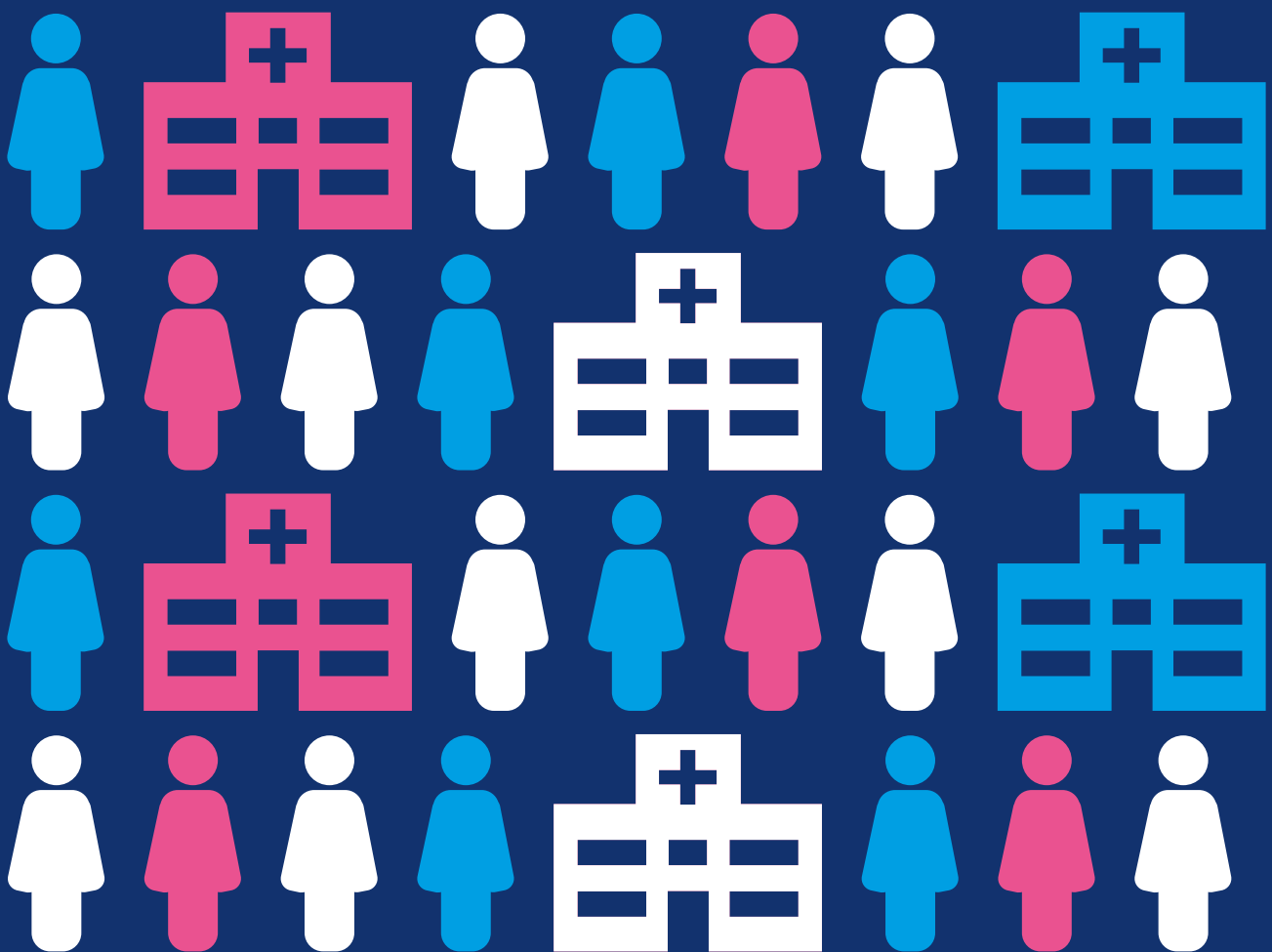

A Cry for Health

Why we must invest in domestic abuse services in hospitals



A Cry for Health

Why we must invest
in domestic abuse
services in hospitals

About SafeLives

SafeLives is a national charity dedicated to ending domestic abuse, for good.

We combine data, research and insight from services and survivors to find out what really works to make vulnerable people safe and well. Every year, over two million people experience domestic abuse; it is not acceptable or inevitable, and together we can make it stop.

Agencies must work together to provide people with wraparound and tailored support. Those at high risk of murder or serious injury should be given a dedicated Independent Domestic Abuse Advisor (Idva) who works on their behalf and is there at every step of the way.

We know that the safety of a victim and the safety and wellbeing of their children are inextricably linked; we need a 'whole-picture' approach to vulnerability.

People should not have to wait until they're in crisis before we pay attention.

We want long-term solutions, not short-term fixes. There needs to be a change in behaviour and culture, not just in structures and processes. The simple existence of a response to abuse is not enough.

Support for vulnerable people must be early, effective and consistent – wherever you live, whoever you are.

What we do

- Use our data, research and frontline expertise to help local services improve and to influence policy-makers, locally and nationally.
- Create a platform for victims, survivors and their families to be heard and to demand change.
- Offer support, knowledge and tools to frontline workers and commissioners.
- Provide accredited, quality assured training across the UK.
- Test innovative projects and approaches that make more families and individuals safe and happy.

How we work

- We focus on the practical: we believe in showing people what they can do, not telling them what they should do.
- We are independent.
- We are informed by evidence of what works; we gather evidence from data, frontline expertise and people with lived experience.
- We problem-solve.
- We learn from local provision and respect local circumstances, but show how national replication can be achieved.
- We work across organisational boundaries.

