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**Greater Manchester IRIS ADViSE pilot**

**A learning and evaluation report**

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**ADViSE (Assessing for Domestic Violence and Abuse in Sexual Health Environments)** is a training and advocacy model designed to increase the identification and referral of people affected by domestic violence and abuse. The ADViSE pilot launched in Autumn 2021 as a partnership between GMHSCP, MFT, Local Authority Domestic abuse commissioners and VCSE partners in four localities:

Manchester – The Pankhurst Trust (3 Advocate Educators)

Trafford – Trafford Domestic Abuse Services (1 Advocate Educator)

Stockport – Stockport Without Abuse (1 Advocate Educator)

Tameside – Jigsaw Support (1 Advocate Educators))

Pilots in Bristol and Tower Hamlets in 2018 ([Sohal, et al)[[1]](#footnote-1)](https://sti.bmj.com/content/sextrans/94/2/83.full.pdf) demonstrated this model to be effective at identifying victims of domestic abuse in sexual health services. The Greater Manchester pilot is testing out adaptation of the ADViSE national model to include victims of sexual violence and to explore barriers and facilitators to multi-partner delivery across four Localities (See Appendix A for logic model).

 This pilot is one of the NHS commitments in the Greater Manchester Gender Based Violence Strategy. Oversight of the pilot is through monthly locality meetings and a quarterly GM steering group reporting into the Gender Based Violence executive group.

# Introduction

## About ADViSE

ADViSE (Assessing for Domestic Violence and Abuse in Sexual Health Environments) has its origins in the IRIS programme for primary care which aims to increase the identification and referral of people affected by domestic violence and abuse (DVA). IRIS has been well evaluated and has shown that providing training for GPs and other primary care staff, alongside a clear referral route into a specialist service, can be highly effective in increasing access to support.

However, there are patient populations who may not come into contact with general practice or other primary care services, and sexual health services are a potential means of reaching some of these. Sexual health and gynaecological problems are the most prevalent and persistent physical health consequence of DVA. Sexual health clinicians are already trusted by their patients with highly confidential, potentially stigmatising, information and are particularly adept at working with diverse populations and vulnerable groups, who may not access other services. Sexual health services are therefore in a strong position to support early recognition of undisclosed or unidentified domestic violence and abuse and offer an appropriate response.[[2]](#footnote-2)

An adapted version of the IRIS programme, IRIS ADViSE, has been developed to support staff teams in sexual health services to recognise and respond to patients affected by DVA, offering them a direct referral into specialist services via a simple, local care pathway. Each local team includes an Advocate Educator (AE) and a Sexual Health Clinical Lead (CL). The AE is a named specialist based in a local DVA advocacy service who runs training for the team and is the point of contact for referrals of patients who would like support and advocacy around DVA. The AE works in tandem with a CL, a sexual health practitioner based in the local services.

## About the Greater Manchester pilot

The ADViSE pilot in Greater Manchester (GM) follows on from two earlier pilots in Bristol and Tower Hamlets, although it differs in two important respects: in GM the concept has been expanded to include sexual violence (including historical sexual abuse) as well as DVA and provides direct support to men as well as women who are victims/survivors.

The GM pilot has been implemented in 4 (of the 10) local authority areas – Manchester city, Stockport, Tameside and Trafford - and is being delivered locally by AEs working in the following organisations working in close partnership with each other:

o Manchester – Manchester Women’s Aid

o Trafford – Trafford Domestic Abuse Services

o Stockport – Stockport Without Abuse

o Tameside – Jigsaw Support.

All four organisations provide the commissioned domestic abuse services in their respective boroughs and, with the exception of Jigsaw Support, (a branch of Jigsaw Homes), all are specialist DA/VAWG services.

The pilot is staffed by 6.5 full-time equivalent Advocate Educators (AEs). Three postholders are based with Manchester Women’s Aid, one with Trafford Domestic Abuse Services, one with Stockport Without Abuse and one with Jigsaw Support in Tameside. The Trafford AE also acts as a coordinator for the pilot. Four Clinical Leads (CLs) were identified early in the pilot, all practitioners within GM sexual health services.

## About the evaluation

DMSS Research were commissioned to undertake a qualitative ‘snapshot’ evaluation of the pilot and to capture and share learning from the process.

The ADViSE logic model (appendix 1) sets out the intended activities, outputs, outcomes and local impacts for local funders/commissioners, ADViSE partners, sexual health clinic teams and for victims and survivors of domestic and sexual violence and abuse (DSVA). The evaluation has aimed to complement the pilot’s internal monitoring of progress against these by gathering independent data, primarily via interviews with key stakeholders.

This report is based on information collected about the progress of the pilot during its first year of delivery. Sources of information have been:

* Interviews with all the AEs and clinical leads conducted in June/July 2022 (n=11)
* Interviews with staff in sexual health clinics conducted between November 2022 and January 2023 (n=14)
* Case studies produced by AEs
* Monitoring and progress information provided to the pilot’s steering group

This report summarises what can be learned from this information and addresses the following questions:

* What has been learned from the pilot about the processes of implementing ADViSE, including the main barriers and enablers to implementation?
* What can we learn from this pilot about what works to engage sexual health practitioners in ADViSE?
* What can we learn from this pilot about the acceptability of the service and outcomes for different end users?
* What has been learned about the demand for and take-up of ADViSE?
* What are the implications of this learning for the future of ADViSE in Greater Manchester?

# What has been learned about the processes of implementing ADViSE?

In our interviews with Advocate Educators and Clinical Leads we explored the experience of implementing ADViSE in the Greater Manchester context in order to identify the key factors which have been either barriers or enablers to the process. In this section we summarise the main learning points about implementation, particularly during the initial 6 months of the pilot.

## Establishing key relationships

Establishing and maintaining positive relationships is central to the success of ADViSE. Key relationships include those across the ADViSE teams (e.g. between AEs and CLs), with decision-makers and gatekeepers within the provider organisations, with the specialist agencies hosting the AEs, between ADViSE teams and sexual health practitioners and, ultimately, with victims/survivors.

