Dancing with the 3rd sector: health care responses to DVA

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Building collaboration and communication in domestic abuse work
Connect Centre conference
3rd October 2018
**scope**

- DV (3rd) sector without primary care
- primary care without DV sector
- How do we engage general practice in responding appropriately and safely to domestic violence?
- How do we improve outcomes for women who engage with domestic violence specialist services?
DV sector without primary care

Historically primary care has been absent
➢ missing partner at multi-agency fora
➢ despite being professionals most accessed by the population, GPs generally do not ask about DVA and, if women do disclose, often do not respond appropriately
➢ results in poor clinical practice
➢ missed opportunity for support and access to specialist DVA services
What do survivors of DVA want from doctors?

**before disclosure/questioning**
- try to ensure continuity of care

**make it possible for women to disclose**
- ask about (current and past) abuse

**when issue of partner violence raised**
- don’t pressurise women to fully disclose

**immediate response to disclosure**
- ensure that the women feel that they have control over the situation, and address safety concerns

**response in later consultations**
- understand the chronicity of the problem and provide follow up and continued support
primary care without DVA sector (and DVA training)

- most medical students have no or minimal DVA training
- uncertainty about how to ask about abuse and about local DVA services
- health issue but ambivalence about GP engagement
- no information about services in practices
a certain kind of evidence...

epidemiology

systematic reviews and meta-analyses

RCTs + nested qualitative studies & economic analyses

guidelines and policy
How do we engage general practice?

- cluster randomised controlled trial
- 1 year follow up
- 48 practices in Bristol and Hackney

Identification and Referral to Improve Safety
aim

To determine the effectiveness and cost-effectiveness of a general practice-based DV training and support programme
IRIS model

Training and support
+ referral pathways including safeguarding children and adults
+ Medical record prompts
+ Recording and flagging system
+ Advocate educator
+ Practice champion

Health education material
+ Clinical enquiry
+ Validation
+ Documentation
+ Immediate risk check and safety assessment

Identification + Referral

Advocacy
Emotional & Practical support

Less abuse
Improved quality of life
+ Mental health

Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse (Review)

crucial partnership with domestic violence advocacy organisations

NextLink

& the nia project

➢ advocate educator

➢ specialist referral service

➢ link to local domestic violence fora and coordinated community response
IRIS Identification and Referral to Improve Safety

Domestic Violence Aware Practice

If you are a woman being hurt by someone in your family, are afraid of someone at home or are in a violent relationship you can talk to doctors, nurses and other staff working here, in private.

You can also call
Next Link domestic abuse services on:
0117 925 0680

Or call the 24 hour
National Domestic Violence Helpline
on: freephone 0808 2000 247

If you are a man who is a victim of domestic violence contact the Men’s Advice Line on:
0808 801 0327

If you have been violent or are worried about your own behaviour, call Respect on:
0808 802 4040

Bristol NHS
IRIS trial results
(very) cost-effective

- NHS *cost savings* of £1.07 per woman per year, equivalent to UK £3155 per practice per year
- societal *cost savings* of £37/woman/year
Beyond the ivory tower

‘Herding cats’: the experiences of domestic violence advocates engaging with primary care providers

Medina Johnson from Next Link in Bristol recently identified and referred toImproving general practices with domestic violence specialists.

Engaging with health care services in support of women experiencing domestic violence is a challenge for domestic violence and expert agencies. Resistance to talk about domestic violence may be a way for both the violent and the apartment to feel in control. Domestic violence can be a subtle issue, and it is not always easy to deal with. The way the woman deals with the situation is not fit with what many see as the traditional medical model of symptom > diagnosis > treatment. In 1990, the first ever domestic violence service in the world was established in the UK.

The Identification and Referral to Improve Care (IRIS) randomised control trial has been working to engage general practices and provide primary care teams with information, confidence and skills to ask patients about domestic abuse and creating an easy and clear referral route for current or former patients. A review of 13 domestic violence services (March 2010) has been completed.

Identifying and Referral to Improve Care (IRIS) randomised control trial

February 2011

IMPROVEMENT IN PRACTICE:
THE IRIS CASE STUDY

Implementation success story: domestic abuse early education

Responding to domestic abuse:
Guidance for general practices

This document provides guidance to general practices to help them respond effectively to patients experiencing domestic abuse, as a Department of Health strategic priority:

www.dh.gov.uk/en/Publichealth/ViolenceagainstWomenandChildren/index.htm

This guidance includes key principles to help you develop your domestic abuse policy:

1. The role of management

A senior person within the practice should be identified to clarify the practice’s response to domestic abuse by:

- Finding out what existing domestic violence services are available (a list of national organisations is on page 4).
- Engaging with local domestic abuse services and the Domestic Violence Co-ordinator – to develop effective working partnerships.
- Commissioning training for the practice team.
- Establishing a simple care pathway for patients disclosing domestic abuse by identifying a local designated person who will be responsible for the initial assessment of victims.
- Ensuring that the practice’s response to disclosure always adheres to its information sharing protocols.

Identifying the designated person

The practice’s designated person can either be:

- An external specialist domestic abuse service practitioner who undertakes the initial assessment on behalf of the practice and liaises with the GP. Specific evidence based training and support programmes for general practice are available: www.irisdomesticviolence.org.uk
- An internal practice nurse or other health professional who is trained to carry out this work.

