagues to champion this work at the level of national policy. Our vision is a world in which GBV is consistently recognised and addressed as a health issue. Our mission is to promote and improve the healthcare response to GBV by working side by side with health and specialist services.

WHY A HEALTHCARE RESPONSE TO DOMESTIC ABUSE IS NEEDED: GBV is a severe human rights violation and public health issue, imposing significant NHS costs. Survivors often hesitate to disclose their experiences, highlighting the need for healthcare professionals to proactively address violence and abuse. Research shows survivors want mandatory inquiries and well-equipped clinicians. Failing to ask about abuse misses critical opportunities to refer victims to specialist support.

ABOUT THE IRIS PROGRAMME

IRIS (Identification and Referral to Improve Safety) is a specialist domestic abuse training, support, and referral programme for general practices that has been positively evaluated in a cluster randomised controlled trial. This programme is a collaboration between primary care providers and third sector organisations that specialise in DA and it is designed to primarily support women affected by DA who come in to contact with general practice. Key components of the programme include ongoing training and consultancy for clinical teams and administrative staff, established care pathways for primary health care practitioners, and an enhanced referral system to specialist domestic abuse services for patients affected by DA. Recognised nationally, the IRIS programme is an evidence-based, effective, and cost-efficient intervention designed to improve the primary care response to DA, enhancing the safety, quality of life, and wellbeing of DA victim-survivors.

ABOUT THE ADVISE PROGRAMME

The ADViSE (Assessing for Domestic Violence and Abuse in Sexual Health Environments) programme supports sexual health clinicians in identifying and responding to patients affected by domestic abuse and sexual violence by providing a straightforward referral pathway to specialist services and embedding an Advocate Educator within the clinic. ADViSE evolved from the successful, evidence-based IRIS programme. Recognising that some diverse and harder-to-reach patient groups may not interact with general practice or other primary care services, ADViSE adapts the IRIS programme for use in sexual health clinics and to support all patients regardless of gender and sexuality. It also expands its remit to cover sexual violence that occurs outside of domestic abuse. It trains sexual health staff to identify the signs and symptoms of DASV, inquire about patients' experiences, provide validating responses, and make referrals to specialist services in accordance with the British Association for Sexual Health and HIV (BASHH) DA guidance.

Methodology

DATA COLLECTION AND ANALYSIS

Findings in this report draw predominantly on data from IRISi's Oasis case management system. Oasis contains information on care providers, training sessions, referrals, service users, and feedback from across the IRISi network. There are two ways in which data can be entered into Oasis. Advocate Educators can enter data directly into Oasis as part of their day-to-day work. Alternatively, they may use a data import tool which allows them to transfer information from a spreadsheet containing the data or from another case management system. Feedback forms from the training sessions can also be completed by training attendees directly.

The data used in this 2023-24 report are based on the data available to IRISi as of June 2024. The dataset was extracted from Oasis and cleaned and analysed by two Data, Research and Evaluation Managers during Spring/ Summer 2024. Whilst the dataset is the best we have available at the time of export, the nature of collecting data from people experiencing DASV means that missing data are common. Unless otherwise stated, percentages in this report are based on the total known responses (i.e. the unknown responses have been removed).

Alongside data from Oasis, this report also draws on existing research and alternative data sources to estimate the reach of the IRIS programme and to estimate the number of additional identifications of DA made due to the programme. Details of the research and sources used are included in the relevant chapters, alongside detailed calculations for these estimations.

THE SAMPLE

This report looks at the 2023-24 fiscal year, running from 1st April 2023 to 31st March 2024. Table 0 gives the sample sizes for each dataset we have worked from.

At various points in this report, we distinguish between service users and referrals. This is because not all referrals in one year translate into people supported by a service (either at all, or in that year). Some people will decide against using the service after being referred. For others, there may be a lag between someone's referral date and someone starting support.[3] For the purposes of this report, 'service users' refers to people who finished receiving support during the 2023-24 fiscal year. We have operationalised this as those referrals where the Advocate Educator has entered an end date in 2023-24 and where one or more types of support has been provided to the service user.[4] Some of these service users will have been referred in the previous year(s). Our choice to focus on closed cases is because data relating to individuals referred to a service are updated over time; this means that data are more complete at the point of closure than at the point of opening. There is a likelihood that some referrals from previous years do not have their closures updated on the system; this means that the dataset will exclude some service users who were closed in this period.

[3] They may be referred in March 2024, but support did not start until April 2024, i.e. the following fiscal year.
[4] For example, for IRIS, there were 4873 referrals with an end date in 2023-24, and 3,235 of these had one or more of the support tick-boxes selected (we excluded the no support tick-box from this calculation).

TABLE 0: SAMPLE SIZES USED IN 2023-24 NETWORK REPORT

	IRIS	ADViSE	TOTAL
INITIAL TRAINING SESSIONS	868	25	893
REFERRALS	6,626	608	7,234
SERVICE USERS (CLOSED)	3,235	387	3,622
REFRESHER TRAINING SESSIONS	198	0	n/a

The sample of sites contributing data to Oasis changes over time. Caution is therefore required when making comparisons across years and between referrals and service users. Although differences in findings may be attributed to differences across years or in those who start a service once referred, such conclusions require further examination.

VARIATIONS OF THE IRIS PROGRAMME

In most areas the IRIS programme is commissioned as per the evidence base, i.e. as an intervention for women patients aged 16+. In around one third of IRIS sites, the IRIS service is for all patients aged 16+ who are victims and survivors of DA. As a result, the data presented here are not only for patients identifying as women. Additionally, two IRIS sites, whose data are included in this report, used an adapted model of IRIS in 2023-24. Devon and Torbay are licenced to use the IRIS training package as part of a broader service incorporating perpetrators, children, domestic abuse and sexual violence and all genders. Northern Ireland delivers an expanded model of IRIS which includes support for both domestic abuse and sexual violence victim-survivors. All other sites use the original IRIS model focussing on DA only. For simplicity, in this report we describe IRIS as a DA intervention.

QUOTES

This report has quotes from people connected to IRISi's programmes throughout. Often these have come from free text boxes on feedback forms (service user and training participant). Qualitative analysis of these feedback forms was beyond the scope of this report. We have instead selected quotes that illustrate and provide context to findings from the data. Quotes have minor spelling and grammar edits to aid readability.

Chapter 1: The ADViSE and IRIS network

The ADVISE and IRIS network

OVERVIEW OF THE NETWORK

The map below shows our IRISi network across the United Kingdom.[5] [iii] This map is an overview of sites that have had either IRIS or ADViSE programmes running in them, up until 31st March 2024. The boundaries shown are the administrative boundary associated with that site's funding. Sites are funded from different sources, often the Local Authority, Integrated Cared Board (ICB) or Health Board, but sometimes through other sources. As such, each site's actual geographic coverage may vary from the map, but it remains indicative of the general spread across the UK.

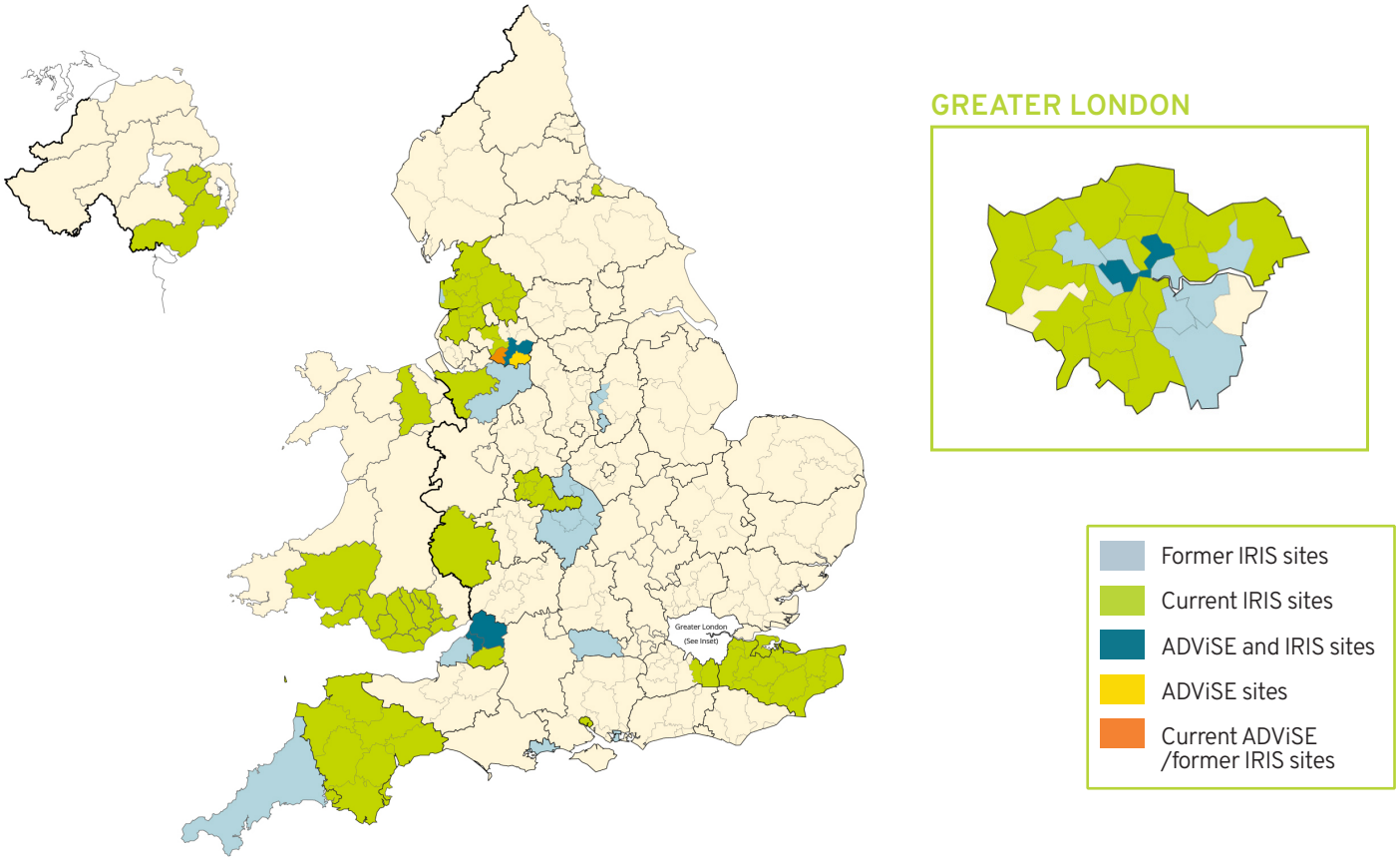


Figure 1.1: Map of current and former IRIS and ADViSE sites across the UK 2023-24.

The IRIS programme has presence in three of the nations: Northern Ireland, Wales and England. Missing from the map is the Jersey site, which is in the Channel Islands. Green sites are sites where the IRIS programme was running in the year 2023-24. Light blue represents sites that formerly had the IRIS programme running, but it ended, usually due to funding cessation. In a minority of cases, some of these sites may resume the IRIS programme (and as such could be regarded as a paused site); Bromley in Greater London is an example as it is anticipated this site will resume in the year 2024-25. Most of the new sites this year were situated in Greater London, as part

[5]Map adapted from ONS reference map. Source: Office for National Statistics licensed under the Open Government Licence v.3.0 Contains OS data © Crown copyright and database right [2021].

of a Violence Reduction Unit (VRU) funding stream. The IRIS programme also launched in Herefordshire – this is with funding that originated from the Home Office (via Standing Together Against Domestic Abuse (STADA)) and is part of a three-site cohort which will also include Halton and Sefton (both launched in early 2024-25). Other than Bromley, which is 'paused' and due to be relaunched, no sites were decommissioned during 2023-24, but three sites ended at the end of the fiscal year when funding ended.[6]

Our map demonstrates that IRIS sites tend to be clustered geographically. We can see clusters of sites in South Wales, Greater Manchester/Northwest England and Greater London. There are also clear patches of the UK that do not have IRIS sites or have very little IRIS provision: Scotland, Northeast England and East England being notable examples. This means that survivors across the UK experience a post code lottery in terms of their ability to access support from the IRIS programme. This clustering also suggests that for the IRIS programme to be successful in a given area, having either successful nearby established programmes or setting up nearby sites alongside each other may be a factor. This information may be important to note when planning areas to set up new IRIS sites.

ADViSE sites are currently based only in England. Given the proximity of the Bristol and South Gloucestershire site, it is possible that it also may serve a (small) Welsh demographic, but our data does not currently evidence this. On the network map, ADViSE sites are shown in yellow. Where they also have the IRIS programme running the site is dark blue, and if it formerly had the IRIS programme (and now just ADVISE) it is orange. No ADViSE sites were decommissioned in 2023-24; two sites were launched in London as part of the above mentioned VRU funding stream.

ESTIMATING THE REACH OF IRIS ACROSS ENGLAND AND WALES

As of March 2024, the IRIS programme has been a commissionable programme for 13 years. To get an understanding of the impact IRIS has on the population, we sought to estimate its reach by looking at the total number of women victim-survivors of domestic abuse in England and Wales who could access the programme at their general practice.[7]

Our first step was to establish the registered patient population for general practices that were based in IRIS areas. Due to data differences, we took separate approaches for England and Wales. Using data from NHS England Digital we were able to obtain the total female adult (16+) population registered at these practices as of March 2024.[iv] As these data were recorded at a postcode level, we used the Office for National Statistics (ONS) postcode look-up to filter this population to only include those that fell in 2023-24 IRIS areas.[8] [v] Data from Wales were available at a health board level rather than postcode level.[vi] We hand sifted through the health boards and their sub-areas to determine which practices fell in the IRIS commissioned areas. This gave us the population of individuals aged fifteen and over that were registered in Welsh IRIS sites.[9] We finally applied the female population ratio for Wales (51.1%).[vii]

Adding together these figures for England and Wales, the combined potential patient population came to 7.2 million women. We reduced this figure to 77.5% of the total to reflect that not all practices in an area will be considered fully trained.[10] Applying the ONS lifetime domestic abuse rate (27%) gives us an estimate of the England and Wales IRIS programme reach of just over 1.5 million women victim-survivors of domestic abuse, which is 1 in 5 women victim-survivors.[viii]

TABLE 1.1: ESTIMATE OF ACCESS TO IRIS (ENGLAND AND WALES) FOR VICTM-SURVIVORS

	NUMBER OF WOMEN VICTIM-SURVIVORS	PERCENTAGE OF REGION WITH IRIS PROGRAMME
England	1,308,988	19%
Wales	200,017	52%
Combined	**1,509,005**	**20%**

[6] Denbighshire & Waltham Forest ended 31/3/24. Manchester also ended temporarily while other options and the availability of funding were considered but is due to relaunch in 2024/25.
[7] Both the Northern Ireland and Devon & Torbay sites offer support to victims of sexual violence in addition to domestic abuse. To simplify our estimate, these sites were removed from our calculations. Jersey was also removed as it is outside of the UK.
[8] Because not all commissioned sites align exactly with Local Authority geography, after obtaining patient population figures for each site, we inspected any that appeared to be outliers (overestimates only). If the outliers did not fit in with IRISi staff knowledge about the coverage of that site, we reduced the population number to fit in with the known patient population that was commissioned to be worked with.
[9] Data were only available in age bands (rather than singular years). 15 and over was chosen as the most appropriate cut off.
[10] 77.5% figure is the mid-point in IRISi's 'adequate' range (75-80%) for the IRIS KPI around percentage of sites that are up to date with IRIS training. This gave us a figure of 5,588,907 women.

There are limitations to the above estimate (as with all estimates!). The ONS has recently started to alter their methodology for estimating domestic abuse rates. Whilst revised figures have yet to be released, early indications suggest that previous lifetime estimates have been underestimates. Furthermore, we have not adjusted for the (limited) impact of 'former' IRIS sites. Alongside the omission of Devon & Torbay, these issues suggest a potential underestimate of the reach of the programme. Additionally, whilst we mitigated to some extent for partial coverage of sites, the approach taken only looked at outliers, and it is possible that some overestimation occurred in sites that didn't appear to be outliers. We also didn't adjust for sites that are new; typically, it takes sites up to two years to reach a steady state in terms of percentage of practices trained.