Relationships across the ADViSE teams were described by AEs and CLs as positive. On the whole people did not know each other before the pilot, and COVID restrictions continued to place limits on the face-to-face contact people could have, so some of the informal team building which often occurs naturally in new initiatives was less likely to happen. Despite this, it was clear from our interviews that considerable mutual respect built up between CLs and AEs. CLs were very complimentary about the skills of AEs, and AEs were appreciative of the CL’s specialist knowledge and of their support in facilitating training and ‘opening doors’ to their colleagues in sexual health services.

CLs were described as ‘pivotal’ in getting the training organised. There seems to have been some differences of opinion about the timing of the initial C1 training. CLs were keen to get it off the ground and were very aware of the difficulties of negotiating the closure of clinics for the training to take place. For CLs this meant the priority was getting dates agreed and adhering to them. This left some AEs feeling that the process had not been as consultative as they might have wished. The introduction of SPECSS was given as another example of a decision being made with little discussion. However, overall relationships have been very positive:

*The CL has been great in training – a great advocate for the project.*

*The CL has been absolutely instrumental. Prior to C2 virtually all my referrals came from them. She’s a real champion and I can’t praise her enough.*

We also asked AEs about the relationships between themselves as ADViSE workers and their host organisations. Again, responses were very positive. Most observed that ADViSE fits well with the work of the host organisation - for example, it was noted that Manchester Women’s Aid already had an IRIS programme so there was good synergy. AEs described their colleagues as very supportive, and some commented that despite having a different role as an ADViSE worker they still felt very much part of their organisation’s team. Where workers are on their own in the role this can be particularly important. AEs also felt that having ADViSE as part of the service brought some benefits to their host organisation, including the expansion of their networks into sexual health. In the other direction, AEs also commented that the connections they had as part of their host organisations brought advantages to their role as ADViSE workers:

*We’re quite well established and well connected so we’re able to use those for IRIS referrals. I also work at the SARC so have good links there.*

With regard to relationships between the AEs and sexual health practitioners, the CLs have played a critical role in forging links and promoting the project. CLs have been particularly important in promoting ADViSE and explaining about the AE role. AEs commented that because sexual health practitioners already did DASH assessments and were accustomed to signposting people to other support services, they were initially unclear what ADViSE was all about:

*There can be a bit of a sense that they’re not sure what ADViSE is for – they don’t understand the difference between signposting people to other support and making a referral – they perhaps don’t all see the point of it.*

This perception gradually changed as the pilot got established and AEs increasingly developed independent relationships with clinic staff, particularly as they were able to spend more time in the sexual health clinics:

*I now walk into clinic and staff are asking me questions about LBGTQ and forced marriage and discussing/disclosing. C2 was very interactive with [discussion of] lots of patients they had concerns about. They are really engaged and seem to welcome me as expert source of advice.*

## Implementing the training

Delivering the training to sexual health clinic staff was a critical early implementation task and as we have noted CLs played a key role in getting dates diary for delivery and negotiating the time for staff to undertake the training. Contextual factors, not least continuing restrictions because of COVID-19, impacted on training delivery, much of which has had to be delivered on-line. Early clinical 1 (C1) training was delivered on-line in December 2021 with large cohorts of participants from a range of roles including doctors, nurses and health advisors. Overall, this was felt to have been well-received and feedback was positive. However, it was acknowledged that the attention of participants may have been affected by the training taking place quite close to Christmas and at a point when practitioners were still absorbing the implications of the recent change in the commissioned provider of sexual health services in Tameside and Stockport.

The content of the training (which was adapted by IRISi from materials initially developed for primary care settings) was largely considered to be appropriate. However, some AEs and CLs received feedback that the 2 hours of C1 training was too long and in part duplicated training that practitioners had already undertaken as part of their level 3 safeguarding training. Both AEs and CLs felt that overall levels of DVA awareness among sexual health practitioners was good and that the training needed to reflect that:

*I have the sense that sexual health clinicians are more interested and aware than many GPs. They already ask routinely about sexual violence, and they complete the DASH anyway.*

It was felt to be important for the training to focus more on issues of implementation, specifically how to make a referral and what support their patients will receive:

*In C1 there was a lot on what is DVA and we skipped through that quickly as people want to know more about what to do and what happens when they make a referral. Intend to focus more on that especially in C2. They want to know what support their patients will get... More emphasis on the referral pathway so they know what the offer is.*

*Content of C1 is good but there’s not enough about what the AEs actually do – don’t think people realise the range of support that we can provide. We will basically do anything that clients need.*

The content of C2 was felt to be generally appropriate, although there were some comments about the number of topics covered and the balance of content.

Training has also been carried out with admin and reception staff and AE feedback suggests that went down well and highlighted the important role of these staff in observing and interacting with patients:

*In one of my sessions, reception staff talked about how they noticed things going on in the carpark which rang alarm bells.*

Once COVID restrictions were lifted, some face-to-face training was delivered with smaller groups. Trainers who had experience of delivering the training both on-line and face-to-face had a clear preference for the face-to-face version. They felt that people were more likely to get distracted when the training was on-line, although this could be improved by people having their own screen – one interviewee noted that if there were a few people clustered round the same screen they seemed less engaged. Trainers reported much higher levels of engagement in face-to-face training and were very positive about it:

*In the face-to-face training they were very engaged and asking lots of questions. It included some survivors in the room with people willing to share their experiences. The C2 in smaller groups feels more relaxed – we can talk about the experience of supporting people rather than just giving a lot of dry information. There were more barriers in C1 – people didn’t always see it as relevant – it wasn’t tailored enough to SE clinics.*

We summarise the views of practitioners on the training in section 3 of this report.

