

Partnership working to increase recognition and disclosure of domestic violence and abuse to improve the responses of sexual health services: a qualitative evaluation

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Background

Domestic violence and abuse (DVA) has a large social, clinical and public health impact and poses a major challenge to health services. People who experience and live with DVA often do not disclose their experience of DVA to health care professionals. The IRIS (Identification and Referral to Improve Safety) programme⁽¹⁾ is an evidence based training intervention for general practice staff to identify, respond and refer appropriately female victims of DVA. IRIS is now being implemented nationwide in general practice.

This study examined whether an IRIS training programme can be adapted and implemented in sexual health clinics – (IRIS ADViSE: Assessing for Domestic Violence in Sexual Health Environments). Sexual health services are well placed to be points for intervention⁽²⁾, because of increased unintended pregnancies^(3,4) and sexual health problems in people who experience DVA or associated physical or sexual violence⁽⁵⁾. This study is a collaboration between the University of Bristol, UHBristol and NIHR CLAHRC West who evaluated the pilot.

Method

Aim and design

The study aimed to examine the experiences of IRIS ADViSE training and implementing the IRIS ADViSE approach in sexual health settings. A qualitative study featuring in- depth semi-structured interviews with health care professionals who received the training was conducted.

Analyses

Interviews were audio-recorded, transcribed and imported into NVivo10 and analysed using inductive thematic analysis.

Findings

During the 12 week intervention there were 162 disclosures of DVA, and 11 referrals. Interview participants ($n=15$) included nurses, health care advisors, consultants and doctors. Three major themes were identified:

Views of training

Participants welcomed the IRIS ADViSE training as it could help justify clinical enquiry and provide information / knowledge / pathways that had been previously lacking. Training provided clinicians with the knowledge and conceptual tools to be able to discuss DVA sensitively and manage disclosures:

Well I think without the proper training or – it's like knowing what to say or what to do and how to go forward with it. It's a bit difficult to explore completely (Mrs I).

In tandem, the training package was described as instilling belief in the project, confidence and motivation to engage with the IRIS approach:

So by the time I'd gone through the training session, I felt much more confident about it (Mrs A).

yeah, I was very impressed with the training and it kind of did feel that ... again, sort of generally, people were quite motivated (Mr F)

Improvements: One gap was the lack of male focused content (victim / perpetrator):

Probably because it's very under-reported, it was ... there wasn't anything in regards to, really, with male victims (Mr E).

Participants also thought that the training would benefit from recognising the emotional impact on patients:

I wondered about whether we actually had enough time to think about how it might feel to be asked that question when you're not expecting it (Mrs B).

Working to make clinical enquiry feel comfortable

Participants described some initial discomfort about asking the questions in practice, often because they were concerned with offending patients or making the question stand out. Participants described eventually settling on a way that they felt comfortable with to use routinely:

All of us have our own style and our own way of asking questions, so we all know that you get told how to do something, but then you just have to go off and find your own way of doing it (Mrs C).

I generally ask, "have you got any issues with any domestic violence?" And it's just a professional question, like I ask every other question – like, "When did you last have sex with anybody?" – you know, it's not wrapped up with anything else (Mrs D).

Opportunities for development

Participants all stated that they thought that screening for DVA was important and appropriate for sexual health settings after piloting the modified IRIS programme. Two key areas for development were highlighted:

Child protection and Trust safeguarding: The process of referral to the DVA advocate was considered clear and straightforward for adults. However, when children were involved the process of notifying safeguarding at the NHS Trust involved a large amount of time:

It sounds terrible to say it, but I'm delighted when we don't have children [laughs], 'cause then I know that it's them and I can refer them to Next Link and that's fine, but I don't have to do the whole safeguarding and social services thing (Mrs C).

Male perpetrators / victim support: Reflecting critique of the training, some staff stated the level of support they could provide to males who disclosed was unsatisfactory:

I mean actually, it is more awkward because there's not such good referral path. You know, so what am I going to do with that information, "oh yes, I used to hit my girlfriend" (Mrs G).

Conclusions

The IRIS ADViSE training intervention helped to provide a formalised process for responding to DVA. Training instilled a sense of confidence and certainty of approach and process in participants. Despite this participants needed to experiment and practice embedding screening into their usual clinical care and a 'one size fits all' approach may not be appropriate.

The IRIS ADViSE approach is acceptable to clinicians but could be improved by providing a better framework for managing males (perpetrators and victims) and recognising the impact of existing child protection and safeguarding processes.

References

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