GEOGRAPHICAL SPREAD OF PATIENTS REFERRED TO ADVISE

The IRIS programme is linked to general practices, which usually require a patient to be registered, and a condition of that registration is linked to a person's address. As such the area that the practice is located in is a good indicator of the area that an IRIS programme service user would live in. ADViSE works somewhat differently as this intervention is linked to sexual health clinics. Clinics do not have the same 'patient address' requirement, and as such can serve patients from wider areas. We have kept the ADViSE areas on the network map (Figure 1) limited to just the Local Authority areas of the clinics included in the commissioning, but we have analysed some patient address data below to explore this further.

When the ADViSE programme was first introduced home address information was not routinely collected in the IRISi database. Advocate Educators shared that the programme had a further reach than just the areas where the sites were based. As such, during 2023-24 the ADViSE network newly started collecting data on the home Local Authority of those who have been referred to the programme. This additional data capture occurred mid-year, so we do not have full or sufficient data to draw thorough conclusions. Looking across the ADViSE network, 13% of the people referred lived outside the area the sexual health clinics are based.[11] The ADViSE sites are clustered into three areas: Inner London, Greater Manchester and Bristol/South Gloucestershire, so we have analysed the referrals in these groupings.

Greater Manchester

There are 4 ADViSE sites within Greater Manchester: Stockport, Tameside, Trafford, and Manchester. Of the referrals that contained data for the residency of the person referred, 86% of these were from the areas commissioned.[12] A further 12% came from 6 neighbouring boroughs; notably Salford made up half of these. 2% of the referrals came from 6 other locations (5 within England, one outside of the EU).

TABLE 1.2: THE LOCAL AUTHORITY RESIDENCE OF SERVICE USERS REFERRED TO GREATER MANCHESTER ADVISE SITES

LOCAL AUTHORITY OF RESIDENCE	NUMBER OF REFERRALS
Commissioned areas: Stockport, Tameside, Trafford & Manchester	253
Neighbouring Local Authorities	34
Other	6
Unknown	57

[11] 62 out of 470 referrals. Referrals with missing residency data (136) removed from % calculation.
[12] The number of referrals that contained data was 293.

Bristol and South Gloucestershire

The Bristol and South Gloucestershire ADViSE site works with a range of sexual health services across the area. Of the referrals that had data for the residency for the person, 91%of the individuals referred came from the Bristol/South Gloucester region.[13] A further 8% came from neighbouring Local Authorities (North Somerset, Bath & Northeast Somerset, and Wiltshire). One referral came from further afield.

TABLE 1.3: THE LOCAL AUTHORITY RESIDENCE OF SERVICE USERS REFERRED TO THE BRISTOL AND SOUTH GLOUCESTERSHIRE ADVISE SITES

LOCAL AUTHORITY OF RESIDENCE	NUMBER OF REFERRALS
Commissioned area: Bristol & South Gloucestershire	143
Neighbouring (English) Local Authorities	14
Other English Local Authorities	1
Unknown	45

Inner London

There are 2 ADViSE sites in London: Homerton and Imperial. These are based in the boroughs of Hackney (including City of London) and Westminster, respectively. More than half of the referrals did not contain patient address data, and as such analysis is limited. It is worth noting that whilst the clinics are situated in three London boroughs, referrals came from 6 boroughs. Of the 'other' referrals, 3 came from other London Boroughs, whereas 2 came from Local Authorities outside of London.

TABLE 1.4: THE LOCAL AUTHORITY RESIDENCE OF SERVICE USERS REFERRED TO INNER LONDON ADVISE SITES

LOCAL AUTHORITY OF RESIDENCE	NUMBER OF REFERRALS
Commissioned areas: Hackney (inc. City of London) & Westminster	12
Neighbouring Local Authorities	2
Other Local Authorities	5
Unknown	36

[13] The number of referrals that contained data was 158.

DISCUSSION AND SUMMARY

In this chapter we have looked at the geography of the IRISi network, focusing on the spread of the two programmes. Understanding the potential geographic footprint of the ADViSE network is an important next step to understand the coverage the programme has. The analysis of referrals reveals a mixed picture in terms of data collection and geographic coverage across the three areas. However, it is clear that there is a cohort of people who access support from ADViSE outside of area the sexual health clinics are based. More consistent data capture would allow us to how big this cohort is, and also if it varies across different site areas. This information would inform both commissioning approaches and the service user support offered.

An estimated 1.5 million women survivors being able to access the IRIS programme is a mammoth achievement. One in five survivors in England and Wales being able to get support is a significant milestone, but it also tells us that four in five are unable to access the IRIS programme via their general practice healthcare. The IRIS programme has been shown to be scalable and further commissioning of sites across the whole of the UK would reduce the postcode lottery that survivors currently face. Our observation that IRIS sites appear to cluster geographically provides suggests that where the IRIS programme is successful, nearby areas may be more likely to introduce the programme. This knowledge is useful and should influence approaches in choosing potential areas for new sites.

Chapter 2: Initial training

Initial training

The IRIS and ADViSE programmes are comprised of initial training for healthcare staff in new sites, followed by refresher training every two years afterwards. The training sessions are delivered by the local team of the Advocate Educator and the Clinical Lead and can be face-to-face or online. Initial training for clinicians is two sessions (Clinical 1 and Clinical 2); non-clinical staff (typically reception, administrative and management staff) have one session. At the end of the training sessions attendees are invited to complete a feedback form to record their self-reported outcomes of the training.

INITIAL TRAINING SESSIONS AND ATTENDEES

In 2023-24, Advocate Educators delivered 893 initial training sessions across the IRISi network; 868 of these were for the IRIS intervention and 25 were for ADViSE. Training reached a total of 4,643 healthcare staff, including 4,522 IRIS programme healthcare staff and 121 ADViSE programme healthcare staff, from a total of 1,091 care providers (912 general practices, 16 sexual health clinics, 164 not recorded).

TABLE 2.1: INITIAL TRAINING SESSIONS AND PARTICIPANTS

INITIAL TRAINING	IRIS		ADVISE	
	No. of sessions	No. of participants	No. of sessions	No. of participants
Clinical Session 1	321	2780	12	120
Clinical Session 2	208	1609	7	101
Reception Training	339	2913	6	20

METHOD OF DELIVERY

54% of IRIS initial training sessions were delivered face-to-face, compared to 88% of ADViSE training sessions. Across both programmes, this averaged out at 56% of initial sessions being delivered face-to-face.

TABLE 2.2: METHOD OF DELIVERY FOR INITIAL TRAINING SESSIONS

	IRIS		ADVISE	
METHOD OF DELIVERY	Online	Face-to-face	Online	Face-to-face
Clinical Session 1	152	169	2	10
Clinical Session 2	107	101	1	6
Reception Training[14]	139	197	0	6
Total	**398**	**467**	**3**	**22**

JOB TITLES OF ATTENDEES

Attendees completed feedback forms at the end of training sessions, which included a question on their job titles, with a free text option where 'other' was selected. The data from this question are presented in figure 2.1 below. Not all attendees completed feedback forms, nonetheless the data give an idea of the spread of job roles.

The 'other' category in ADViSE training sessions included advanced nurse practitioners, clinical fellows, deputy heads of nursing, educational outreach workers, healthcare technicians and staff nurses. Looking across all the job titles (free text entries and prefilled) those in nurse roles were the largest category of attendees completing feedback forms at ADViSE clinical training sessions, followed by doctors and health advisors. For IRIS clinical training sessions, the largest group of attendees were doctors, followed by nurses. A range of other healthcare staff also attended IRIS training sessions including pharmacists, paramedics, and counsellors.

[14] The method of delivery was not recorded for three IRIS reception training sessions.

Figure 2.1: Job titles for clinical session 1 & 2 attendees

Unsurprisingly, receptionists made up the largest proportion of attendees at the reception training sessions, both for IRIS and ADViSE. Administrators and secretaries were also well represented at IRIS training sessions. 23% of participants chose the 'other' category indicating improvements can be made to the prepopulated list.[15] Roles here included assistant managers, business managers, care co-ordinators, office managers, operation managers, patient co-ordinators, practice managers, prescribing clerks, and social prescribers.

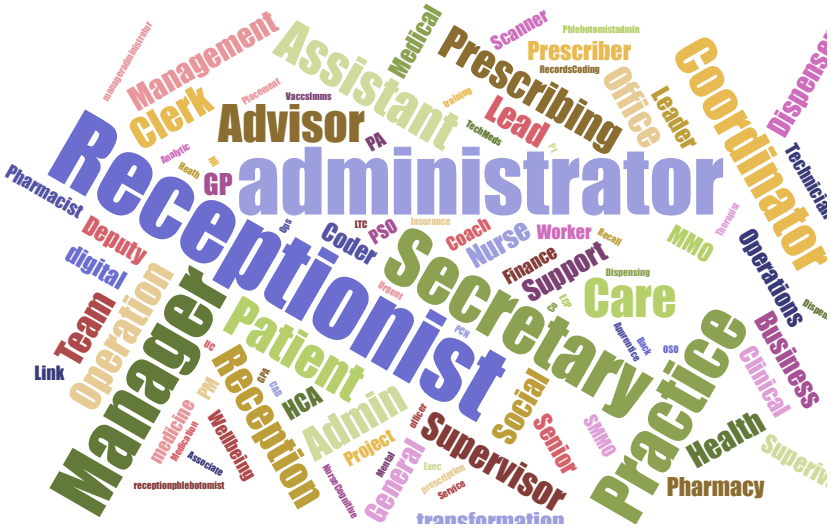


Figure 2.2: Job titles for reception training attendees

IMPACT OF TRAINING SESSIONS

Attendees are required to complete both pre- and post-training feedback forms, rating their knowledge and understanding of DA (for IRIS) and DASV (for ADViSE) on a scale of 1 to 10. In this scale, 1 signifies no knowledge on the subject, while 10 indicates excellent knowledge. Attendees are asked different questions across the different sessions. Not all training attendees completed feedback forms.

[15] 283 out of 1251 forms.

For each training session we have given the completion rate of feedback forms broken down for each programme. Overall, 38% of training participants completed a feedback form.[16] Advocate Educators often share that is difficult to get training participants to complete feedback forms. However, the completion rate of feedback forms varied enormously across sites, with some reporting 0% completion and others nearing 100% completion. This variability suggests that whilst participant reluctance accounts for some of the non-completion rate, the AE is able to influence the rate of completion of forms.

CLINICAL SESSION 1

The feedback from clinical session 1 showed increases in the understanding and knowledge of participants across all areas, both for IRIS and ADViSE clinical 1 sessions. The graphs below present the change in scores, from the pre to the post feedback form. There were 967 feedback forms completed for IRIS clinical session 1, representing 35% of attendees.[17] There were 51 feedback forms for ADViSE representing 43% of attendees.[18]

CHART 2.1: IRIS AVERAGE FEEDBACK CLINICAL SESSION 1 (n=967)

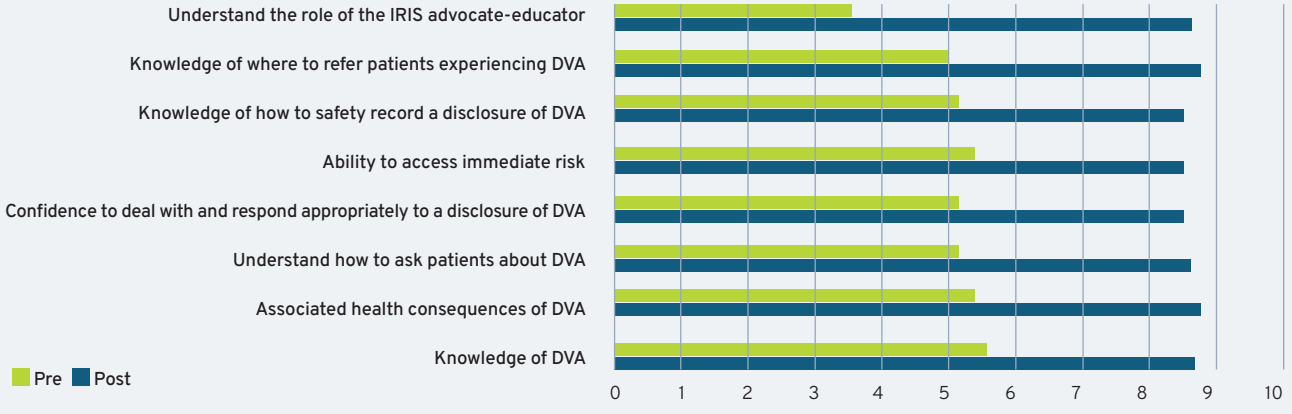
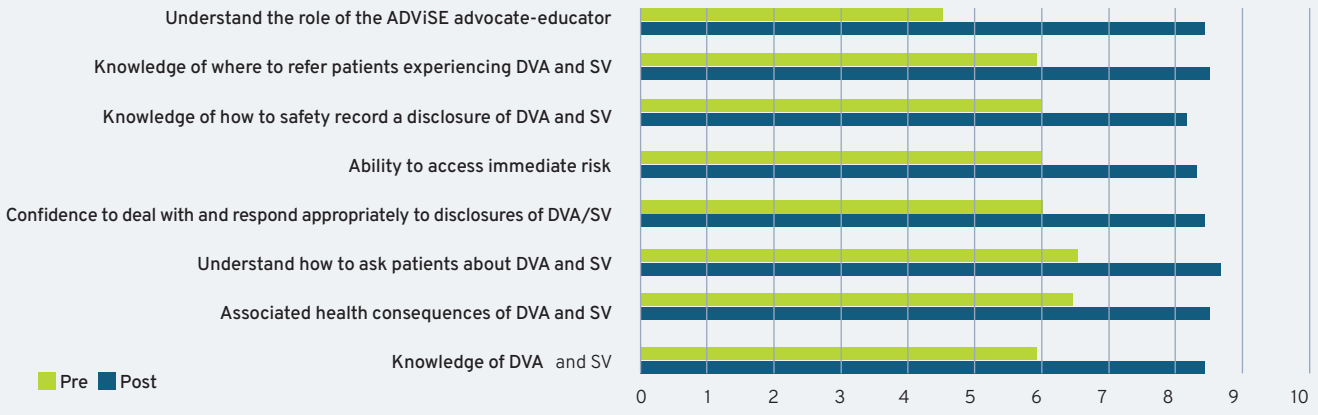


CHART 2.2: ADViSE AVERAGE FEEDBACK CLINICAL SESSION 1 (n=53)



Excluding the statements about understanding the role of the Advocate Educator, the pre scores for clinicians at the ADViSE training sessions are slightly higher than clinicians at the IRIS training sessions. This suggests that in the context of sexual health services, clinicians rate themselves as having slightly more awareness of DVA and SV than in general practices. The change between pre and post scores was slightly smaller for ADViSE. This is likely due to these higher pre scores and the fact that attendees are unlikely to rank themselves as a 10 out of 10 for any statements.

[16] 7,543 attended training spaces vs 2,904 forms. Note, because one person can attend two trainings (clinical 1 & 2 usually) there were not 7,543 unique training participants.
[17] Due to missing data, the sample for each statement ranged from 925 to 967.
[18] Due to missing data, the sample for each statement ranged from 52 to 53.

CLINICAL SESSION 2

There were 592 forms completed by attendees at IRIS clinical session 2, representing 37% of all attendees.[19] There were 41 ADViSE attendees who completed feedback forms, which represents 41% of attendees.[20]

As for clinical session 1, the feedback for clinical session 2 was overwhelmingly positive. All statements saw an increase in the average score given by attendees. The biggest shifts for both sessions were around the perpetrator questions. The statements about knowledge of where to refer perpetrators of DVA, skills to respond to perpetrators and knowledge of how perpetrators may present all saw large increases in the average post score compared to the pre score, reflecting the content of the clinical session 2 training session. The increase in the awareness of services for patients and colleagues reflects the need for the second training session: even though attendees had already participated in clinical session 1, their pre-score averaged 5 out of 10. After the training, this had increased to over 8.5.