## Achieving referrals and supporting survivors

Referrals were initially slow to start – there were just 10 in the first quarter of the pilot, but this is to be expected given the need to focus on getting practitioners through the training, encouraging the routine exploration of DSVA and building awareness of the role of ADViSE. At the time of our June/July interviews with CLs and AEs, numbers were increasing as more C2 training was completed and practitioners were experiencing the benefits of making referrals. However, there was still some concern that referrals were lower than hoped for. One of the CLs felt there was still some work to do to get the exploration of DSVA embedded and to build the confidence of staff in asking the question about DSVA:

*I would have liked there to be more referrals by now – it’s not yet embedded. I’m not certain whether people are asking in a way that promotes disclosure. I’d like people to feel more comfortable about asking. The training needs to help people feel more confident. Maybe some supervision in clinics would be good but that would be very time consuming.*

Another informant felt that practitioners were not so much concerned about asking about DSVA as about the possible *repercussions* of asking:

*It’s more the safeguarding issues and knowing what the right thing to do is. It’s not so much the asking but the aftermath – especially where there are children and that we have to refer with or without their consent (cos Mum can be really scared that ‘children will be taken away’).*

In these situations, it was felt that ADViSE was welcomed because it gives practitioners someone to consult with and a clear pathwayfor making a referral*.* Having a known, named person to refer to was viewed as key:

*Referring to a named person on a personal basis is just so different to referring to an organization!*

AEs were very positive about the early referrals they had received. They were viewed as appropriate and there were already several common themes in AE’s observations including:

* Referrals had been very varied in terms of age, gender, ethnicity and sexuality. It was noted that there had been several LGBT referrals – gay men, particularly.
* Many were quite complex referrals with multiple issues requiring support, and often the people referred had not had any support before.
* It was felt that ADViSE was reaching people who might not get support via the GP route.

A couple of AEs commented on the ethnic diversity of referrals, and they felt that this was enhanced by the fact that ADViSE gives people a choice about where they can access support.

*A lot of communities rely on [their] own community support or don’t know about specialist services or don’t feel they are for them. What’s different about ADViSE is the choice about where people can get support across GM.*

Although the primary reason for referrals was domestic abuse, there had been several disclosures of historic sexual abuse, including one off sexual assaults in the past which clients had not previously disclosed to anyone. In these cases, it was noted that the support often entailed helping clients to deal with traumatic past events rather than helping them with safety planning in the present.

More information about the profile of referrals and support offered is included in sections 4 and 5 of this report.

## Responding to contextual factors

All initiatives are impacted by the context in which they are implemented. Some of these factors may be known in advance and can be factored into planning, others occur during the course of an initiative and have to be responded to.

For the GM ADViSE pilot, there have been several contextual factors to take into account. One is the complexity of the system within which sexual health services operate. CL interviewees described the challenges of being part of a relatively small service within a very large Trust which has Trust-wide systems, policies and procedures for safeguarding. These were designed to encompass all parts of the Trust, including in-patient services, which means they are not always compatible with the way in which sexual health services (and the ADViSE model) work. For example, any safeguarding disclosure requires the completion of a DASH assessment and the Trust’s Safeguarding leads were described as reluctant to allow sexual health services to try new ways of risk assessment. It took some persistence to achieve a compromise arrangement:

*They initially ignored our concerns about it, and we had to escalate to a senior level to get a response. They were willing for us to adopt SPECSS+ and some clinical discretion as a pilot – but historic disclosures still lead to a DASH - though if the risk score is less than 14 it’s been agreed that ADViSE can manage cases.*

Influencing these decisions within a large Trust can be challenging. A CL working within sexual health services may have extensive influence and authority within those services but struggle to get the procedural changes needed unless they have allies higher up the system. For example, the pilot was successful in getting IT to insert a prompt into the assessment system to ask patients about DSVA. However, the prompt was ‘tagged on’ to the end of the assessment rather than inserted at an appropriate juncture and getting it moved has proved to be difficult.

Another contextual factor is the configuration of sexual health services themselves. There are varying numbers of clinics in each of the pilot areas – for example, there are five in the north of Manchester whilst in Tameside there is just one. Staff can move around, and they may be mainly based in one clinic but do drop-ins in others. This can make it hard to keep track of who is working where and what proportion of staff in each clinic has been trained.

As well as staff being more mobile than is usually the case in general practice, the patient population is also more fluid. People can opt to attend a sexual health clinic anywhere in GM regardless of where they live and frequently do so (e.g. someone living in Oldham but working in central Manchester is quite likely to attend a Manchester clinic). This has implications for how ADViSE provides ongoing support with AEs likely to be supporting patients from a wide catchment area.

An additional contextual issue, which emerged after the initial planning of the pilot, was the change in the commissioned provider of sexual health services in Tameside and Stockport. The transfer of these services to Locala involved re-negotiating the implementation of the pilot in the Stockport and Tameside clinics and working with the new provider’s policies and systems. It impacted on lines of accountability and communication, and affected the staffing of the pilot, with two of the CLs moving across to Locala. These changes initially had some impact on the progress of the pilot, adding another set of relationships to establish and negotiate with over issues such as training, referral processes and AEs being able to spend regular time in clinics. However, by the time the pilot was part-way through, our informants were largely confident that Locala had been reassured that ADViSE was compatible with their own safeguarding systems and training and they were engaged with, and supportive of, the pilot:

*Locala delayed delivery of C2 because they had loads of other stuff going on, other training to deliver etc. But they’ve been accepting and engaged– so not resistant but having to address other priorities. Locala seem to be seeing it as positive and have implemented everything needed.*

## Summary of barriers and facilitators to implementation

* **Facilitators**

**Staffing:** The main facilitator of progress on this pilot has been the people involved. The initiative has been very successful in recruiting experienced staff into the AE role and our interviews with them suggest that they all have a high level of commitment and skill. The pilot has also succeeded in recruiting committed and experienced staff into the CL role. However, this has been more difficult because the time commitment required on top of the ‘day job’, but the pilot has been able to develop the role of a link nurse in some clinics who have undertaken some aspects of the CL role:

*When it came to it, we couldn’t get a CL from every clinic – there’s too much time involved in doing 2.5 days of training*. *The role of link nurse has naturally developed.*

During our interviews there was some anxiety expressed about future availability of CL support should the current CLs move into different roles, and this suggests a need for ongoing ‘succession planning’ to encourage other clinicians to step into the role if required.