Acknowledgements

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Domestic abuse in numbers

The cost of domestic abuse to health services

£1.73bn



With mental health costs estimated at an additional

£176m



Each year an estimated

1.9 million people

in the UK suffer some form of domestic abuse



Each year more than

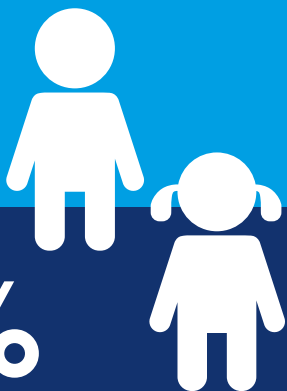
100,000

British adults are at high and imminent risk of being murdered or seriously injured as a result of domestic abuse

Over

130,000

children live in these homes



51%

of hospital victims have children in their households

According to research by Sylvia Walby, an estimated 1 in 8 of all suicides and suicide attempts by women in the UK are due to domestic abuse. This equates to just under

200 women

a year dying from suicide and nearly

10,000

attempting suicide each year because of domestic abuse

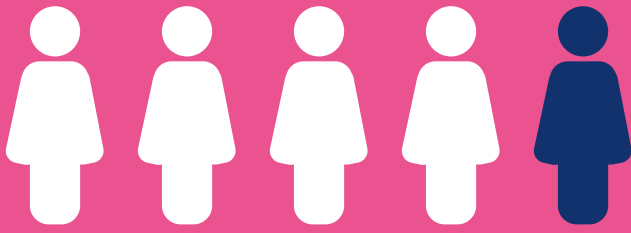


85%

of victims sought help five times on average from professionals in the year before they got effective help to stop the abuse



The British Crime Survey found that 4 in 5 victims of domestic abuse don't tell the police



The Crime Survey for England and Wales reports that

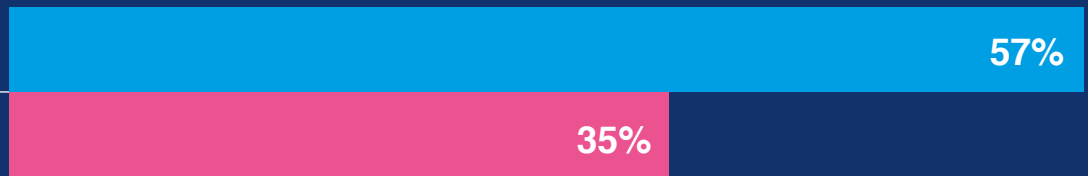
486,720 

victims experiencing partner abuse in the past year sought medical assistance

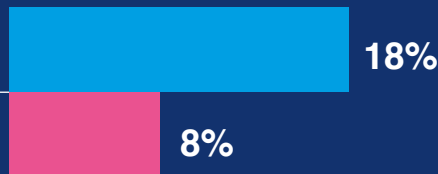
Idvas help victims disclose other difficulties



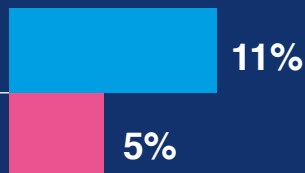
mental health difficulties



alcohol difficulties



drug difficulties



 hospital based Idvas
 community based Idvas

51,355 

NHS staff are likely to have experienced domestic abuse in the past 12 months

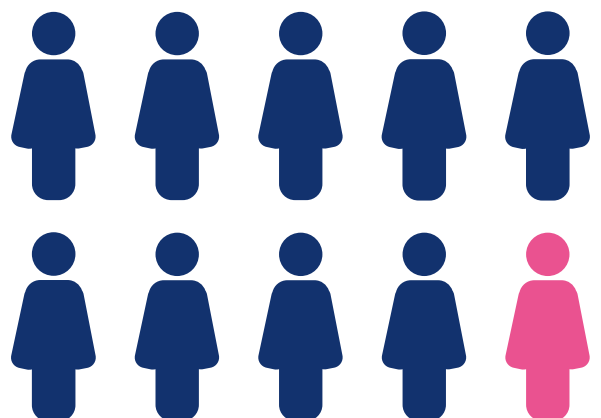
This breaks down as 44,825 women and 6,530 men

£15.7m 

the cost of securing a team of specialist Idvas for every NHS acute provider in England

9 out of 10

victims reported improvements in safety following an intervention by a hospital Idva



Executive summary

Domestic abuse has a devastating effect on the health and wellbeing of victims and families, and is a national public health epidemic.

The UK Government defines domestic violence and abuse as:

Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members, regardless of gender or sexuality. The abuse can encompass, but is not limited to, psychological, physical, sexual, financial and emotional.

Each year an estimated 1.9m people in the UK suffer some form of domestic abuse - 1.3 million women (8.2% of the population) and 600,000 men (4.0% of the population).¹ In the 12 months to March 2015, the police service in England and Wales received more than 900,000 calls about domestic abuse – an average of over 100 calls an hour. Domestic abuse victims and their children are among the most vulnerable in society; domestic abuse accounts for 10% of all recorded crime.²

Women are much more likely than men to be the victims of high-risk or severe domestic abuse:³ 95% of victims referred to a Multi-Agency Risk Assessment Conference (Marac) or accessing an Independent Domestic Abuse Advisor (Idva) are women.⁴

Each year, more than 100,000 British adults are at high and imminent risk of being murdered or seriously injured as a result of domestic abuse.⁵ Over 130,000 children live in these homes.⁶

Through its extensive national dataset, Insights, SafeLives has found that on average, adults at high risk live with domestic abuse for 2.6 years before getting help,⁷ and that an estimated 85% of victims sought help from professionals an average of five times in the year before they got effective help to stop the abuse.⁸ Domestic abuse has a severe influence on a child's physical and mental wellbeing, with 62% living with domestic abuse also being directly harmed themselves. SafeLives' Children's Insights national dataset⁹ identified that high proportions (47%) are not known to children's services, and would not receive support following the abuse; 80% were known to at least one public agency.

