



Spotlight #7

Podcast transcript

Welcome to Spotlight, the podcast for the domestic abuse sector. In this series SafeLives are shining a spotlight on people affected by domestic abuse, who are also experiencing mental health problems. In this episode, SafeLives Research Manager, Martha Tomlinson met with Professor Gene Feder, based with the Bristol medical School, Gene is an eminent domestic violence researcher with particular expertise in the response of healthcare professionals to survivors of partner abuse. In this podcast Gene discusses his newly published paper on the PATH research trial, a project which has shown the benefits of equipping domestic abuse advocates to offer specialist psychological interventions. Gene also discusses other areas of promising practice, including the IRIS Project.

Martha: Gene thank you so much for joining me on this podcast for our Spotlight series on mental health. So you've recently published the Psychological Advocacy Towards Healing, or PATH paper, could you tell us what PATH is about and what problems the approach is trying to address?

Gene: PATH is a programme for survivors of domestic violence who have crossed the threshold into a service, into a domestic abuse service, and it's trying to address their psychological health needs over and above the excellent advocacy and support that they're going to get anyway from that service. So what we identified as an unmet need was that even if, taking it from the perspective of the health service, even if a doctor identifies that a woman is experiencing abuse, even if they do the right thing and refer them in to a domestic abuse service, which they can do through the IRIS programme, which is another piece of work that we've done around getting doctors to identify and refer, even then, and even if that woman gets good support around her safety and around legal issues, around housing issues and around her children, she will have psychological health needs.

Depression, anxiety, post traumatic stress are all much greater among survivors of domestic violence than women who've not been abused, and we've found that within the services, those needs were not being dealt with, and that's not a criticism, it's simply the fact that your average support worker or average advocate isn't trained in any kind of psychological work. So, we developed a programme, and this is Roxanne Agnew-Davies who developed it, who's an eminent psychologist who's done work around domestic abuse, and it was a training programme for advocates and support workers. In other words, for people who are already in the system providing support but giving them extra skills around the psychological needs of their clients.

And we then tested this in a randomised controlled trial, we did it because we're interested in trying to have the least biased way of assessing whether a programme is actually effective, and what we did is we randomised women to either getting normal advocacy and support, and this was done in Cardiff Women's Aid and in Next Link in

Bristol, and if they're randomised to the other group, they got this extra help from this specialist psychological advocate, a SPA. Now, a SPA is in essence a support worker or advocate who has had this additional training, and we then followed those women up for a year, and in all there were over 250 women who were recruited, about a third from refuges and two-thirds from community support, and randomised into these two arms.

The follow-up for a year was particularly interested in measuring their mental health, and we used two measures that aren't particularly important to specify what they are, but one was certainly focusing on depression and the other one was more focused on general psychological wellbeing.

M: So could you tell me a little bit about what the key conclusions were?

G: The key conclusion was that this intervention, this programme works, so that the women who just got advocacy, and high-quality advocacy, had higher depression scores and higher psychological wellbeing scores than the women who got the SPA intervention. So, the women who got the SPA intervention did better in terms of their mental health and psychologically.

M: That's great. I was wondering if you could describe a bit more about what the SPA role actually entails, so how is it different to the traditional Idva role?

G: The SPA role is an extension of the traditional Idva or advocate or support worker role, because of the ability through training, and also through clinical supervision, to work with a client around her anxiety, around her PTSD symptoms, around her fears and her psychological fragility, if you like, or frailty that is a consequence of the abuse, and it's a non-pathologising way of facing up to what are symptoms of mental health problems. And it's not that we were training the SPAs to become psychologists because the training wasn't long enough for that, but we gave them the confidence to tackle some of those issues, and the training gave them like a toolkit for ways of doing that.

It had elements of CBT in it, it had elements of feminist psychology in it, so it was a sort of hybrid intervention which was manualised, so it's very structured, but an important aspect of it was that this the SPA was started from where the woman was, and the woman helped prioritise what issues or symptoms, or psychological problems should be tackled. So in that sense it was perhaps different from CBT, which has a much more pre-set structure. Essentially we were equipping the SPAs with tools so that they didn't have to avoid this major consequence of domestic violence.