**The quality of the training** has been another key facilitator. As already noted, pilot staff have made some minor adaptations to the training, mainly to reflect the priorities of sexual health clinic staff, but overall, the training was reported to have been well received. There were some IT and practical glitches to overcome but these seem to have been ironed out. There is an ongoing question about the relative advantages of on-line and face to face training. Large group on-line training is very different to small group face to face. Some AEs prefer delivering face-to-face training but doing more of this has been difficult given clinic staff’s workload and an understandable reluctance to close clinics for training.

**Building relationships with clinic staff.** As the pilot has got established these relationships have developed well, particularly where AEs have been able to spend time in clinics. As engagement has increased so have referrals.

* **Barriers**

The main barriers seem to have been practical ones.

**The location of the prompt** in the on-screen assessment tool has been identified as an issue. Getting this changed is more of a challenge than one might expect as one of our interviewees explained:

*Main barrier has been the IT – we had unexpected problems negotiating with the software developers who were managing multiple projects and ours wasn’t a priority. Have also had to do the negotiations through a third party because there has to be a single point of contact. The location of the prompt is an issue but there’s no perfect solution – we can’t move it to where people want it because it can only be mandated where it is. On the positive side, people must have adopted the screen tool or they wouldn’t be criticising the location of the prompt!*

**The move of two of the pilot areas to a different provider** created some initial uncertainty and delay. However, these issues seem to have been resolved and by the mid-year point the ADViSE pilot was reported to be progressing well within Locala.

# What works to engage sexual health practitioners in ADViSE?

Between November 2022 and January 2023, the evaluation team conducted interviews with a total of 14 clinic staff working in the following services: Hathersage; Urmston; Trafford; Wythenshawe; Withington; Ashton-under-Lyme; Tameside and Stockport. Interviews were carried out with interviewees in a variety of roles including specialist doctor, consultant in sexual and reproductive health, specialist nurse, nurse team leader, outreach nurse, sexual health practitioner, outreach engagement worker.

The interviews explored staffs’ views on the ADViSE training, referral processes and support from the AE, the impact of ADViSE on their practice and the available support for victims/survivors.

## Views on training

Thirteen interviewees had attended ADViSE training with almost all completing both C1 and C2 sessions either in person or on Teams (one interviewee had only recently returned from maternity leave and had not yet had chance to join a course). The majority of staff gave positive feedback on the training including finding the content relevant, the input well-structured and the trainers excellent:

*I found it really informative and thought it was delivered well in a way which made sense. It was good having it co-delivered by someone who works in the service so they understood the nature of our work.*

A couple of interviewees had clearly found the training to be a significant personal learning experience:

*It was excellent, so in depth and I learned so much. At the start I thought: ‘How can we fill two hours on domestic violence?’ but for me it could have gone on for another two hours. The physical consequences, links with heart disease, cancer…these were issues never covered in GP training.*

However, as observed by AEs and CLs, a number of interviewees reported that the training, particularly the Clinical 1 session they had attended, did not take appropriate account of the pre-existing high levels of awareness of sexual and domestic abuse amongst sexual health practitioners in general, or the previous training covering these issues that many staff had undergone.

*It was good training well delivered, but it did duplicate a lot of training we’ve already done: our mandatory safeguarding training covered the same ground.*

A few interviewees expressed considerable frustration that the training had not been more clearly focussed on what they did need to know:

*I felt it was a complete waste of time for me and most of my colleagues. We’re all level 3 safeguarding trained so there was nothing new. It would have been more helpful to know what ADViSE could offer, how to refer etc and this was only briefly covered at the end by which time I’d switched off. It felt very long. The trainers themselves were excellent and the content would be useful to people who hadn’t had such training but for me it was not a good use of time.*

*The trainers knew their stuff – but they also knew that we knew it too – so it felt like a tick box exercise: they had a script to get through and it didn’t matter that it wasn’t appropriate to the audience. Given this was our introduction to IRIS and ADViSE it didn’t get off to the best start.*

Some interviewees were aware that some of their colleagues had perceived the training as duplicating previous safeguarding courses but personally felt that it was always helpful to have a refresher on the issues. Others were conscious that levels of awareness amongst clinic staff varied:

*It was all quite familiar to me …but I’m aware that that’s not true for everyone – I’m still shocked sometimes at the lack of awareness, so the training is a good thing. It’s also good to have training specific to sexual health so people get to think about it in that context.*

There were also a number of specific topics on which people said they had gained useful new knowledge including:

* It opened our eyes to what we can do for patients who have experienced abuse in the past
* Learned more about spotting the signs of abuse
* Identified warning signs for how to spot potential perpetrators
* About providing patents with additional security equipment
* The possible gynaecological indicators of DV

Most commonly, people cited their main **gain** from the training as having a clear understanding what ADViSE could offer and how referrals would work. The most **satisfaction** was expressed in relation to Clinical 2 - particularly the more interactive parts which drew upon people’s own clinical experience of cases and the ‘physical booklet with flowcharts’ provided to participants.

## Influence on practice

Interviewees were asked whether the training had influenced their practice in any way and some made a direct connection between what they had gained from the training and specific changes:

*I’m much more vigilant now. I listen for cues and I’m more aware of the impact of historical abuse. For example, I referred a young woman who had been sexually assaulted in her teens. Before the training I’d never have done that.*

However, most interviewees said that while their practice had indeed changed in some respects it was not as a direct consequence of the training per se but because of the availability of the ADViSE referral route and provision:

*It hasn’t particularly [influenced my practice] I think because I mainly work with vulnerable groups and sexual abuse and DV has always been on my radar. Having ADViSE as a source of support has been invaluable though.*

Most interviewees identified that the main impact of the ADViSE pilot had been the sea-change in asking about abuse. In many cases routine enquiry of all clients about any experience of sexual and domestic abuse had clearly become embedded:

*[The influence is] not the training but the fact of being prompted to ask the question – this means I now ask every patient. Before I would not have done so – I’d ask about sexual violence but not DV.*

*Routine enquiry now happens at every visit, so we are getting more disclosures. Sometimes it’s the third time of asking that is the one that matters. Staff are more confident about asking – including new nurses.*

