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Rogers, M. orcid.org/0000-0002-7214-4375 and Ali, P. (2021) Manchester IRIS evaluation : Stakeholder feedback - services users and IRIS general practice. Report. The University of Sheffield , Sheffield.

Manchester IRIS evaluation: Stakeholder feedback - Services users and IRIS General Practice

Dr Michaela Rogers and Dr Parveen Ali

May 2021

IRIS
Identification & Referral to Improve Safety

MANCHESTER WOMEN'S AID

FREEDOM

The University Of Sheffield.

Manchester Health & Care Commissioning
A partnership between
Manchester City Council
and NHS Manchester CCG

Acknowledgements

Gratitude is extended to all the service users of the MWA IRIS service, General Practice GPs, Practice Nursing Teams and Practice Managers who took part in this evaluation as without their time and contributions, this report would not have been possible. It is hoped that this report accurately reflects their perspectives and experiences. Thanks is also extended to the IRIS team (especially IRIS Leads Nabeela Hussain and Dr Clare Ronalds) who helped to facilitate the completion of this study.

Disclaimer

This evaluation was funded by Manchester Health & Care Commissioning (MHCC). The views expressed are those of the authors and not necessarily those of MHCC, Pankhurst Trust (trading as Manchester Women's Aid, PTMWA) or Manchester IRIS (MWA IRIS).

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Suggested Citation:

Rogers, M. and Ali, P.A. (2021) *IRIS evaluation: Stakeholder feedback - Services users and IRIS General Practice, Manchester.* Sheffield: University of Sheffield

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Executive summary

Between October 2020 and April 2021 the University of Sheffield completed an evaluation of Manchester IRIS (a specialist domestic violence and abuse (DVA) service). A mixed-methods approach was taken to capture stakeholder feedback from: service users (n=11) using telephone interviews; and practitioners employed in GP practices (n=75) via an online survey. The following areas were explored through the evaluation:

- Experiences of DVA through COVID-19
- Impact of COVID-19 to service provision
- Accessibility and COVID-19: barriers and facilitators
- Practitioner views on IRIS training and HARK*
- Current and future IRIS services: what works and what could be developed

* HARK is a recording template which prompts GPs and other practice clinicians to ask about domestic violence and abuse

Overall, the findings highlighted that IRIS is highly regarded and valued by both sets of stakeholders. Ten key recommendations are highlighted.

IRIS AE Team and GP practices:

1. Consider the use of videoconferencing to support service users either when face-to-face support is not possible (due to COVID-19 or other reasons), and to complement face-to-face support;
2. Strengthen the IRIS AE Practice liaison role;
3. Review employment practices and cover when staff are ill, leave employment and in handover periods.
4. Review promotion of IRIS in GP practices and in communities (e.g. review the distribution of material of different languages and consider awareness-raising with sessions in different religious spaces);
5. Change to two-yearly IRIS Update training for GP practices;
6. Continue the use of the IRIS HARK template;

External / future work:

7. Undertake planned work to increase the awareness of domestic violence and abuse (DVA) and the Manchester IRIS service;
8. Explore further the barriers and facilitators for vulnerable groups;
9. Explore the ways in which a more holistic service can be offered to victims/survivors *and* their children;
10. Explore the role and development of IRIS in relation to high-risk cases.

1 Introduction

1.1 Introduction to this report

This report describes work carried out to evaluate Manchester IRIS and was commissioned by Manchester Health & Care Commissioning (MHCC). The evaluation was carried out between October 2020 and April 2021 by a team of researchers based at the University of Sheffield in the Department of Sociological Studies and the School of Nursing and Midwifery. Manchester IRIS is a General Practice programme of training combined with a specialist service that addresses domestic violence and abuse.

1.2 Background

In the UK domestic violence and abuse (DVA) is defined as "any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial or emotional"[1]. This definition also includes acts of so-called 'honour'-based violence, female genital mutilation (FGM) and forced marriage. It is a global challenge for health and social care services in delivering an appropriate response[2] and this has been made more challenging during the COVID-19 pandemic[3]. DVA affects people of all ethnicities, cultures, sexual orientations, gender, socio-economic classes, mental capacities, physical abilities and age at any point during the life-course.

There is strong evidence that highlights the physical and mental health impacts of DVA[4,5]. Whilst calculating the economic costs to healthcare provision resulting from DVA is problematic, due to the varied ways data is collected and definitional inconsistencies in existing studies, Walby estimated this to be calculated at £1.73 billion with mental health costs estimated to be an additional £176 million[6]. Whilst it has been subject to critique, a more recent estimate has been given at £66 billion[7]. The estimate health costs are unsurprising as it has become increasingly apparent that it is practitioners in primary and secondary health services (General Practitioners [GPs], health visitors, emergency and ambulance staff, midwives and sexual health practitioners) who are often the very first point of contact for people suffering from DVA [8]. Victims-survivors of DVA frequently identify healthcare practitioners as the most trusted professionals whom they would be most likely to speak to about their experiences [9]. Conversely, it has been argued, clinicians and healthcare professionals are often reluctant to ask about DVA, due to various factors including lack of confidence, not wanting to offend patient, lack of time[10, 11]. It is, therefore, unsurprising that the health sector has been described as a relatively 'late entrant' into the response to DVA [12].

Despite this, effective recognition, management and pathways to support are now acknowledged to be key priorities for healthcare settings [13]. Professional standards across healthcare reflect the recognition that responding to DVA is 'everybody's business' [14, 15]. There is national guidance on recording information about DVA [16, 17] albeit these guidelines have been described as ambiguous in terms of which healthcare professional should have access to a patient's information pertaining to DVA [18]. In addition, it is claimed that DVA is

still under-recorded in general practice in particular[19] with GP's poor record keeping as a factor in failing to prevent harm or death in an analysis of domestic homicides [20].

1.3 Manchester IRIS

In 2011 Feder et al. [21] published the results of research which piloted the Identification and Referral to Improve Safety (IRIS) programme. It is a General Practice DVA training and support programme which aims to improve recognition of and responses to DVA through referral from General Practice teams to specialist support. Conducted in GP practices in London and Bristol, the pilot study had considerable success demonstrating that the IRIS intervention increased the identification and referral of patients experiencing DVA. It was found to be cost effective[22, 23] and is now cited as an example of best practice in national policy guidance documents as an evidence-based DVA intervention[15].

In Manchester, IRIS is a collaboration between health and third sector specialist domestic abuse organisations. In February 2012 Public Health, now part of Manchester City Council (MCC), commissioned IRIS, with the Pankhurst Trust incorporating Manchester Women's Aid (PTMWA) as the specialist DVA service. Since 2015 IRIS has been jointly commissioned, in receipt of continued support from Public Health, MCC, with most of the funding coming from NHS Manchester CCG. This funding facilitates practitioners from all GP practices across the city to undertake IRIS training and have an IRIS service within their practice. MWA IRIS has trained all 85 GP practices (originally 96) across North, Central and South Manchester, and to date has delivered 3 yearly IRIS Update training with all the GP Practices.

All GP surgeries are IRIS trained with IRIS support delivered by specialist domestic abuse workers called IRIS Advocate Educators (AEs), employed by PTMWA, to any patient in need of support who are referred to the IRIS service. Unlike some IRIS programmes in other geographical locations, MWA IRIS is available for all patients whatever their gender identity (that is, MWA IRIS is accessible to women, men and people of non-binary gender). IRIS AEs and IRIS GP trainers (Clinical Leads) co-train GPs, nursing teams, practice managers, reception and administrative staff in addition to offering the specialist support service to those patients who need it. IRIS AEs see patients at their GP practice to enhance patient safety and confidentiality. In 2020-2021 during COVID-19 the service has been telephone-based whilst GP surgeries have provided limited access to patients and mostly offering remote consultations. Manchester IRIS is also available to staff working across General Practice surgeries in Manchester.

The MWA Annual Report[24] for the period from April 2019 to March 2020 highlights the impact of IRIS in contrasting the number of referrals for this period from the 85 Manchester GP practices as being 964 when prior to the commissioning of IRIS in 2012 there were fewer than 10 referrals from Manchester General Practices to any DVA agency each year. The following information is taken from the IRIS Annual Report [25]. Of the total 964:

- 84% were made by GPs;
- 3% were made by Practice Nurse teams (nurse practitioners, practice nurses);
- 3% were self-referrals;
- 10% other (e.g., practice staff or unspecified).

Most service users were female (93%) with a small proportion were male (7%)*. Less than half of all service users (n=416, 41%) reported having at least one child, totalling 494 children. Of these children, 416 (84%) were aged under 16. Fifteen (3%) of 541 female service users disclosed that they were pregnant. Other social characteristics, age, sexuality, and ethnicity are detailed in the following tables bearing in mind that data is sometimes missing or unknown.