Domestic abuse is so prevalent in our society that NHS staff will be in contact with adult and child victims (and perpetrators) across the full range of health services. The NHS spends more time dealing with the impact of violence against women and children than almost any other agency, and is often the first point of contact for women who have experienced violence.¹⁰

The cost of domestic abuse to health services has been calculated at £1.73 billion (with mental health costs estimated at an additional £176 million) so there is a pressing need to find cost effective ways of supporting victims.¹¹ Both adult and children's outcomes improve significantly across all key measures after support from specialist services.

About Themis

In November 2012, Themis was launched as the first research project of its kind in the UK. It set out to explore the impact of co-locating Idva services in hospitals. We wanted to develop the evidence base to highlight the benefits of stronger links between the health sector and domestic abuse services through innovative models.

This report builds on the findings of SafeLives' report, *Safety in Numbers*,¹² which recommended that the health response to domestic abuse needed to be strengthened. The report summarised extensive research into the negative impact of domestic abuse on the physical and mental health of women with both short- and long-term health consequences.

In SafeLives' report, *Getting it Right First Time*,¹³ nearly a quarter (23%) of victims at high risk of harm and 1 in 10 victims at medium-risk went to Accident and Emergency (A&E) because of acute physical injuries. In the most extreme cases, victims reported that they attended A&E 15 times. If domestic abuse were to be responded to effectively when identified in hospital, wider and more detrimental costs could be minimised and harm to victims and children avoided. In the current climate of budget cuts, the value of researching, smarter and more cost-effective interventions for domestic abuse is obvious. Evidence from research studies exploring the effectiveness of health professionals asking about domestic abuse shows that without a service to which they can immediately refer, such as a hospital-based Idva service, the opportunity to intervene will be ignored or ineffective.¹⁴

SafeLives initiated the Themis research across four geographical areas, examining five English hospitals that had adopted the approach of locating specialist domestic abuse services within their A&E and Maternity units. In each of the four areas, a comparison group of domestic abuse victims from a community domestic abuse service was also recruited. We interviewed: hospital staff, hospital-based Idvas, Idva Service Managers and Commissioners at all sites to understand how the service works in practice, and establish learning points in relation to the effectiveness of the model.

This report presents the first multi-site evaluation of hospital-based specialist domestic abuse services conducted in the UK.¹⁵ The project reached a total of 692 hospital victims and 3,544 community victims in the three years we were collecting data.

About hospital-based Idvas

The role of the hospital-based Idva:

- To provide immediate support and advice to victims of domestic violence within hospital
- To link individuals and families to longer-term community based support
- To provide hospital staff with expert training so that they have the confidence to ask about domestic abuse

Immediate support and advice

Victims of domestic abuse in hospital are often in the immediate aftermath of a crisis: severe physical assault, drug/alcohol related medical needs, attempted suicide or self-harm. The risk of immediate harm must be reduced; particularly when hospital release is imminent (half of the clients in hospital are still in a relationship with the perpetrator which means they face additional risk).

Hospital Idvas provide practical support, empathy and understanding. The safety needs of the client are paramount, as well as ensuring longer-term community support. The Idva may: liaise with the police regarding bail conditions/remand, engage with housing and refuge providers, work with community and hospital-based mental health/drug/alcohol services, organise applications for civil remedies, refer to adult and/or children's social care (both within and outside of the hospital). The aim of the hospital Idva is to reduce the risk of further harm and homicide, and to ensure that specialist community-based support is sustained.

Linking victims and their children to the support they need

When an individual is assessed as being 'high risk', an Idva will ensure that the victim is referred to the Marac. They will act as an advocate for their client within a multi-agency context, supporting the client to access safety as well as working with longer terms services such as outreach based in the community.

Providing expert training, advice and support to hospital staff

In hospital environments where staff turnover is high, training should be embedded as a core aspect of the Idva role. It should be delivered in multiple forms such as regular safeguarding training, drop-in sessions, workshops and staff inductions. The content will vary, but may include: the dynamics of domestic abuse, the stages of change, the relationship between domestic abuse and complex needs (drug and alcohol, mental health, disabilities, age, pregnancy) medical signs and symptoms of abuse, effectively asking about abuse and responding to disclosures, risk and referring to Idva and the Marac process. It is advised that training also includes Information Sharing and Confidentiality Guidelines for high risk cases or cases where there are adult or child safeguarding concerns. Effective training will translate into confident staff who feel able to ask about domestic abuse safely and also typically results in staff disclosures.

Overview of key findings

SafeLives' Themis research found that co-locating Idva services within a hospital setting can significantly improve health and wellbeing outcomes for victims of domestic abuse.

The cost of securing a team of specialist Idvas for every NHS acute provider in England would be £15.7 million. These specialists help to train hospital staff to better identify victims who come through their door every day and ensure they receive the support they deserve. It makes neither human nor financial sense to ignore the needs of victims and their children – and without this provision, we will continue to fail people who most need help.

Our research found that:

1. We can support the most vulnerable victims

Our evaluation revealed that hospital Idvas were more likely to engage victims who disclosed high levels of complex or multiple needs related to mental health, drugs and alcohol, compared with community domestic abuse services:

	Hospital	Community
Victims with mental health needs	57%	35%
Victims with alcohol related issues	18%	8%
Victims with drug related issues	11%	5%

The high disclosure of complex needs is likely to be predominantly due to the healthcare setting, which is seen by victims to be confidential and focused on wellbeing, rather than on criminal justice issues, which victims may not see as a priority, or as being accessible.

As might be expected because of their location, hospital Idvas were more likely to engage with victims who were pregnant (17% in hospital setting compared to 6% in community setting).

"I think [victims in hospital] have higher needs because they come in with overdose, attempted suicides and injuries due to alcohol-related issues"

Senior Idva

Hospital victims were also more likely to have been suicidal or to have self-harmed, and many were referred to the Idva after taking an overdose linked

to the abuse they were facing. Just under half (49%) of hospital victims screened positive for post-traumatic stress disorder (PTSD), eight times as many as in an inner-city community sample (6%). One in six hospital victims (16%) had been to A&E for an overdose in the six months before seeing a hospital Idva, compared to 1 in 38 (3%) before seeing a community Idva.