CHART 2.3: IRIS AVERAGE FEEDBACK CLINICAL SESSION 2 (n=592)

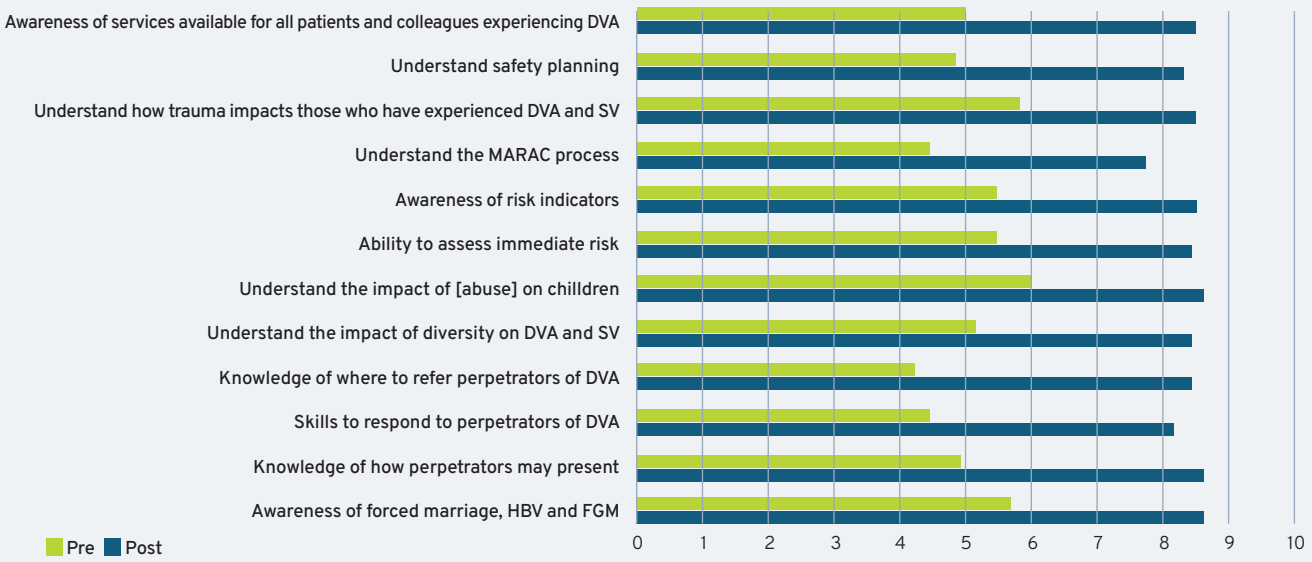
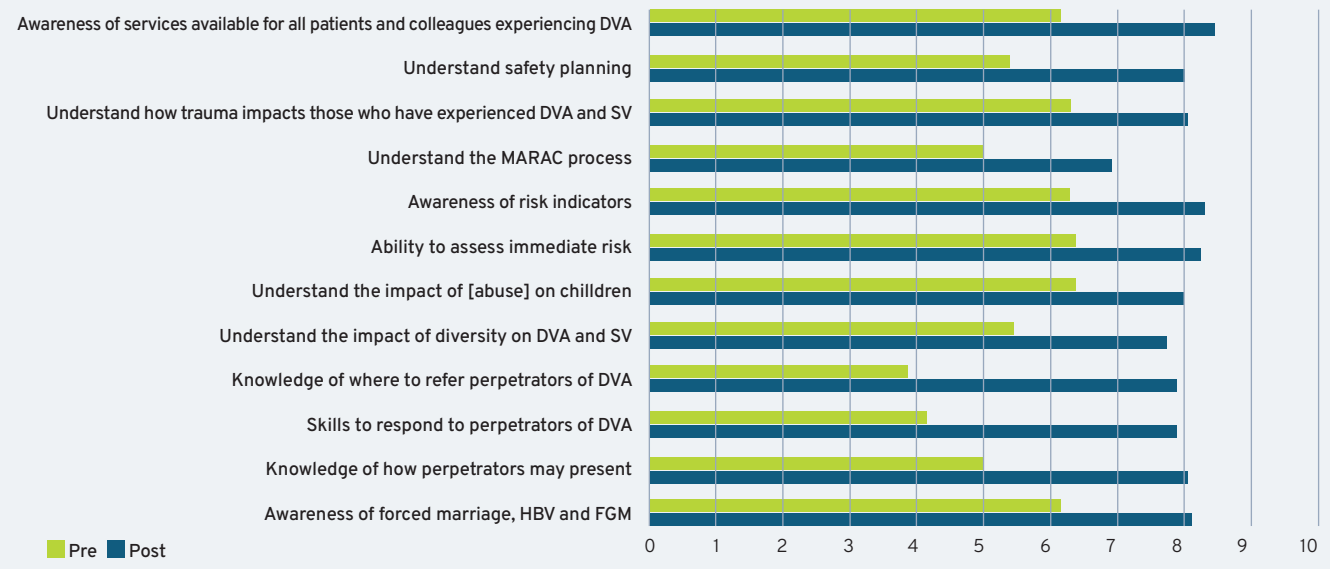


CHART 2.4: ADViSE AVERAGE FEEDBACK CLINICAL SESSION 2 (n=41)



[19] The data in Chart 2.3 are based on between 571 and 584 forms, accounting for missing data.
[20] There was minimal missing data and the number of forms the statements in Chart 2.4 below is based on ranges from 39-41.

RECEPTION TRAINING

Similar forms were used for the reception training sessions. For IRIS, 1241 attendees completed forms (43% of attendees) and for ADViSE, 10 attendees completed forms (50% of attendees).[21] As for the other training sessions, the feedback from both IRIS and ADViSE attendees is positive, with large increases in awareness and knowledge. Mirroring the trend identified in the clinical sessions, attendees at the ADViSE reception training sessions reported a higher pre score, suggesting the base awareness and knowledge on DASV for sexual health reception staff is higher than those in general practice.[22]

CHART 2.5: IRIS AVERAGE FEEDBACK FROM RECEPTION TRAINING (n=1241)

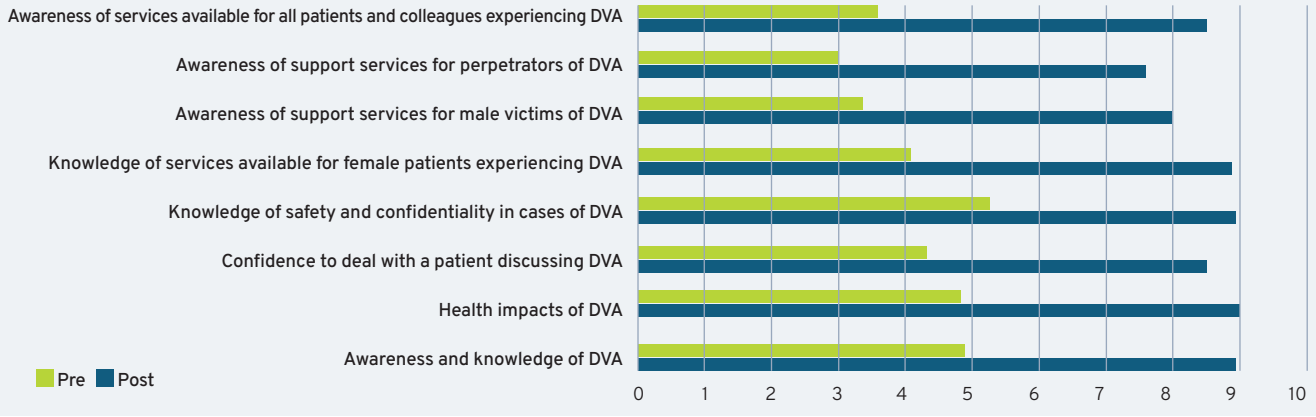
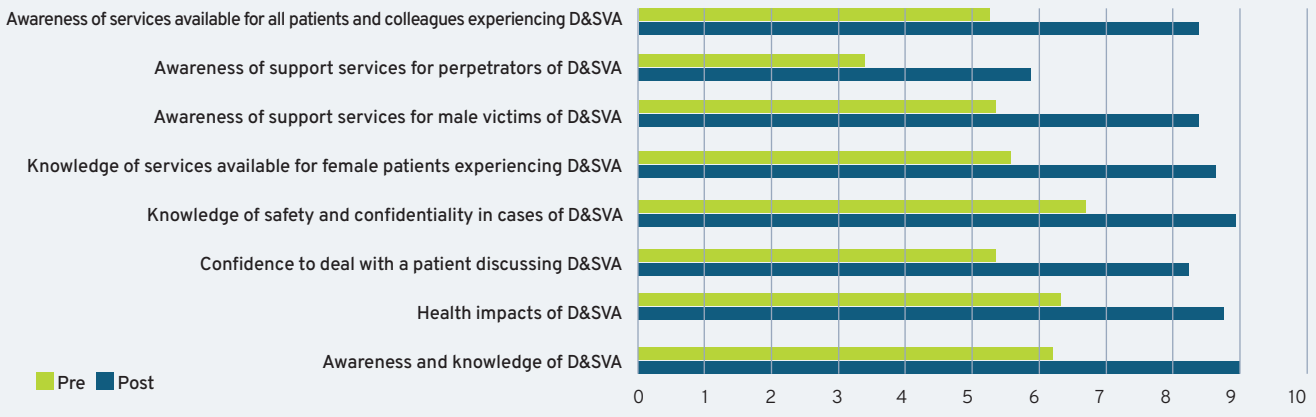


CHART 2.6: ADViSE AVERAGE FEEDBACK FROM RECEPTION TRAINING 1 (n=10)



[21] Chart 2.5 is based on between 1163 and 1220 form responses. There were no missing responses in the ADViSE forms.
[22] The feedback form refers to D&SVA; for our purposes this is synonymous with DVSA.

QUALITY OF TRAINING DELIVERY

The feedback forms also asked attendees about the delivery of the training, using a scale 1 to 10, where 1 indicates low/extremely dissatisfied and 10 indicates high/extremely satisfied. Attendees were asked about the relevance of the topics covered, delivery of presentation, method of presentations, quality of hand-outs and their likelihood of recommending the training to colleagues.

The feedback is positive, with scores averaging above nine for most statements. The exception to this is for the ADViSE hand-outs and supporting information which stands at 8.7. This difference is driven by the reception training score. It may be due to the newness of the ADViSE programme compared to the IRIS programme, and further modifications based on trainee feedback should improve this score.

TABLE 2.3: FEEDBACK ON TRAINING DELIVERY FOR IRIS AND ADViSE INITIAL TRAINING SESSIONS

	Average of "Relevance of the topics covered"	Average of "Delivery of presentation"	Average of "Methods of presentation"	Average of "Quality of hand-outs/supporting information"	Average of "What is the likelihood of you recommending this training to colleagues?"
IRIS (OVERALL)	**9.4**	**9.3**	**9.2**	**9.1**	**9.3**
Clinical Session 1	9.4	9.3	9.2	9.0	9.3
Clinical Session 2	9.4	9.3	9.1	9.1	9.3
Reception	9.5	9.5	9.3	9.1	9.4
ADVISE (OVERALL)	**9.5**	**9.3**	**9.3**	**8.7**	**9.5**
Clinical Session 1	9.6	9.3	9.4	8.8	9.5
Clinical Session 2	9.5	9.3	9.3	9.0	9.5
Reception	9.7	9.7	8.9	7.0	9.5
TOTAL	**9.4**	**9.3**	**9.2**	**9.1**	**9.4**

“Really enjoyed the training and listening to the experiences of others as well as the case studies. Made me realise, shamefully, how little I knew about domestic abuse and its impact on health. It has really made me think about current and past patients and how I could have potentially done things differently. Great training and would really recommend that all health care providers undertake this should they have the opportunity to do so.”

DISCUSSION AND SUMMARY

This chapter shows that the IRIS programme continues to receive very positive feedback, with attendees praising both the depth of knowledge gained and the exceptional quality of the training provided. This is consistent with previous years' data.[23] We also see that for clinicians, the second training session (clinical session 2) demonstrates further increased knowledge. This highlights the essential nature of the two-step training programme as having both sessions allows proper time for all areas to be covered effectively, safely and fully. We also see that completion rates of feedback forms could be improved. The wide variability in rates between sites suggests that Advocate Educators are able to influence the number of forms being completed. IRISi could facilitate peer support between AEs on this issue, utilising the collective knowledge in the network to further improve the work being done. The higher the completion rate of feedback forms, the more valid the impact findings are.

The data show that the ADViSE programme comparably enhances the confidence, knowledge, and skills of healthcare professionals. This comparability supports the potential for ADViSE to be scaled more broadly. There is a notable difference in feedback regarding the quality of training materials between the two programmes. The slightly lower ratings for ADViSE reception training materials may be attributed to its newer status, and ongoing revisions based on stakeholder feedback is needed to optimise the programme.

While outside the immediate scope of this report, examining the differences between face-to-face and online delivery of the programmes could provide valuable insights, particularly in terms of attendee feedback. Combining this detailed analysis with suggested improvements to data collection around connections with the healthcare sector, could also help us understand the impact of different training delivery models have on establishing connections between specialist VAWG services and the healthcare sector.[24]

Lastly, a minor improvement to data collection should be made to better capture the job roles of attendees at reception trainings. This adjustment would enable a more comprehensive analysis of the diversity of staff participating in the IRIS training, further supporting the programme's development and impact.

[23] Previous reports can be accessed on IRISi's website irisi.org. The 2022-23 report can be accessed at: https://irisi.org/national-report-march-2023.
[24] See Chapter 6 for further details.

Chapter 3: Identification and referrals

Identification and referrals

Once trained, healthcare professionals are better able to identify patients who are affected by domestic abuse or sexual violence. At the point of identification, professionals can ask patients if they would like a referral to the Advocate Educator based in a local specialist service. The AE will then contact the victim-survivor to offer more information about the service, assess the level of risk and answer any questions they may have.

ESTIMATING IDENTIFICATIONS FOR THE IRIS PROGRAMME ACROSS ENGLAND AND WALES

Once they have completed their IRIS training, general practice clinicians are better able to ask safe, sensitive questions about domestic violence and abuse and identify victim-survivors and perpetrators. Not all victim-survivors want to be referred to the Advocate Educator; we know there are many barriers for victim-survivors to seek support, and they may not wish to do so the first time that they are asked. However, even if a referral is not made, a correct identification of domestic abuse by a clinician provides value: patients know they can raise issues of domestic violence and abuse with healthcare staff, a confidential record can be made, and more appropriate healthcare can be offered to the patient.

Unsurprisingly, the clinical trials that informed the development of IRIS suggest that there are more identifications of victim-survivors than referrals. We have used their findings to estimate how many identifications clinicians made for the IRIS programme in the year 2023-24. We used two different methods to estimate the number of identifications, as outlined below. We have limited the area for these estimates to England and Wales – see Chapter 2 estimate for further details.

Method 1: Using the estimated number of women who can access the IRIS programme (England & Wales)

We used Feder et al.'s (2011) paper on the IRIS randomised controlled trial to calculate a ratio of identification of domestic violence in the electronic medical records of the general practice to number of eligible women in the intervention areas.[ix] In their study, there were 641 identifications from a population of 70,521 women. This gives as a ratio of 0.00909, or just over 900 identifications per 100,000 eligible women. We applied this ratio to our estimate of the number of women victim-survivors who were able to access the IRIS intervention.[25] This was 1,509,005. Applying the ratio 0.00909 gives us an estimate of 50,800 identifications of women experiencing (or who had a history of) domestic abuse by healthcare professionals in IRIS sites in 2023-24.

Method 2: Using the number of referrals received to the IRIS programme 2023-24

Again, using findings from Feder et al.'s (2011) randomised controlled trial, we calculated a ratio of identification of domestic violence in the electronic medical records of the general practice to referrals to specialist services. In their study, there were 641 identifications and 238 referrals, a ratio of 2.69. We applied this ratio to estimate the number of identifications amongst IRIS trained practices in 2023-24, based on the 5,886 referrals to IRIS recorded by the network.26 Using the ratio of 2.69, we estimate that healthcare professionals made 15,853 identifications of women experiencing (or who had a history of) domestic abuse in IRIS sites in 2023-24.

