PROVIDE Conference Report

Programme of Research on Violence in Diverse domestic Environments

19 November 2014 - Engineers House, Bristol

This much-awaited event was the culmination of a 5-year programme of research funded by the National Institute for Health Research (NIHR), under their Programme Grants for Applied Research scheme (RP-PG-0108-10084). The title of the day encapsulated the main context of the conference, "Domestic Violence and Health: What does it mean for you and your sector?" The organisers had taken a strategic approach to delegate invitation, which followed a stakeholder mapping exercise in order to increase reach so that delegates were representative across sectors engaged with domestic violence and included health care professionals (including GPs), DV advocacy services, commissioners (NHS and local authority), other third sector agencies, researchers and survivors of abuse. This mix ensured lively discussion and debate.

To start the day **Gene Feder** (PROVIDE chief investigator) warmly welcomed delegates, reminded us what the day was about and invited us to watch a short film of 'Jacqui's story'. For many years Jacqui was in a violent and abusive relationship which she eventually left. She tells her story, what it means to be involved in research and what the key message to the audience is from her perspective – which is for health professionals to **'Listen'.**

This account was followed by the first session of the day on **mental health** chaired by **Louise Howard** from King's College London, and kicked off with **Kylee Trevillion** (*pictured below*) reporting the "***experience and prevalence of domestic violence in people with mental disorders"***. Although the association between domestic violence and abuse (DVA) experience and mental health is well known, the magnitude of this association has not been sufficiently reviewed. From published studies, two systematic reviews and one synthesis of qualitative studies sought to address this. Kylee reported that 35% of people who are depressed and 33% with an anxiety disorder reported DVA in the past year. People who report DVA are seven times more likely to develop posttraumatic stress disorder and women who experience DV during pregnancy are three times more likely to develop postnatal depression.

So what comes first? As these findings were based on cross-sectional studies, which assess the abuse experience and the health outcome, causality cannot be established. So it may be that people with mental health problems are more vulnerable to encounter DV, but likewise their DV experience has an impact on their mental health. In short, the relation is likely to be bi-directional. Interestingly and rather worryingly, women who experience DV are not likely to seek mental health care. Even if they get mental health care, it is often inadequate as Kylee's work on healthcare experiences and

expectations of mental health service users showed. For example, service users often fear disclosure and the stigma of mental health in that people with mental health issues fear that their DV experience is going to be attributed to their mental health condition (e.g. she is just making it up because she is crazy).

Patients often fall in the gap, as there is a lack of service delivery and there is an overwhelming dominance of managing symptoms while having little (or perhaps no) time to address the problem. Kylee's key messages were that providers need to be better prepared to respond appropriately; a supportive environment is paramount to disclosure; information could facilitate decision-making and abuse-informed care. So in a nutshell, DVA education and training are pivotal to improve knowledge and competence to tackle DV in the mental health services.

How about the relation between having a psychiatric illness and being violent? This was addressed in the next session "**Mental illness and perpetration of domestic violence**" by **Siân Oram**, also from King's College London. It is known that psychiatric disorder is associated with an increased risk of violence towards others, which is partly explained by co-occurring substance abuse. Yet, the relationship with intimate partner violence (IPV) is much less studied as it has different risk factors. Examining 17 published studies (with over 72,585 participants) the odds ratio (OR) ranged from 1.8.-3.2 for association between lifetime physical IPV perpetration and diagnosed depressive, anxiety and post-traumatic stress disorders (men and women). However, much less is reported on this association for bipolar disorder or schizophrenia.

In an associated analysis, DV and psychiatric disorders in the military population was examined as there is little published data. PTSD was associated with past year violence – physical violence. Yet there are important gaps: few studies examined psychiatric disorder and past year DV. There is also a need to assess the perpetration of DV in people with severe mental illness. Last but not least, the measurement of DV is problematic. There is a general need for current risk of abuse (past year) as much of the published research looks at lifetime abuse.