Nearly twice as many hospital victims had self-harmed or planned/attempted suicide than victims in a community setting (43% compared to 23%).

According to research by Sylvia Walby, an estimated one in eight of all suicides and suicide attempts by women in the UK are due to domestic abuse. This equates to just under 200 women dying and nearly 10,000 attempting suicide each year because of domestic abuse.¹⁶

2. We can support those victims who frequently face barriers to getting help

Victims engaging with hospital Idvas seemed to be accessing effective support at an earlier point. Hospital Idva victims had experienced abuse for an average of six months less than victims engaged with a community service.

Hospital victims have been abused for an average of 30 months, compared to an average of 36 months for community victims.¹⁷

Consistent with this finding, hospital Idvas were more likely to be engaged with victims who were still in a current relationship with the abuser, living with the abuser, and experiencing more severe abuse. Hospital services also identified more victims who were experiencing abuse from multiple perpetrators.

	Hospital	Community
Living with perpetrator	41%	26%
Still in the relationship	53%	31%
Severity of physical (high) abuse	46%	41%
Severity of sexual (high) abuse	14%	10%

We know that some groups of victims may be less visible to services or be given less priority:¹⁸

	Hospital	Community
Older victims 55+	10%	7%
Victims from higher income £36,400+ p.a.	9%	4%

“We found people we were identifying through A&E were not known by other services”

Commissioner

“I think we are meeting people who are hidden from society”

Senior hospital Idva

3. There is a golden window of opportunity to identify victims

After the introduction of a hospital-based Idva service, the referrals of victims significantly increased. In one of the hospitals, there were 11 Marac referrals in the 11 months before the introduction of the Idva service; this increased to 70 in referrals in the 11 months following the start of the Idva service. Another hospital said they had no referrals of patients to domestic abuse services in the year prior to the start of the Idva service, while another said they had only referred five patients in five years.

There are a number of reasons why hospital Idvas may be reporting earlier engagement with a different profile of victim compared with community services:

- The ‘crisis’ element of the victims’ situation may make the root cause harder to hide.
- The disclosure of complex needs, vulnerabilities and unrecognised abuse in the hospital victim population may be higher than the victim population accessing community services, since victims are attending hospital primarily for urgent health issues which may or may not be related to the domestic abuse experienced.
- They are accessing a group of victims who have previously not accessed help elsewhere, including those still in a relationship.
- Victims may be more likely to disclose domestic abuse because of the setting: it is considered by them to be a more benign, confidential and caring environment, free of the potential onward implications of involvement with criminal justice or other statutory services, particularly in relation to children.

“I think patients may seek referral here because they feel it is a safe place they can come. They come [saying] ‘I know you have a service’. I don’t think there are many other places... Coming to hospital equals [a] place of safety and expected confidentiality”

A&E Doctor

The hospital Idva has a golden window of opportunity to support victims because of their setting; for the reasons why the victim has accessed the health service, and because they feel more comfortable disclosing in a health environment. Idvas can help victims to understand, often for the

first time, that what they are experiencing is domestic abuse. While victims may not accept support initially, they leave hospital with knowledge of the support they could receive, should they choose to engage later on.

"I don't think I would have admitted it was a domestic abuse situation. I just felt my ex was just a nasty man. Then hospital Idva went through one of her questionnaires and I was on the border of being high-risk. Quite shocking"

Victim

4. We can help health services to meet their domestic abuse obligations

The National Institute for Health and Care Excellence (NICE) recommends that "people presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion".¹⁹

Recommendation 12 of NICE's guidance on domestic violence and abuse in 2014 recommends that health and social care commissioners, health and wellbeing boards, and practitioners in specialist domestic and sexual violence services should provide all those currently (or recently) affected by domestic violence and abuse with advocacy and advice services tailored to their level of risk and specific needs.²⁰

Our findings support this recommendation: in the year before the hospital Idva service started, 56% of hospital victims had accessed A&E because of the abuse, compared with only 16% of victims who accessed a community service. These represent missed opportunities to intervene, which is particularly important for victims who do not have any contact with other agencies.

56% of hospital victims had accessed A&E in the year before getting effective help, compared to 16% of victims who accessed a community service.

Health professionals interviewed as part of the research told us that being able to refer patients to the hospital Idva made it more likely that they would ask patients about domestic abuse in line with NICE recommendations. They also had greater confidence that identification would result in a meaningful outcome for the victim.

"If we didn't have the service, people would just stop screening. There is no point asking the question if we're not going to do something about it. It's like opening a nasty cut and not doing anything about it"

Nurse

5. We can help improve victim safety and health by increasing referrals and access to wider services

Basing domestic abuse services in hospitals is part of a continuum of support for victims of abuse. It can provide a gateway for the provision of support to make victims safer and address their significant physical and mental health needs. For example, some domestic abuse service providers, such as the Arch service in Staffordshire, run the hospital-based Idva provision as well as the community and refuge provision for the local area. Being based in a healthcare setting makes it easier for domestic abuse professionals to make quick links with services for mental health, abuse, and sexual violence.

Nine out of 10 victims in our evaluation reported improvements in safety following an intervention by a hospital Idva. Hospital Idvas reported that this improvement was significant in 37% of cases (both of these figures are similar to victims in community services).

Victim-reported improvement in safety	Hospital	Community
Much safer	57%	51%
Slightly safer	34%	40%
No change	8%	9%
Less safe	0%	0%

The more intensive the Idva intervention, the more likely it became that victim safety would be sustainably improved. For example, more contact with the victim, a higher number of interventions, and longer periods of casework all improved safety.

Victims reported feeling more confident accessing support as well as more empowered to make significant and meaningful changes to their life as a direct result of hospital Idva support.