2. Establishing a domestic abuse care pathway

The primary healthcare team’s role

- Recognise patients whose symptoms mean they might be more likely to be experiencing domestic abuse.
- Enquire sensitively and provide a safe and empathetic first response.
- Understand the practice’s process for responding to disclosure, and know what to do when there is immediate risk of harm to patients and their children.
- Know who the designated person is for their practice.
- Understand the process for arranging the patient’s initial assessment with the designated person.
- Document domestic abuse within patient records safely and keep records for evidence purposes.
- Share information appropriately. Information will be shared only with the consent of the patient, subject to practice policy on child protection and adult safeguarding. In exceptional circumstances information may be shared without the patient’s consent. Some cases considered at MARAC meetings are likely to constitute exceptional circumstances because MARACs discuss the most serious cases of alleged or suspected domestic abuse.

News


For the Home Office’s definition of domestic abuse visit: www.homeoffice.gov.uk/training/Against-women-girls/domestic-violence/
translation into policy

- cited in Department of Health Violence Against Women and Children taskforce report as an exemplar programme
- cited in WHO partner violence guidelines as evidence for recommendation on training interventions
- part of NICE domestic violence guidelines evidence review
- cited as a “particularly effective remedy” by the Task and Finish Group for the Welsh Government’s proposed ‘Ending Violence Against Women and Domestic Abuse (Wales) Bill’
commissioning guidance
**Interrupted time series results**

IRIS increased the rate of referrals by:

30 times
IRIS into practice

- commissioned by CCGs and local authorities in 32 English localities and 2 Welsh health boards
- 56 advocate educators and 48 clinical leads trained in England
- > 1000 general practices trained
- Total IRIS practice referral to specialist agencies is > 12000
How do we improve outcomes for women who engage with DVA services?

Uncertainty about benefit of DV advocacy/support:

➢ probably reduces risk of further DVA
➢ mixed results from trials measuring mental health and quality of life outcomes for women receiving advocacy

Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse (Review)

How do we improve outcomes for women who engage with DVA services?
PATH aims

➢ to establish the clinical effectiveness of a psychological intervention delivered by domestic violence and abuse advocates

➢ to estimate the cost-effectiveness of the addition of a DVA advocate delivered psychological intervention compared to usual DVA services

➢ to explore advocate and client perceptions of the intervention to inform barriers and facilitators to delivery.
PATH aims

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study design

- 250 Participants recruited & randomised

  125 Usual advocacy ‘CONTROL’ group

  125 Usual advocacy PLUS SPA sessions ‘INTERVENTION’ group

  Qualitative interviews

  Follow up measures
  - 4 months
  - 8 months
  - 12 months
recruitment

- 2 recruiting sites:
  - Next Link, Bristol
  - Cardiff Women’s Aid

- all women presenting at DV agency screened at initial assessment by DV worker

- research associate contacts potential participant & arranges recruitment interview

- randomisation to intervention and control arm
Intervention: Specialist Psychological Advocacy (SPA)

- DV advocates provided with 25 days training in specialist psychological intervention
- based on the ‘Refuge Model’*
- draws from different concepts and technical strategies within cognitive-behavioural, experiential, dynamic, psycho-educational and feminist theories
- topics covered include post-traumatic stress, depression, anxiety and low self esteem

*Agnew-Davies et al: Reframing psychological symptoms in the context of domestic violence. Society for Psychotherapy Research: From research to practice: 37th International meeting; 2006; Edinburgh
outcome measures

➢ primary outcomes
  ➢ CORE-OM & PHQ9 at 12 months

➢ secondary outcomes
  ➢ Composite Abuse Scale (CAS)
  ➢ EuroQoL EQ5D
  ➢ Generalised Anxiety Disorder (GAD-7)
  ➢ Post-traumatic diagnostic scale (PDS)
  ➢ Short form 12 (SF12)
  ➢ Health/social/criminal justice use
Can we enhance advocacy?

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Treated Mean (sd)</th>
<th>Control Mean (sd)</th>
<th>Coefficient (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORE-OM</td>
<td>11 (9)</td>
<td>14 (8)</td>
<td>-3.35 (-5.53, -1.17)</td>
</tr>
<tr>
<td>PHQ-9</td>
<td>7 (7)</td>
<td>9 (6)</td>
<td>-2.23 (-4.12, -0.34)</td>
</tr>
<tr>
<td>PTSD</td>
<td>15 (13)</td>
<td>19 (13)</td>
<td>-3.93 (-7.34, -0.52)</td>
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<tr>
<td>GAD-7</td>
<td>6 (6)</td>
<td>7 (6)</td>
<td>-1.36 (-3.07, 0.36)</td>
</tr>
<tr>
<td>Total abuse</td>
<td>16 (29)</td>
<td>23 (30)</td>
<td>-6.45 (-15.57, 2.67)</td>
</tr>
</tbody>
</table>
dancing with the 3rd sector

➢ essential if we want to evaluate collaborative models as well as the actual care of survivors outside of health care contexts

➢ innovative interventions responding more sensitively to the needs of patients and clients than conventional NHS services

➢ flexibility sometimes lacking in NHS partners

➢ facilitated contact with service users, who have taken the role of advisors, collaborators and co-researchers within our research programme
wrestling with the 3rd sector

- priorities for agencies necessarily differ from those of primary healthcare researchers: 2 cultures challenge
- managing an intervention delivered by specialist agencies in the context of a trial is complex
- trial involvement requires a greater degree of explicitness about content of the service than agencies generally require
- systematic data collection may be problematic
pointer towards a happy relationship

➢ keep senior managers in the loop formally on all intervention decisions
➢ give time to explain the research/ methodology and the context/philosophies of the services involved
➢ separate the evaluation (trial) and the intervention teams, but bring them together on a regular basis
➢ keep checking that everyone’s ‘on the same page’
what we are aiming for...
Thank you

to survivors
to their families
to colleagues
to funders