*These figures are significantly different to the breakdown by sex of victim-survivors in the Crime Survey for England and Wales year ending March 2020. This reported that of 2,357,000 victim-survivors, 68% (1.6 million) were women, and 32% (757,000) by men. This is a prevalence rate of 7 in 100 women and 4 in 100 men.[25]

	16-20	21-29	30-39	40-49	50-70	70+	Total
Service users	14 (2%)	137 (23%)	190 (32%)	135 (23%)	103 (18%)	14 (2%)	593 (100%)

Table 1.1 Service users by age

Ethnicity	%
Asian / Asian British	24
Black /African / Caribbean / Black British	9
Mixed / multiple ethnic backgrounds	3
Other	3
White	49
Total	**100**

Table 1.2 Service users by ethnicity

Sexuality	Number	%
Heterosexual	491	96
Bisexual	9	2
Lesbian	6	1
Gay	3	1
Total	**509**	**100**

Table 1.3 Service users by sexuality

Foundation training offered by IRIS is divided into Clinical 1 and Clinical 2 and delivered jointly by an IRIS AE and an IRIS GP Clinical Lead. Table 2.4 details the total number of attendances at Clinical 1 (C1), Clinical 2 (C2) or training for reception/administrative staff.

	C1	C2	Reception	Total
Participants	73	63	36	172

Table 1.4 Participants in Clinical 1 and 2 training

Please note that most people who undertake IRIS training should complete both Clinical 1 and Clinical 2.

1.4 The evaluation: aims and objectives

In 2020 Manchester Health & Care Commissioning (MHCC) commissioned the University of Sheffield to undertake an evaluation of IRIS to capture stakeholder feedback from both service users and practitioners employed in GP practices. The evaluation aim was to explore stakeholder perspectives in relation to the IRIS with a specific focus upon the impact of COVID-19. The following objectives underpinned the evaluation:

1. To explore the impact of COVID-19 in respect of changing practices to understand what works (identifying barriers and facilitators);
2. To understand accessibility and issues of digital literacy and digital inclusion;
3. To consider high risk and vulnerable groups (e.g., BAME communities, people with mental health needs).

1.5 Structure of the report

This report provides the findings of the evaluation draws on both quantitative (survey) and qualitative data (semi-structured interviews) collected from January to March 2021. The report is structured as follows:

- Section 2 outlines the methodology and research methods that shaped the evaluation.
- Section 3 presents the findings of survey data collected from GP practices.
- Section 4 presents an analysis of the findings from one-to-one interviews held with service users.
- Section 5 presents in a discussion of the analysis of the findings.
- Section 6 offers a conclusion and recommendations

2 Methodology

2.1 Methods

This evaluation used a mixed-methods approach involving two workstreams including a survey of a GP practices and a one-to-one telephone interviews with service users. Both workstreams are discussed below.

2.2 Survey of GP practices

We developed a self-report survey, using Google forms, to collect data about the perspectives and experiences of practitioners within GP surgeries (GPs, practice nurse teams and practice managers). The draft survey was constructed in collaboration with members of the IRIS team. Feedback was used to make appropriate changes to ensure consistent phrasing, with the addition and deletion of some statements, and to ensure that questions enabled the research team to address the objectives. The survey was piloted with a small number of IRIS GP trainers located in GP surgeries before electronic distribution via email to the 85 GP practices in Manchester.

The purpose of the survey was to capture professional's views about the IRIS service in general and, specifically, in relation to the impact of COVID-19. The survey contained 25 questions about participants demographic characteristics (7 questions), their perspectives about the IRIS programme (5 questions), their perspectives about IRIS and DVA during COVID 19 (7 questions) and their perspective about IRIS training (7 questions). The questions included a combination of single choice answer questions, multiple choice answer questions and descriptive explanation answer questions. The questionnaire is attached in Appendix 1. The questionnaire took approximately 10-15 minutes to complete.

A letter of invitation was sent with the survey. The invitation extended to professionals across the practices and the final breakdown of numbers and role is detailed in Table 3.1 in accordance with respondents' self-identification. Respondents were asked to provide a consent before start of the survey. The survey was open from January to March 2021. It was circulated three times (after every three weeks) with a request to GP Practice Managers and GP Safeguarding Leads to distribute across their practices. It was also sent to IRIS training attendees during this period. The timing of the survey coincided with the role out of the national COVID-19 vaccination programmes and it is acknowledged that this additional demand on practices will have affected the completion rate.

Seventy-five surveys were returned (all usable) along with informed consent. We are unable to establish the return rate as we are unable to ascertain the total number of GPs (partners, salaried, locums) and other eligible employees across all 85 Manchester IRIS practices. Of the total respondents, 53 were GPs, 12 were from Practice Nursing Teams and 10 were from Practice Management. Data is presented numerically or thematically.

2.3 Qualitative data: Telephone interviews

Telephone interviews were held with service users (*n* = 11) who had been in receipt of support from IRIS in the period following the onset of the first national lockdown (March 2020). The background of participants is detailed in Table 3.1 below. It should be noted that the ages of participants range between 30-49 but this is not representative of all service users of Manchester IRIS as the service supports adults who are younger and older than individuals in this evaluation's sample.

Telephone interviews were agreed to be the best option in the continuing circumstances associated with the global pandemic. The question schedule followed a semi-structured format and included the following questions:

- Has your experience of DVA changed during COVID-19? (That is, have circumstances changed? Has the level of risk and type of abuse changed? Have there been issues in relation to contact with the perpetrator? Have there been changes in relation to children?)
- How did you learn about the IRIS service (e.g, from a practice clinician, GP practice admin staff, GP website, poster at GPs, friend, known previously about it, other)?
- Were there barriers/facilitators to accessing support from IRIS? (e.g., face-to-face meetings at the surgery or home visit, via telephone, video call, email, other? How was contact with the IRIS AE? How long before you could talk safely? Were there delays to support?
- What would help to improve the IRIS service for you and other people experiencing DVA?

All discussions were recorded via notes or a digital device.

Service User	Age range	Children	Ethnicity	Employment
SU1	40-49	N/A	Black/mixed other	Employed but off sick due to poor mental health
SU2	30-39	1	British Asian	Employed - keyworker
SU3	30-39	5	Pakistani	Not employed
SU4	30-39	1	British Bangladeshi	Made redundant from retail position during lockdown
SU5	40-49	2	British Pakistani	Not employed
SU6	30-39	1	Indian	Employed - IT sector
SU7	30-39	1	White British	Not employed
SU8	40-49	3	Caribbean	Not employed
SU9	40-49	1	White British	Employed – Education sector

SU10	40-49	1	African	Employed but off sick due to poor mental health
SU11	40-49	2	White Irish	Not employed

Table 2.1 Background of participants

In Section 5 which reports on the interviews, we use SU1, SU2 and so on to denote different participants. Rather than providing a pseudonym, we have de-personalised each participant in this way in our quest to completely anonymise all participants.

2.4 Data Analysis

Responses from Google survey were gathered into an excel sheet. Following cleaning, quantitative data were transferred into Statistical Package of Social Sciences (SPSS) version 22. The data were initially analysed using descriptive statistics (frequencies, mean, median, mode, standard deviation, percentages, and range).

Transcripts of individual interviews were anonymised prior to thematic analysis [26]. NVivo 11 was used to aid data management and analysis. Interview data were initially coded line-by-line, and themes and sub themes were iteratively developed through an internal process of validity and reliability testing.

2.5 Ethics

The study was subject to the procedures required by the ethics approval process of The University of Sheffield. Ethical approval was granted in December 2020 and all data collection activity commenced thereafter. Project information was provided to all survey respondents and informed consent was taken. A Project Information Sheet and Consent Form were distributed prior to telephone interviews. Informed consent was gained from all participants and it was treated as an ongoing process during telephone interviews, enabling participants to contribute as they wished and to end interviews when they wished to. Throughout the evaluation, great care has been taken to ensure the anonymity of participants and confidentiality has been continually addressed.

The lead researcher is a qualified social worker and registered with the professional body, Social Work England and the co-researcher is a qualified nurse. Both are experienced researchers and have completed a range of programme evaluations pertaining to ethically sensitive topics and many focussing on domestic violence and abuse [27, 28]. These projects have integrated the ethical guidelines laid down by the British Sociological Association and Social Work England. All data was anonymised and stored securely in line with the Data Protection Act 1998 (updated GDPR) and the University of Sheffield Research Data Management Policy.

3 Survey of GP practices

3.1 Introduction

This section presents the data from the survey which was distributed to all 85 GP practice surgeries in Manchester. In total, we received 75 responses from 53 GPs, 12 respondents located in Practice Nursing Teams and 10 from Practice Management. The respondents included 58 females and 16 males. One respondent did not disclose their gender. Most of the respondents were between 30-60 years of age. A majority of the respondents (81.3%) stated that they had IRIS Update training as well as the IRIS foundation training. Nearly 69% of the respondents mentioned that they had made an IRIS referral. Sixty four percent (64%) of the respondents stated that they act as the Safeguarding Lead for DVA (please see Table 3.1).

Table 3.1. Demographic Characteristics of the Respondents

Characteristic	N (%)	Characteristic	N (%)
Gender		**IRIS foundation training**	
Female	58	Yes	61
Male	16	No	9
Did not Answer	1	Don’t Know	5
Age		**IRIS Update training**	
18-29	3	Yes	61
30-39	22	No	11
40-49	28	Don’t Know	3
50-59	21	**Ever made an IRIS referral?**	
60-69	1	Yes	50
GP safeguarding or DVA lead?		No	22
Yes	48	Don’t Know	1
No	26		
Don’t Know	1		

3.2 IRIS service rating

The respondents were asked to rate the IRIS domestic abuse service on a scale of 1-5 with one being poor and 5 being excellent. A total of 71 respondents responded and the mean score **4.63**. Of the seventy-one (n=71) participants who had experience of using IRIS services responded to the question and rated service as excellent (n=35; 49.3%), very good (n=17; 23.9%) and good (n=14; 19.7%). Five (n=5; 7%) responded that they did not have any experience of using the service (Figure 3.1). No respondents indicated that they rated IRIS as poor or not good.