[25] See Chapter 2 for how this estimate was calculated.
[26] Total referrals to IRIS in 2023-24 aside from those that are not in England and Wales (Northern Ireland (211) and Jersey (13)) and those that use a version of IRIS that is modified from the trial version (Devon & Torbay (516)).

The two methods produced two different figures for an estimate of the number of identifications made across the IRIS programme. Our lowest estimate shows that some 15,800 women were likely identified as survivors of domestic abuse by their general practice and offered support in line with this, whereas our upper estimate puts this around 50,800, giving a discrepancy of about 35,000 between the two. While it is challenging to determine which estimate is more accurate, looking at this difference between the two presents some interesting questions. Method 1 is using a figure that is itself an estimate.[27] This increases the uncertainty around it. That method 2, based on known referral numbers for 2023-24, is lower than the estimate from method 1, points potentially to suboptimal resourcing in some areas, i.e. deviations from the original IRIS model. Both estimates rely on ratios derived from a study that used data from 2007-2010, which may be outdated now. They also do not consider any longitudinal effects of a practice being part of IRIS. For example, we do not know if clinicians from a practice that has been part of IRIS for ten years have different referral or identification rates compared to a newly trained practice. Despite these limitations, the estimates illustrate that the reach of IRIS extends beyond the number of referrals. We conclude that at least 15,800 women in IRIS trained practices across England and Wales were identified as victim-survivors of domestic abuse in 2023-24.

REFERRALS TO IRIS AND ADVISE PROGRAMMES IN 2023-24

In total, there were 7,234 referrals to the programmes, comprised of 6,626 referrals to IRIS sites and 608 to ADViSE sites. The breakdown of referrals to the IRIS programme by site (and over time) is presented in Appendix A. Table 3.1 presents the number of referrals received by ADViSE sites per fiscal year. Sites may start the programme at any point through the year, so a site's first year figures may reflect a partial year of delivery. For both IRIS and ADViSE sites, comparisons between sites are not possible due to variation in patient populations and subsequent resourcing. Year on year analysis is also limited, as resourcing may change over time. Additionally, sites may start or end their programmes mid-year, meaning that it runs for less than 12 months. This would lead to a reduction in the number of referrals during the year.

It is worth noting that for some cases where we see referral numbers drop this can be linked to delayed funding decisions impacting on staff retention of Advocate Educators. For example, in Stockport, insecure funding led to a lapse in staffing, causing a drop in referrals. Whilst interim plans were made to redirect these patients to other AEs across Greater Manchester, the disruption of losing the link between AE and the sexual health clinic appears to have impacted on referral numbers.

TABLE 3.1: REFERRALS TO THE ADViSE PROGRAMME PER FISCAL YEAR BY SITE

SITE	2021-2022	2022-2023	2023-2024	TOTAL
Bristol and South Gloucestershire		123	203	**326**
Homerton			32	**32**
Imperial			23	**23**
Manchester	6	154	207	**367**
Stockport		53	22	**75**
Tameside	2	56	61	**119**
Trafford	2	47	60	**109**
Total per year	**10**	**433**	**608**	**1051**

[27] Further limitations of this value are discussed further in Chapter 2.

REFERRALS TO DATE

To date, there have been 43,586 referrals to IRIS and ADViSE programmes since IRIS first became a commissionable programme in 2011. There have been 42,535 referrals to IRIS and 1,051 referrals to ADViSE. In 2023-24, the ADViSE programmes collectively reached the milestone of 1,000 referrals. As the number of IRIS and ADViSE sites increases over the years, so too does the number of referrals. The 2023-24 fiscal year saw a further increase in the combined number of referrals to IRIS and ADViSE programmes compared to previous years

CHART 3.1: NUMBER OF IRIS SITES AND NUMBER OF PATIENTS REFERRED TO IRIS PROGRAMME

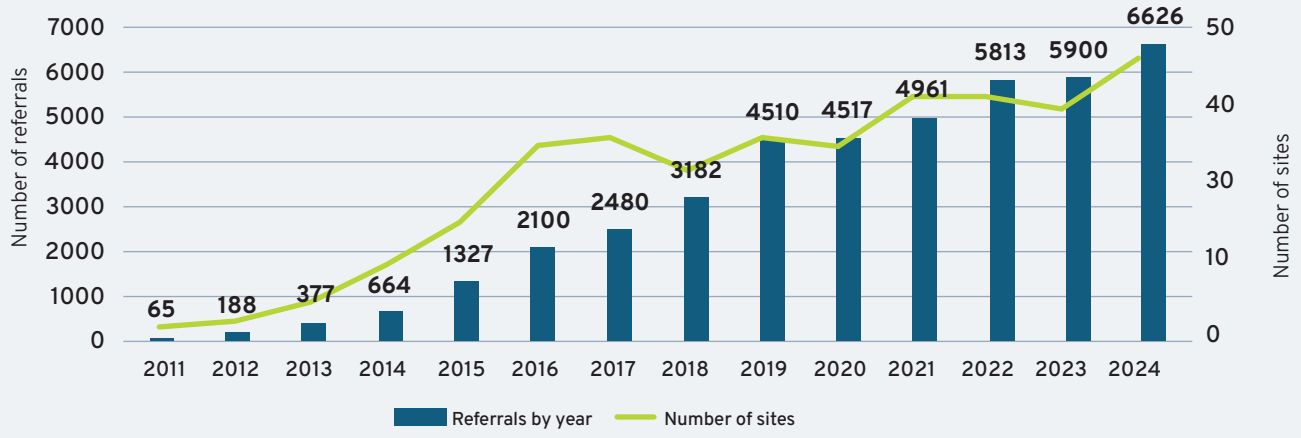
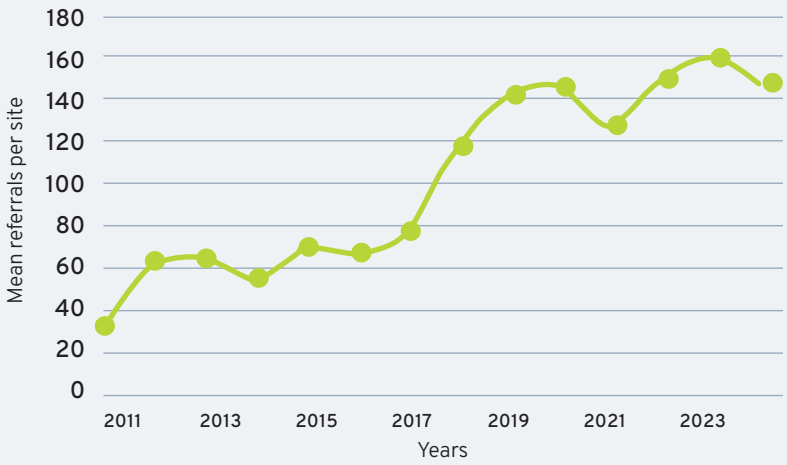


CHART 3.2: AVERAGE YEARLY IRIS REFERRALS PER SITE



> **"I am so grateful for the support, and I was so glad that Dr X recognised what I was struggling with, as I kept getting triggered by appointments and internal examinations."**
>
> ADViSE service user

Chart 3.2 shows us the mean number of IRIS referrals per site each year. What we see is that since IRIS first became a commissionable programme, there has been a positive trend, i.e. even if we adjust for the increase in the number of sites over time, we still see increases in referral numbers. This suggests that IRIS sites tend to get busier over time. In contrast, ADViSE sites have not yet experienced the same increase in referral numbers. This is likely due to the programme's relative newness and differences in implementation.

DISCUSSION AND SUMMARY

This chapter shows that both the IRIS and ADViSE networks continue to grow, with now nearly 44,000 patients who have been referred to the programmes. The report notes a drop in referrals at some sites, often linked to funding issues that hinder the recruitment and retention of Advocate Educators, meaning that there can be a disruption to programme delivery, training and referrals. For our IRIS programme there is an established positive trend in the mean number of referrals per site over time, telling us that not only do the number of referrals grow because there are more sites, but that also, on average, sites get busier over time too. A more granular analysis of this that considers changes in resourcing would help us understand this trend further . To maintain programme efficacy, funders should periodically review and potentially increase resources to ensure that victim-survivors are always able to receive necessary and timely support with staffing at safe levels.

Funding challenges in ADViSE sites, like those in IRIS, have led to staffing gaps, which in turn impact referral rates and clinician confidence. The break in the connection between the specialist service and the sexual health clinic will likely have had an impact on the confidence of clinicians to make referrals. The situation underscores the critical need for stable funding to ensure consistent service delivery across both programmes.[27] X

Earlier in this chapter, our analysis on identifications of DA by clinicians across the IRIS network shows that both estimates indicate that the actual reach of the programme far exceeds the number of referrals received, with at least 15,800 women being identified as victim-survivors of DA by their general practitioner in 2023-24, and potentially up to 50,800. The range between the two estimates raises interesting questions. Whilst beyond the scope of this report, further analysis exploring where the resourcing of commissioned programmes differs from the original trial (and the impact this has on key outputs and outcomes) could provide further insight.

[27] Panovska-Griffiths' paper looking at the impact of the disruption of two IRIS programmes provides additional insight.

Chapter 4: Profile of victim-survivors

Demographics

Profile of victim-survivors - demographics

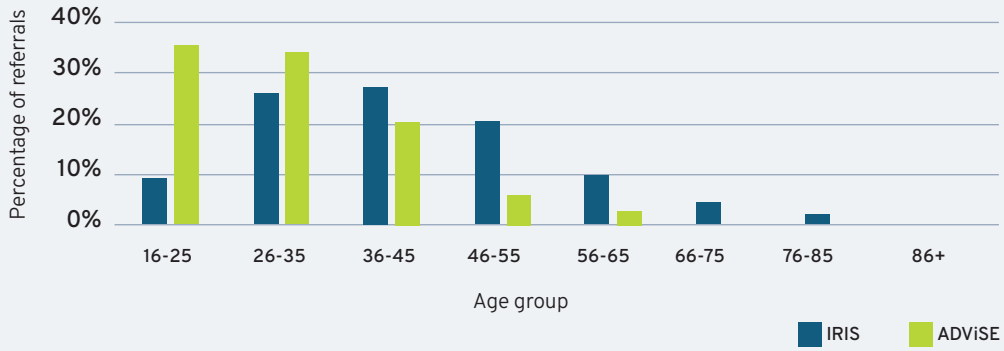
Advocate Educators record various information about the people referred to their service. The next two chapters present these data for victim-survivors who have come into contact with IRIS and ADViSE services during the 2023-24 fiscal year. We use 'come into contact with' to refer to both those who have been referred and those who were service users.[28] We have split this across two chapters given the breadth of topics covered. This first chapter looks at common demographic data relating to these victim-survivors. The next chapter focuses on the health needs reported by victim-survivors.

Where there are notable differences between the data of referrals and service users we have highlighted this. This is because differences between the two cohorts may suggest that the demographic being examined influences the take up of support. Otherwise, we have deferred to referral data in line with previous years' reports. Similarly, where there are notable differences between the profile of IRIS and ADVISE victim-survivors we have discussed these separately. If not, we present these data together. Unless stated otherwise, all percentages given have had non-responses removed from the sample.[29]

AGE

Chart 4.1 depicts the distribution of age groups for those patients referred to the IRIS and ADViSE programmes. This distribution remained consistent for service users too. This year's data supported previous findings that the ADViSE programme serves a younger group of people than the IRIS programme. In 2023-24, just over two-thirds (70%) of those referred to the ADViSE programme were in the 16-35 age group, whereas for IRIS nearly two-thirds (65%) of people referred were aged 36 and above. It seems likely that the difference in age distribution is at least in part due to potential differences in age distributions between the typical attendees of sexual health clinics and general practice. It may also be influenced by other factors too: currently ADViSE is primarily in urban areas, which tend to have higher rates of those in the 20–35 age bracket.[xi]

CHART 4.1: AGE OF PATIENTS REFERRED TO IRIS (n=3,567) and ADViSE (n=485) programmes



[28] For more details on the difference between these two terms, please see our Methodology chapter. The two sample sizes are as follows: IRIS: referrals - 6,626, service users – 3,235; ADViSE: referrals – 608, service users -387.
[29] There are limitations to this method, as it may be that the prevalence of missing data are dependent on the variable being looked at. However given the scope of this report, this method was chosen for expediency.

GENDER AND TRANS IDENTITY

Across both IRIS and ADViSE, women make up the majority of people who came into contact with the programmes. We did not see a significant difference between referral and service user data. For the IRIS programme, 95% of referrals received were for women and 5% for men.[30] This was as expected, as most IRIS programmes are solely for women. The ADViSE programme, however, is for all genders. Here, we still see predominately women being referred though the proportion of women was slightly lower at 83%. [31]

Looking at the trans identity of people, again we did not see differences between referral data and those who engaged.[32] This is promising, as trans people often cite more broadly that services have systems that act as barriers to them getting the support they need, and this lack of a difference between referral and service user data may indicate that ADViSE and IRIS do not have these same barriers. We do see a difference between the two programmes. The ADViSE programme received a much higher proportion of referrals for trans people: 5.6% compared to 0.6% for IRIS.[33] This may be due to local service design; some of the ADViSE Advocate Educators have formed specific pathways with trans clinics in sexual health settings.

> **"The trans clinic has been amazing in providing consistently good health-care which I have not seen in other parts of the NHS. Being able to see my ADViSE worker at the GP was a game changer, as this is not common. Thank you."** ADViSE service user

SEXUAL ORIENTATION

Advocate Educators record details of a service user's sexual orientation. We see differences between the IRIS and ADViSE programmes in terms of the proportion of those identifying as LGBQ+. For the ADViSE programme only, we also see a difference between the proportion of LGBQ+ people in the referral group vs the service user group.[34] Looking at those referred to the programmes, 25% of people referred to the ADViSE programme were LGBQ+, compared to only 3% of those referred to the IRIS programme. This difference may be driven by factors explored earlier on in this chapter, that is by the differences inherent to the populations that attend the difference health services, or perhaps due to location of the sites. It also could be driven by the inclusion of sexual violence support in the ADViSE programme; LGBQ+ people are disproportionately likely to experience sexual harm, and it may be that mainstream sexual violence support services are less able to meet service user needs.[35][xii]

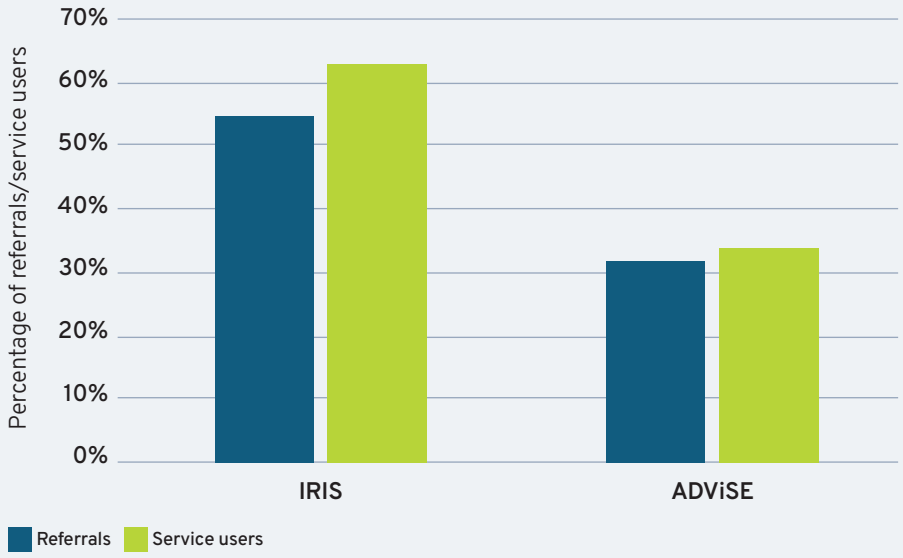
For the ADViSE programme only, when we look at the difference between referrals and service users, we see an increase in the rate of LGBQ+ people from 25% to 30%. This may be explained by 'missing data' – that is, that LGBQ+ people referred to the programme were more likely to have missing data than their heterosexual counterparts, and this mis-recording is corrected at the point of a case being closed. However, it may also suggest that LGBQ+ people are more likely to engage with the ADViSE programme than heterosexual people, which might be influenced by there being fewer alternative services that meet their needs.