Why is this research so important? When looking at the homicide data 1 in 10 (10%) are committed by people who were mentally ill at the time of offence (National Confidential Inquiry into Suicides & Homicide by People with Mental Illnesses 2014 based on data from 1997-2008). Of these, 20% had mental illness at the time of homicide and 30% of those with mental illness at the time of homicide had been in contact with mental health services in the past year.

Key messages from Sian are that further research is needed to investigate whether psychiatric disorders are associated with current risk of violence towards partners; men and women with psychiatric disorders have increased risk of having ever been physically violent towards a partner, with a greater increase in risk among men; and (for both men and women with mental disorder), the

increase in risk of having ever been violent towards a partner is lower than the risk of having ever been a victim of IPV.

Sue Jones (*pictured left*), from the Centre for Gender Violence Research in Bristol, and now a researcher at CAADA, looked at DVA and mental health in male patients attending an appointment with their general practitioner (GP): "**Key mental health messages from GP medical records**". Sue and colleagues successfully recruited 1368 unaccompanied male patients in general practices to fill out a survey. This asked about experiences of victimization (4 questions e.g. "are you afraid of your partner?" and "do you need permission to shop or visit friends?") and perpetration of domestic abuse, depression and anxiety. 517 men gave consent for accessing their medical records and 31 men were interviewed. The mean age was 53, 98% were heterosexual and 95% white British. One third had experienced symptoms of mild depression and mild anxiety. There was an overlap between perpetration and victimization: half victims had also perpetrated domestic abuse and vice versa. One in six men told their GPs about mental health problems and have also been in recent abusive relationships. Both perpetrators and victims want help – but when looking at the medical records, the reports were patchy, hardly ever mentioning domestic abuse in the relationship and referral rates to specialist services were rare.

This highlights the need to identify these men since GPs are in a good position to offer advice or signpost to an appropriate service.

In a similar vein, with a theoretical framework based upon Johnson's coercively controlling behaviours (Johnson 2008), PhD student **Cassandra Jones** examined the experiences and consequences of "**men who identify as victims of DVA**". Cassandra used an online survey and additional telephone interviews with seven men aged 36-59, all of whom had female partners. In her analysis she looked at how many forms of violence or abuse these men experienced (physical or sexual violence and controlling behaviour). Coercive controlling behaviour would be for example questions relating to isolation from friends and families and receiving threatening messages. She also looked at experiences and use of violence. The men had a range of experiences – for example, while one experienced more forms than he used against his partner, for another man the opposite was true. So it seems very likely that he was a perpetrator rather than the victim of violence. Men experiencing DVA often report depression and anxiety – they were afraid of their partners and it also had a negative impact on their work and their relationship with their child/children. In terms of help-seeking, men primarily wanted information. They often used formal sources such visiting the GP, contacting a helpline (Mankind or Respect) or the police.

A Panel discussion chaired by **Thangam Debbonaire** from RESPECT followed this morning session on DVA and mental health. It started with a reflection that, similar to men, some women may not want the help currently available and that, like men, some women may just want information of how to move on with their lives. The discussion elicited a lot of questions, for instance whether there was any research on carers of patients with dementia.

1. Q: is any research being conducted on carers of patients with dementia?

A: a review on DV & dementia is ongoing; Lucy Knight, (Somerset Partnership NHS Trust) has looked at this using case notes to disentangle trajectories (e.g. abuse before dementia vs. dementia trigger for violence) – see http://www.rcpsych.ac.uk/pdf/Knight%20Lucy.pdf.

2. Q: Please explain some of the methodological issues you alluded to.
   A: Sian commented that studies often used different questions – some used a single item only to assess violence (e.g. "Have you ever been hit or slapped by your partner?"), little is known about when the abuse took place (lifetime, last year) and the context – whether or not the violence resulted in injuries.
3. Q: Do you think that the sample of men in the GP study was inherently skewed?
   A: The sample is pretty representative of the general practice population.
4. Q: Are mental health problems the cause of DV?
   A: Further longitudinal studies are needed and there is a lack of recorded information. We need to do more to disentangle, although it seems that victims are more likely to develop symptoms of mental illness. However it is dangerous to stigmatize people with mental illnesses as inherently more violent.
5. Q: There should be more responsibility for abusive behaviour, but in seeking help, is there a danger that men might hide behind their mental health problems?
   A: Context is important and should always be considered.