*The introduction of routine screening means I now ask everyone about DV as well as SV. Feels OK to do that – we tell people in advance that we’ll be asking personal* *questions and we already ask about sexual assault etc so I just ask as part of that and it’s fine.*

*Now that routine enquiry is mandatory I ask all patients whereas previously I would have only asked where there were indicators or if the patient was young or vulnerable.*

*It’s changed my practice completely. I now ask every time.*

A few practitioners were a little less definitive:

*I think I definitely ask more and now feel more comfortable about asking. I have had more disclosures which I think is due to asking direct questions.*

*I’m asking in the majority of cases, but there are lots of pressures on clinical time and it’s so hard to address all their issues.*

People contrasted what would have happened previously when abuse was disclosed with the confidence they now felt in the ADViSE referral route:

*Previously I would ask if there was anything indicating that abuse was an issue but probably wouldn’t raise DV generally. Now I ask all the time and feel comfortable doing it – helped by [the Advocate Educator] giving us suggestions about how to ask. I think it’s good to ask and I am definitely getting more disclosures especially of DV.*

*I feel now that it’s good to ask because I can refer on to someone who will provide support – including historic abuse – previously if someone disclosed historic abuse I wouldn’t have known where to refer them – would probably have suggested they go to their GP to request a counselling referral.*

No-one interviewed expressed any concern or personal difficulty about asking the question, but a couple didn’t think it was entirely unproblematic for all their colleagues and suggested that some staff might require additional training or guidance:

*I feel that people still struggle to know how to ask. The question has to be asked by everyone including health care technicians and they need to feel confident both to ask and to manage any possible disclosure – because even though they should always have a health advisor they can go to for support they’re still the one hearing the initial disclosure and it can be difficult on an emotional level. There’s an enormous breadth of issues that people can start to disclose. I don’t think the training gives enough space to this.*

**The placement of the prompt**

The fact that it had so far proved impossible to place the prompt in an appropriate place in the INFORM system was clearly an irritation and meant that the question was being asked in slightly different places by different staff:

*In my flow I ask after the non-consensual sex question. It’s infuriating that the prompt about DV is at the end.*

*The prompt is in the wrong place but I always ask as part of taking the patient’s history.*

*I add it to the blood-borne virus screening questions. Some of them are a bit wacky and mostly not relevant so I ask it there along with ones about amateur piercing and tattoos and whether someone has paid for sex. But I think it would be asked much more often if the prompt was placed appropriately.*

## The patient response to being asked

Overall, patients were reported to have found being asked about domestic abuse acceptable and unproblematic. In many instances the response to routine enquiry had been very positive – irrespective of whether the individual had been personally affected by the issue:

*I was quite apprehensive about asking routinely but have found that there has been lots of positive feedback from patients including people who have thanked me for asking. If the question is normalised there isn’t a problem.*

*I’d say 90% are fine with it. I always make it clear that we ask everyone so that patents don’t feel ‘singled out’. Have had a few disclosures – all have been of previous abuse, but some have still wanted a referral because they haven’t had support before.*

Staff commented on responses from some particular groups of patients:

*It hasn’t been problematic. Women are not surprised to be asked. Men are sometimes but it hasn’t been an issue.*

*Patients have been fine about it. I do a trans clinic and there have been a lot of disclosures – trans people seem to be disproportionately affected – they often have lots of trauma in their lives…. It’s really helpful that ADViSE is not a gender specific service, for instance we have trans patients who may not be comfortable being referred to Survivors (which is for men) or to Women’s Aid.*

*Overall people don’t mind being asked. Some say ‘yes’ but don’t want to discuss it further, others welcome the opportunity - including people with histories of abuse who are still struggling with it.*

*I’ve had a couple of disclosures from gay men who’ve been surprised to be asked but were pleased to have it acknowledged even though they didn’t want a referral.*

Most people had encountered no negative reactions from patients they had asked, and lots reported positive feedback from people saying it was ‘such a good idea’ or that it felt ‘good to be asked’. Only one practitioner reported any negative reactions:

*Some people don’t want to be asked and even get angry. Others think it’s brilliant. It makes them feel cared about even if they don’t want to do anything about it.*

Many patients had responded to the question by disclosing abuse. Almost all interviewees reported an increase in disclosures and in some cases considered this to be a considerable increase – particularly of historic abuse. While only a small proportion of the increased disclosures were leading directly to a referral, staff still thought there was value in the acknowledgement of abuse as a significant issue in people’s lives:

*It has led to more disclosures – so far all of previous rather than current abuse. We do a screening assessment and mostly they are not scoring high on risk, so these would be patients who we would not previously have been able to offer anything. It provides them with the opportunity to talk about their experiences and it means we have some further support to offer.*

## The referral experience

All but one of the staff interviewed had made referrals to an ADViSE Advocate Educator and most had also consulted with an AE on particular cases or issues that had arisen in their practice. They were overwhelmingly positive about every aspect of their experience so far and frequently contrasted it with what had previously been possible:

*In the past I’m not sure I’d have known where to go for advice beyond asking my immediate colleagues.*

*The fact we can refer across such a range of issues: rape and DV but also grooming. And men as well as women. Previously I’d have suggested Rape Crisis or the SARC and said ‘take a photo of this number’. Having ADViSE is completely different: you are saying I can refer you to [AE], she works here, she really knows her stuff on this. It’s a person not a helpline and you feel so much more confident about encouraging someone.*

Clinic staff were impressed that the process was ‘smooth and easy’ and with the speed and flexibility of the ADViSE response to referrals:

*It’s excellent. From my knowledge of cases I’ve been involved with the referrals have been picked up really quicky and responded to very flexibly.*

They identified the value of being able to access and consult with an AE and many commented on how they were now very much part of the clinic team:

*I have made about 10 referrals so far. All women. It’s really useful having ADViSE there knowing that we can offer some support. I really value having [the AE’s] presence in the service. She sometimes uses our rooms to see patients and having her around means we can access her for advice. She also attends safeguarding meetings and can give her perspective and provide feedback on referrals (with patients consent).*