[30] Gender sample size (IRIS): 4509.
[31] Gender sample size (ADViSE): 504.
[32] IRISi's database currently does not record trans identity well. It does record gender at birth and gender identity. We have operationalised trans identity to be someone who either records a different gender at birth to gender identity, or someone who has stated their gender identity to be non-binary, other or trans.
[33] Trans identity sample size - IRIS: 4,623; ADViSE: 502.
[34] Sexual orientation sample sizes. Referrals: IRIS: 3,962; ADViSE: 446. Service users: IRIS: 2,669; ADViSE: 365
[35] For example, in the year ending March 2022, 12.8% of gay/lesbian & 16.4% of bisexual women experienced sexual assault in the last year compared to 1.7% of heterosexual people.

CHILDREN

55% of patients referred into IRIS had children compared to 32% for patients referred into ADViSE.[36] We also saw that the proportion of service users with children was higher for both programmes, with 63% for IRIS and 34% for ADViSE.[37] This suggests that a higher percentage of individuals with children remain engaged with the services through to the closure stage.

CHART 4.2: PROPORTION OF PEOPLE WITH CHILDREN - REFERRALS AND SERVICE USERS



> **"I feel like I am safe in my own home now and able to provide good care to myself and child."**
>
> IRIS service user

[36] 2,247 out of 4,119 IRIS referrals and 146 out of 461 ADViSE referrals.
[37] 1,532 out of 2,437 IRIS service users and 125 out of 371 ADViSE service users.

ETHNICITY

For both programmes, one-third of referrals were for victim-survivors who identified their ethnicity as Black or minoritised for both programmes. This is shown in Table 4.1. This percentage surpasses the figure for the overall population of England and Wales.[38][xiii] The IRIS programme receives more referrals for people with Asian ethnicity, whereas the ADViSE programme receives more referrals for Black people. These differences may be due to the geographic locations of the IRIS and ADViSE sites, or there may be other factors influencing this.

TABLE 4.1: ETHNICITY OF REFERRALS

	IRIS		ADVISE	
	No. of referrals	%[39]	No. of referrals	%
Asian, Asian British	39	9%	776	19%
Black, Black British, Caribbean or African	56	13%	277	7%
Mixed or Multiple ethnic groups	33	7%	142	4%
White	295	67%	2688	67%
Other ethnic group	20	5%	108	3%
Total	**443**		**3991**	

When we compare the referral rate to the service user rate, for our IRIS programme only, the percentage of Black or minoritised service users decreases from 33% to 28%.[40] There are several possible reasons. Those from Black or minoritised ethnicities may be less likely to engage past referral stage with the IRIS programme. This could potentially indicate that the programme is not meeting the needs of this group, which of course would be concerning. However, the difference may just reflect changes to the geographic spread of the programme; if new sites in 2023-24 were in areas with higher rates of people with Black or minoritised ethnicities (e.g. ethnically diverse boroughs in London), then this could have skewed the referral rate to be higher than the service user rate.[41] Further analysis would let us understand this further and allow us to see how the trend differs for different groups within the broad category of Black and minoritised ethnicities.

RELIGION

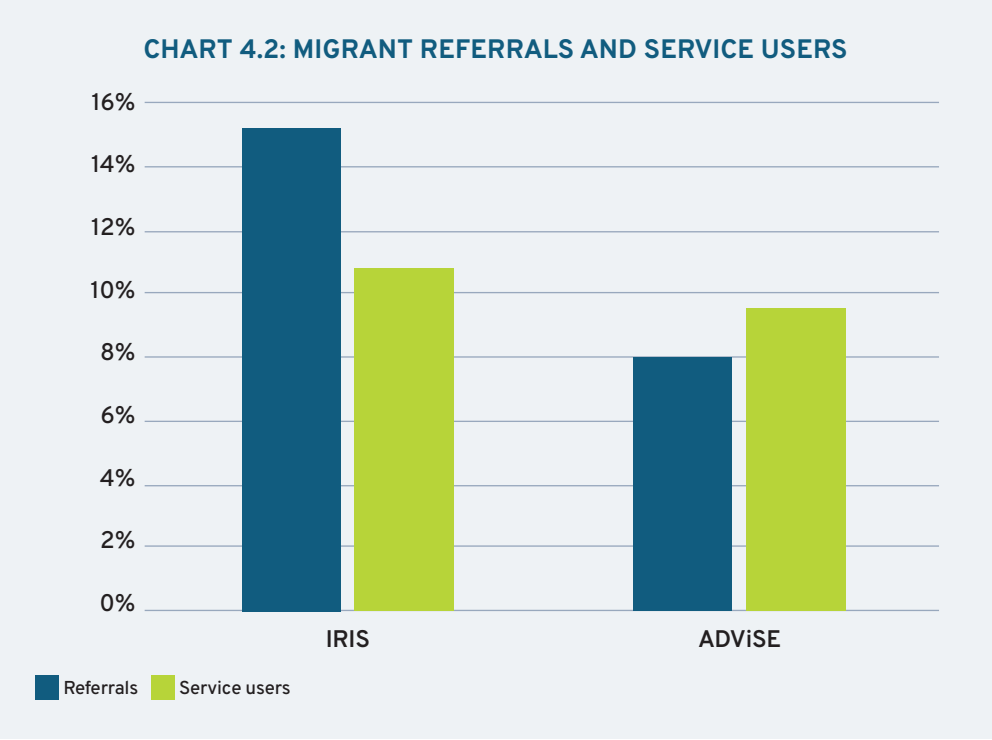
Over half of the patients referred into the IRIS programme indicated a religion.[42] This contrasted with only a third of people referred to the ADViSE programme.[43] As discussed previously, this may be reflective of the different age profiles between IRIS and ADViSE, different geographical locations, and/or differences in the use of sexual health services.

Similarly to the above analysis of ethnicity, for IRIS only there is a similar gap between the referral group and the service user group of those who follow a religion.[44] Given that in the UK those from Black or minoritised ethnic groups are more likely to follow a religion than those from White ethnic groups, it seems likely that these two trends may be interlinked.

[38] Around 18% of the population of England and Wales identify as Black or minoritised. The figure fluctuates slightly depending on which groups are included as minoritised ethnicities.
[39] Total percentages sum to over 100 due to rounding.
[40] 738 out of 2,675 IRIS service users.
[41] The service user group contains people who would have been referred in previous years.
[42] 1,521 out of 2,855 IRIS referrals.
[43] 96 out of 311 ADViSE referrals.
[44] 910 out of 1,922 IRIS service users.

IMMIGRATION STATUS

Migrant victim-survivors accounted for 15% of referrals to IRIS and 8% of referrals to ADViSE.[45] However, this distribution shifted among service users, as is shown in Chart 4.2. For the IRIS programme, the percentage of migrant service users decreased to 11%.[46] In contrast, for ADViSE, the percentage of migrant service users increased to 9.5%.[47]



It is not obvious what may be driving this difference. It is very likely that the factors discussed above regarding ethnicity and religion are also influencing the differences we see here for migrants. As discussed above, the geographic spread of sites (and the changes to this spread over the time) may explain the differences both between the two programmes, and between the referral/service user groups. Additionally, migrants have additional barriers to accessing NHS services, and it may be that this accounts for some of the difference in rates between the two programmes. For example, it may be the case that migrants are more likely to use GP practices than sexual health clinics. Without being able to account for this first, we are unable to make clear conclusions from these data.

[45] 444 out of 2,914 IRIS referrals and 35 out of 441 ADViSE referrals.
[46] 267 out of 2,466 IRIS service users..
[47] 36 out of 379 ADViSE service users.

DISCUSSION AND SUMMARY

As with previous years, our data supports the conclusions that the victim-survivors of domestic abuse and sexual violence are predominantly and disproportionately women. The ADViSE programme is open to all genders, so it is notable that this holds to be true even when we disaggregate between the IRIS and ADViSE programme. Conversely, for other demographics we see substantial differences in the cohorts of people accessing support for these two programmes. This appears to be particularly the case in terms of the age distribution of service users and the prevalence of those identifying as LGBTQ+. The conclusion we can draw from this is that even in areas that already have IRIS programmes, it is likely that ADViSE is identifying and supporting a different group of people who previously were unidentified and/or had unmet needs.

As yet, we are unable to conclude what is driving this difference in cohorts of service users between IRIS and ADViSE. The variances between the two programmes may simply be due to differences between the typical users of sexual health clinics and general practices. Or it may be that a different aspect of the programme is the driving factor. Whilst beyond the scope of this report, understanding more about the typical demographics of those accessing these healthcare settings would allow us to further analyse these distinctions.

Additionally, further work is needed to understand more about what about influences engagement rates in the IRIS programme. We see a difference in referral/engagement rates for Black people and those with otherwise minoritised ethnicities and for migrants. It is important to not rush to conclusions, but there is a possibility that these data are showing us that the programme is failing to engage these groups at the same rate as their non-migrant / white counterparts. On the other hand, because we are comparing referrals and service users over the same time period, it could just be reflective of the distribution of new sites over 2023-24 which were more likely to be in areas with high numbers of people from these groups. For IRISi to properly understand these data and draw meaningful conclusions, it is important we analyse this further , including seeking input from specialist by and for services in the sector. Should analysis highlight that there is an engagement issue, steps can be taken to understand why and provide resolution.

Chapter 5: Profile of victim-survivors

Health

Profile of victim-survivors - health

In this chapter we explore data on the health needs reported by the victim-survivors who came into contact with IRIS and ADViSE services during the 2023-24 fiscal year.

Where there are notable differences in the data between referrals and service users we have highlighted this.[48] Otherwise, we have deferred to referral data in line with previous years' reports. Similarly, where there are significant differences between the profile of IRIS and ADVISE victim-survivors we have discussed these separately. If not, we present these data together. Unless stated otherwise, all percentages given have had non-responses removed from the sample.[49]

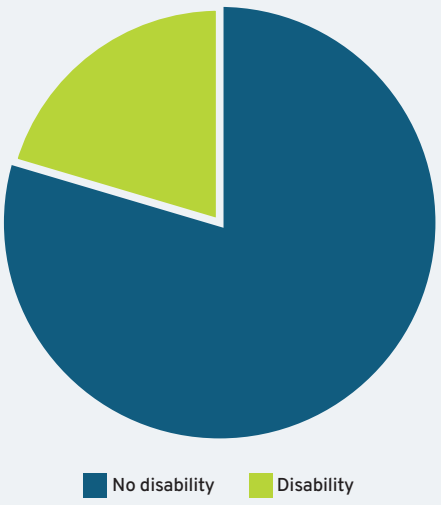
PREGNANCY

Slightly more patients referred into the ADViSE programme reported being pregnant at some point during their support compared to IRIS: 6.7% of patients referred into ADViSE reported pregnancy compared to 2.4% for IRIS.[50] There were no substantial differences between referrals and service users for either programme. It is likely that this difference between the two is driven by the different age profiles of the service users of the two programmes. Additionally, ADViSE sites receive referrals directly from clinics that include abortion services. As such, it is likely that the pregnancy rate of people who attend these services is higher than the pregnancy rate of people attending general practice, and this may further explain the difference.

DISABILITY

One-fifth of victim-survivors had a disability.[51] This was consistent across IRIS and ADViSE and referrals and service users. This rate closely matches the figure from the 2021 England and Wales Census. However, given that disabled people face a higher risk of abuse, we might expect to see a higher proportion of victim-survivors reporting a disability, which could indicate that the training sessions could benefit from increased emphasis on identifying and referring survivors with disabilities.

CHART 5.1: PROPORTION OF PEOPLE COMING INTO CONTACT WITH THE IRIS/ADViSE PROGRAMME WHO HAVE A DISABILITY



> **"This service has taken into account all aspects of my identity, but specialist services are really important and there is a lack of services which are accessible for people with multiple needs e.g. experiencing domestic abuse and disabled"**
>
> ADViSE service user

[48] For more details on the difference between these two terms, please see our Methodology chapter. The two sample sizes are as follows: IRIS: referrals - 6,626, service users – 3,235; ADViSE: referrals – 608, service users- 387.
[49] There are limitations to this method, as it may be that the prevalence of missing data are dependent on the variable being looked at. However given the scope of this report, this method was chosen for expediency.
[50] Pregnancy sample size: 3,864 IRIS referrals; 448 ADViSE referrals.
[51] 887 out of 4,058 IRIS/ADViSE referrals and 578 out of 2,858 IRIS/ADViSE service users.

MENTAL HEALTH

We compared the prevalence of various mental health conditions for people who have come into contact with the ADViSE and IRIS programmes. Table 5.1 gives the breakdown of these and looks at the differences in rate between referrals and service users. In general, we see that the prevalence of each mental health condition is higher for service users than for those who have been referred. We also see that the prevalence of those who have reported no conditions (rather than just missing data) decreases. Part of this trend may be due to better completion rates of these data between referral and service user stage. It may also be that being in the programmes has helped the person seek a diagnosis around their mental health.[52] However, it may also indicate that those with poorer mental health are more likely to engage with the IRIS and ADViSE programmes.

TABLE 5.1: MENTAL HEALTH CONDITIONS OF REFERRALS AND SERVICE USERS FOR IRIS AND ADViSE

	REFERRALS				SERVICE USERS			
	ADViSE		IRIS		ADViSE		IRIS	
Depression	183	55%	1516	68%	190	58%	1410	70%
Anxiety	175	52%	1434	64%	183	56%	1345	66%
PTSD	57	17%	263	12%	64	20%	245	12%
Personality Disorder	26	8%	68	3%	25	8%	73	4%
Other	25	7%	126	6%	33	10%	114	6%
None	79	24%	248	11%	62	19%	186	9%
No. of people with responses	*336*		*2236*		*329*		*2030*	

Depression and anxiety were the most common conditions, with more than half of the people who have come into contact with the programmes reporting these. IRIS tended to support slightly more people reporting these conditions than ADViSE. PTSD was less frequent but still notable, particularly in the ADViSE service user group where this was reported by nearly one in five people. We also found a higher prevalence amongst ADViSE referrals and service users of patients reporting personality disorders and 'other' mental health conditions. This suggests overlapping but differing mental health profiles for the individuals who use IRIS and ADViSE programmes. Whilst beyond the scope of this report, further analysis juxtaposing mental health conditions with the primary reason for referral into the ADViSE programme might tease out whether this difference is driven by the type of abuse experienced, or if it is more to do with the populations that use the respective health services.

> **"Mental health is really important. If I had not received the support I received, I don't know if I would have still been here"**
>
> ADViSE service user

In addition to recording the conditions that patients report, Advocate Educators also record indicative risk factors for the severity of (potential) harm as a result of someone's poor mental health: self-harm, suicidal ideation and suicide attempts. Broadly, these risk indicators were twice as prevalent amongst patients referred to the ADViSE programme compared with the IRIS programme. Among those referred to ADViSE, 10% reported self-harm, compared to 4% for IRIS, with similar trends observed among service users.[53] Suicidal ideation was reported by 18% of ADViSE referrals and 10% of IRIS referrals.[54] For IRIS service users, the rates were comparable. However, there was a notable increase for ADViSE service users, where 25% of service users reported suicidal ideation. Finally, 10% of those referred to ADViSE and 5% of those referred to IRIS informed their AEs about previous suicide attempts.[55]

[52] IRISi has a 'social model' understanding of disability, and part of this means that we do not require a diagnosis of a condition for us to record it. However, it may be that some people are more likely to inform us of a condition (or have the language for it) once they have received a diagnosis.
[53] Response to self-harm sample size:160 out of 3,843 IRIS referrals and 38 out of 373 ADViSE referrals.
[54] Response to suicidal ideation sample size: 234 out of 2,281 IRIS referrals and 66 out of 371 ADViSE referrals.
[55] Response to suicide attempts sample size: 142 out of 2,618 IRIS referrals and 36 out of 375 ADViSE referrals.