A recent review by Hind Khalifeh from UCL reports that people with severe mental illnesses who have an increased risk to experience violence, but women with severe mental illness have a much higher prevalence than their male counterparts relative to the general population.

Associated publications and further reading

Systematic review and meta-analysis of psychiatric disorder and the perpetration of partner violence.
http://journals.cambridge.org/download.php?file=%2F781_111E5DD0742C1E9AED24E1AAEA4270EA_journals__EPS_S2045796013000450a.pdf&cover=Y&code=2aea16bc4be15ba5f111c69b82140018

Domestic violence and perinatal mental health: systematic review and meta-analysis.
http://www.plosmedicine.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pmed.1001452&representation=PDF

Prevalence and risk of experiences of intimate partner violence among people with eating disorders: a systematic review. http://www.sciencedirect.com/science/article/pii/S0022395613001404

Prevalence of domestic violence among psychiatric patients: systematic review
http://bjp.rcpsych.org/content/202/2/94.long

Experiences of domestic violence and mental disorders: a systematic review and meta-analysis.
http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0051740
Linking abuse and recovery through advocacy: an observational study.
http://www.ncbi.nlm.nih.gov/pubmed/23628450
http://journals.cambridge.org/download.php?file=%2F807_111E5DD0742C1E9AED24E1AAEA4270EA_journals__EPS_S2045796013000206a.pdf&cover=Y&code=6ea5641f78ed044f8a9e7b504bdd5319

Disclosure of domestic violence in mental health settings: A qualitative meta-synthesis
http://www.ncbi.nlm.nih.gov/pubmed/25137109

Domestic and sexual violence against patients with severe mental illness
http://journals.cambridge.org/download.php?file=%2FPSM%2FS0033291714001962a.pdf&code=f766dba50a37dc656798fcc5c0bfb3b2

Annual Report of the Chief Medical Officer 2013 Public Mental Health Priorities: Investing in the Evidence - Chapter 14: Violence and mental health
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351629/Annual_report_2013_1.pdf

Johnson M 2008, A typology of domestic violence: intimate terrorism, violent resistance and situational couple violence, Northeastern University Press, Lebanon

The next session chaired by **Thangam Debonnaire** (*pictured below with Ana Maria Buller and Marianne Hester*), looked at the two surveys from the PROVIDE study that focused on men. The first, presented by **Marianne Hester** from the Centre for Gender Violence Research at the University of Bristol looked at **experience, perpetration and impact of DVA for men accessing General Practice health clinics.** Marianne's earlier work showed that men report perpetration to family doctors and accept being asked about domestic violence. So in this first large scale UK study of men and DVA prevalence in general practice, which is also the largest study of its kind internationally, a 'Health and Relationship' questionnaire was completed by 1368 men who attended 16 general practices within the south-west of England.

The survey asked men about **potential DVA experience** over their lifetime and past 12 months and whether they perpetrated or were victims of potentially abusive behaviours. It also asked about the frequency and escalation of this 'negative behaviour', and the perceived impact. Health state was measured using the HADS score (Hospital Anxiety & Depression Scale) for anxiety & depression. Information on the use of alcohol and illicit drugs was also collected.

Results from the survey showed that the majority of men questioned (91%) reported **never** being in a DVA relationship. However, of the 9% that said they had been in a DVA relationship, 35% of men identified as victims and 31% identified as perpetrators. Men reporting their experience as DVA were positively associated with: frequency, duration and multiple forms of negative behaviour. Men who perpetrated more than one negative behaviour were more likely to say they had been in a DVA relationship. These findings add to our understanding of the complex association between male victims and perpetrators.

The key messages from Marianne's work is that GPs can help to identify and prevent DVA; there are strong association between negative behaviours/ DVA and men's mental health state – whether

victim or perpetrator – but importantly, GPs can identify men for appropriate referrals but do not need to differentiate between victim or perpetrator.