The value of the service in relation to cases that were concerning, but not clearly ‘high risk’, was highlighted:

*The AE has been so useful in filling a gap for us. When a case is very high risk and obviously requires a MARAC referral or there is a child safeguarding concern, it’s straightforward (not necessarily easy but at least it’s clear what we have to do), but where there’s an adult who is not obviously high risk or particularly vulnerable but who we’re really concerned about, it’s brilliant to be able to refer to ADViSE. You know they’ll get a quick response and you know that someone else will do an assessment and go into more detail. That’s very reassuring. It’s also helpful because they can access information we can’t, for example if someone’s been referred to MARAC they can find out what’s happened and share information.*

*It’s particularly good for people who don’t score high on the risk assessment but who still want some support e.g. with future safety planning or just coming to terms with what’s happened to them.*

Staff spoke of the feedback they routinely received on referrals they had made and how much they appreciated this:

*Knowing what’s happened to someone and feeling like you’ve made a difference as a professional really buoys you up. Normally referrals just disappear into a void and you never know if they’ve been useful. [AE] is a great communicator and the feedback loop really works.*

Some practitioners also reported on the direct feedback they had had from patients:

*I’ve lost count of the number of patients I’ve referred. Generally, people are more than willing to use the AE and I get good feedback. People don’t feel judged and it is very welcoming.*

*Patients definitely get a better service. One lady who was separated but still owned a business with her ex told me how she’d been seen straight away: had a risk assessment, had an appointment with a solicitor, debt support and information from Surviving Economic Abuse. The feedback was fantastic and means next time we see her it improves the service we give too.*

*One referral was a [very vulnerable] young woman who’d experienced both SV and DV. There’d been multiple referrals to social care but she’d not been allocated a social worker nor provided with safe housing. [The AE] did a lot of work with her and coordinated everyone’s input so that a social worker was allocated and she has been offered supported housing.*

*It was particularly good in one case where the support was very timely – it came just at the right point for the patient. It’s very helpful for [AE] to be in the clinic sometimes for example when I had a patient I was able to get her to talk to there and then which was great.*

## Views on the future of ADViSE

The major concern of interviewees was that ADViSE should continue beyond the pilot period. In a very short space of time it had clearly become an integral and highly valued aspect of sexual health services in Greater Manchester. Typical comments from staff included:

*If ADVISE did disappear it would leave a big hole.*

*I’d be devastated to lose it.*

There was concern that routine enquiry would be more difficult to carry out without access to ADViSE. Interviewees felt that it was the provision of direct support and high quality referral that made asking the question about violence and abuse appropriate and meaningful:

*Now that routine enquiry is embedded, we are not going to stop asking the question, but without somewhere to provide follow up support there’s a risk that people will just be left more vulnerable.*

There were very few suggestions of improvements to the service. The appropriate tailoring of the training to recognise existing knowledge and avoid too much duplication of the content of mandatory safeguarding training was raised – and it was recognised by some staff that this was in hand. The need for refresher training and for courses to be run regularly so that staff joining the service could participate at an early date was highlighted. In addition there were some requests for training to cover some issues in more depth such as the DASH assessment and what constitutes ‘high risk’.

A few interviewees thought there needed to be more recognition of the additional clinical time routine enquiry sometimes required:

*It needs to be recognised that asking the question and getting more disclosures does increase our work. I’m really committed to asking and think we should but we have 20 minute appointments for patients and if we get a disclosure and need to follow it through, the next patient can be waiting 45 minutes.*

*It does take more time for us – because if you ask and people disclose you do have to take the time to listen – and that’s a good thing but needs to be factored in.*

Otherwise, the only improvements were actually suggestions for expanding provision. Two people particularly highlighted their wish for an equivalent service for young people:

*I work with a lot of 16/17 year olds and I’d love the service to be available to them.*

*I only wish they also dealt with under 18s – we get a lot of college students and a similar service for them would be very beneficial.*

In fact, ADViSE does accept referrals from 16/17 year olds so this suggests there is a need for this to be communicated more strongly.

## Summary of key success factors in engaging sexual health practitioners

Ultimately, ADViSE can only work if sexual health practitioners support it and are prepared to engage with it. The learning from this pilot so far is that the following factors are helpful in securing this engagement:

**Quality and relevance of training.** There is some variation in how practitioners have perceived the training, from those who thought it was brilliant through to those who found it a waste of time. Fortunately, most seem to have found it useful and were appreciative of the efforts made to make it relevant to them. They particularly valued the information they could directly use to access the support of AEs. The training has also been useful for some in building their confidence in asking about DSVA. The way in which the training is delivered does affect people’s experience but there are pross and cons to both. On-line is quicker and more efficient, face to face is better for more in-depth exploration of issues and sharing of practice. For the future it is important to take into account the previous training people have received in order not to alienate staff who would normally be allies.

**Clarity of expectations and the prompt to ask.** We did not encounter any resistance from interviewees about asking the question, but many admitted that it was not something they had routinely asked about previously: mostly they said they would previously have asked if there were indications that DSVA was an issue. They welcomed the clarity of expectation that it should be asked of everyone and liked the fact that the system contained a specific prompt, even if the location of this prompt is not ideal. In the absence of the prompt being sensibly located it may be wise to provide staff with more direction on the most appropriate placing of the question in the assessment.

**A clear and simple referral route** to the AE is particularly valued and has probably been the single most important factor in reassuring practitioners that it is OK to ask. Knowing there is a source of support is what has given many practitioners the confidence to ask.

**Building relationships between AEs and clinic staff** has also been very helpful. For many practitioners having a named person whom they have got to know is not only beneficial for their confidence but also means they can reassure patients when they make a referral. The informal interactions between clinicians and AEs have become important spaces to discuss issues and clarify whether a referral is appropriate or not. AEs spending time in the clinics seems to have clear benefits.

**The role of CLs** has been particularly valuable in brokering the relationship between practitioners and AEs. They are seen as trusted ‘insiders’ – people who know what it’s like to work in a sexual health clinic and who understand the pressures and issues faced. They are appreciated by colleagues for their support and expertise around DSVA and by AEs for acting as a crucial bridge between them and clinic staff.