M: That's brilliant, that was exactly about to be my point, is it's actually allowing workers to have the tools to tackle these issues where they see them, rather than a completely new role that you're bringing into these services. So, what are your hopes for the project now that you've published the paper, are there plans to roll out further work?

G: Before I answer the question about what our next step is, I just want to make a point that we're actually talking about two papers here. So we're talking about a conventional randomised controlled trial paper which measures and effectiveness and does a statistical analysis to do that, but we're also talking about a rather, kind of, wonderful, qualitative study that was nested within the trial where the researcher, Maggie, talked to women when they were still in the early stages of getting the intervention, and she then followed up a proportion of those women to get their stories about what it was like to take part in PATH. She also talked to some women who dropped out, to make sure that we weren't getting a totally 'Pollyanna' view of how

wonderful this is, I mean, as researchers we're really interested in getting as near to the truth as possible.

I'm not saying other evaluators don't do that, but we want to look at any warts and all, and look at what's strong about it and what's not so strong. So in the qualitative paper you actually hear the voices of the women who are exposed to the intervention, to use a rather cold word of exposure, and many of whom very eloquently described how it affected their lives and how it helped them to come out of this very traumatised place that they were in when they first sought help. And first of all it takes great courage to seek help anyway as we know around domestic violence and abuse, and once you've managed to cross the threshold and begin getting that help, the fact that that help then included, without referral to a psychologist or a counsellor, but included as part of the advocacy, psychological support just made a tremendous difference.

And for me the effect size measured in the trial is important, but the stories of the women who benefited from it is equally important, and in trying to really understand what PATH is about, I would argue that we need both of those perspectives, and that's one reason why we published our sister papers together in the same online journal, and these papers are...there's no pay wall, these are open access papers which we hope together will create the case for this kind of intervention, this kind of programme. So coming back to your question, which is like, what are we going to do next, you know, are we just going to do another research study and just forget about this because we've done our work as researchers, let the world do with it what they like?

And no, we don't do that, in our research group we're really interested in taking the findings we've researched into the world and into practice and into policy. So we're in a cold commissioning climate at the moment as you know, and domestic abuse services have suffered greatly from that. We are interested in putting this forward as a package which could be commissioned, we're interested in taking the model, the PATH model and promoting it as a way of up-skilling Idvas and other support workers and domestic violence advocates. So that's our next step, and if doing research is challenging, doing what's called knowledge mobilisation, a fancy word for getting outside the ivory tower, is even more challenging particularly when, despite what we're being told, austerity is still out there and it's still affecting the various services.

So we want to ally ourselves with services on the ground to talk to Commissioners about making this part of their commissioning, part of their budget, and we know that services are very keen. For instance Cardiff Women's Aid and Next Link, who are our research partners in this, are keen as mustard for it to be actually commissioned as something they can do, but there is a cost involved, and part of what we haven't published yet, but we hope to sooner rather than later, is we're still doing an economic analysis, a cost effectiveness analysis to try to bolster the case that this is not just good to improve psychological outcomes for survivors, but actually is a cost effective thing to do.

M: Yes, it's spending money to actually help people to not rely on services in the future.

G: That's the idea, but I'm not at liberty to disclose yet what the economic analysis is saying, because we're still working on it.

M: And much easier to say than to do.

G: That's true, yes.

M: So for Idvas listening out there, who are really keen to improve their mental health response that haven't had access to SPA training, are there any basic

things that you would recommend they can read, or access or learn to enhance their advocacy with victims of domestic abuse?

G: That's actually quite a tough question because I'm not sure there's a shortcut to this. This is training that takes weeks to do, not many months, so it's not like you have to go out and get a degree in psychology, but I don't think there's a shortcut to that. As it is, we pared the training down to the minimum that we thought was safe, so I wouldn't recommend learning some techniques to do a bit of psychological work with your clients. For anybody to do that I think would be problematic, it might be problematic for the client, but also for [the worker], because part of this work requires clinical supervision, so the SPAs got clinical supervision from Roxanne Agnew-Davies mostly by phone, but there was also some face to face support.