LEARNING DIFFERENCE

The data reveal a significant difference in the proportion of individuals referred with learning differences between the ADViSE and IRIS programme, as well as among service users.[56] For patients referred to ADViSE, 11% reported learning differences, compared to 3% for IRIS.[57] This disparity is also reflected in the service users, which showed no differences compared to the referrals. It is not apparent that this difference is related to the cohort of people who attend the respective health care settings. These findings suggest that ADViSE may possibly be more likely to attract individuals with learning differences compared to IRIS. It will be interesting to see if this difference between the two programmes is sustained over time.

SUBSTANCE USE

Victim-survivors are asked about their drug and alcohol use. We didn't find significant differences between the data for referrals and service users. Referral data are presented in Table 5.2.

TABLE 5.2: PREVALENCE OF ALCOHOL AND OTHER DRUG ISSUES AMONGST REFERRALS

	ADViSE		IRIS	
	No. of referrals	%	No. of referrals	%
Issues with alcohol use	10	2.6%	147	4.4%
Issues with other drug use	23	5.9%	54	1.6%
Issues with both alcohol and other drug use	13	3.3%	54	1.6%
No. of responses	*390*		*3369*	

People referred to the IRIS programme were more likely to report issues with alcohol use, whereas those referred to the ADViSE programme were more likely to report either issues around drug use or issues around drug and alcohol use. This is difference is perhaps reflective of the age profiles of the service users of the two programmes.

> **"Thank you so much for all your patience and support, I am very grateful and hope my medical conditions will settle once the abuse has stopped."** IRIS service user

[56] The language used in our data collection is 'learning difficulty'. Language has evolved, and we now use the term 'learning difference', so we will use this term in this section.
[57] Response to learning difficulty sample size: 396 ADViSE referrals and 3,876 IRIS referrals.

DISCUSSION AND SUMMARY

As with Chapter 4, understanding the differences between the health needs of those who use general practice and those who use sexual health clinics may shed some light on as to whether it is the referring health care setting that drives the difference in prevalence of various health-related conditions between the two programmes, or if this is a feature of the programmes themselves. The much higher rates of learning difference amongst the ADViSE service users is intriguing, and further insight is crucial to ensuring the programme is adapted to meet all needs.

It is clear that both programmes support many people who are experiencing poor mental health. Indeed, the majority of service users indicated that they had a mental health condition. It appears that the two programmes have diverging profiles in terms of the mental health needs of the service users. IRIS service users were more likely to disclose depression and anxiety, whereas ADViSE service users were more likely to disclose other mental health conditions. These other conditions tend to have lower prevalence rates in wider society. Additionally, we see ADViSE service users being far more likely to disclose self-harm, suicidal ideation and previous suicide attempts. Looking at the intersection of the types of mental health conditions disclosed and the prevalence of risk factors indicating distress and harm, it appears that those engaging with the ADViSE programme are, as a group, experiencing relatively worse mental health than IRIS service users. Equipping Advocate Educators with the tools to help bridge the gap between sexual health services and mental health services is essential to meet the needs of these service users.

Chapter 6: Victim-survivors' experiences of abuse

Victim-survivors' experiences of abuse

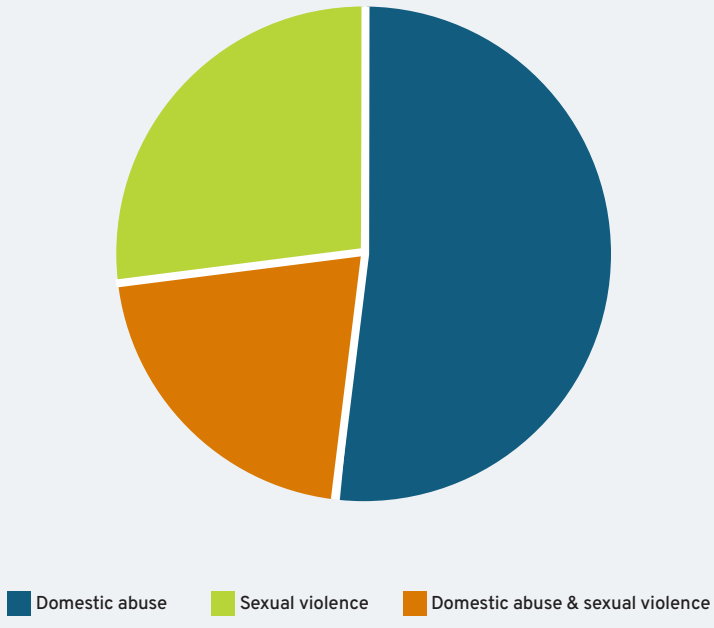
Advocate educators receive brief details about a victim-survivor's experience of abuse as part of the referral, including details about their perpetrator(s). Inevitably, an AE will gain more insight about the nature of abuse during the course of supporting the service user. We present data here from service users whose support ended in 2023-24.[58] The sample is comprised of 3,622 service users, including 3,235 IRIS service users and 387 ADViSE service users.

In general, our IRIS programme supports those who have experienced domestic abuse.[59] This means that the perpetrator will be either an intimate partner, former intimate partner, or a family member. Whilst domestic abuse may include sexual violence, we treat this violence as part of a wider pattern of abuse. The ADViSE programme supports both survivors of domestic abuse and survivors of sexual violence. When someone has been referred to the ADViSE programme because of sexual violence, we collect further information on the type of sexual violence experienced. Perpetrators of sexual violence can be anyone, including acquaintances, friends or colleagues. For these reasons, we present the data for the two programmes separately.

ADVISE PROGRAMME

Clinicians indicate whether the primary reason for making a referral is due to domestic abuse, sexual violence, or both. This gives us a picture of the patients that the programme supports. Of those who finished their support in 2023-24, 52% had been referred for support around domestic abuse, 27% for support around sexual violence and 22% for support with both.[60] This means that nearly half of those referred needed support around sexual violence and nearly three quarters needed support with domestic abuse.

CHART 6.1: PRIMARY REASON FOR REFERRAL FOR ADViSE SERVICE USERS



[58] For details about how this dataset was operationalised, please refer back to the methodology.
[59] There are some IRIS sites that also support survivors of sexual violence. For details on these please see our methodology.
[60] DA: 200 people; SV: 103 people; DA & SV: 84 people. Percentages add up to over 100 due to rounding.

In the following tables we look at the breakdown of the abuse and/or violence experienced by those that were referred for support around domestic abuse (table 6.1) and sexual violence (table 6.2). Both tables include data for those that were referred for both domestic abuse and sexual violence.

TABLE 6.1: ADViSE SERVICE USER'S EXPERIENCE OF DOMESTIC ABUSE

EMOTIONAL	256	92%
PHYSICAL	173	62%
FINANCIAL	63	23%
COERCIVE CONTROL	147	53%
HARMFUL PRACTICES	5	2%
STALKING AND HARASSMENT	112	40%
SEXUAL ABUSE	128	46%
ANY DOMESTIC ABUSE RECORDED	*277*	

Nearly all those referred for support around domestic abuse had abuse details recorded, and most service users experienced more than one type of abuse.[61] Nearly all ADViSE service users reported emotional abuse, more than half experienced physical abuse and just under half experienced sexual abuse. Just under a quarter of victim-survivors disclosed financial abuse.

TABLE 6.2: ADViSE SERVICE USER'S EXPERIENCES OF SEXUAL VIOLENCE

SEXUAL ASSAULT	127	71%
RAPE	91	51%
CHILD SEXUAL EXPLOITATION/ABUSE	20	11%
ANY SEXUAL VIOLENCE RECORDED	*178*	

Most of those referred for support around sexual violence had details about the violence recorded. The majority of these service users experienced either sexual assault or rape (or for some, both).[62] We also see a relatively high number of service users disclosing childhood sexual exploitation and/or abuse.[63][xv] These service users do not appear to come disproportionately from just one ADViSE site (i.e. it is not a specialist pathway created by a site that is generating this high rate). It is unclear if the survivors accessing the ADViSE service who have experienced child sexual exploitation or abuse are doing so to specifically get support about this or if, because this field is available in IRISi's database, it is being used to record disclosures but this is not the primary reason for accepting support.

> **"I have never spoken out about being forced into marriage before"**
>
> Service user

[61] 98%, 277 out of 284 service users.
[62] 95%, 178 out of 187 service users.
[63] NSPCC most recently estimated that 1 in 20, or 5%, of children in the UK have been sexually abused.

IRIS PROGRAMME

Advocate Educators are asked to record the types of abuse service users experience. Most service users will experience more than one type of abuse. Abuse details were recorded for 2,820 of the 3,235 referrals – 87% of service users.

TABLE 6.3: IRIS SERVICE USERS' EXPERIENCES OF DOMESTIC ABUSE

EMOTIONAL	2551	90%
PHYSICAL	1321	47%
FINANCIAL	844	30%
COERCIVE CONTROL	1345	48%
HARMFUL PRACTICES	185	7%
STALKING AND HARASSMENT	819	29%
SEXUAL ABUSE	577	21%

The rates of different types of abuse experienced by IRIS service users remain relatively similar to previous years. The only exception to this is the rate of those experiencing coercive control. Women's Aid defines coercive control as "an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."[xvi] This has increased from previous years and is now recorded for nearly half of IRIS service users. It is difficult to know what is driving this increase in coercive control rates. We hypothesise that this may not be that prevalence has increased amongst IRIS service users, but rather that experiences of coercive control are more widely understood, therefore leading to improvements in recording.

COMPARISONS BETWEEN THE TWO PROGRAMMES

As mentioned earlier in the report, the IRIS programme is broadly only for those experiencing domestic abuse, whereas the ADViSE programme is for those who have experienced domestic abuse or sexual violence. Given this, it only makes sense to compare the data for these two programmes in relation to domestic abuse. IRIS and ADViSE service users experienced similar levels of emotional abuse and coercive control. We see that ADViSE service users are more likely to have physical and sexual violence perpetrated against them. They are also more likely to disclose stalking and harassment. IRIS service users are more likely to disclose financial abuse.

Harmful practices are defined as *"forms of violence which have been committed primarily against women and girls in communities and societies for so long that they are considered, or presented by perpetrators, as part of accepted 'cultural' practice. The most common are forced or early marriage, so called 'honour' based violence, female genital mutilation or cutting (FGM) and other lesser reported forms such as faith-based abuse, menstrual huts, acid attacks, corrective rape and others."*[xvi] The data suggest that IRIS service users experience higher rates of harmful practices, although we should be tentative about this conclusion, as the difference may appear more pronounced than the reality due to the small sample sizes. It may be that ADViSE service users, having been referred from a sexual health setting, feel more comfortable disclosing sexual violence. For the other differences, we hypothesise that the age profile of each group is an influencing factor; ADViSE service users are a typically younger cohort whereas IRIS service users are typically older.

GENDER OF THE PERPETRATOR

Advocate Educators record brief details of the person who has perpetrated abuse against the victim survivor. Because of the gendered nature of domestic abuse & sexual violence, it is also interesting to explore the gender of the perpetrator.

CHART 6.2: PERPETRATOR GENDER

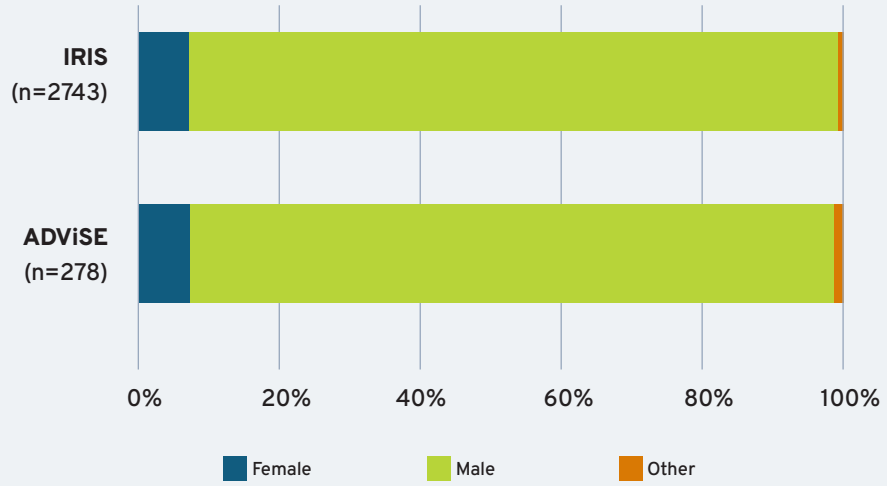


Chart 6.2 shows us that for both IRIS and ADViSE service users, 92% of perpetrators were men.[64] For the IRIS programme, just over 7% of perpetrators were women, and 0.2% were recorded as 'other', 'non-binary' or 'trans'. For the ADViSE programme, just under 7% of perpetrators were women, and 0.7% were recorded as 'other', 'non-binary' or 'trans'. Given that the ADViSE programme is open to all genders (whereas the IRIS programme is primarily just for women) we might expect to see variation between the two sets of perpetrators.[65] When we disaggregate men who accessed the two programmes for support we find that 30% of them had male perpetrators.[66] If the gender of a perpetrator was not a factor in the likelihood of perpetrating DASV against men, then we would expect to see the percentage of male perpetrators broadly matching the percentage of men who are in relationships with other men. This is not the case. This underlines that whilst domestic abuse and sexual violence can be perpetrated by people of all genders, it is disproportionately the case that the perpetrators of abuse of both IRIS and ADViSE service users are men.

[64] 109 out of 387 ADViSE service users and 492 out of 3,235 IRIS service users were missing details on the gender of perpetrator.
[65] Some IRIS sites work with all genders – for further information on IRIS variations, see the Methodology chapter.
[66] Records missing data on either perpetrator or service user gender were removed from the sample. Total sample of men service users with gender data for perpetrators was 136. 41 of these recorded male perpetrators.

DISCUSSION AND SUMMARY

The abuse profiles of the service users supported by the IRIS and ADViSE programmes in 2023-24 give us a picture of what victim-survivors of domestic abuse and sexual violence experience. We continue to see service users reporting a range of different types of abuse. It is of note that nearly half of ADViSE service users are victim-survivors of sexual violence; before the ADViSE programme launched IRISi modelled that around 15% of ADViSE service users might express a need for specific sexual violence support, so it is important to continue to monitor this trend as the ADViSE programme expands. It is also important to understand what support ADViSE service users who disclosed child sexual abuse/exploitation are seeking. If these experiences are central to why they wished to be referred to the programme, then the ADViSE Advocate Educator training should cover this in more detail in order to best meet the needs of survivors.

Finally, whilst not surprising, it is important to note that domestic abuse and sexual violence continue to be gendered in their nature, both in terms of who the victim-survivors are, and also in terms of who perpetrates the abuse. This is evidenced in our 2023-24 data. That the ADViSE and IRIS programmes continue to see disproportionately high rates of men perpetrating abuse evidences that these programmes are essential in IRISi's continued mission to improve the healthcare response to gender based violence.

Chapter 7: Support and feedback

Support and feedback

As with chapter 6, this chapter presents information on service users who finished receiving support from either IRIS or ADViSE programmes in the 2023-24 fiscal year, regardless of the year in which their referral was received. The sample is comprised of 3,622 service users, including 3,235 IRIS service users and 387 ADViSE service users. The chapter looks at the type of contact and support they received from their Advocate Educator, and whether service users had received support before. We also look at the length of the support given and the feedback from service users.

CONTACT METHOD AND FREQUENCIES WITH SERVICE USERS

We asked Advocate Educators to record the types of contact with service users, looking at both the method and frequency. Method of contact included face to face meetings, phone, online (including Zoom, Skype etc.), and email. Frequency of contact is disaggregated between one off and ongoing, and for face to face contact the data are more granular. Each service user may have several types of contact recorded (for example, one face to face meeting, plus ongoing email support).

Just over 40% of service users received in person support of some kind from their Advocate Educator, with some service users having ten or more meetings.[67] At least 18% of ADViSE service users and 24% of IRIS had just one contact with their AE.[68]

In Table 7.1 we have broken down the contact type service users had with their AE. The percentages below have been derived after removing unknown values. Over 93% of service user records had details on the method and frequency of contact.[69] Service users may have multiple contact types ticked (e.g. one face to face meeting, plus ongoing telephone support).