“Up until this point, I was trying so hard to get help – but now I have so much support and I know it’s there all the time. It has been wonderful, absolutely wonderful... My confidence is coming back. I feel like now I can be there for the children, and my mum. It has gone right round the family. I have seven children and grandchildren. It has touched the entire family. You have no idea what a mess you have been in and how it’s affecting the entire family. I don’t know what would have happened without that support. I think we would have seen somebody die”

Victim, commenting on the value of the hospital Idva

Domestic abuse services can also provide support for members of hospital staff who are victims of abuse. By looking at the incidence of domestic

abuse in the general population, we extrapolated and found that a potential 2,065 members of staff across the five hospital sites were likely to be victims of domestic abuse.²¹

The total number of NHS staff likely to have experienced abuse in the past 12 months is 51,355 (male and female). This breaks down as 44,825 women and 6,530 men.

We know that four out of five victims don't tell the police about their abuse,²² which means that a key route into accessing specialist domestic abuse services may remain closed to victims if they don't know how to, or don't want to, self-refer. Our findings show that locating Idvas in hospital settings can give support to victims who have not contacted the police – only 58% of victims in hospital had contacted the police in the year before receiving support, in comparison to 77% of community victims.

6. We can help safeguard unborn babies, infants and young children

Around 30% of domestic abuse begins during pregnancy, while 40–60% of women experiencing domestic abuse are abused during pregnancy.²³ The hospital Idva services that had developed strong links with maternity services were likely to support more pregnant women than community services. NHS staff are under a duty to safeguard children at risk of harm through the provisions of the Children Act (1989/2004),²⁴ and a hospital Idva service is well placed to help with identification, referrals and support, to enable hospitals to fulfil their duties, not least by ensuring mothers at risk are identified early on.

It was found the 51% of hospital victims had children in their household.

Although having links with maternity services is key for identifying pregnant women experiencing domestic abuse, for hospital-based Idva services to work most effectively, they should have strong links with all hospital departments.

7. Hospital Idvas could reduce future health costs

The cost of domestic abuse to health services has been calculated at £1.73 billion (with mental health costs estimated at an additional £176 million) annually, which highlights the pressing need to find cost-effective ways of supporting victims.²⁵ An earlier study by Walby estimated that around 3% of NHS expenditure is due to the physical injuries associated with domestic violence.²⁶

Our evaluation included an analysis of the potential cost savings a hospital Idva service could produce, although the sample size was small.

Before accessing the Idva service, hospital victims cost on average £4,500 each year in their use of hospital, community and mental health services, whereas community Idva victims cost £1,066 per year for the same services.

An annual saving to the public purse of £2,050 per victim in health service use was estimated.

This consisted of savings of £2,184 in reduced hospital use by victims after they had been referred to the Idva service, and £200 in reduced ambulance use, balanced against rises of £196 in mental health service use, £64 in local surgery use, and £74 in alcohol/drug service use.²⁷ The increased use of these services is likely to be beneficial to the victims, particularly if they have complex needs which have remained unaddressed up until this point.

An increased annual cost of £282 in children's social care use was also calculated. Often it was the Idva service that identified victims who were parents and made referrals to children's social care for additional support. Referrals were made to safeguard children, so the cost associated can be seen as an investment in the child's future emotional health, which has the potential to reduce public spend in the longer term.

Hospital staff recognised that the expertise of the Idvas saved them time, which made them economically worthwhile to the organisation.

"We do leave a lot of work to them... They do so much more with patients than we could ever dream of doing because of time. Their role is so important. I don't know what we would do without them"

A&E Consultant

"It is really helpful to have input from an Idva... One of my nurses spent a whole day and I spent a whole afternoon trying to find one refuge"

Consultant Psychiatrist

8. Specialist domestic abuse services in hospitals are effective

Specialist domestic abuse services were most effective when they were:

- embedded in the hospital;
- highly visible to health professionals working in different hospital departments;
- regularly involved in training staff about domestic abuse;
- linked to community specialist domestic abuse providers;
- supported in a team (rather than lone working); and
- adequately and sustainably funded.

In practice, this means:

- establishing clear referral routes;
- Idvas being based in a central office and having a daily presence within the hospital;
- the Idva service operates across shift patterns; and
- systematic involvement in the delivery of training of all hospital staff.

“For something that’s quite a complex and emotive subject, it is really nice to have a person available when we know we have concerns... Sometimes we have a hunch and we have somebody to say ‘Can I just run it past you?’”

Hospital Midwife

“They [Idvas] have lunch in the staff room. They socialise with the team. That is where the success really comes from. They are not seen as a separate and aloof service that we just refer to”

A&E Nurse

The provision of clinical supervision for hospital Idvas should also be given priority so that Idvas feel well supported in a complex hospital work environment.

Recommendations

For national policy-makers

- **National leaders should prioritise domestic abuse as a health issue.**

There is the opportunity for NHS England and the Department of Health to play a greater role in showing leadership in tackling what has traditionally been seen as a criminal justice issue. The cost of domestic abuse to health services needs to be taken seriously by all parts of the NHS to ensure that victims aren't passing through a 'revolving door' – returning time and time again without the cause being identified and addressed.
- **All hospital settings (particularly those with A&E, maternity and sexual health departments) should host an Idva (and Isva) service.**

There are 157 registered acute NHS providers in England.²⁸ A minimum complement of two Idvas is required to ensure staff are not lone working across a seven-day service (particularly one which extends across busy evening periods), equating to a spend of £100,000 per NHS provider, or £15.7 million in total.
- **Increase provision for victims and children of domestic abuse.**

In order to safeguard children, there must be effective referral pathways into services, particularly for pregnant victims of abuse given the potential impact on the unborn child.
- **NICE guidelines for asking every individual presenting with indicators of domestic abuse should be applied comprehensively.**