**Timeliness and flexibility of response and feedback** are all appreciated. Practitioners value the swiftness of response to a referral and the AE’s willingness to be flexible in the support they offer.

**The benefits to patients.** Ultimately, most clinicians will continue to engage with a service if they can see benefits to patients. As the ADViSE pilot has got established there are increasing numbers of examples of patients deriving benefits and this is being fed back to practitioners. Not all practitioners see patients more than once, but some do, and as this ‘feedback loop’ is developed and clinicians hear about the support patients have received, so the engagement with ADViSE will grow. Already this is happening, with practitioners especially appreciative of the support available to patients who would not normally reach the threshold for DVA/safeguarding services, those experiencing the effects of abuse which occurred earlier in their lives, and those from groups whose needs frequently go unidentified.

# Acceptability of the service and outcomes for different end users

The above feedback from front-line practitioners provides evidence that for most patients accessing sexual health services, being asked about experience of DSVA is acceptable. Interviewees’ Clinical experience suggests that most do not mind being asked and some positively welcome it. This is supported by the gradual increase in patients being willing to be referred to an AE and taking up the offer of support.

Gathering direct feedback from patients was beyond the remit of this evaluation, but there is some qualitative evidence of how victims/survivors have experienced the service and the range of outcomes that have been achieved from case studies recorded by AEs.

The following case examplars have been fictionalized to avoid any possibility of identifying actual clients. However, the details are all drawn from real case studies produced by AEs, or discussed with AEs in the course of meetings and interviews for the evaluation.

**Example 1**

Marina is a White British woman in her mid-40s. She is divorced with two adult children. Her experience is of historic sexual and domestic abuse. She was sexually abused as a child and has been further abused by a number of men in the course of her adult life. She had rarely spoken of her abusive experiences and never previously received any formal support. She was pleased to be asked the question in clinic as she would like to have another partner but is afraid she ‘attracts the wrong sort of men’. With the support of an AE Marina is making sense of her past experiences, gaining an understanding of the patterns of power and control in unhealthy relationships and becoming more confident and assertive in her everyday life.

**Example 2**

Karen is a White single parent in her 20s. She has two young children and is suffering post-relationship harassment and abuse from their father. She is also concerned for the safety of her daughter during access visits with her father but has felt too scared to seek advice ‘in case the children get taken into care’. When asked about abuse, she broke down and was referred directly to the AE who was in the clinic at the time. The outcome so far is a non-molestation order protecting her and her daughter, sessions with a children’s domestic abuse worker for the little girl and Karen has started the Freedom Programme which she is very much enjoying.

**Example 3**

Carlene is in her early 30s. She was sexually exploited as a teenager by an older man with whom she remained involved for the next 10 years. He introduced her to sex work, which she would now like to leave behind, but having dropped out of education early she is afraid she has no chance of an alternative life. Carlene has never sought support because she didn’t think sex workers would be welcome in abuse services. With encouragement from an AE she has now applied for a college place, started some voluntary work and re-evaluated the relationship with her current boyfriend.

**Example 4**

Patrick is a gay man in his early 50s. He has a diagnosis of bi-polar disorder and ADHD. His lifestyle is chaotic. A year ago, he began a relationship which rapidly became abusive and he has been stalked and harassed ever since. He had been committed to managing the situation without help because he thought he had ‘brought it on himself’ but he was surprised and grateful to be asked about abuse at the clinic – and delighted to have a referral to an AE. When the harassment escalated the AE helped Patrick put some robust safety plans in place and a MARAC referral has subsequently been made.

**Example 5**

Keon is a young Black British man in his early 20s. In clinic he disclosed for the first time the sexual abuse that had occurred in his childhood. He was shocked to have done so and took some time to decide to accept a referral to an AE. Since then he has made excellent use of the support provided to explore his uncertainty about his sexual orientation and to deal with his drug use and depression. He still lives at home with his parents but family relationships have become problematic and he has now been registered as in priority need for housing.

**Example 6**

Chris is 30, non-binary and bi-sexual. They were referred via the trans clinic. Autism, chronic pain and illness make life very difficult for Chris and they were trapped in a shared tenancy with an abusive ex-partner. The AE has provided intensive and flexible support to help Chris settle into new, safe accommodation including liaising with their GP and practical support with benefits.

One of the key differences between the GM pilot and the usual IRIS service is that it offers support for both women and men. During a steering group discussion there was a question raised about whether men would be deterred from accepting the service if it was provided by an organisation strongly associated with supporting women (e.g. Women’s Aid). This is an issue to monitor, but overall interviewees did not think it had been a major barrier, though they were aware of it as a possibility and AEs tended to introduce themselves as being an ADViSE worker.

# Demand for and take-up of ADViSE

## Context for these figures

As part of the development of GM ADViSE, a modelling exercise was carried out to estimate the likely demand for the service across the four pilot areas.[[3]](#footnote-3) The figures which emerged from this modelling need to be viewed with caution for the following reasons:

* they were based on a number of assumptions about clinic footfall, the likely numbers of patients who would make a disclosure, and the number of those patients who would accept a referral. As the programme was new and in a new setting, several of these assumptions were based on only partial data.
* The modelling used to plan staffing requirements across the pilot was based on IRISi’s estimate of each FTE Advocate Educator receiving up to 125 referrals per year. This is a pre-pandemic figure, drawn from established IRIS sites (running for two or more years), with a good number of referrals. It needs to be borne in mind that this may not be a fair comparator for GM ADViSE which is a new programme in new sites established in the aftermath of the pandemic.
* Almost all new programmes experience a slow start before they pick up to a more normal level of operation. This was certainly true for ADViSE but this ‘time-lag’ effect was not included in the original modelling.

There are clearly some lessons here for future modelling both for GM ADViSE going forward and for other IRIS initiatives in new areas.

