Whole Health London: Q&A
31st March 2021

1. **We recognise what 'safe' levels of provision look like with regards to nurses in acute wards, for example, but what does safe provision look like for Idva support in health settings?**

   SafeLives recommends a minimum of two Idvas per Acute Trust and Mental Health Trust. This allows for provision when an Idva is on leave or off work due to sickness, and can mean there is provision beyond one Idva's working hours. It also means that Idvas have a colleague who can discuss cases and provide support. In reality, most Acute Trusts will include more than one Acute Hospital: there are 18 Acute Trusts in London and 33 hospitals with Emergency Departments, alongside ten Mental Health Trusts. That would mean we require 66 FTE Idvas at a minimum to cover 33 hospitals in London. We also encourage commissioners to ensure Idvas are 'co-located' from community-based specialist domestic abuse providers to ensure smooth onward referral routes into other forms of support, for example step-down and recovery services and specialist responses for children.

   IRISi works to the IRIS programme model of one full time advocate educator (AE) to a general practice patient population of 200,000. This ensures their dual role (trainer to the general practice teams and advocate to the patients referred) is manageable and safe. The AE brokers in support where appropriate and as agreed with each patient referred, and also has a caseload of patients to support. Where a patient is assessed as being at high risk, she is referred into the local Idva service.

2. **When looking at health-based domestic abuse provision, did the research also look at what other DA provision there was in that borough, for instance voluntary sector agencies? If the health providers had a better understanding of abuse, they can then refer patients on to specialist agencies.**

   Our research solely focused on specialist domestic abuse health-based provision at this stage. It is true, however, that well-funded community and accommodation-based domestic abuse services are vital to a whole-health approach. For example, IRIS Advocate Educators (AEs) in GP surgeries provide a key link to local services and GPs are empowered to refer survivors and victims of domestic abuse on to specialist services, rather than being expected to provide the necessary level of support themself.

   Our Cry for Health (2016) evaluation of five co-located hospital-based Idva services highlighted that 29 per cent of victims accessing community-based Idvas had been to A&E in the six months before accessing the Idva service. Moreover, in one of the hospitals in the evaluation, there were 11 Marac referrals in the 11 months before the introduction of the Idva service; this increased to 70 in referrals in the following 11 months. Therefore, health-based provision can act as a conduit into local domestic abuse services and is often an earlier intervention than interventions accessed by survivors without access to health-based provision.

   Even if clinicians are equipped with a better understanding of domestic abuse, however, that does not necessarily translate into sustained increased referrals into specialist agencies, which is why we advocate for health-based domestic abuse practitioners working alongside clinicians, rather than just training. It is the continued relationship with health-based Idvas or an IRIS Advocate-Educator which enables the clinician to have faith in the referral pathway, rather than feeling that they have to decide how a victim should access support.

3. **Your research estimates 120,000 men in London are victims of domestic abuse each year. Why do you think so few men are accessing support through health settings?**

There are certain barriers to help-seeking which affect male survivors of domestic abuse.

In our 2019 survey of male survivors of domestic abuse, 26 per cent of respondents said they did not tell anyone about the abuse and/or the impact of the abuse. The most common reasons for this were: shame or embarrassment (80 per cent), not thinking anyone could help (69 per cent), not knowing where to go for help (57 per cent), feeling there was no support available (57 per cent), and feeling the abuse was their own fault (18 per cent).

72 per cent of respondents told someone about the abuse and/or the impact of it, but only 40 per cent received some form of help or support. A third of those respondents (33 per cent) received support from a specialist domestic abuse service (17 per cent from a helpline, 12 per cent from an outreach or similar service, and 4 per cent from an Idva).

58 per cent of respondents did not receive help or support. The most common reasons for this were that support was not available for male survivors and victims of domestic abuse (48 per cent), shame or embarrassment (39 per cent) or that the person or organisation they went to for help did not believe them (22 per cent).