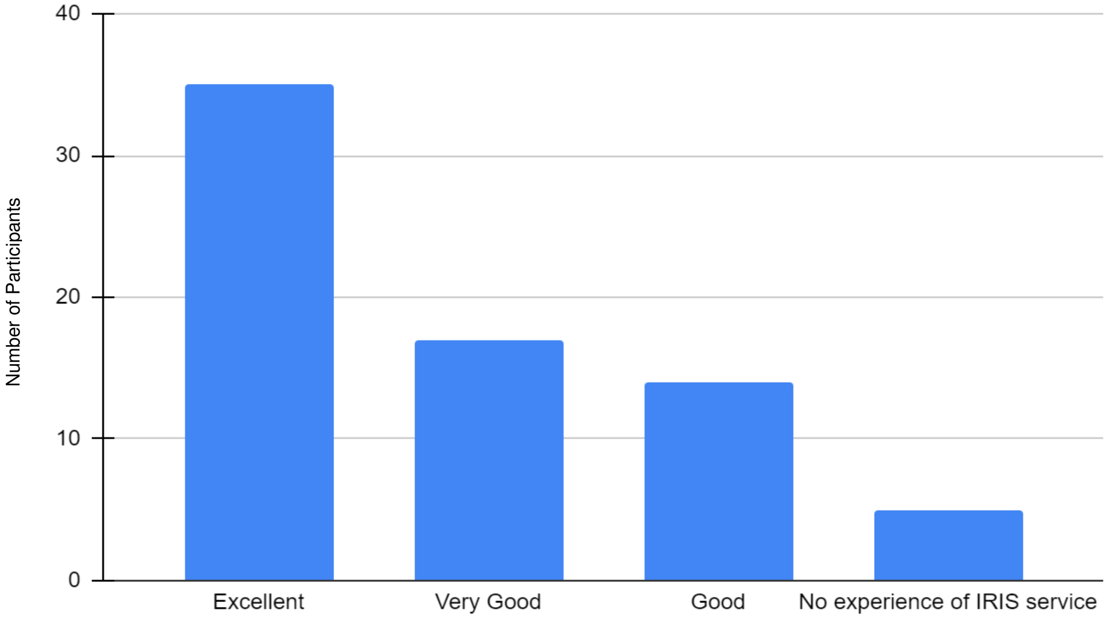

Figure 3. 1 How do you rate the IRIS service?

3.3 Features of the service that work well

Respondents were asked to choose features of the IRIS service (from a list of MWA IRIS service features) that they think work well (see Appendix 1 for list). A total of 72 responses were provided and the majority of these were positive. Top three features rated high by respondents included; display of IRIS poster in practice (n=60; 83.3%), feeling supported by IRIS team (n=57; 79.2%) and knowing how to contact IRIS office (n-57; 79.2%) as shown in Table 4.2.

Respondents were also asked ***about any particular features of the service that they liked the most***. We received 35 responses to this question and all statements very positive. Training provided by IRIS was identified as a very useful feature. In addition, prompt referral, ease of access to the IRIS Advocate Educator (IRIS AE), prompt response from the service, sensitivity and personal approach to the service seem to be liked most by the respondents as one respondent articulated:

> *'Good that named advocate for each area and able to give expert advise on how to manage complicated DVA cases and how to support survivors. This was never in place prior to IRIS service and has been invaluable'.*

Another respondent stated:

> *The service through training has allowed us to identify people who we never identified in the past and we are confident to do this now that we know we have a robust in-house service to refer into.*

And another one stated:

> *Prompt response to referrals, sensible advice given when calling to discuss/for advice*

Features	N	%
We have IRIS posters on display in our practice	60	(83.3)
I feel supported by IRIS team	57	(79.2)
I know how to contact the IRIS office	57	(79.2)
The HARK domestic abuse template prompts clinicians to explore DVA	55	(76.4)
I can discuss cases with the IRIS AE	54	(75.0)
During COVID-19 the patient has been supported by IRIS via telephone support service	47	(65.3)
The service is for practice staff as well as patients	47	(65.3)
The patient is seen in the practice by the IRIS AE enhancing safety and confidentiality	46	(63.9)
I know how to contact the IRIS AE directly	45	(62.5)
Patients are allocated to an AE within 5 working days	34	(47.2)
We have IRIS GP information on our practice website	21	(29.2)
IRIS AE attends practice meetings	4	(5.6)

Table 3. 2. Features of the MWA IRIS service that work well

In response to the question about future development to the service. The top three suggestions included developing a liaison with MARAC IDVA high risk service (n=47; 69%), improving notification from other agencies re DVA (n=45; 66%) and having an IRIS service for patients at high risk of DVA (n=44; 65%) as shown in Table 3.3 below.

Future Recommendations	N	%
Liaison with MARAC IDVA high-risk service and feedback to GP practices	47	(69.12)
Improve notification from other agencies re DVA to GP (e.g. housing)	45	(66.18)
Have an IRIS service for patients at high-risk of domestic abuse	44	(64.71)
Offer an IRIS holistic service for victim, children and perpetrators	44	(64.71)
IRIS website with information	40	(58.82)
Run an outreach service for homeless	37	(54.41)
Improve service accessibility for people from from BAME communities	36	(52.94)
Offer an IRIS perpetrator service	31	(45.59)

Table 3.3 Future recommendations

3.4 IRIS service & DVA during COVID-19

The majority of respondents agreed that COVID-19 affected their recognition of DVA as shown in Figure 3.2.

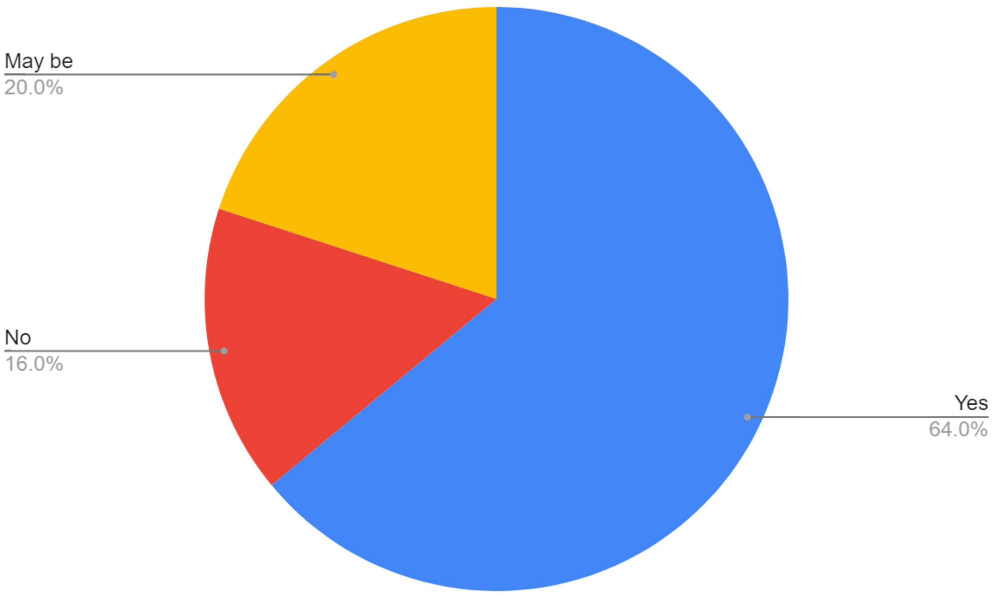

Figure 3.2 Recognition of DVA

The respondents were asked to expand on their response to explain how it has affected their ability to recognise abuse. We received 54 free text responses to the question and majority of the respondents identified lack of face-to-face contact opportunities, and the need to do remote consultation as the biggest reason of their decreased ability to recognise DVA. For example, one respondent maintained:

> *'Seeing less patients face to face has made a difference as don't tend to have the visual cues etc. Overall, with less patients seeking help and trying to keep away the cases are probably not being picked up*

Another stated:

> *'We have had less contact with/from some patients including those with vulnerabilities, drug service has not been working from Practice premises with our patient/clients, we have however as a team had/spotted consultation that have raised concern & been aware of the safety aspect of remote consulting & worked well with wider MDT (midwives/adult MASH)'*

Respondents mentioned that their awareness is heightened because of more coverage of DVA on news and via training. Majority of the respondents mentioned that they faced barriers in asking patients about DVA during COVID 19 as shown below

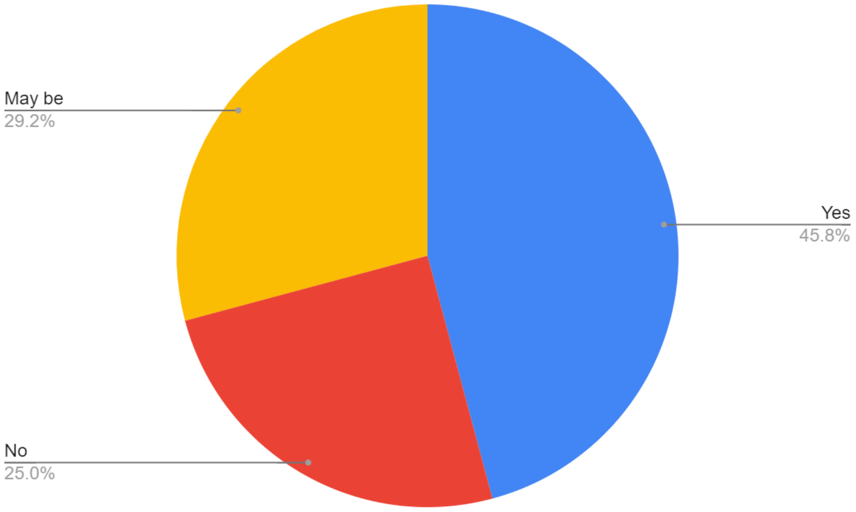

Figure 3.3 Barriers to asking about DVA

Respondents were asked to elaborate their responses via free text responses. A total of 54 respondents responded. Lack of face-to-face contact, remote consultation, not knowing if the patient is on their own or accompanied by someone else on telephone calls and therefore not feeling safe to ask questions, not being able to see body language of the patient were identified as biggest barriers.