## Number of referrals to the pilot

The table below shows the estimated number of likely referrals for DVA and SV in each area compared to the actual number of referrals received by December 2022.

|  |  |  |  |
| --- | --- | --- | --- |
| **Area** | **DVA Estimate** | **SV estimate +** | **Actual number over pilot** |
| **Manchester** | 442 | 508 | 107 |
| **Tameside** | 80 | 92 | 40 |
| **Trafford** | 47 | 54 | 37 |
| **Stockport** | 87 | 101 | 33 |
| **Totals** | 656 | 755 | **217** |

As noted above, ADViSE had a slower start in the first quarter of the pilot period, as would be expected given that the programme was new and the focus in quarter 1 was on getting clinic staff through the training. As ADViSE has become more embedded referrals have steadily increased:

Quarter 1 (Jan-Mar 2022) 10

Quarter 2 (Apr-Jun 2020) 46

Quarter 3 (Jul- Sept 2022) 89

Quarter 4 (Oct – Dec 2022) 72

**Total 217**

The above pattern of referrals suggests that there is likely to be a continued gradual increase before the end of the pilot in March 2023. However, the actuals are still likely to be substantially lower than the original estimates. The referral data so far also suggest that the future estimates of where referrals are likely to come from may need to be adjusted. Although Manchester has received the largest number of referrals, the proportion of Manchester referrals is not as high as predicted, whilst the proportion of Trafford referrals is higher than anticipated.

## Primary reason for referral

Of the 198 referrals received at the time of the steering group in December 2022, 128 (64.3%) were primarily for domestic violence and abuse, 32 (16%) for sexual violence and 37 (18.5%) for both DVA and SV.

As expected, DVA was the primary reason for referral in most cases but sexual violence was either the primary or a significant feature of patient’s experience in over a third of cases.

## Demographics

**Ethnicity**

The table below shows that 109 of the 217 referrals (50.2%) were for White British, Irish or White other. 20 (9.2%) were of Asian background (Pakistani, Bangladeshi, Indian or Other Asian) and 18 (8.3%) were of Black African, Caribbean or other Black background. 21 people (9.6%) were of mixed/multiple ethnic background (White & Asian, White & Black African or Caribbean, other multiple ethnic background). For 46 of the referrals (21.2%) ethnicity is unknown.

|  |  |  |
| --- | --- | --- |
| White British | 100 | 50.2% |
| Irish | 2 |
| White other | 7 |
| Pakistani | 13 | 9.2% |
| Bangladeshi | 1 |
| Indian | 1 |
| Other Asian | 5 |
| Chinese | 1 |  |
| Arab | 1 |  |
| Caribbean | 5 | 8.3% |
| African | 12 |
| Other Black/African/Caribbean | 1 |
| White & Asian | 4 | 9.6% |
| White & Black African | 2 |
| White & Black Caribbean  | 9 |
| Other mixed/multiple ethnic background | 6 |
| Any other ethnic group | 1 |  |
| Declined/prefer not to say | 3 | 21.2% |
| Not asked/don’t know/not recorded | 43 |

These figures show that 28.6% (over 1 in 4) referrals were of people from minoritised ethnic groups.

**Gender**

The following table shows the self-identified gender of people referred (in 4 cases the male or female gender assigned at birth differed from current self-identified gender). 71% of the 217 referrals were for females and 16.1% males.

|  |  |  |
| --- | --- | --- |
| Female  | 154 | 71% |
| Male  | 35 | 16.1% |
| Non-binary | 7 | 3.6% |
| Trans | 1 |
| Prefer not to say | 12 | 9.2% |
| Not recorded  | 8 |

**Sexuality**

Just over half of those referred described themselves as heterosexual. 22.6% described themselves as either gay, bisexual or pansexual, which supports the argument that ADViSE is reaching populations not commonly reached by other services.

|  |  |  |
| --- | --- | --- |
| Heterosexual | 111 | 51.1% |
| Bisexual | 21 | 9.6% |
| Gay | 23 | 10.5% |
| Pansexual | 5 | 2.3% |
| Other | 2 |  |
| Prefer not to say | 2 | 25.3% |
| Don’t know/not asked/nor recorded | 53 |

For a quarter of referrals sexuality is unknown, but in only two cases is this recorded as because the client preferred not to say. This suggests that there may be a recording issue which should be addressed for the future.

# What are the implications of this learning for the future of ADViSE in Greater Manchester?

The pilot experience makes clear that ADViSE works in reaching diverse populations and vulnerable groups who may not access other services. It confirms that sexual health services can play a key role in the recognition of previously undisclosed or unidentified domestic and sexual violence and abuse and offer an appropriate response. Routine enquiry can be embedded in sexual health assessments ADViSE has effectively supported this process through the provision of training and a simple and clear referral route to expert SDVA practitioners. ADViSE has improved interaction between sexual health services and DVA services through the role of the AEs acting as a bridge.

Being ‘asked the question’ in a sexual health setting is acceptable, and even welcomed, by the majority of service users and has enabled patients who may not otherwise disclose their experiences to do so and to access support. Referral data provides good evidence that ADViSE is reaching minoritised groups who frequently do not access other support services.

As illustrated by the case examples, ADViSE has been successful in reaching victims/survivors who may otherwise have not accessed support. These include those with multiple and complex needs including long histories of abuse across the life-course, poor mental health and disability and those impacted by intersectional inequalities.

Sexual health practitioners highly value the ADViSE service and are keen for it to continue. As one practitioner put it:

*I think I’d be lost without it now.*

**Appendix A.**

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1. Improving the healthcare response to domestic violence and abuse in sexual health clinics: feasibility

study of a training, support and referral intervention Alex Hardip Sohal, Neha Pathak, Sarah Blake, Vanessa Apea, Judith Berry, Jayne Bailey, Chris Griffiths, Gene Feder *Sex Transm Infect* 2018;94:83–87. doi:10.1136/sextrans-2016-052866 [↑](#footnote-ref-1)
2. IRIS ADViSE Commissioner Prospectus, IRISi, 2019 [↑](#footnote-ref-2)
3. Information about how this modelling was conducted was presented at the steering group meeting in December 2022 [↑](#footnote-ref-3)