The presence of Idva services makes this much more likely to happen in practice. We recommend that further research is undertaken to ascertain the extent to which NICE guidelines are being followed in the NHS.
- **A wider study on the cost-effectiveness of Idva services based in hospitals should be conducted** to evaluate whether our initial findings are replicated with a larger sample.
- **Continued study should be undertaken into basing specialist domestic abuse services within other health settings where there is not yet an evidence base**, for example, in mental health and sexual health services. In primary care, IRIS (Identification and Referral to Improve Safety) is an effective and proven model, which should be rolled out nationally alongside hospital-based domestic abuse services.
- **The Department of Health and the Home Office should investigate ways of incentivising and monitoring the development of Idva services within hospitals.**

For Commissioners²⁹

- **Commissioning strategies should include Idva services within hospital settings**, as they have the potential to reduce future health service use by victims of domestic abuse through more robust pathways.
- **Ensure commissioning of a health-based Idva service is sustainable**; sustainable funding is necessary in order to attract confident, high-calibre Idvas, who can network and train all levels of staff. Health-based Idva services should form part of a wider commissioning strategy, rather than being standalone posts, and should not detract from wider provision of Idva services within community settings.
- **Embed hospital-based Idva services within local referral pathways** to ensure victims receive ongoing support from other services once they have exited the Idva service.

For hospital Idva services and hospitals

- **Embed the service within the hospital setting** by developing strong referral routes, IT access, a daily presence, a central office base, service coverage across shifts, and support from senior clinical staff.
- **Ensure the service is visible across all departments of the hospital.**
- **Ensure staff are implementing NICE guidance** by identifying victims early and ensuring they get the right support for their safety, and their health and wellbeing. An audit could be conducted within the hospital to ensure the guidance is effectively followed and referrals could be dip-sampled to ensure consistency.
- **Involve the hospital Idva in delivering domestic abuse training to all hospital staff** in a systematic way that ensures it is regular, and can cope with high staff turnover.
- **Ensure hospital Idvas are given additional training in how to respond to victims with complex needs** (for example, mental health, and alcohol or substance misuse); hidden and very vulnerable victims (for example, older victims, pregnant victims, and victims with poor health) and training on how to respond to victims at crisis point in a medical setting.
- **Make strong links with community specialist domestic abuse services** to ensure effective onward referral pathways for victims and children, and consider opportunities for shared training and opportunities to train each other (unless the hospital Idva service provider is the same as in the community).

- **Create a feedback loop between the hospital-based Idva service and clinicians.** Ensure you feedback to hospital referrers (where appropriate) about cases, so that they feel involved in the outcomes for the victim and can learn from cases.
 - **Ensure that Idva staff have adequate clinical supervision to feel well supported in the complex hospital work environment.**
-

For hospital staff

- **All hospital staff should be trained in referral pathways through the hospital Idva.** If you have a hospital Idva service, ensure you know how to make a referral and share information appropriately – including for staff who are victims. If you do not have a hospital Idva service, ensure you know how to make a referral to the community domestic abuse service.
 - **Ensure that you ask patients about domestic abuse, as recommended by NICE.** This should include making a referral if a victim of domestic abuse is identified.
 - **Implement a domestic abuse awareness raising campaign and appoint champions in each ward.** Hospital screening for domestic abuse and hospital Idva engagement may be the first time victims recognise their experience as domestic abuse.
-

For non-hospital-based (or community-based) Idva services

- **Seek funding to extend your existing service** into the hospital, building on your expertise and helping to provide a seamless service to victims and their children.
- **Develop referral pathways with your local hospital.** If the hospital(s) in your area do not have an Idva service, make sure referral routes are established and known to health professionals across hospital departments.
- **Develop cross-training opportunities with hospitals and local health services.** Through making links with the local hospital service, domestic abuse services can maximise shared training opportunities as well as opportunities to train each other and increase knowledge.

Chapter 1 – The role of the Themis project

The primary objective of the Themis project was to evaluate the effectiveness of domestic abuse services in hospitals. This research evaluated Idva services operating in several different hospital sites and departmental settings, and using different models of service delivery. The World Health Organisation (WHO) acknowledges domestic abuse against women and children as an “urgent public health priority”.³⁰

In the UK, the Department of Health included the need to address domestic abuse within their strategic goals, producing an action plan to improve services for women and child victims of violence. The strategy recommended in particular that “Primary Care Trusts (PCTs) and NHS Trusts should work together with other agencies to ensure that appropriate services are available to all victims of violence and abuse”.³¹ Furthermore, the change in the commissioning of services within the sector requires robust evidence regarding the effectiveness and cost-effectiveness (in both financial and human terms) of health-based domestic abuse interventions, which Themis aims to provide.

This makes the Themis project timely and beneficial to both the health sector, due to the recent priority of addressing domestic abuse within health, and victims of domestic abuse. The hypothesis underpinning the research was that hospital-based Idva services would reach a different demographic of victim that might not access help via any other route. We also intended to explore whether hospital-based Idva services were a point of earlier intervention, thus potentially reducing the amount of time a victim suffered abuse before seeking help. This could reduce the impact of the many health consequences associated with domestic abuse.

In order to evidence this, we gathered data regarding the abuse experienced, demographics and the physical and mental health of victims before and after intervention. Ultimately, we hope that the findings from this research will feed into commissioning guidance through providing evidence of best practice in hospital-based Idva provision. We also hope that demonstrating the effectiveness of hospital-based Idva services will lead to more similar services being commissioned across the UK, to add to the small number (around 20) that currently exist.

Design of the Themis project

The aim of this study was to evaluate the model of domestic abuse intervention that bases Idvas in hospitals. This multi-site study included Idvas in five hospitals across England, operating different models of service delivery.

An Idva is a named professional case worker for victims of domestic abuse who works to address the safety of victims at high risk and their children. They assess the level of risk, discuss a range of suitable options and develop co-ordinated safety plans. These can include referral to the Multi-Agency Risk Assessment Conference (Marac), as well as sanctions and remedies available through the criminal and civil courts, housing options, and services available through other organisations. In some cases, hospital Idvas are Idsvas – Independent Domestic and Sexual Violence Advisors – but for brevity, all are referred to as Idvas in this report.