In a similar survey, but this time in men that attend a sexual health clinic, **AnaMaria Buller** from the London School of Hygiene and Tropical Medicine shared her findings from the survey subset of gay and bisexual men (men who have sex with men – MSM) attending a clinic aimed at this population. It is known that the prevalence of domestic violence in MSM is as high as it is for heterosexual women – between 30% and 78%) and much higher than for heterosexual men. MSM DVA is associated with substance misuse, depression and anxiety symptoms, unprotected anal sex and HIV.

AnaMaria presented findings from the "Relationships & Health" Survey which included information on demographic characteristics including self-reported sexual orientation, diagnoses of sexually transmitted infections in the last 12 months; current anxiety and depression were measured by the Hospital and Anxiety Scale (HADS); alcohol and illicit drug use were assessed using AUDIT 13 and the survey asked men whether they had experienced, and/or carried out, one or more of four negative behaviours that might be consistent with DVA. Of 1,132 responses, 53% of the men were heterosexual, 42% gay and 5% bisexual. Of these gay and bisexual men, 46% **(**75/163) had experienced negative behaviour associated with DVA more than once between 6 months and over a year.

The impact on these men of perceived negative behaviour from a partner showed that 85% reported that the behaviour made them feel anxious or depressed. This also affected their work or studies and increased the use of alcohol or other drugs.

Of the sample of 532 gay and bisexual men, 45% (238/532) consented to having their medical records reviewed and of these, 89% (211/238) were retrieved and extracted. Interestingly there was no documentation of DVA recorded in any of the medical records despite the impact of exposure reported in the survey data.

Associated publications and further reading

Associations between Intimate Partner Violence and Health among Men Who Have Sex with Men: A Systematic Review and Meta-Analysis.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3942318/pdf/pmed.1001609.pdf

A generous lunch was provided for all and lively discussions continued during the networking space. There were also three well attended optional satellite discussions where experts in the field facilitated discussions on 1. Collaborative partnerships in DV research (Carol Metters from Next Link and Missing Link); 2. Knowledge Mobilisation, engagement and impact (Jude Carey, Bristol CCG and University of Bristol) and 3. Ethical considerations in DVA research (Emma Williamson from the Centre for Gender Violence Research, University of Bristol).

Following lunch, there was a change in tempo and time for something a little different. The PROVIDE Team and associated colleagues are conducting a wealth of research related to DVA and we were privileged to hear several three minute snapshots delivered in 'Pecha Kucha' style. This rapid-fire method of delivering a memorable message included work from Louise Howard on LARA – linking abuse and recovery through advocacy; Eszter Szilassy played part of a training module for how GPs can talk to children about DV in the family, from the RESPONDS study; Emma Howarth used a series of colourful slides demonstrating the 'pick and mix' solutions and interventions aimed at parents and children and young people who have been exposed to DVA. Continuing the theme, Christine Barter presented STIR -Safeguarding Teenage Intimate Relationships, which is a research project funded by the Daphne III Programme of the European Commission's Directorate General Justice. This project explores, for the first time, young people's experiences of online and face-to-face forms of IPVA in Europe (Bulgaria, Cyprus, England, Italy and Norway). We then moved rapidly on to the juggling act (ably demonstrated by Emma Williamson) that is the new study led by Maggie Evans called Experience of Survivors, which is part of the HealthTalk Online project, but aimed at women being interviewed about their experience of DVA in order to help other women as an online resource. Marianne Hester then went on to do a similar juggling act, this time using colourful balloons to demonstrate the many and varied perpetrator interventions in her IMPACT - European evaluation of perpetrator programmes research. The final three minutes were filled with Alison Gregory's PhD research showing the impact of DVA on friends and family. There was no time for questions in this format, but delegates were signposted to posters that were displayed, or were invited to speak with the presenter during the breaks.