4. **When will IRIS be available for men in London?**

IRISi promotes evidence-based practice to improve the health care response to gender based violence. The research and real-world evidence base for IRIS in general practice is that it works for female patients aged 16 and above – it meets their needs and has good outcomes in terms of health, wellbeing and quality of life. We do not yet have this evidence base for male patients, although all IRIS programmes have always had, and continue to have, care pathways in place for men who are affected by domestic abuse and who disclose within general practice.

An adapted version of the IRIS programme, IRIS+, is being researched and tested in general practices to see whether it has good responses and outcomes for male patients as well as for children. The work of IRISi will be informed by the results of this research.

5. **Is there anything similar to Iris intervention for dentists?**

A research trial called DRiDVA (Dentistry Responding in Domestic Violence and Abuse) used an adapted version of IRIS and trialled it in a cluster of dental practices in Manchester. The results paper is being finalised and revised ahead of publication.

6. **Does a whole-health approach risk medicalising survivors of domestic abuse?**

Survivors in London told us about their experiences of health professionals treating the medical issues they were presenting with without appearing to demonstrate professional curiosity and examining the reasons behind them. One survivor explained that the issues they presented with were, to them, 'symptoms' of the abuse they were experiencing but were not linked by her health professional, while a survivor in a case study in the report explained that one health professional merely prescribed sleeping tablets in response to the partial disclosure of her experience of abuse.

Therefore, some survivors are already receiving a response to domestic abuse in healthcare settings which exclusively 'medicalises' their experiences, rather than one which provides them with the routes to support that they need.

Experiencing abuse does, at times, require a medical response in conjunction with the access to support and safety survivors need. Studies have shown that experiencing psychological intimate partner violence (IPV) is associated with a range of physical health conditions, including: hypertension; chronic prostatitis and chronic pelvic pain syndrome; urinary frequency and urgency; type 2 diabetes; disability preventing work; arthritis; migraine and other frequent headaches; stammering; sexually transmitted infections; irritable bowel syndrome; and stomach ulcers. A nationwide German survey with 10,264 women showed that among those aged 16-65, psychological IPV was strongly associated with allergies; problems maintaining weight; gastrointestinal syndromes (e.g. nausea, and eating disorders); psychosomatic symptoms (e.g., numbness and thrombosis, shaking and nervous twitching, cramps and paralysis, heart and circulation illness, dizziness, low blood pressure, breathlessness, and chronic throat problems);

and pelvic problems (e.g., 21 We only do bones here abdominal pain, pain or infections in intimate areas, menstrual cramps, and heavy, weak, or irregular menstruation). All are known symptoms of psychological stress. Women aged 65+ also experienced gastrointestinal syndromes and problems maintaining weight.

Therefore, by embedding domestic abuse specialists in health settings, including IRIS Advocate Educators in GP surgeries, and Idvas in acute hospital trusts and mental health trusts, health services will be able to respond to both the medical aspects of the abuse, and the need for specialist support from domestic abuse practitioners. Rather than creating an either/or system, a whole-health approach will enable health professionals to respond to survivors in a more holistic, sensitive, and appropriate manner.

7. **Do domestic abuse policies exist in Trusts across the country?**

   There is a template in the *Pathfinder Toolkit for creating a Domestic Abuse Policy (Appendix 8, page 93), but there is no obligation currently on Trusts to have such a policy - something we would like to see change and hope that NHS England might make it a requirement on Trusts as part of the Domestic Abuse Bill rollout.*

8. **Do you have any advice for completing a business plan to highlight the benefits of co-locating domestic abuse professionals in health services?**

   There is a template in the *Pathfinder Toolkit for creating a business case for health-based Idva provision (Appendix 10, page 107).*

9. **What are your thoughts on the importance of early intervention services? Did anybody surveyed in your research receive a positive experience of early identification and assistance?**

   The survivors who were asked about abuse by the health professional, and who received a sympathetic approach, said that they were grateful and were supported to get safe. We know that when there is an IRIS service or Idva support in a health setting, survivors are hugely supportive and, crucially, have much better outcomes in terms of safety and wellbeing.