3.5 Barriers to patients' access to IRIS during COVID-19

Respondents were asked to identify barrier for patients in accessing IRIS support during COVID 19. Various barriers were identified as illustrated in Table 3.4. The top three barriers identified by respondents included not seeing patient in surgery due to COVID 19 (n=54; 76%); lack of privacy (n=47; 66%) and not seeing patient in practice (n=42; 59%).

Barriers in accessing IRIS support during COVID-19?	N	%
We see less patients in surgery because of COVID-19	54	76.06
Lack privacy	47	66.20
Not seeing patients in practice	42	59.15
Can't ask safely about DVA on phone	34	47.89
Patient worried that the perpetrator will find out	33	46.48
Patient worried that children will be taken away	30	42.25
Lack phone / laptop	27	38.03
Patients don't want to be seen in surgery	15	21.13

Table 3.4. Barriers for patients in accessing IRIS support during COVID-19

The respondents were also asked to comment on how to reduce barriers to accessing IRIS services for vulnerable groups such as: Black women? Asian women? People with mental health problems? LBGTQ+ through free text responses. A total of 42 responses were provided. Suggestions included employing interpreters, increasing awareness via sessions in religious places (mosques, church, etc), employing Asian women, having information in various languages, asking DVA related questions more frequently. One respondent explained the issue in much detail when stating:

> *I have referred women who would identify as being one or more of these groups and I don't feel there were barriers to referral. But then they successfully made their way through the process and many more don't. I guess their access to the service is being referred by their GP - so is the problem maybe not with IRIS but prior to IRIS itself: 1) the GP not recognising that there is a DA issue? 2) GP doesn't offer IRIS as an option? 3) Patient is offered IRIS but declines? 4) Patient does not present about DA and does not give verbal cues? I would suspect GPs might not pick up on verbal cues in some patient populations because of subtle 'cultural differences', although the myth of abuse being ok because its culturally acceptable has been debunked. I think in very subtle ways it is still present.*

3.6 Facilitators for patients' access to IRIS during COVID-19

Respondents were asked about what has helped patients in accessing IRIS support during COVID-19. A total of 65 responses were received and majority of respondents (n=44; 68%) identified IRIS DVA and COVID19 training for reception and admin staff. Giving the telephone number of the IRIS AE allocated to their practice to ring directly (n=40; 62%) was another most common helpful factor as identified by respondents as shown in Table 3.5.

Table 3.5 What helped patients in accessing IRIS support during COVID-19?

What has helped	N	%
IRIS training for reception/admin staff about domestic abuse and COVID19	44	(67.69)
Giving them IRIS AE number to ring	40	(61.54)
Clinician seeing patients in the practice and linking them to IRIS AE by phone/ video	36	(55.38)
Spare room for them to see IRIS AE at practice	29	(44.62)

3.6 IRIS training

In response to the question about important aspects of IRIS training, 73 responses were received. The majority of the respondents suggested that they would like IRIS update training every two years (n=36; 49%%) as shown in Figure 3.4 below.

Table 3.6 Positive Aspects of Training

Aspects of Training	**N**	**%**
Chance to discuss difficult cases	52	71.23
Delivered jointly - by an IRIS GP and IRIS AE	50	68.49
Delivered online during COVID -19	49	67.12
Chance to meet your practice IRIS AE	40	54.79
Delivered in the practice	39	53.42
Peer training by an IRIS GP	26	35.62
Training by IRIS AE	21	28.77

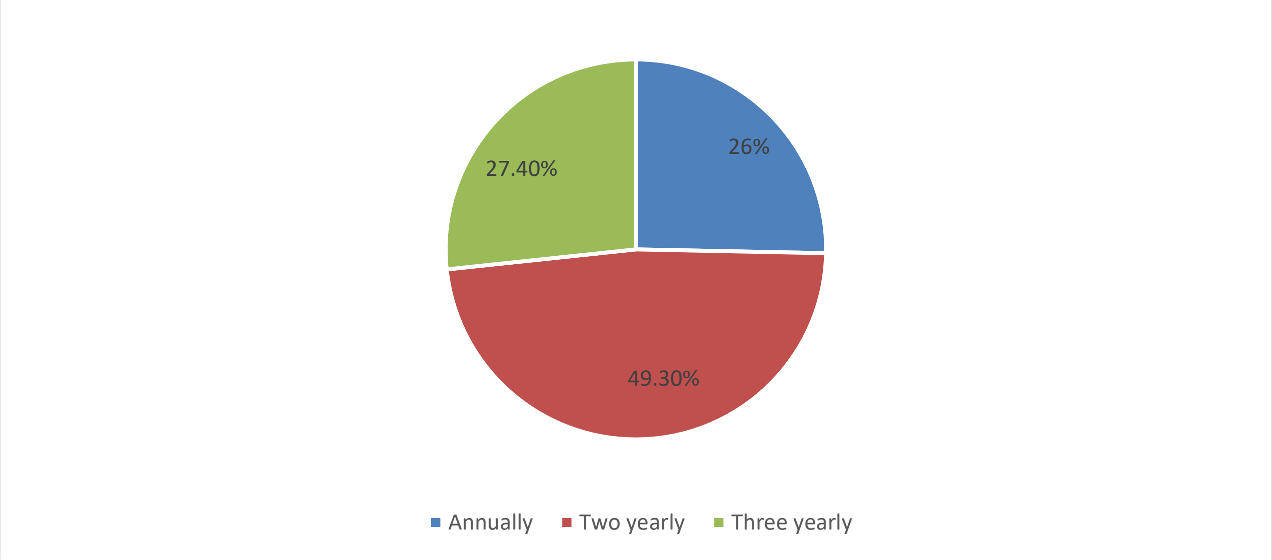

Figure 3.4 Frequency of IRIS Update training

Out of 73 respondents, 54 (73%) stated that they find the HARK template to be a useful prompt to explore DVA as shown in Figure 3.5 below. Only 10 participants mentioned that they did not find the template useful.

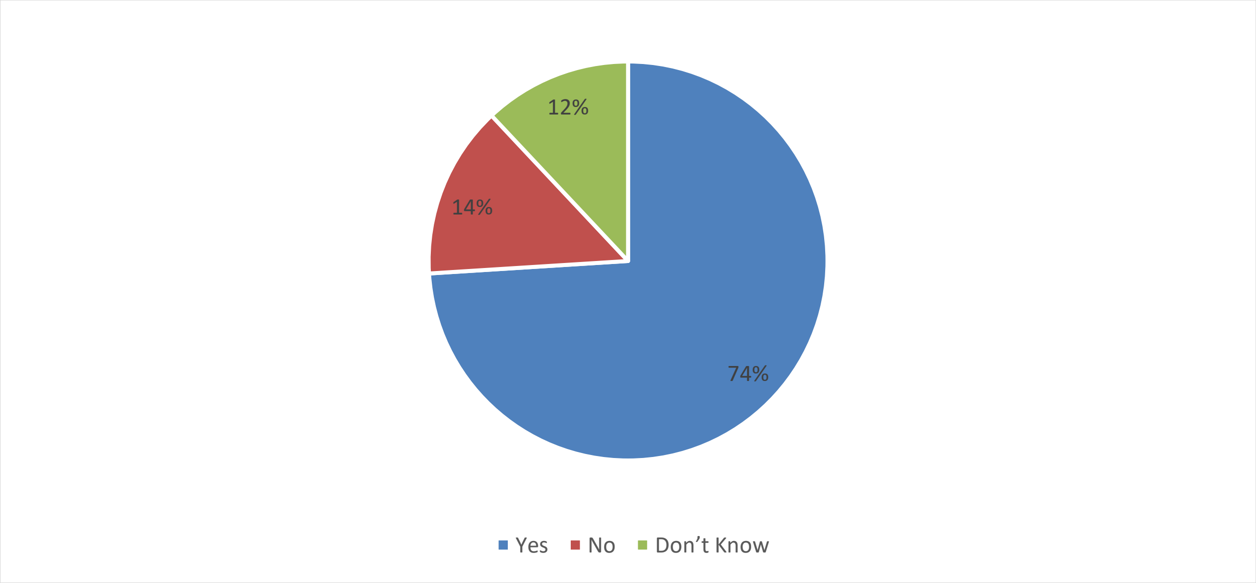

Figure 3.5 Do you find the HARK Template useful as a prompt?