Having said that, I think reading up around the mental health dimensions of domestic abuse is something I would recommend to every Idva, which if they haven't already done it, I think even in Idva training there's a reference to how impactful in a bad way domestic abuse is on mental health. There is a book, a short book, a thin book called 'Domestic Violence and Mental Health' edited by Louise Howard and me and Roxanne, which is worth a read, because it really gives an insight into this overlap and interaction between domestic abuse and mental health problems.

But in terms of actually enacting that and becoming more proficient about dealing with mental health problems in your practice as an Idva, I think that that does require training. Obviously we think PATH would be a good thing to do, but that needs to be commissioned. I guess one other thing I would say, I know this sounds a little bit negative about why there's nothing you can do, I mean, I think being able to hear in your clients distress and indeed symptoms of mental health problems, like rumination, like flashbacks with PTSD, like anxiety, and you can almost see that in the body language of your clients. I think if you observe that, my suggestion, and I would say this wouldn't I, is that you suggest to the client that she sees her GP, and then she'll say, yes but it's a three week wait to see them, and I'm afraid that's the situation we're in, in general practice at the moment.

But, most GPs are experienced in mental health problems, most GPs can help, particularly a client who's already getting support from an Idva, or indeed any domestic violence support worker, they're already getting help with their safety, maybe some help with their legal issues with housing, so then the GP can focus on helping with some of the mental health consequences of abuse in terms of referring to counselling. One then hopes that counselling is trauma informed, so there are other issues there about the competence of counsellors and psychologists around working with survivors, that's another research area we're interested in, but essentially, I think for the Idva to signpost and not be slow to come forward and say, actually I think you might benefit from some further support with your mental health, I would recommend doing that.

Now, I expect every Idva worth their salt is already doing that, but yes, that is something you can do.

M: Thinking outside of the PATH project, you're based at the Centre for Academic Primary Care, can you tell us about the work that's being carried out at the Centre in relation to domestic abuse?

G: We are the domestic violence and health group, research group within the Centre for Academic Primary Care here in Bristol Medical School, which has a wide-ranging research programme mostly around the healthcare response, not surprisingly because we're based in a medical school, of healthcare response to domestic violence. Although we're also interested in the upstream kind of epidemiological work about the impact of domestic violence, so I'll just say a little bit about some of the other projects

that we're doing. Our sort of jewel in the crown of the work that we've done here around the healthcare response to domestic violence is the IRIS Programme. IRIS is an identification referral to improve safety, it's a programme of training and setting up a referral pathway for general practices which we tested in a randomised controlled trial, which is now a national programme commissioned in about 35 areas in England and Wales.

It's now embedded within a social enterprise called IRISi, and it's an unfortunately all too rare example of a research study which actually managed to get out into practice policy on a national level. And we're very proud of that, but we're very aware that it has limitations and particularly around addressing the needs of children exposed to domestic violence, and men exposed to domestic violence, and indeed, men as perpetrators. IRIS does not engage with that and of course perpetrators are our patients too. As healthcare professionals, we need to think about how we engage with them. So thanks to the National Institute of Health Research, we have a five year applied research programme, which gives us funding to extend the scope of IRIS to take on the needs of children exposed to domestic violence and the needs of men.

And we've just finished our two and a half year pilot phase of that, so again, it's a training intervention for practices, we're trying to equip them to ask about children being exposed and the impact on them, and then to ask men about whether they're worried about their behaviour about the perpetration, or actually experiencing abuse from their partner, whether they're in a heterosexual relationship or a gay relationship. So trying to include populations of people that were kind of excluded from the original concept of IRIS, which was really focusing, as it should have done and we are proud of, on the needs of women survivors.

So, the bottom line there, we've not published this work yet, but just as a little whiff of what we're finding is that we have managed to really get children into the picture and refer them for further support in domestic violence agencies. Our partner here is Next Link again, the Bristol agency which has been the most stalwart collaborator with us over the years, we have not managed to find a way of identifying male survivors, although there may not be that many male survivors, but the fact is we know there are men experiencing domestic violence who either have not been asked by their GP within this pilot, or really didn't want to disclose.