Associated publications and further reading

LARA - (http://journals.cambridge.org/download.php?file=%2F2871_AB633ACA289F65564E6BAB855028FAC3_journals__EPS_EPS23_01_S2045796013000206a.pdf&cover=Y&code=a9a903d12b14bf8f3e3ad43a422129d3)

STIR: www.stiritup.eu

Before lunch we heard about the PROVIDE surveys in men in general practice and sexual health clinics. The next session looks at the initial findings from an intervention that was built on the successful IRIS trial of a DVA training and support intervention for GPs and nurses in how to recognise and refer appropriately when a woman discloses DVA. **Marianne Hester** chaired this session on **HE**alth professionals **R**esponding to **ME**n for **S**afety - or **HERMES -** like IRIS a messenger from the Gods!

Emma Williamson (*pictured*) started the session reporting on **feasibility of a general practice training intervention to improve the response to male patients who have experienced or perpetrated domestic violence and abuse (DVA).** The HERMES intervention looked at pre- and post-training knowledge of general practitioners using the provide intervention measure. Overall the HERMES training increased clinicians' confidence in responding appropriately to male patients affected by DVA.

A similar HERMES intervention was conducted in a sexual health setting, with **Ana Maria Buller (***pictured right)* once again presenting, this time **multi-method evaluation of a pilot domestic violence and abuse (DVA) training and support intervention in a sexual health clinic for lesbian, gay, bisexual and transgender people.** The intervention was a 3 hour training session and a follow up session delivered by the research and clinical team to increase training and awareness of MSM DVA and for developing relevant training in questioning skills.

Both HERMES studies produced a flowchart to help clinic staff identify and refer appropriately for men who may be either victims or perpetrators of DVA. This material is available on the PROVIDE web page. Further work is planned to develop and further test the HERMES intervention.

Associated publications and further reading

Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial http://ac.els-cdn.com/S0140673611611793/1-s2.0-S0140673611611793-main.pdf?_tid=15d43718-748f-11e4-bb12-00000aab0f02&acdnat=1416912042_0348eeaa9e9693250efdea9dff9e8faa

http://www.irisdomesticviolence.org.uk/iris/

http://www.bristol.ac.uk/social-community-medicine/projects/provide/evidence-into-practice/papers-and-briefing-notes/

Gene Feder chaired the session that reported the **PATH trial** (Psychological Advocacy towards healing), but first, we hear '**Nicola's Story'** which is a moving account of a survivor who experienced years of psychological abuse from her male partner and the consequences to her health and daily living. This set the scene for **Roxane Agnew-Davies** of DBL Training Ltd, who recognised the need for women to receive additional psychological support as well as the very practical advocacy support given when women present at a domestic violence agency, often as a last resort. Roxane eloquently gave an account of her early work of trying different psychological therapies in this group of damaged women, one therapy being to tense and relax muscle and giving the instruction "tense your stomach like you are preparing to take a blow". Realising the impact of this statement, it was at this stage that she recognised something more specific for this population should be developed. She aimed to address the gap between DV advocacy workers and mental health workers. **The PATH intervention** was the result of this development work and PATH is aimed at helping the women to 'reclaim themselves'.

After a successful pilot stage, the intervention went into a randomised controlled trial as part of the PROVIDE Programme of research and the programme's statistician and economist **Giulia Ferrari** presented the preliminary findings of the trial: women in the intervention group, compared with women in the advocacy as usual control group, showed a greater decrease in their mental health symptoms at 12 months follow up.

After a break, we resumed the discussion on further findings from the PATH trial, but this time what it means from a practical perspective. To offer that perspective, the session was chaired by **Amy Campbell** (*pictured left with Gene Feder*) from Bristol City Council.

From the 260 women recruited to PATH, 31 agreed to be interviewed about their experience. **Maggie Evans** conducted a nested qualitative study and presented '**the inside Story – women's experiences of the PATH intervention, benefits and difficulties'.**

Key messages that came out of Maggie's research is that PATH filled a gap in the availability of psychological / emotional support, highlighted as a significant lack in service delivery amongst usual care group. The model of delivery by DVA specialist advocates, with a specific focus on DVA, in tandem with practical support was well received and gave enduring benefit over a year. However, it is important that the service delivery needs to target women who are assessed as emotionally 'ready', and ensure good continuity with specialist worker including support for emotional fall-out from sessions.