54% of the 70 respondents stated that they find HARK template useful for recording DVA as shown in Figure below. Majority of the respondents (58%) wanted to continue to use the HARK template though ten respondents (14.8%) wanted to stop using it. A vast majority of 71 respondents (94.4%) felt that IRIS service was value for money.

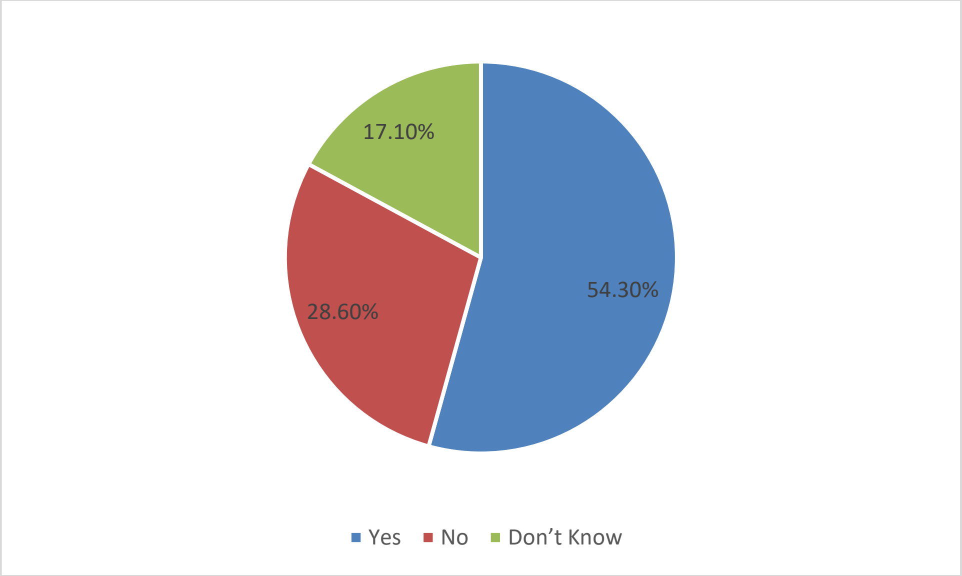

Figure3.6 Do you find the HARK Template useful for recording DVA?

3.7 Conclusion

This chapter has presented the findings from the survey of practitioners (n=75) from 85 GP practices in Manchester. Themes include: IRIS service rating; IRIS service and DVA during COVID-19; barriers to patients' access to IRIS during COVID-19; facilitators for patients' access to IRIS during COVID-19; and IRIS training. These are discussed in conjunction with the qualitative data, from telephone interviews, in Chapter 5 Discussion and Concluding Comments.

4 Service user perspectives

This section presents the data from telephone interviews with eleven women who had received support from the IRIS service since March 2020 when England went into the first national lockdown due to COVID-19. Data was analysed thematically. The main themes presented here include: experiences of domestic abuse during COVID-19; the impact of COVID-19 and children; COVID-19 and the family courts; awareness of the IRIS service; referral and initial contact with the IRIS Service; positive impact of IRIS's support; IRIS support and accessibility throughout the pandemic; barriers/facilitators to accessing support from IRIS; future developments and improvements to the IRIS service.

4.1 Experience of domestic abuse during COVID-19

A number of interviewees described how their experiences changed during COVID-19. Three women framed their experience of abuse in relation to the impact of COVID-19 and their subsequent isolation:

> I have been married to my husband for more than 7 years and the situation has always been very difficult and abusive for me. I have been in the UK since 2017 and COVID 19 did not cause the abuse but because of this my contact with other people was limited. (SU6)

> My experiences did change during COVID-19 mainly because I did not have anywhere to go and I was locked in the house. For three months between March-July 2020, myself and my daughter spend all our time in the attic of the house. I will go to make something early in the morning before anyone else was awake in the house, cook something and come back upstairs. I felt really isolated. (SU5)

SU5 describes how she kept herself and her daughter away from other family members and describes the types of experiences she had when she was in the family space:

> One such day, I came downstairs and washed my children's clothes. To do so I took clothes already in the washing machine out and washed my children's clothes. The clothes that I took out of the washing machine were of my brother-in-law and when he saw that he started abusing me, cursing me and calling me names in front of his mother and my 12-year-old daughter. He then started talking bad about my daughter and swearing and screaming at her and I just could not bear that. (SU5)

After this incident SU5 contacted the police and managed to leave.

Paradoxically, the increased isolation represented a catalyst for this woman:

> I could not visit my parents or anyone else and that helped me think through this and I thought I had enough of everything and it was a high time for me to get out of the situation and so I decided to speak about it and shared it with my GP. (SU6)

Other participants described the lockdown as having negligible impact in relation to their abuse experiences.

4.2 The impact of COVID-19 and children

SU1 had been in a relationship for 7 and a half years and described both the abuse and its impact as a "build-up" albeit for many years she did not recognise the behaviours as abuse. SU1's partner and his 12-year-old daughter (Eve, a pseudonym) moved in with her in the year prior to COVID-19 and in June 2020 when the country was coming out of lockdown, the couple decided to stop living together. She described the lockdown period:

> To be fair, lockdown, it was okay because we all had our little things. But the arguments, so to speak, were a little bit more frequent, they became more frequent. Some of it was around his daughter, so he was…even though we were co-parenting I had to run everything by him, to a point where sometimes I didn't know…you know, like, you'd casually say something to the child, or you say something just in a conversation, not to keep it a secret from your partner or anything, just as mothers do, I had to be very cautious of, oh, well, should I say that now… or should I tell him. And that was a very, very hard thing to do, because I was the one that was spending all the time with his daughter, it was me and her, he was in the office all day. (SU1)

This quote illustrates SU1's dilemma and self-doubt as her partner's scrutiny and control over her decision-making and the actions that she took in her role as a step-parent to his daughter. After SU1 separated from her partner in June 2020, initially she maintained contact with Eve via text messages and by sending presents through the post:

> Well, after, I kept in contact with her via message […] I was sending her little monthly parcels with all her little favourite things, you know, like a little face mask and little sweets. So, I was sending those, and three months down the road I got the message from him saying that he totally understood why I was keeping in contact with [Eve], and he fully appreciated it and appreciated the gifts that I was sending. But then he put something like, but she's not receiving them in the way that you would like her to. And I thought that was really strange because for the three months she had been messaging me and she had been saying thank you, and thanks for the gifts, and we'd been messaging each other, keeping in contact. (SU1)

Over those first three months SU1 had requested face-to-face contact with Eve but “he said no”. COVID-19 and social distancing was not given as the reason but may have been why SU1 readily accepted the situation. SU1 attempted to negotiate with her estranged partner:

> I also said to him, as the adults, if there’s a change in her life, you know, obviously you’ve moved now, you’ve moved out, I felt that it was important for both of us to just sit down with her and talk it through and just see if there was anything that she wanted to say or she was upset about. And he said no to all of that. (SU1)

SU1 found this really upsetting as she had invested in the relationship with Eve during lockdown and had seen a significant change in Eve’s wellbeing and in their relationship. SU1’s partner also told her that his mother (Eve’s grandmother) “didn’t want me sending things to her address” and that “his daughter wasn’t ready for contact”. SU1 realised that “this is not anything about what his daughter is saying or has said, this is something more to do with his mum or him.”

4.3 COVID-19 and the family courts

Two participants spoke about their experiences of legal proceedings during the lockdown and subsequent time period.

> No contact since Nov 2019, except for family court where it is likely he will have no contact, trial June. I have also reported to the police in Nov 20, CID will be arresting him and charging him as a judge has already found allegations to be true. There is a risk he will react to no contact and be arrested. (SU11)

One participant provided context to the ongoing legal situation despite separating from her ex-partner in the winter of 2019:

> I’m still going through very complicated child legal proceedings, privately paying, which is costing me thousands in legal fees. And in the last one, I read in one of the court reports that my ex-partner… Well, he was threatening suicide, and then saying that he’s self-harming, and then threatening that if he doesn’t get custody, this is what he’s going to do. (SU2)

SU2 described this in the context of “reliving the trauma” when all she is doing is “trying to move on”. She understood her support to be provided by Manchester Women’s Aid, rather than IRIS, describing it as “really good at providing emotional support” which was particularly helpful as she was finding that navigating the family court process to be stressful. SU2 described an unexpected benefit from the first lockdown measures:

> The first hearing just started just when lockdown hit, so it was via telephone. Every hearing was via telephone. In one way, it made it a lot easier because every time before March … I obviously had to attend in person and I remember when I attended court about a week or two weeks in advance, I'd request special measures. So, things like screens so that I don't have to see him, and things like that. And it made it really stressful because when I attended court, …they'd also forget the special screens, even though I sent it like two weeks before. You have to remind them. So, in a way the telephone… got rid of that pressure. (SU2)

This participant did note the limits of support as COVID-19 affected all face-to-face contact as she could not receive emotional support during a telephone family court hearing.

By the summer SU2's child begun to exhibit "behavioural issues" in school and was referred to the Child and Adolescent Mental Health Service (CAMHS) and SU2 was referred to IRIS.

4.4 Awareness of the IRIS service

Across the participant group, there were different levels of awareness that domestic abuse specialist services existed. None of the participants were aware of IRIS prior to the support that they had received as this exchange illustrates:

I: Did you know about IRIS and the Women's Aid Service before your GP spoke to you?

SU4: Never in my life. I never knew that type of service can be available…I never knew that there were refuges. I never knew that Social Services can provide help in transport.