TABLE 7.1: METHOD OF CONTACT WITH SERVICE USERS

	IRIS	%	ADViSE	%
CONTACT ONE TELEPHONE CALL/SKYPE/ZOOM	816	27%	89	24%
CONTACT ONGOING TELEPHONE SUPPORT	1510	50%	201	55%
CONTACT ONGOING ONLINE SUPPORT	81	3%	12	3%
CONTACT ONGOING EMAIL SUPPORT	381	13%	86	23%
CONTACT ONE MEETING	398	13%	56	15%
CONTACT 2 - 4 MEETINGS	683	23%	64	17%
CONTACT 5 - 9 MEETINGS	200	7%	22	6%
CONTACT 10+ MEETINGS	100	3%	15	4%
TOTAL SERVICE USERS WITH CONTACT RECORDED	*2993*		*367*	

For the most part, there are not significant differences between the contact profile of ADViSE and IRIS service users. Notable exceptions to this appear to be influenced by email support; nearly double the amount of ADViSE service users received support over email compared to IRIS service users. This figure means that ADViSE service users are also more likely to receive support via multiple contact methods than IRIS service users.[70] It isn't clear what is driving this difference. It could be related to ADViSE service users being a younger cohort than IRIS service users, and therefore perhaps more comfortable with email communication. It also may be driven by risk: sexual violence cases are less likely than domestic abuse cases to carry ongoing risk implications, and as such there may be more service users who can communicate using email safely.

[67] Either solely in person support, or in combination with other kinds of support.
[68] 71 out of 387 ADViSE service users; 805 out of 3,235 IRIS service uses
[69] 2,993 out of 3,235 IRIS service users; 367 out of 387 ADViSE service users
[70] 40% of ADViSE service users compared with 29% of IRIS service users.

SUPPORT PROVIDED TO SERVICE USERS

Service users received a range of support from their Advocate Educator. The services are designed to tailor support to the victim-survivor's specific needs. The majority of service users request emotional support (70% of IRIS service users and 90% of ADViSE service users[71]) and advice and information (58% of IRIS service users and 84% of ADViSE service users[72]). All other support categories were far less likely to be ticked for each service user.

> **"This is the first service I have been involved with that makes me feel seen, heard, understood, and supported. I very much appreciate the help given to me and will always be grateful."**
>
> ADViSE service user

Advocate Educators provided support to 264 service users seeking civil justice interventions, such as non-molestation orders, occupation orders and assistance with child contact matters. This comprised of 7% IRIS service users and 11% ADViSE service users.[73] Additionally, AEs assisted 312 service users in pursuing criminal justice interventions. This represents 8% of IRIS service users and 13% of ADViSE service users.[74]

> **"Thank you very much for support and information with regards to court and non-molestation order you have been great."**
>
> IRIS service user

MARAC AND SAFEGUARDING

IRIS and ADViSE are designed to support victims and survivors who are categorised as "standard" to "medium" risk. However, the level of risk the perpetrator poses to service users may change, and accordingly, the type of support service users need may change. In the year ending March 2024, Advocate Educators have supported in 378 MARAC processes (342 for IRIS service users and 36 for ADViSE service users), 163 adult safeguarding processes (138 for IRIS service users, 25 for ADViSE service users) and 384 child safeguarding processes (323 for IRIS service users and 61 for ADViSE service users).[75]

[71] IRIS: 2,280 out of 3,235; ADViSE 349 out of 387.
[72] IRIS: 1,892 out of 3,235; ADViSE 325 out of 387.
[73] IRIS: 223 out of 3,235; ADViSE 49 out of 387.
[74] IRIS: 262 out of 3,235; ADViSE 50 out of 387.
[75] By supported in, we include both making a referral to a MARAC and supporting a service user who has been referred to a MARAC by a different organisation.

ONWARD REFERRALS

During the course of support, Advocate Educators, alongside the service user, may identify other services that are needed to provide more holistic support. This might be 'in-house' support provided by the specialist service: counselling, educational support groups, sanctuary schemes being just a few. AEs will also connect some service users with survivors' groups where they can access peer support from other people who have also experienced domestic and/or sexual violence and abuse.

Referrals may be made to external services, e.g. housing support, mental health groups, or community groups. There may also be reason to refer the service user onwards to a different specialist DA/SV service. This can happen for several reasons – the service user may have moved home during the course of the support, and a more local service is now better suited, or a service user may prefer support from a 'by and for' group (for example, a Latin American Women's Service or a service specifically for bisexual women).

Table 7.2 below shows the number of IRIS and ADViSE service users who were referred to these other services. Service users could have referrals in more than one category, and this is why we see them total over 100% for ADViSE. In total 73% of ADViSE service users and 39% of IRIS service users had referrals to other services. Interestingly, a higher proportion of ADViSE service users were referred on to other external agencies, suggesting a different pattern of need amongst this group

TABLE 7.2: ONWARD REFERRALS[76]

	IRIS SERVICE USERS	% OF IRIS SERVICE USERS	ADViSE SERVICE USERS	% OF ADViSE SERVICE USERS
Referral to another service in-house	693	21%	114	29%
Referral to another external agency	385	12%	129	33%
Survivors' group	170	5%	100	26%
Referral to an external specialist DA support service	290	9%	40	10%
Referral to an external specialist SV support service (ADViSE only)	n/a	n/a	81	21%

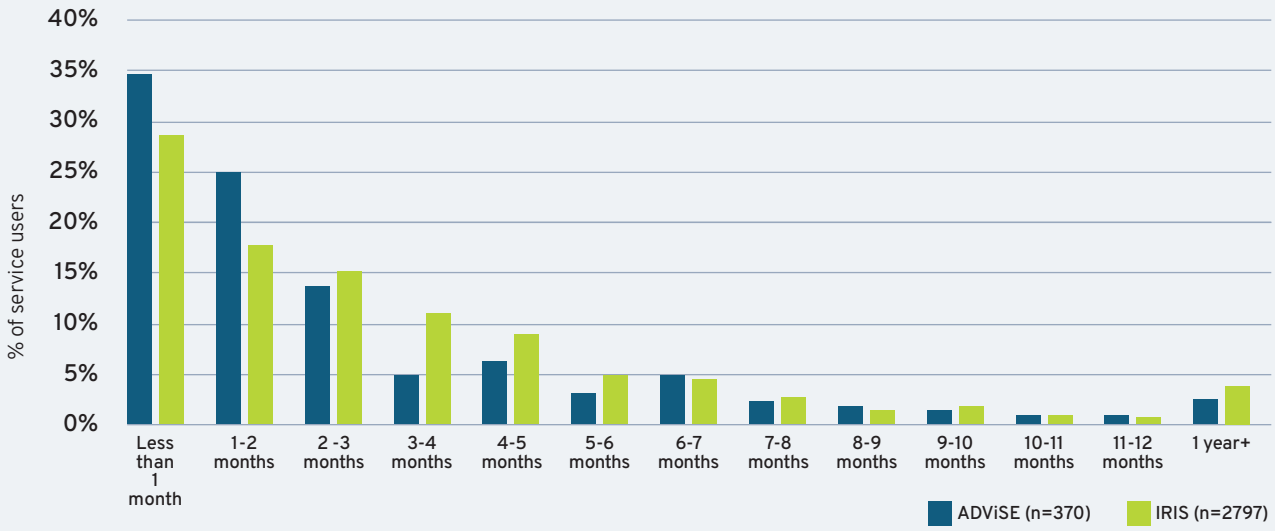
> "Thank you, the counselling referral will help me move forward."
>
> IRIS service user

[76] Percentages derived from total of 3,235 IRIS service users, 387 ADViSE service users.

LENGTH OF SUPPORT

The length of support was tailored to the needs of service users, with many service users receiving support for less than a month, whilst others received support for over one year.[77] Both IRIS and ADViSE programmes have a similar profile in terms of the length of time service users were supported. For 2023-24, the median length of support provided by the ADViSE programme was 47 days, slightly shorter than the figure for IRIS (69 days).

CHART 7.1: LENGTH OF SUPPORT

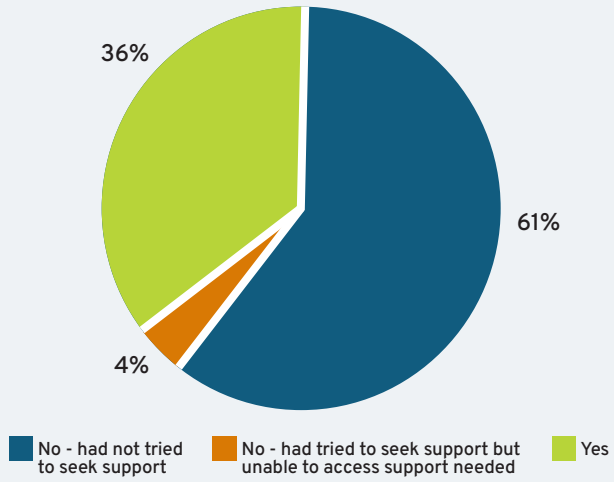


SERVICE USERS' PREVIOUS SUPPORT

Service users were asked whether they had previously accessed specialist domestic abuse and/or sexual violence support. Data for both IRIS and ADViSE were similar, so we have presented aggregated data. Nearly two thirds of service users who gave a response to this question had not successfully accessed support before; of those a small proportion had previously tried to seek support but were unable to access it.[78] This continues to evidence that both the IRIS programme and now the ADViSE programme reach people who have not received specialist VAWG support previously.

> **"The appointments I had were very well structured and my AE was very easy to talk to and very personal goal oriented which was done at a speed which was comfortable."**
>
> IRIS service user

CHART 7.2: PROPORTION OF SERVICE USERS WHO HAD TRIED TO SEEK SUPPORT BEFORE (n=2511)



[77] Support for less than a month: ADViSE - 126 people out of 370 people (34%); IRIS - 773 out of 2,797 people (28%). Support for over a year: ADViSE - 7 out of 370 people (2%); IRIS - 111 out of 2,797 people (4%)
[78] 64.4% - 1,617 out of 2,511 responses from service users.

FEEDBACK FROM SERVICE USERS

At the end of the period of support, service users are asked if they would like to provide feedback about the support they have received. There are limitations to this sample, as it is likely only those that find the support positive will continue to engage with the advocacy on offer. Service users are asked two types of questions: the first set is feedback about the service and support, and feedback about how they themselves feel about their situation. The second set focuses on use of healthcare settings pre/post support. For both sets, service users are asked to choose from a five-point scale how they feel about a statement.[79]

As shown in table 7.3, the feedback for the first set of questions is overwhelmingly positive for both IRIS and ADViSE, with the over 90% agreeing or strongly agreeing with all the statements below. In general, the feedback between the two services is similar, with positive response rates not differing by more than a few percentage points.

TABLE 7.3: SERVICE USER FEEDBACK FOR IRIS AND ADVISE PROGRAMMES

	IRIS			ADViSE		
	Strongly agree + Tend to agree	Total responses	%	Strongly agree + Tend to agree	Total responses	%
I am pleased that my health practitioner asked me about [abuse]	525	538	97.6%	153	161	95.0%
I am pleased that I have been referred to a specialist [...] worker	533	538	99.1%	155	161	96.3%
I feel listened to by the Advocate Educator	510	515	99.0%	161	161	100.0%
I found the support provided by the Advocate Educator helpful	508	513	99.0%	160	161	99.4%
I now know where to go for support	511	517	98.8%	159	161	98.8%
I now know how to access support	509	515	98.8%	160	161	99.4%
I feel safer as a result of the support	493	511	96.5%	154	161	95.7%
I feel more confident	492	510	96.5%	157	161	97.5%
I feel more able to cope	485	508	95.5%	155	161	96.3%
I feel good about myself	468	508	92.1%	146	161	90.7%
I feel optimistic about my future	468	508	92.1%	146	161	90.7%

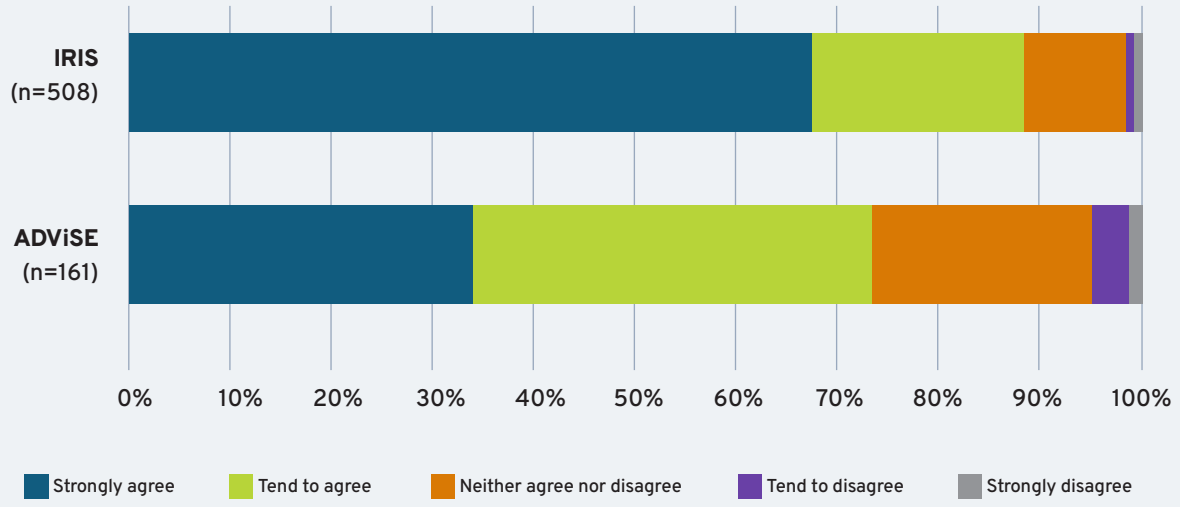
> **“Thank you for all the information and links provided for me to move forward. I am so grateful to my GP approaching me to make this referral this has really helped me.”**
>
> IRIS service user

[79] Options were: strongly agree, agree, neither agree nor disagree, disagree, strongly disagree

USE OF HEALTH SERVICES

Service users were also asked questions about their use of healthcare services post intervention compared to before. Both IRIS and ADViSE service users were asked whether they visit their doctor/nurse (IRIS), or sexual health clinic (ADViSE) less than before. As we see in Chart 7.3, there are marked differences in responses to these questions between IRIS and ADViSE service users. For the IRIS programme, nearly 9 in 10 people said that they agreed with this statement. This drops to just over 7 in 10 people for ADViSE service users. We also see double the proportion of ADViSE service users saying that they neither agree nor disagree.

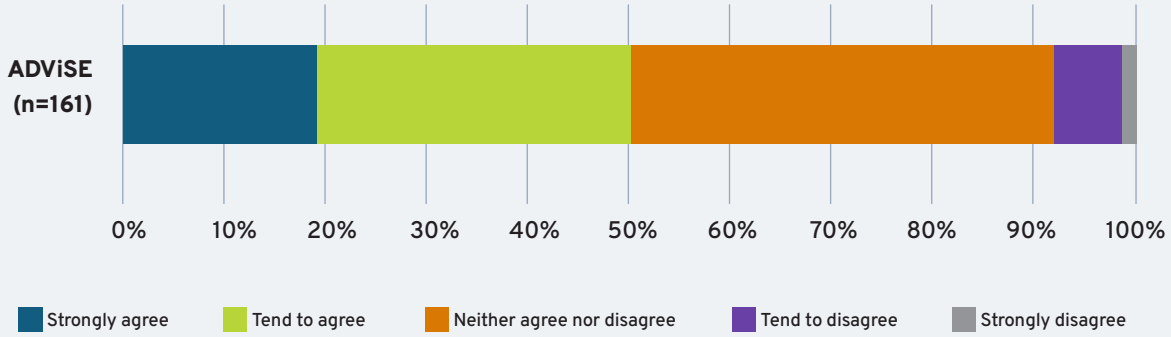
CHART 7.3: RESPONSES TO "I VISIT MY [REFERRING HEALTH CARE SERVICE] LESS THAN BEFORE"



ADViSE service users were also asked whether they use other parts of the health system less than before.[80] The breakdown in responses is given in chart 6.4. 1 in 2 people agree that their use of the health care system has decreased since they started receiving support from the programme. However, nearly as many people stated that they neither agreed nor disagreed with this statement.

[80] For IRIS, 508 responses were recorded. For ADViSE, 161 responses were recorded for both sets of questions.