The key questions addressed by this research were:

1. Who are the victims accessing help through hospital-based services compared to domestic abuse services based in the local community?
2. What do hospital-based Idvas do (compared to those based in the local community)?
3. What impact on victims' risk, safety, and health and wellbeing do hospital Idvas have (compared to Idvas based in the local community)?
4. What are the facilitators/barriers to basing domestic abuse services in hospitals?

Idvas based in five English hospitals (one in a large city, one in a medium-sized city, and three in smaller towns in more rural areas) recruited victims aged 16 and over, with capacity to consent, who were judged safe to take part in the study. In each of the four geographical areas (with two hospitals being in one area), a comparison group of community Idva victims was also recruited. Community Idvas work with victims at high risk referred to them by the police, the local Marac and other agencies, and self-referred victims.

Telephone interviews were conducted with victims, with their consent, at the start and end of the Idva intervention, and three, six and nine months afterwards, where possible. These included standard measures of physical and mental health and questions about health service use. Initial interviews were conducted with 76 hospital Idva victims and 38 community Idva victims. Face-to-face interviews were also conducted with 15 victims (with their consent) after the intervention, to discover their views of the hospital-based Idva service and find out about their help-seeking journey.

Details of client demographics, complex health needs, levels of abuse and previous help-seeking, collected through SafeLives' anonymised Insights data monitoring service, were analysed for all participating sites. In addition, 692 intake forms from hospital Idva services between April 2012 and November 2015 were used for the data analysis, compared with 3,544 intake forms from the same period from community Idva services.

A total of 64 hospital staff, Idvas, Idva Service Managers and Commissioners at all sites were interviewed about how the service works in practice, and what factors hinder and facilitate its effectiveness.

At all times, victims' safety was paramount. Only those judged by Idvas as safe to take part were recruited. After the interviews, and with consent, any concerns about victims' safety and relationship with the abuser were referred to the Idva, and concerns about their mental health were referred to their GP for help and support.³²

Analysis

Insights data for all sites from 2012–2015 were analysed descriptively and differences between hospital and Idva victims were ascertained using appropriate tests – chi-squared for categorical variables, and Mann-Whitney U for non-parametric variables. Factors relating to successful client outcomes were identified through logistic regression.

Victims' health and health service use journeys (pre- and post-Idva intervention) were assessed using Wilcoxon's repeated measure non-parametric test.

A health economist carried out the cost analysis, comparing hospital and community Idva victims' mean health service use in the six months before the intervention, and comparing hospital victims' mean health service use pre- and post-Idva intervention. (The 95% confidence intervals (CI) were estimated using the bootstrapping methods in Excel, where the initial cohort was resampled 1,000 times.)

Qualitative semi-structured interviews with Idva victims were audio-recorded and analysed by the interviewer, while those with hospital staff, Idvas and Commissioners were shorthand-noted and transcribed by the interviewer, and analysed by two other researchers. These interviews were analysed using codes related to the research questions, which were then incorporated into sub-themes using thematic maps to aid the generation of final themes as suggested by Braun and Clarke (2006).

Fifteen hospital Idva victims across three sites (large city, medium city and small town in rural area) were interviewed after they had exited the Idva service: 14 were female, one male. Thirteen had received support because of partner abuse, one had been abused by an adult daughter, and another had been raped by an acquaintance.

Victims described a range of abusive behaviours perpetrated against them, including physical abuse (some injuries requiring medical attention), psychological abuse, controlling behaviours, harassment, threats, sexual abuse, property damage and financial abuse. For many, who had not sought or needed medical treatment for injuries, the impact of the abuse had been such that they were self-harming, having anxiety attacks, or it had triggered physical health problems, which prompted the visit to the hospital A&E.

Chapter 2 – Domestic abuse victims and health services: The policy context

Introduction

In our groundbreaking 2009 report, *Safety in Numbers*,³³ SafeLives highlighted that physical and mental health problems are documented with greater frequency among victims of domestic abuse compared to those who are not abused. The research also highlighted gaps in service provision and concluded that there was a need to strengthen links between generic and specialist health services, especially since studies had shown that the delivery of integrated services to address domestic abuse in tandem with health-related issues (for example, mental health or substance misuse) facilitates improved outcomes for victims.

Use of health services by domestic abuse victims

Compelling data captured by SafeLives' measurement tool, Insights, has subsequently affirmed these findings. Among a suite of other measures, Insights is the largest database of domestic abuse cases nationally (over 50,000), and tracks the use of public services by victims, drawing on data from over 50 domestic abuse services in England and Wales annually. The dataset is populated with cases from Idvas and outreach workers. This year's Insights dataset (2015/16)³⁴ included 77% of victims at high risk, who had experienced abuse for three years on average. It indicated that nearly half of the victims (46%) had visited their GP in the 12 months prior to seeking support from an Idva service, and had done so 4.6 times on average. Furthermore, in 17% of cases, victims in the Idva dataset reported having attended A&E 1.3 times on average as a result of the abuse. In our 2013/14 Idva and outreach datasets, in the most extreme cases, victims reported that they attended A&E 15 times during the preceding 12-month period before receiving support from a domestic abuse service.

The SafeLives' Insights dataset for outreach cases³⁵ found that victims had experienced abuse for 4 years on average. It found that 55% of victims visited their GP an average of 4.9 times. A smaller percentage of victims in the outreach dataset reported that they had attended A&E as a result of the abuse (12%), but they had done so 1.5 times on average. Both the Idva and outreach datasets had missing data on these questions for up to a quarter of victims, and were based on self-report, meaning that individuals might over- or under-report the number of times visits were made over a 12-month period.