10. **Could you please clarify the eligibility of women with 'No recourse to public funds' (NRPF) conditions to access support from refuges?**

    Sadly, very few women who have NRPF status can access a refuge. This is why SafeLives supports the non-discrimination clause in the Domestic Abuse Bill currently going through Parliament, so that everyone can access services no matter who they are or what their immigration status is. It should be a human right for victims to be able access life-saving support. Southall Black Sisters' website has further information about NRPF status.

11. **My current area is in the process of developing a partnership approach to safeguarding vulnerable children and adults with learning difficulties, who can be at an increased risk of experiencing domestic abuse. Do you know of work in other areas around these survivors and victims of abuse?**

    Stay Safe East do fantastic work around disabled and deaf survivors of domestic abuse. Unfortunately, there aren't any national initiatives in this area. For more information on the experiences of disabled survivors of domestic abuse, you can read our Spotlight report on disabled people and domestic abuse.

12. **You highlighted that there are groups of patients who are unable to access support and are poorly recognised: is there evidence around the notion of a 'perfect victim' and how we can address this?**

    As we saw in our research, there are still myths around who is affected by domestic abuse and what those relationships look like. Programmes like IRIS and the training offered by hospital-based Idvas seek to address these by being clear about what domestic abuse is and how it can affect people's emotional and physical health, and wellbeing. Healthcare professionals need to have a low threshold for asking patients about domestic abuse, be professionally curious and

not worry that they will offend patients by asking them direct questions.

13. **As a domestic abuse practitioner, I have experienced the minimisation of domestic abuse by some male GPs who have dismissed it as 'cultural'. How can we address this?**

    The IRIS programme has been shown to improve the response to domestic abuse by GPs and practice staff. The training and consultancy, alongside the referral pathways, means GPs are able to address ingrained myths around domestic abuse, including that it is somehow 'inevitable' among certain groups, including those from Black, Asian and racially minoritised backgrounds, or LGBT+ people, for example. IRIS teams examine, discuss and challenge the attitudes and beliefs of clinicians to improve their practice and their subsequent response to patients experiencing domestic abuse; this is a process and cannot be addressed by one-off training courses.

14. **Is there intersectional work around older people who present with health and social care issues related to their experience of domestic abuse, or any training to address ageist attitudes that leave older victims more invisible?**

    As with many groups with protected characteristics, the experiences of older survivors are under-researched and underreported. Hopefully this will change with the inclusion of survivors over 74 in the Crime Survey for England and Wales. Dewis Choice do provide training in addressing the specific needs of older survivors and you can also read our Spotlight report on older survivors. You can also contact us at SafeLives if you would like to know more about specialist training regarding older people and domestic abuse – we have specific provision for this which has been delivered in England and Wales.
    https://safelives.org.uk/training/responding_to_older_people_training

15. **How can we support GPs sharing information with Marac? Often the pushback is around lack of notice or capacity for surgeries to share accurate and timely information.**

    Sandi Dheensa's research on this has highlighted a range of issues when it comes to GPs recording and sharing information about domestic abuse, so it is certainly a widespread issue.

    Some areas employ Marac nurses who act as a point of liaison between Marac coordinators and health care practitioners, and support with information gathering and sharing. Local GP Safeguarding leads can also support with challenges alongside the national safeguarding lead at the Royal College of GPs.

    Our Marac guidance for GPs explains in detail how GPs engage with their local Marac. The information gathering process should be five working days, which should give GPs to time to gather the right information.

    When a victim of domestic abuse is referred to Marac, they are at high risk of murder or serious harm. Therefore, this must be a priority patient for the GP surgery. GPs are no different to other professionals in such a situation, and this must be recognised. If necessary, GPs can work with the Marac to improve the local process and build bespoke arrangements which are more accessible to them.