Another participant was similarly unaware of IRIS until the point of being offered an IRIS referral:

> I was referred to IRIS by my GP... I didn't know anything about the service before but when I told GP about my situation, and he referred me to IRIS. (SU5)

When asked about IRIS at the start of the telephone interview, some participants said that they did not know what IRIS was. Other responses indicated that participants had heard of Women's Aid, but not IRIS:

> I only ever heard of, like, Women's Aid, but I've never actually heard of IRIS before. So, I'd heard of Women's Aid and various other things, like, you know, helpline numbers. But I wasn't aware of the group IRIS at all until my GP mentioned it. (SU1)

> Through the doctor. I wasn't aware or I'd forgotten it was part of Women's Aid. (SU6)

One participant contrasted her experience of support from IRIS with her previously support from Manchester Women's Aid as she noted:

> So, IRIS were absolutely fantastic. They were more sort of specialising in domestic violence and more from a medical point of view, because they deal with doctors' surgeries with health professionals rather than an overview, like an all rounded. (SU2)

In this quote the service user perceives a clear difference in the types of support on offer and recognises the role of the specialist IRIS service working with General Practice to support GP patients who disclose DVA. This is in contrast to the support offered by main MWA.

4.5 Referral and initial contact with the IRIS Service

In order to understand the context and experiences of initial referrals and engagement with the IRIS service, interviewees were asked how they came to receive support from the IRIS service. All were referred by their GP as described:

> I explained my situation to my GP who then put me in touch with the social worker and the [IRIS] service and they helped me. (SU6)

> It was actually a visit to my GP surgery, and through a very thorough conversation about events that had happened over the years, she suggested that I talk to somebody from IRIS just to clarify certain things. Sometimes when things happen you kind of brush them off and you don't know how to pinpoint them, or what they are, or what type of behaviour you're having to put up with… I explained several scenarios to her, and she identified those as emotional abuse… And that's why my GP, when I was after speaking to her, she suggested that I spoke to somebody from IRIS. (SU1)

One participant had attended her GP with postnatal depression and described the professional curiosity (something that is encouraged during the delivery of IRIS training) demonstrated by her doctor whilst also commenting on the value of the questioning technique "and she asked me a question…how are things at home? And no one says that to me". This participant benefitted from an inquisitive and astute GP as she described here:

> […] I used to always tell my GP, whenever I speak to them, that my husband doesn't believe in mental health…can you not share any of my medical records with him, or any of his family members…and I once spoke to her, and I was speaking in a coded

> language. So, my husband was right next to me, and I wasn't giving her all the details. And then she decided to call later, and just say, how are things in the house? And I replied back, that no, things are actually really bad, he's very, very abusive. And she was the one who referred me to IRIS. (SU4)

Some participants commented on the time that lapsed between the GP referral and the first contact from IRIS:

> It was really quick, like, the contact, so I wasn't kind of waiting around for a phone call or anything, things happened quite quickly. And that's always reassuring as well…I don't think it was any longer than a week. Yeah, I don't think it… It was quite quick, and I thought, oh, that's good, someone's got back to me. (SU1)

All participants who commented on initial contact from IRIS represented the view that the time between the initial referral and contact made was short.

4.6 Positive impact of IRIS support

Most participants described the support that they received as beneficial lasting a few weeks or months. Mostly this was emotional support and for some participants they additionally benefit from advice and information. Quite often support was after separation or at the point at which service users decided to leave the abusive relationship. One participant had support over four telephone conversations at the point at which her relationship ended and whilst the IRIS support was brief, the service user found it incredibly helpful in validating her experiences of abuse:

> An [IRIS AE] actually just confirmed, because I was asking the question 'has it been abuse?' What is it, like what is it when somebody plays with your mind so much that you just you get to that point where you think, I can't, like, this is awful, I can't keep hearing those words, I can't…you know, the comments, the criticism, you know, it's not right. And I suppose now I know that if something doesn't sound right or feel right, or you've got to question it, then it's not right, it can't be. (SU1)

SU1 also found writing about her experiences to be cathartic and sharing these written accounts with her IRIS AE was similarly validating and helped her to recognise her experiences as abuse:

> So, I was trying to work out what it was. And in writing things down and explaining some of the situations to [IRIS AE], she did actually say to me, that's emotional abuse and you've obviously been putting up with it over the years. (SU1)

SU2 was in the middle of court proceedings in relation to child contact with her ex-partner. She described how her ex-partner was making threats of suicide and the support she got from her allocated IRIS AE enabled her to make sense of his behaviour:

> And then I had to contact with IRIS again because, like I said, with this threat of suicide and things like that, I thought, oh my goodness, what's he playing at? What's he trying to do, take me back to the relationship of a year and a half ago? Is he still not moving on? … And again, is it that narcissistic traits and behaviours? I even…because I really wanted to know the science of why someone behaves or has these traits… And with IRIS, they really helped me to understand that this is how perpetrators behave and (by leaving) you've taken the power away from them. (SU2)

Another participant, SU3, benefitted from emotional support from IRIS following the end of her abusive partnership but during further abuse which was being perpetrated from her ex-partner "through a family member". SU3's ex-partner had left the country but made frequent threats to return to take the children.

Several participants benefitted from practical support from IRIS when they left their abusive relationship. SU4 said:

> I never knew that I could have that much support. I only had £250 on me, and I made the decision to move back to London in a refuge. I didn't want to bother my family, because it's just, they will get blamed for everything, if, you know, I move into them…So I moved into a refuge. And they organised everything for me.…I wanted something to be self-contained …you know, with a young child, just going to the toilet, sometimes is difficult. So [IRIS AE] organised all of that for me.…she was amazing.

Another service user also described more practical intervention in getting help to secure housing and helping to arrange utilities. She saw this as incredibly helpful in her attempts to settle with her children in a new country where she had no existing support network.

In addition to emotional and practical support, a number of participants referenced support and information around legal proceedings. On participant highlighted this:

> And my caseworker […] really helped me to understand about the children proceeding, the procedures, when I don't understand things, and really helped. And one of the things she said to me is, when it comes to your trial, I'll be able to offer you that support. I'll be able to come in court, hopefully. Because we all thought, oh yeah, in six months' time, everything will be back to normal […] (SU2)

Another participant came to England to escape an abusive situation and was unequivocal about the support she had received framing this in the context of giving her “hope”:

> But IRIS gave me [much] help, because they give me hope you know, they give me hope. They help me for many things. (SU8)

This service user highlights not the type of support received, but the emotional impact that enabled her to see an abuse-free future for herself and her children.

4.7 IRIS support and accessibility throughout the pandemic

All participants described receiving support via the telephone; no-one had support via face-to-face contact or videoconferencing. The following quote highlights good practice in that on making the call to a service user this IRIS AE always checked that the woman was free to talk:

> I have always spoken to them on the phone and they always ask and make sure that my daughter is not listening to the conversation and is safe. (SU6)

Most participants felt that telephone support was sufficient as these quotes illustrate:

> I had a number that I could access if I needed it. … So that was always good to know that there’s a number that you can reach out to someone. And I think that that’s the main thing, as long as you know that there’s a number there, a contact that you can reach out to somebody, then that’s the main thing. Because lockdown, we’re all at home, and obviously everyone’s in, and you need that reassurance that you can pick the phone up. And she did (the IRIS AE) … just knowing that you knew that someone was at the end of a phone if you needed it, just knowing that you could pick up the phone is just…it’s that layer of support and confidence that somebody will be there to listen. (SU1)

> The person contacted me in the GP surgery and then via phone afterwards. I could talk to them straight away after I was referred to them as I was already ready. I was experiencing abuse for more than 13 years and by this time I was ready to explain my situation to anyone. They always asked me if it is safe to talk and if my children are around or not so we can talk privately. (SU5)

For SU5 she had one telephone conversation at the GP following the referral to IRIS and then this was followed up by support giving using her personal mobile telephone. When asked if telephone support was enough, another participant responded “no” but found it difficult to articulate what could have been more helpful. She did, however, describe the effects of isolation as “some days were much worse than others”. When asked about the frequency of the support that she had received, SU3 described a confusing exchange:

> I have got a poor memory but [telephone calls] weren’t scheduled every week, everything just seemed to stop all of a sudden. And then it was picked up. And then the [IRIS AE] was first, I think, to call me, but I can't remember how often and then all of a sudden she disappeared because the phone broken or something. It was all a bit of a mess and I just felt like I was being a burden…It was just, yeah, I don’t know, I just felt so uncomfortable but that’s probably due to lockdown... [then] she said, okay, we can't have any telephone communication. And then a colleague of hers… called me and said you can contact us on this number. It was all a bit confusing and I just felt like I was just being dropped from the service… Then I was told that I could have, I think, email contact with her… I did feel like I was a burden to be honest with you. (SU3)

The participant did admit to the whole incidence being confusing and she was unsure whether she had understood things. She did also appreciate the help that she had received (e.g., on a number of occasions the IRIS AE helped her to access a food bank), but described this as “inconsistent”. Further, SU3 had tried the telephone number that she had been given but could not get a response:

> Then there came a time when I was trying to contact [the IRIS AE] and I was having no contact whatsoever and I actually physically felt sick, because I remember that very clearly that when I was trying to call her, there was no reply for a good number of weeks and I felt like, oh wow, have I done something wrong. Am I a burden on them and it just did not sit right with me. I did feel pretty bad. (SU3)

When asked if a face-to-face meeting in a safe, socially distanced space at the GP surgery would have been preferred to telephone, SU3 replied “yes, definitely”, but that “it was just not offered at all”. SU3 indicated that she would have been preferred to have used videoconferencing (e.g., Skype or FaceTime) to the telephone support that she received. Another participant described some dissatisfaction with the ending of her support:

> IRIS looked at my case and I was with them, I was with [IRIS AE], but she left before Christmas. And then the next worker, [X] I think her name was, she was off sick, so they were just looking at closing cases, the ones that didn’t need immediate help, type of thing, so they closed it. I mean, I still feel that I still need that ongoing support because I’m still going through a lot of legal proceedings. (SU2)

The usual practice of the IRIS Service is to close a case but to inform the service user to self-refer should they need to in the future and it was unclear why this did not work on this occasion. Another SU4 felt that telephone support was adequate as she got short-term support at the point at which she had decided to leave. In this instance, telephone communication with the IRIS AE enabled them to agree arrangements for SU4 to leave and go to a refuge in the South. Despite having made such arrangements, on the day, things did not go to plan as the pre-booked taxi did not turn up.