Although early findings from the PATH trial are encouraging, there is further analysis to be done including the **cost effectiveness of the intervention** if it is to become a commissioned service. **Sandra Hollinghurst,** who is the health economist on PROVIDE, gave an overview of the importance of cost effectiveness and broke down some of the costs in the training and delivery of PATH. Early indications are that the cost of the full intervention (ie 8 one hour sessions with 2 follow ups), is

roughly equivalent to a course of CBT for depressed patients in general practice. However, further evidence from the PATH trial will follow as soon as we have completed a full analysis of the findings.

With any health intervention research, researchers should engage with practitioners and commissioners in order to consider what is required along the way for the intervention to be commissioned as a service. In PATH and PROVIDE, we have worked closely with our practitioner and commissioner partners. **Morgan Fackrell** (*pictured below*), Chief Executive of Cardiff Women's Aid, gave an overview of the '**View of the Provider'.**

Morgan refreshingly didn't use a presentation, but gave a passionate overview of her early work and current view that something else was required in addition to the evidence based tool kits and criminal justice system, in order to help women to move forward to start the healing process. As potential research partners and collaborators, Morgan enthusiastically and in a timely manner enquired about being involved in an earlier study, but then jumped at the chance of being a collaborator on the PATH trial. For a service, this meant having to put processes in place to make it work and to adapt their 'usual' advocacy model in order to fit the required PATH sessions. She also emphasised the need for good communication at all levels and for everyone to play their part. Morgan and her colleagues feel that PATH fills a gap for women and will be discussing how to introduce the intervention into the service in the future.

Due to the excellent time keeping of organisers and presenters, we were able to give sufficient time to the panel discussion that as well as the speakers from the PATH sessions, included Jacqui and Nicola, the expert advisors. Q&A or points raised are summarised below; please get in touch with the **PROVIDE Team** if you require any further clarification on any issues.

- Many women who attend advocacy services are still in the violent or abusive relationship and often therefore cannot seek support to leave. There are multiple reasons why this may be the case, but it should be considered in the support services.
- Please continue to be aware of the support that male victims need and the importance of help lines for men.
- Vulnerable women are often the target of violence and abuse, so strategies or interventions around this are required.
- DV services on the whole are data-poor so emphasised the need for quality data in the services in order to keep them open.
- Should commissioners of DV services be considering an advocacy service, or a mental health support service and how do we balance or make a choice? It is hoped that the PATH study may be able to advise on this question in due course.
- The expert advisors were thanked and asked about their experience of being involved in research. Both felt that it was important to be involved in order to 'give back' and that if even one woman could be helped, then it was worthwhile.
- Health research often refers to 'avoiding tokenism' when involving patients or the public in research; how did the team avoid this? In this case both women were not made to feel like

a token, but felt that their input was taken seriously. They also acknowledged that research and evidence needs to be of sufficient quality in order for it to be funded.

- Expert advisors are able to give practical help and advice in areas that the researchers would not necessarily consider.
- How can a 3rd sector agency make everyone in the organisation feel involved in research? Communication, enthusiasm, good leadership and readiness to adapt is key, whilst also acknowledging that it is not plain sailing and there needs to be commitment even when things go wrong. Building good relationships with the research team is also vital.
- How did the PATH team manage the risk of the intervention sessions becoming too overwhelming for the women? The training of the advocates included learning about the stages of change and importance of 'outside safety' and 'inside safety'. The model included techniques to support this and advocates were trained to take one thing at a time.
- Are there benefits of specific parts of the PATH model? This isn't known yet, but will be considered in the further analysis. However, the qualitative study suggested that the model had positive effects on the women even though they did not complete the course.

Associated publications and further reading:

Psychological advocacy toward healing (PATH): study protocol for a randomized controlled trial http://www.trialsjournal.com/content/14/1/221

Domestic violence and mental health: a cross-sectional survey of women seeking help from domestic violence support services http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4199331/

The final presentation of the day was chaired by **Emma Williamson** and presented by **Karen Morgan** *(left),* both from the Centre for Gender Violence Research at University of Bristol, who synthesised the interview transcripts from across PROVIDE and related studies in relation to help-seeking: **'Help-seeing: a synthesis across the PROVIDE Programme'.** Karen analysed commonalities and differences amongst male and female victims (in some cases perpetrators) of DVA. Specific questions for the synthesis were 1. How do gender and sexuality affect the way help-seeking in the context of domestic violence and abuse (DVA) is viewed? 2. Do these views differ in relation to formal or informal sources of support? Studies across PROVIDE offer a unique opportunity to examine formal and informal help-seeking strategies for all patients affected by DVA, irrespective of gender.