We have a male survivor advisory group, the patient/public involvement group, who've been working with us on why that is, and how we can do better around identifying male survivors. We also haven't really managed to identify perpetrators within the general practice, I mean, there were two who were identified and referred into what we call the IRIS Plus Hub, which can take referrals for men and women and children. So we're working on how to improve the training around GPs talking to men, either survivors or perpetrators, but alongside that we're now running a randomised controlled trial of a perpetrator programme. A group programme based on Respect standards and we're working with Respect as our collaborators to really measure, and also through qualitative work, find out the deeper stories, the effect of a group on the behaviour of men, and particularly obviously on the violent behaviour of men.

We're also recruiting their partners, or ex-partners, because we'd like to measure that through their experiences as well. Why are we doing this, given that the perpetrator programme has been around for donkey's years? Well, because the evidence on perpetrator programmes isn't that good, and I know that SafeLives is doing excellent work with other collaborators here in the University of Bristol on the Drive project, but it's just a sad fact that we don't have the confidence yet about what the actual magnitude of the effect is of perpetrator programmes. So we're trying to test that in a sort of robust way, with a one year follow up for the men and their partners and ex-partners.

So that's work in progress, is it linked to mental health, well, you bet it is because a proportion, I'd say a high proportion, I can't give numbers as yet, of men who are in the programme have some mental health symptoms, I'm not saying mental health conditions, but you know, anxiety, low mood, some post-traumatic symptoms are very common among men perpetrating abuse. So mental health is in there, in fact mental health is, you know, like the red thread through all our research, because it's part of the reality both for survivors and perpetrators. The other work we're doing which is mental health related is, we're developing a mindfulness-based intervention for survivors of domestic violence, women who have symptoms of PTSD.

So we're in the early stages of developing that as an intervention, because the standard MBCT (Mindfulness Based Cognitive Therapy) programme isn't specifically trauma informed and there may be some aspects of MBCT which actually isn't appropriate if you've survived rape and assault and emotional humiliation, you know, it may not work for you, and we're now developing a form which is trauma informed, and obviously we're trying to test to see whether it has the effect that we think it does. There's work around supporting friends and family. So Alison Gregory, one of the researchers here, has worked an approach to understanding the needs of friends and family, and we're interested in extending that work.

We have other work looking at the impact of domestic violence inter-generationally, so in Bristol we're the curators of ALSPAC data, that's children of the 90s cohort, children then who now have their own children, so in the second generation and ALSPAC is measuring domestic violence from the get go, and was very far sighted of the researchers way back then, when nobody was measuring domestic violence in these cohort studies. We've just got a grant now from the Medical Research Council looking at inter-generational effects of domestic violence, and looking at issues around resilience, and again, mental health is writ large in that, because ALSPAC measures everything very forensically and one thing that they measure uber-forensically is mental health and psychological health.

And finally, our work recently is looking outwards towards Europe (a moment's silence for Europe...) and to the rest of the world, so we're collaborating with researchers in European countries around adaptations of the IRIS Programme, particularly in antenatal clinics, that's in Romania, Austria, France and Germany and Spain. And now we're doing work for lower and middle income countries, Palestinian territories, Brazil, Nepal and Sri Lanka, again trying to adapt, it's all about the healthcare response, so working with primary care clinics or in reproductive health settings, trying to find ways of training the clinicians there and linking them to, it varies, in some clinics the co-case managers, so like an equivalent of an Idva, working within the clinic, kind of the equivalent of an Idva working in a hospital, to support survivors.

But because those cultures are very different and the healthcare structures are so different, I kind of feel like I've gone right back to the bottom of the learning curve about that, because there's so much to understand how that works, and we're doing that with researchers, and activists, and service providers in those countries. So our role is just to, not in a kind of neo-colonial way to drop down this, oh this wonderful model, we think you should be doing it, it's about supporting them to do the development and research which is country specific. So yes, that's what we're up to, lots, and I've probably forgotten about half a dozen, but apologies to my colleagues that I've managed somehow to skip over, but that's the sort of scope of the kind of work that we do here.

M: That's fascinating and it kind of shows how, you know, you talked about with the IRIS programme and then actually branching out, because GPs can be so important in terms of the identification of the victims and therefore helping them

get support before they actually have to reach out to a service, before they get to that crisis point.

G: Yes.

M: So, thank you so much, that was brilliant Gene.

G: Okay.

M: Really appreciate taking time to speak to us, and good luck, yes, with all the future work.

G: Thank you, thanks for that.