> I told [IRIS AE] to organise a taxi at 5.30, so that I can leave before he comes home from his night shift. But the taxi never turned up that night… At that moment, yes, I was very angry, I was like, what's happening, I was meant to leave, but, you know, the cab's not coming, the 24-hour helpline, no one's answering.

IRIS does not run a 24-hour helpline and it is likely that the participant was confusing the National Domestic Violence Helpline with MWA IRIS which operates during the usual office hours. However, as part of a safety plan service users are advised to telephone the police in an emergency and SU4 did call 101 to seek advice as she noted "the very lucky thing that they did is, [the police] came in and they straightaway removed me and my child" and so they got safely away. On being asked if IRIS could improve or do anything differently, this participant said:

> I think, where I struggled the most…I was on the [24-hour helpline] with them for about ten minutes. And the phone was ringing constantly, no one was picking up. Eventually, the line cut off. I called them again, and no one picked up. (SU4)

As such, this participant highlighted the limitations of 9-5 support albeit this is not an issue that is just tied to the impact of COVID-19. Staffing and resources might be, but this is unknown.

4.8 Barriers and facilitators to accessing support from IRIS

All participants indicated that IRIS AEs contacted them by telephone and reported no barriers in accessing support. Some had already escaped from abuse and this also meant that there were no or low risks for these individuals (albeit recognising that for a high number of women there are great risks following the separation from their perpetrator):

> The doctor referred me to IRIS then it took about a week, maybe 10 days. I could speak freely from first contact. No barriers for me, as I am at a different stage in support so phone calls were appropriate. (SU11)

The next quote highlights the one potential barrier for this service user in relation to a lack of knowledge about specialist service provision, but clearly the IRIS programme worked as it should and, as such, facilitated support for this individual soon after she arrived in the country:

> I was new in the country and did not know any of these services and how to access them and I think these services are really great and I am really grateful for the help and support I have received from the service. (SU6)

On being asked if meeting face-to-face in a safe, socially distanced way would that have made a difference to the support that she received, one participant replied that telephone support was sufficient, but she recognised that for victims/survivors in more controlling environments, accessing telephone support could be more problematic:

> For me it was enough. He wasn't controlling in terms of me going out or anything, so I knew that because I'd got family that live near to me, that I could just get in my car and drive off somewhere. But there may be other situations where people didn't have that freedom… So, I don't actually know how they would manage that, if they didn't have the freedom to just go out or use their phone in private, that would be really difficult. (SU1)

These participants recognised the different barriers posed by the pandemic and lockdown measures:

> I mean even if there was a place where you could go to for support, in the lockdown, even that would have been…that would have been hard to do, to access … but, like I said, if it's lockdown and it's not open, or there's nobody there, you're just better knowing that there's a number that you can reach out to somebody (SU1)

> When COVID hit, you can't have your caseworker on the telephone, a telephone conference type of thing, and that's where I felt, oh my gosh…And then you can't go and see your caseworker and it's very difficult … You don't want to be sending legal documents via email, type of thing. (SU2)

The latter quote illustrates some of the barriers to accessing support in relation to legal proceedings in that she was unable to have an IRIS AE give her synchronous support during a conference.

4.9 Future developments and improvements to the IRIS service

Overall, there was some excellent feedback for the support received through the IRIS service; for example, one service user said: "it's an excellent service and I can't thank you enough". Some participants did think of ways that the service could develop or introduce new initiatives however. SU1 considered safety for women who might be subject to surveillance as an aspect of their experience of DVA and offered a suggestion:

> Looking through your phone, like, instead of putting women's helpline, or Women's Aid, that starts ringing alarm bells then if you've got a partner that goes to your phone, they'd be thinking, oh, she's in touch with somebody. But if you went through and saw Iris, or whatever… So IRIS is actually quite a good name, because you can store it in your phone as a person…. So, I did. I stored it in my phone as Iris, and it just comes up, you'd just think it was a lady's name. (SU1)

Several participants were from non-British backgrounds and English was not their first language. One participant said:

> It would help if there were multilingual staff in the service as my English is poor and I cannot always explain myself well. Other than that, it is an excellent service and I cannot thank them enough for the support they have provided me. (SU6)

Another participant reflected on what she thought is missing from the service and said:

> I think one of the things, if I ever got involved in domestic violence policies or anything like that, one of the things that I would propose is education, healthy relationships and things like that. It really needs to be from the very start and get-go. (SU2)

> More funding for staff, facilities, outreach work and educational programmes for schools. (SU11)

This participant referred to educational programmes for schools and another participant also felt that specialist one-to-one support for children and young people would be beneficial:

> I thought one of the things, especially for my son, a CIDVA worker. I don't know if you've heard of them, Child Independent Domestic Violence Advocate… for my child, for him to understand that…you know, things like the rough playing was something that was heavily embedded in him when I was with my ex-partner and he couldn't get rid of it when we fled and it carried on. Hitting and things like that, and feeling frustrated, having outbursts of anger. All these negative emotions and he couldn't understand, …So behaving in this way, the problem it causes and how other people will feel, how that will… You know, looking at the solutions, looking at behaving, if you don't share or if you have outbursts of anger, how do you think your friends in your class will feel? Do you think that they're going to play with you? Are they going to feel scared? (SU2)

SU2’s son was of primary school age and she felt strongly that the therapeutic parenting approach that she was implementing (on the advice of CAMHS) would be complemented by some specialist input around DVA for her son.

One participant talked about the need for more knowledge of the support available as she had no prior knowledge of IRIS, Women’s Aid nor the availability of refuge accommodation. She also said:

> I never knew, that is if you can’t speak (on the telephone) to press 55. I think it is 55? Have I got that wrong? …if you call the police and if you call 999, and if you can’t speak at that moment, call…press 55. I think it was 55. And apparently, the police get alerted that it might be a DV, or it might be something where you can’t speak… Yes, that’s another thing that most people don’t know... I didn’t know. And I personally think we should have advertised on national TV regarding that. Because it’s a service that no one knows about. (SU4)

In essence, the participants were overwhelmingly positive about the support that they had received but were able to draw on their individual experiences to identify some of the ways in which existing provision could be extended.

4.10 Conclusion

This section illustrates the perspectives from a small group of service users (n=11) who shared their varied experiences during COVID-19. Whilst a small sample, the interviews provided rich data and there are important implications to be drawn (see Chapters 5 and 6).

5 Discussion and Concluding Comments

5.1 The impact of COVID-19

There is diverse literature that describes the impact of COVID-19 on DVA. There has been a rise in reported incidents albeit this does not necessarily mean a rise in prevalence. It is possible that the influence of public health measures on risk factors could explain the rise in reported incidents of different forms of DVA (child abuse, intimate partner violence) since the first lockdown in 2020[29]. It has also been argued that lockdown measures have created enabling environments that have exacerbated existing abusive situations [30]. Simultaneously, there have been cautious messages about making claims that COVID-19 has caused DVA.

On the whole, service users in this study did not report significant changes in their experience of DVA as a result of the public health measures resulting from COVID-19. Mostly participants stated that it had little significant effect. Of the minority who did report an impact, this was in relation to increased social isolation and one woman noted that there was an increase in arguments with her (now ex) partner. For those participants with children, two were involved in court proceedings in relation to child contact, and they described a small impact to their experience of the family court system. One participant framed this in two ways. First, as positive in that proceedings were held via telephone and this meant that she did not have to see her ex-partner in person. Second, as negative as she did not have the benefit of an IRIS AE by her side to offer emotional support. Well-timed telephone or videoconferencing support would have been apt for this woman at the time but she noted that it was not available.