The common message across all studies was that it was "hard to talk about the abuse". It often took a 'severe incident', such as an excessive physically violent attack, or worry about the children in the household, as a trigger for the person to help-seek. The need for confidentiality around issues involving information exchange was emphasised and the message that victims wanted to be asked, but were not willing to volunteer the information, although this latter did seem to differ somewhat between men and women. A key message from this session was that, when considering the provision of opportunities for those seeking help and intervention strategies in the context of DVA, both gender and sexuality should be taken into account.

After a long and interesting day, **Gene Feder** was left to summarise and reflect on the conference. He started off by highlighting that PROVIDE was the largest research programme of domestic violence and health in the UK and Europe (and possibly the world). He paid credit to the NIHR for taking the risk of funding the programme and reminded the audience that this was the work of three universities, five 3rd sector organisations a local authority and the NHS, all of whom work within their own cultures or on 'different planets'. Since funding was received, there has been the publication of the 2010 Task Force report on Violence against Women and Girls and the NICE DVA guidance appeared in 2014. Both of these publications show how DVA has become core business for the NHS and address legitimate issues for healthcare. This recognition of the role of health services in responding to gender violence is also clearly expressed in the Lancet series on Violence against women and girls (a link to this appears below).

Gene summarised on what we now know and the successes of PROVIDE:

- *Impact on mental health:* The association between DVA and mental health recurs throughout the programme of research and it is probable that these estimates are underreported. Although we are confident of the strength of these associations we need to better understand the causal pathways to inform how we support survivors.
- *PROVIDE surveys of male patients:* Before these surveys in general practice and sexual health clinics were conducted, very little was known about the prevalence of DVA and its health impact on men in clinical populations.
- *Men as victims and perpetrators*: Our research adds further evidence about the overlap between men as victims and perpetrators and the association with health status. These findings will inform how the NHS responds to male patients who report or disclose DVA.
- *The HERMES studies* show that training of clinicians around DVA and male patients is feasible, but we need to use the lessons learned from the pilot into further research. HERMES also importantly shows that knowledge and attitudes of staff can be changed with training, but it is likely that a referral pathway to advocacy will be needed.
- *The PATH trial* has shown a positive effect on the mental health of woman survivors. The next stage of analysis will determine the extent of this benefit and its implications for mainstreaming the intervention: should PATH move straight to commissioning?
- We are applying for a new programme grant to take forward the findings of PROVIDE and tackle the new questions it raises, particularly how to integrate the needs of children and men into the IRIS programme, could we implement an effective perpetrator programme in primary care and how can we address the needs of families of mental health patients who perpetrate DVA.

The organising team, presenters, chairs, helpers, delegates and hosts were thanked and post conference discussions took place in a social environment with a very welcome drink and even more delicious food. Thank you to our hosts for the conference at Engineers House, Clifton, Bristol and to The NIHR for funding this research.

Photographs from l-r: Gene Feder and Roxane Agnew-Davies, Rosie Davies and Viram Patel discussing PPI, Giulia Ferrari, Eszter Szillasy, LynnMarie Sardinah, Jude Carey and Jayne Bailey, Emma Howarth and Neha Pathak.

Associated publications and further reading:

Improving services for women and child victims of violence: the Department of Health Action Plan https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215919/dh_122094.pdf

http://www.thelancet.com/series/violence-against-women-and-girls

Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively http://www.nice.org.uk/guidance/ph50

http://www.nihr.ac.uk/

http://www.eefvenues.co.uk/conference-venues/bristol/

Report prepared by Dr Jayne Bailey and Nadia Khelaifat

The views expressed in this publication are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.