CHART 7.4: RESPONSES TO "I USE OTHER PARTS OF THE HEALTH CARE SYSTEM LESS THAN BEFORE"



The disparity in responses shows in Chart 7.3 is likely explained in part by the health care service the patients were referred from. General practice is, by its very nature, generalist in the patients it supports. What this can look like in reality is that someone who is experiencing a lot of distress (i.e. a victim of domestic abuse) may use their GP as (non-specialist) support for this domestic abuse. The introduction of specialist support by way of an Advocate Educator might then lead to that person to no longer need to access their GP in the same way. On the other hand, sexual health services are less likely to be this 'catch all' safety net for those in distress. For example, people may routinely attend sexual health clinics for STD check-ups and would continue to do so regardless of accessing support from the ADViSE programme, as it is not the domestic abuse (or sexual violence) that was influencing their decision to attend that particular health care setting.

> **"The whole project has helped me realise I may have ADHD as well and the AE has supported me with providing information to my GP in order to get an assessment and this is going to be life changing for me."**
>
> ADViSE service user

DISCUSSION AND SUMMARY

The data from across the network continue to show that it is primarily emotional support and practical advice and information that survivors seek when they access support. That so many survivors receive support in these categories suggests that additional qualitative research could provide further specificity of the nature of this support. Less than one in ten service users sought support about criminal 'justice' interventions, whereas over four in ten wanted onwards referrals to other organisations.[81] This highlights the importance of national government funding a wide range of services to provide holistic support to survivors and not focusing resources solely into the criminal justice system.

The IRIS programme continues to reach a group of people who may not otherwise access support. It is encouraging that this appears to also hold true for the ADViSE programme. Nearly two thirds of the people accessing the programmes have not been able to access support previously; this is clear evidence that these IRISi interventions are meeting an unmet need. Moreover, given that both programmes appear to support different cohorts of people, this highlights the real strength of embedding survivor interventions across a range of different health services.[82]

Looking at differences in data between the two programmes, Advocate Educators for ADVISE appear to deliver more of their support via email than IRIS AEs. Given the relatively small numbers of service users in the ADViSE programme, this trend may not be sustained in future years, however learning more about this from Advocate Educators would provide further insight. Should this insight confirm that ADViSE service users are more likely to access support digitally, IRISi can play a role by highlighting this from the outset to AEs and supporting the ADViSE network to develop and hone the (digital) support given.

A further difference is service users' usage of health care services after receiving support from their Advocate Educator. Anecdotally, we know that general practice clinicians spend some of their clinical time providing non-clinical emotional support to survivors. IRIS service users consistently report a decrease in their use of general practices after IRIS support. Given that many survivors access emotional support through the IRIS service (either directly or through onwards referral) it seems fitting that attendances at general practices would decrease. Sexual health clinics have a different pattern of use in that people are more likely to attend for specific health needs. As such, it is perhaps not surprising that the ADViSE programme does not show a similar outcome. Further exploration of healthcare use (for both programmes) would provide more insight.

[81] Justice is written in inverted commas to highlight that most victims of domestic and sexual abuse do not receive this through our current systems.
[82] See Chapter 5 for further details of the differences between ADViSE and IRIS service users.

Chapter 8: Building connections with the health sector

Building connections with the health sector

A large part of the work of the IRIS and ADViSE programmes is focussed on building bridges between specialist VAWG services and the healthcare system. When new sites are established, Advocate Educators and Clinical Leads work in collaboration to establish connections with the general practices or sexual health clinics in the area. This is a considerable piece of work that takes place before the training can begin. Once the programme is set up, in addition to delivering initial training sessions for healthcare staff, the AE will attend meetings with healthcare professionals, deliver refresher training, and respond to enquiries from clinicians about referrals. Maintaining this ongoing connection is key to the success of the programmes.

PRACTICE MEETINGS AND CONSULTATIONS

There are a variety of non-training interactions that Advocate Educators have with healthcare professionals. Practice meetings provide space for clinicians and AEs to share best practice and troubleshoot complex situations. They also give opportunity for clinicians who are hesitant to make referrals to see the benefits of doing so in a group environment. Individual consultations about patient cases facilitate joint working between the healthcare team and the AE.[83] AEs also participate in other events, typically stakeholder events to help promote the IRIS/ADViSE programme in their area.

To date, attendance at practice meetings and consultations is inconsistently recorded in IRISi's data system. Table 8.1 below presents the number of sessions and attendees for consultations, practice meetings and other engagements for the IRIS and ADViSE programme. The numbers reported are significantly lower than expected. Unpicking this further, we see that only 14 IRIS sites and 1 ADViSE site recorded sessions. That less than a third of sites complete these data suggests that IRISi's data collection method is ineffective.

TABLE 8.1: ENGAGEMENTS BETWEEN ADVOCATE EDUCATORS AND HEALTHCARE PROFESSIONALS

		IRIS	ADViSE	TOTAL
CONSULTATION	Sessions	47	0	47
	Attendees	74	0	74
PRACTICE MEETING	Sessions	64	3	67
	Attendees	568	13	581
OTHER ENGAGEMENTS	Sessions	103	8	111
	Attendees	622	20	642

[83] It is worth stressing that Advocate Educators work confidentially with service users. Besides significant safeguarding concerns, discussions with any professional outside of the specialist VAWG service (including healthcare professionals) will only be done with the active consent of the service user. Maintaining this trust between the AE and service user is vital to ensure safe, supportive and effective work.

REFRESHER TRAINING

Refresher training is offered to healthcare services every two years after they complete their initial training sessions. As ADViSE has not yet been running for long enough, there were no ADViSE refresher training sessions in the 2023-24 fiscal year. For the IRIS programme, 150 clinical refresher sessions, for 1346 attendees, and 48 reception refresher sessions, with 341 attendees, were delivered by local IRIS teams across the network.

TABLE 8.2: REFRESHER TRAINING SESSIONS

	IRIS	
	No. of sessions	No. of participants
CLINICAL REFRESHER	150	1346
RECEPTION REFRESHER	48	341
TOTAL	198	1687

> **"Really useful refresher – I shall really have [domestic abuse] on my radar in my consultations with patients now."**
>
> Refresher training attendee

ONGOING CONNECTEDNESS

The theme of connectedness was explored in Dowrick et al.'s (2022) paper looking at the social value of the IRIS programme.[xvii] As one clinician stated "Feedback after the patient / client has been seen is crucial. As clinicians in primary care feedback is scarce. This makes us feel our efforts are a waste of time. If we want IRIS to become embedded in primary care permanently and effectively that closure of the feedback loop to the clinician showing all the interaction and services the client has been offered and / or used is very powerful. It simply means that clinicians will ask the [domestic abuse] question more often and find more clients and more lives will be saved and improved." Across the network, there were over 100 Advocate Educators working to deliver the IRIS and ADViSE programmes in 2023-24. These AEs were employed across 38 specialist service partners. They provided training to 593 GP practices and sexual health clinics and received referrals from 1,072. Significant work will have been conducted by AEs (and their Clinical Leads) to establish and maintain connectedness with all of these general practices and sexual health clinics.

DISCUSSION AND SUMMARY

We know that Advocate Educators interact with healthcare settings beyond providing initial training and receiving referrals. The IRIS programme provides ongoing refresher training, ensuring that VAWG and its impact on both the physical and mental health of patients remain on the radar of healthcare professionals. ADViSE will follow suit in 2024-25 as established sites come up to their two-year anniversary. Beyond refresher training sessions, our data do not currently accurately describe the additional connections being formed and maintained between AE and healthcare settings. With only a minority of the network recording data in this area, we know that the above picture presents a significant underrepresentation of the work done to build and continue the connections between healthcare services and specialist services. These ongoing connections are the critical third component towards improving the health outcomes for victim-survivors of VAWG who access healthcare services. To further explore and evidence the impact of these connections, improvements to the data capture of these connections is essential. By making structural improvements to the IRISi database, we will be able to link healthcare professionals to training attendances, referrals and other connections, helping IRISi and its network to further understand the relationship between these activities.

Recommendations

The following recommendations stem from the findings in this report. They are clustered into external recommendations for parliament and funding bodies, internal recommendations for IRISi, and broader recommendations for research themes.

FOR CENTRAL GOVERNMENT AND DEVOLVED PARLIAMENTS AND ASSEMBLIES:

Recommendation One: Domestic abuse and sexual violence are not solely criminal justice issues, and many survivors will not want to pursue criminal justice solutions. Health has a key role in addressing DASV by recognising and supporting victims and survivors. For this role to be fulfilled, domestic abuse and sexual violence must be recognised and addressed as health issues and health priorities at every level within the health system, beginning with the Department of Health and Social Care, and working hand in hand with the specialist VAWG sector to achieve this. *(Chapter 7)*

Recommendation Two: Health commissioning bodies must be awarded enough funding to enable them to properly address DA and SV as health issues by commissioning expert VAWG sector partners to provide training, support and advocacy. *(Chapter 3)*

FOR LOCAL AND REGIONAL FUNDERS AND COMMISSIONERS:

Recommendation Three: Commission ADViSE and IRIS programmes as effective, evidence-based interventions to improve the local health response to domestic abuse and sexual violence. Ensure that funding for programmes that support victims of sexual violence has parity with the funding of domestic abuse services. *(Chapters 1,3 and 6)*

Recommendation Four: Prioritise long-term, sustainable funding for IRIS and ADViSE programmes, and ensure that decisions around funding are made in a timely manner to support retention of staff.[84][xviii] *(Chapter 3)*

Recommendation Five: Improve equity of access to effective services by commissioning IRIS and ADViSE across the whole commissioning area and work with specialist partners to ensure provision and team capacity are at safe levels. *(Chapter 3)*

FOR IRISI:

Recommendation Six: Facilitate peer to peer support across our network to improve training feedback form completion rates. Consult with ADViSE stakeholders to make improvements to ADViSE handouts and supporting information. *(Chapter 2)*

Recommendation Seven: Further explore unexpected differences for the ADViSE programme. Develop and adapt the ADViSE support offer with these in mind:

- Monitor trends to see if digital support continues to be a key method of support. *(Chapter 7)*
- Consult with Advocate Educators to explore the support needed for service users disclosing childhood experiences of sexual abuse and exploitation. *(Chapter 6)*
- Work with Advocate Educators to understand further the high prevalence of less common mental health conditions and learning differences. *(Chapter 5)*

[84] In line with a joint letter by key stakeholders working in health and VAWG to the new government in July 2024 we recommend funding and contracts be awarded for a minimum of three years at a time.

FOR IRISI (CONTINUED):

Recommendation Eight: Improve data collection via the IRISi database in a number of areas:

- Embed system changes to better evidence the work Advocate Educators do to connect healthcare and specialist DA services, for example, by improving data collected on AE attendances at practice meetings, consultations, and other events. *(Chapter 8)*
- Quality assure ADViSE data to ensure the recording of patients' home Local Authority, allowing for further geographic analysis of the patient population supported by the programme. *(Chapter 1)*

FOR FUTURE RESEARCH:

Recommendation Nine: Prioritise exploration of the following themes to further embed evidence-led changes to the IRIS and ADViSE programmes

- Examine how the method of training delivery (online or face-to-face) impacts key outputs and outcomes for patients and training attendees. *(Chapter 2)*
- Analyse how resourcing and funding arrangements impact the number of referrals per site over time *(Chapters 1 & 3)*.
- For both migrants and people from minoritised ethnicities, investigate what is driving the difference between referral and engagement rates. *(Chapter 4)*
- Understand if the health care setting (i.e. general practice or sexual health clinic) is driving the difference between the profile of IRIS and ADViSE service users. *(Chapters 4 and 5)*
- Explore further what Advocate Educators mean by 'emotional support' and 'advice and information' in terms of the holistic support offered to service users. *(Chapter 7)*
- Explore how use of healthcare services changes as the result of the IRIS and ADViSE programmes. *(Chapter 7)*

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For readability, referrals prior to the 31st of March 2015 are grouped in one column. IRIS sites may start and finish the programme at any point in the year, so a site's first and last year figures may reflect a partial year of delivery. Comparison across the sites is not possible due to variation in both the size of the patient population and level of resourcing.

TABLE A: NUMBER OF REFERRALS TO THE IRIS PROGRAMME PER FISCAL YEAR BY SITE

IRIS SITES	UP TO 2015	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	TOTAL
Barking & Dagenham*[84]							29	74			103
Barnet				1	61	51	91	108	115	65	492
Bath & NE Somerset		52	148	128	162	157	350	158	88	76	1319
Berkshire West*	65	6									71
Birmingham & Solihull		90	222	286	419	164	689	725	942	1147†[90]	4684
Blackpool*					3	94					97
Bolton	16	144	142	199	245	348	268	243	338	368	2311
Brent*							3	56			59
Bristol	363	120	161	202	286	276	198	243	185	145†	2179
Bromley[85]			32	116	99	106	92	79	152		676
Camden*	139	35	7	108	132						421
Cardiff & the Vale		119	132	133	156	267	3	239	266	200†	1515
Carmarthenshire									8	29†	37
Cheshire East*	9	5									14
Cheshire West		10	25	95	101	96	95	117	114	156	809
Cornwall*	5	1	3								9
Coventry					72	125	150	219	180	228	974
Croydon*							30	82		45†	157
Cwm Taf		46	144	160	106	133	101	202	275	191†	1358
Denbighshire*									20	19	39
Devon & Torbay					154	357	241	311	337	516	1916
Dudley					29	110	105	107	110	117	578
Ealing*							7	50			57
East Surrey		22	23	49	45	16	32	43	35	50†	315
Enfield	94	42	107	134	112	172	117	99	145	78	1100
Greenwich							15	63	34		112
Gwent								201	311	510	1022
Hackney	462	191	127	123	99	122	160	176	197	136	1793
Hammersmith & Fulham*							11	95		1	107
Haringey			15	50	55	63	47	100	79	75	484
Havering										8	8
Herefordshire										2	2
Islington	6	52	49	84	132	79	64	7	43	57	573
Jersey				1	38	32	43	16	19	13†	162
Kent & Medway								1	1	67	69
Kensington & Chelsea*						37					37
Kingston										11	11
Lambeth	321	113	39						87	114†	674
Lancashire										57	57
Lewisham*			22	57	84	4					167
Manchester	312	268	478	759	827	961	740	767	759	875†	6746
Mansfield & Ashfield*	52	45	15								112
Middlesbrough							3	41	93	59†	196
Newham										18	18
North Somerset*		9	3								12
Northern Ireland							23	125	141	211	500
Nottingham City*	138	115	21								274
Nottingham West*	17	60	22								99
Poole*		19	9								28
Portsmouth*	149	80	18								247
Redbridge										58	58
Richmond										10	10
Salford		2	52	126	231	251	213	271	285	301	1732
Sandwell			7	5	71	85	81	106	72	97†	524
South Gloucestershire	118	88	132	60	189	49	116	109	90	79†	1030
Southampton	258	87	74	63	64	7	30	23	12	6	624
Southwark		9	65	13	65	46	38	57	34	33	360
Swansea Bay						11	60	114	53	151	389
Tameside										44†	44
Tower Hamlets	81	149	86	32	109		170	189	97		913
Trafford*		31	52	87	18						188
Vale Royal & S. Cheshire*	26	21			82	112	49				290
Walsall				36	153	31	97	107	139	143	706
Waltham Forest*							22	39	43	29	133
Warwickshire*		69	48	75	111	155	186				644
Westminster*							7	51		6	64
Wolverhampton									1	25	26
TOTAL PER YEAR		**2100**	**2480**	**3182**	**4510**	**4517**	**4776**	**5813**	**5900**	**6626**	**42535**

*denotes that the IRIS programme is no longer commissioned due to lack of local funding

[84] Data for this report (and this table) was extracted in June 2024. We are aware that referral numbers for the sites marked with † have since changed.
[85] Funding for the Bromley site stopped in 2023-24 but will resume in 2024-25.

Network Report 2023-24
IRISi

IRISi is a social enterprise established in 2017 to promote and improve the healthcare response to gender-based violence. We work collaboratively with partners to develop innovative, evidence-based healthcare interventions for those affected by gender-based violence.

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