Survey data illustrated more significant consequences for practitioners as it was felt by 64% of respondents that COVID-19 had affected the recognition of DVA due to lack of face-to-face contact and the move to remote consultations. Because of the latter, respondents felt that there was a lack of privacy for their patients and this meant that they did not know if it was safe to ask the question about DVA. This posed a barrier for them in asking about DVA and for patients in making disclosures. When asked what had helped practices during COVID-19 to identify and respond to DVA, a high number of participants (68%) felt that training for reception and administrative staff had been beneficial as had the practice of giving patients the telephone number for Manchester IRIS (62%). There are clear messages for the IRIS service in terms of changes that can be retained once everyday contexts had returned to a more ‘normal’ state and the COVID-19 pandemic has less restrictive effect on communities. Manchester IRIS is a whole practice training programme and, as indicated by this study’s survey data, it is important to continue training for reception and administrative staff as well as the Clinical Update training. It is also important for referrers to provide patients with MWA

IRIS number, when safe to do so, to enable self-referrals. However, it is of critical importance that the person responding to the patient makes the referral first and then provides the patient with the telephone information for IRIS. It will be necessary for the IRIS AEs to ensure that GP practices do not view the provision of the IRIS telephone number to patients as a replacement for referral making. This is of importance because if staff in GP practices merely give out the IRIS telephone number, there is a danger that patients will not self-refer and many will go without the vital support they need.

5.2 Reaching vulnerable groups

When asked about how to reduce barriers for vulnerable groups (e.g., women from black and minority ethnic communities, people with poor mental health, people from LGBTQ+ communities), survey respondents suggested various actions including: employing interpreters; increasing awareness via sessions in religious places (mosques, church etc); having information in various languages; asking DVA related questions more frequently. Some of these actions are already embedded in Manchester IRIS activity: interpreters and translators are frequently used and posters are currently produced in eight languages. It might be beneficial to consider a more in-depth review of existing actions and strategies; e.g., whilst information is already produced in different languages, are these the most useful languages to serve the communities of Manchester? Does material distributed in different areas of Manchester reflect the language needs of the communities residing in those areas?

In terms of findings from service user interviews, only two of the participants offered distinct areas for service development in relation to specific group needs: one mentioned the need for multilingual staff; another discussed support for children and young people - see below. In terms of employing multilingual staff within the IRIS service, this already takes place and multilingual IRIS AEs are in post.

Of note, there was a general finding that there was little awareness of IRIS, and other DVA-specialist support, prior to an individual being offered the option of a referral. Therefore, in order to reach vulnerable groups, it would seem that there is further work needed to understand the barriers and facilitators and that awareness-raising is key.

5.3 Current service provision: what works

In terms of what currently works well from a service user perspective, participants described a responsive service with minimal waiting time following their disclosure to their GP and subsequent referral. All participants spoke enthusiastically about the support that they had received, with clear appreciation for the amount of emotional and practical support as well as legal, housing and justice advice and information. Service users reported that emotional support helped them to recognise their experiences as abuse (when they previously had not recognised and named non-physical behaviours as abusive). Importantly, this had validated their experiences.

Emotional support also enabled some women to gain awareness of perpetrator strategies and the impacts of DVA on their children. Having this greater understanding of the complexity of DVA was clearly valued by women in these different ways and had a lasting impact. For example, two participants spoke about their desire to volunteer for a DVA service once they were further along in their recovery in recognition for the influence that IRIS support had for them and both stated their insights in terms of the widespread and pernicious problem of DVA and their desire to work to support other victim/survivors and enable more people to access support and recognise their experiences as abuse.

Reflecting the positive feedback from interviewees, almost half (49%) of the survey respondents considered that Manchester IRIS is ‘excellent’ and when asked to rate the service using a scale of 1-5 (with 1 being poor, and 5 being excellent), the average rating was an impressive 4.63. Participants indicated that they knew how to contact IRIS and valued the support offered by an accessible IRIS team. Positive feedback was received about the IRIS training and this is discussed in more depth below.

5.4 Areas for development

Overall, interviewees’ awareness of Manchester IRIS was poor prior to their receipt of IRIS support. At the start of the interview, most did not recognise the name when asked how they came to be referred to IRIS. Most had no prior knowledge of IRIS albeit a small number were aware of Manchester Women’s Aid (MWA). It may be that some of the interviewees lacked an awareness as they had not actually visited the GP practices due to COVID-19 measures and therefore not seen the posters for IRIS in the various locations of surgeries (in waiting rooms, toilets and consulting spaces). Alternatively, it may be that they have attended GP surgeries but posters have been removed as a result of infection control during COVID-19. For those interviewees who had received support prior to COVID-19, this had been delivered by main MWA and so they were aware of MWA or DVA support in general, but not of the IRIS GP specialist service.

One limitation of the evaluation is that interviewees were not asked how long they had been patients registered with their Manchester GP practices and it may be that this was the first time that they had been registered in a location that commissioned IRIS. However, it is more prudent to consider that there is work to do to raise awareness of IRIS within communities (as noted earlier). A high number of survey respondents felt that the IRIS posters worked well to highlight the service and it is likely that they were basing their response on pre-COVID-19 circumstances.

Every service user who was interviewed had been referred to IRIS by their GP. This is reflected in other literature which shows that members of GP practices, other than GPs, do not frequently respond to and ask about DVA[10, 11]. Indeed, earlier research undertaken for Manchester IRIS was commissioned due to the lack of referrals made by practice staff other than GPs [11]. This is already an ongoing area of development for the service; the need only reinforced by this evaluation. Awareness of IRIS was obviously good for our General Practice survey respondents, by the very fact of their participation, and we can assume that they have good understanding of what IRIS offers and how it operates. However, only 6% said that their IRIS AE attends practice meetings and addressing this could only improve communication between GP practice members and their allocated AE. It would be helpful to communicate any changes to IRIS, or to the training offer, and it would also serve as a reminder keeping IRIS at the forefront of people's minds.

There were comments from two service users about disrupted or confusing support arrangements, or support ending when they perceived an ongoing need for support of some level. It must be acknowledged that this evaluation has covered the pandemic period and everyday service delivery has been severely disrupted by COVID-19 for both MWA IRIS and GP practices. The closure of GP surgeries to members of the public in order to deal with the demands of the pandemic and more latterly, the roll out of the vaccination programme has resulted in additional local demands. However, there are still some clear messages for reflection in relation to IRIS support. These are summarised as:

1 Consider support via video conferencing, rather than telephone alone;
2 Consider the strategy for staffing cover during sickness, staff departures and handovers;
3 Consider the support needs of children and young people;
4 And, ensure that service users understand the process for self-referral in the future once their case is closed to IRIS.

Finally, a high number of GP survey respondents agreed that the future development of the IRIS service should consider the needs of patients deemed to be at high-risk of DVA (which means that they are at risk of significant harm or death). This finding contrasts with the existing service offer as Manchester IRIS currents supports patient deemed to be at low or medium risk of DVA.

5.5 IRIS Training

Survey respondents were asked specific questions about the current training offer. These elicited very positive responses. In terms of what worked most and should be retained, respondents appreciated the chance to discuss difficult cases (71%), they appreciated the chance to meet their IRIS AE (55%) with training being delivered in their practice (53%) and they liked joint training by a GP Lead and IRIS AE (68%). In terms of the latter, this preference stood out even more when compared to other responses as only 29% noted that they liked training by the IRIS AE only, and 36% noted that would like training by the IRIS GP Lead only. Respondents were also asked about frequency as the intercollegiate guidance states that GPs and Practice Nurses should undertake 8 hours Level 3 Adult Safeguarding training every 3 years, but almost half of respondents stated that they would want IRIS Update training more regularly, at least every two years (with 26% indicating that they would like this each year).

This finding means that three-quarters of all GP survey respondents would like IRIS Update training more frequently than the intercollegiate guidance for Adult Safeguarding training.

They were certainly findings in this evaluation that could be used in a developmental manner with regards to training. First, to retain the approach to training delivery that includes reception and administrative staff. Second, to include some discussion of barriers for patients including the fear that some have that children's services will remove their children due to DVA if a disclosure is made. Third, to explore ways that GPs can ask about DVA during a telephone consultation. In terms of this last finding, it is noted that IRIS training since summer 2020 was amended to a webinar format which focused heavily on this very skill. It is likely that some of the respondents had not undertaken this training.

5.6 Conclusion

The findings and analysis from this evaluation have some clear implications for current service delivery or for future exploration. Recommendations are set out in the subsequent chapter. A final comment is in relation to the last question asked of GP survey respondents which was:

> The 2020 MWA IRIS Cost Effectiveness Analysis showed that IRIS costs £0.02 pence per woman aged 16 or over registered with a Manchester GP Practice and is cost saving for societal costs, saving £42.63 per woman per year. Do you think IRIS offers Value for money?

It is heartening to note that overwhelmingly respondents agreed (94.4% and 5.6% respondents opted for 'don't know') that IRIS offers value for money in congruence with the 2020 MWA IRIS Cost Effectiveness Analysis.

6 Recommendations

Ten key recommendations are highlighted.

IRIS AE Team and GP practices:

1. Consider the use of videoconferencing to support service users either when face-to-face support is not possible (due to COVID-19 or other reasons), and to complement face-to-face support;
2. Strengthen the IRIS AE Practice liaison role;
3. Review employment practices and cover when staff are ill, leave employment and in handover periods.
4. Review promotion of IRIS in GP practices and in communities (e.g. review the distribution of material of different languages and consider awareness-raising with sessions in different religious spaces);
5. Change to two-yearly IRIS Update training for GP practices;
6. Continue the use of the IRIS HARK template;

External / future work:

7. Undertake planned work to increase the awareness of domestic violence and abuse (DVA) and the Manchester IRIS service;
8. Explore further the barriers and facilitators for vulnerable groups;
9. Explore the ways in which a more holistic service can be offered to victims/survivors *and* their children;
10. Explore the role and development of IRIS in relation to high-risk cases.

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