The Crime Survey for England and Wales reports that 32% of victims in England and Wales experiencing partner abuse in the last year aged 16–59 sought medical assistance due to the abuse, equating to 486,720 victims.³⁶ Of those, 13% (or 63,000 victims) sought medical assistance in a hospital or A&E.

Help-seeking for domestic abuse victims in a health setting

The high proportion of victims found to be accessing the NHS illustrates the potential opportunities for healthcare professionals to be recognising and responding to domestic abuse. Despite this, a fear of not being believed or validated; a fear of social services involvement; feelings of shame or embarrassment; and a lack of interest, time and domestic abuse awareness among health professionals mean that healthcare settings often fail to be recognised as opportunities to disclose or access relevant support.³⁷ Over 70% of victims in one study did not know how to get help locally, and many women may not recognise healthcare services as potential providers of support.³⁸ Another common reason for not seeking formal help is the victims' belief that the abuse wasn't serious enough to warrant support.³⁹

The British Crime Survey found that four in five victims of domestic abuse don't tell the police.⁴⁰ Therefore, as SafeLives' policy report *Getting it Right First Time* highlighted, considerable opportunities for victims to access support continue to be missed across the NHS and other health and public services.⁴¹

Citizen's Advice research in 2015⁴² highlighted that friends and family are more likely to be aware of abuse than anyone else. The British Crime Survey of victims found more than two-thirds (71%) of individuals who experienced domestic abuse last year told someone close to them. The report argued that, since informal networks directly report abuse to specialists (in almost a fifth of cases which were reported to police, the information came from a third party), there ought to be "clear and accessible pathways to specialist support". Health-based domestic abuse services could provide a good way for friends and family to hear about the availability of services and learn about how to refer victims of domestic abuse.

Cost of domestic abuse to health services

Domestic abuse costs the NHS £1.73 billion (with mental health costs, estimated at an additional £176 million) according to research conducted by Sylvia Walby.⁴³ If domestic abuse were to be responded to before the point of crisis, wider and more detrimental costs later on could be minimised. In the current climate of cuts to budgets, the value of researching not only safer but smarter, more cost-effective interventions for domestic abuse is obvious.

According to a NICE⁴⁴ report on the costs of self-harm to the NHS, the cost of someone attending A&E is £110, while ambulance call-outs cost on average £246 each. This increases to £2,200 for a patient who needs treatment for poisoning with major complications, while treatment for other wounds or injuries with major complications costs £4,231.

Identifying and supporting victims in healthcare settings

Research in 2002 found that without a service to immediately refer on to, such as a hospital-based Idva service, the effectiveness of health professionals asking about domestic abuse is likely to be limited.⁴⁵ Since then, there have been a number of positive developments in healthcare settings to identify and support more victims sooner. In a hospital setting, research published in 2016 looked at domestic abuse screening and provision at the Royal Free Foundation Trust in London. It found that “having an in-house hospital screening service results in high numbers of referrals to the hospital-based Idsva, and that people referred from the hospital are more likely to take up the referral than people referred to domestic violence services from elsewhere”.⁴⁶ However, the research was unable to collect data on pregnancies, children or types of abuse, all of which Themis has included. Other findings raised by this research have also been highlighted over the course of the Themis project, including: the need for regular training of health staff; ensuring there is private space without the abusive partner present; and clear, integrated referral pathways to support services. Interestingly, the lack of long-term funding for the Idsva service presented a challenge to embedding the service successfully within the hospital which suggests an important learning point for Commissioners.⁴⁷

Another evaluation of Idva services at Saint Mary's Hospital, Manchester in 2010 found that the number of referrals to the Idva service increased after an Idva was seconded for two years to work five days a week in the maternity unit.⁴⁸ The study also found that the time frame in which referrals are made was an important factor in improving safety for women and their children – 82 of the women in the study were seen and assessed within hours, and 16 within minutes. The research also confirmed that the midwives involved with the study felt more confident in routinely asking patients about domestic abuse because of the presence of the Idva. Institutional advocacy was also improved through training provided to staff by the Idva. One of the main recommendations from the review was that specialist Idvas should work with more patient groups, not just in maternity.

In 2000, the Department of Health endorsed a routine antenatal enquiry for domestic violence, which was also endorsed by the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives, and NICE, who in 2001 recommended that all pregnant women should be asked routinely about domestic violence as part of their social history. A follow-up study into the routine asking of pregnant women by midwives about domestic abuse in the Bristol Pregnancy Domestic Violence Programme (BPDVP) has found that improvements in antenatal enquiry for domestic violence and abuse, developed through the 2004/05 BPDVP, have grown over time, with the support of mandatory training. Nevertheless, barriers continue to exist which include presence of a male partner and lack of face-to-face interpreting services. Both these obstacles need to be addressed if all women and, in particular, those who are most at risk of abuse, are to be identified and supported.⁴⁹ Research by the same authors in 2011 into the views of pregnant women themselves found that routine enquiry by midwives into domestic violence “is a positive move forward”.⁵⁰ More recently, the Royal College of Nursing has called for mandatory domestic abuse training.⁵¹

In a primary care setting, the Identification and Referral to Improve Safety (IRIS)⁵² model has recently been implemented in 32 CCG areas across England and two in Wales. The IRIS model is a training, support and referral programme to support GPs in asking about, and responding to, domestic abuse disclosures. It locates a lead Advocate Educator (AE) in a community specialist domestic abuse service, working in partnership with a local clinical lead to co-deliver training and education across practices supported by the programme (up to 25 practices can be supported by a single AE). GPs are trained to ask, respond, refer and record – with identification helped by a pop-up list of symptoms (known as the HARKS checklist)⁵³ on patient records. AEs add capacity and help develop local pathways for victims and perpetrators. The project has found that women in participating practices were 22 times more likely to discuss referral to a domestic abuse service compared to controls, and actual referrals were six times higher.

The RESPONDS study aimed to bridge the knowledge and practice gap between domestic violence and child safeguarding.⁵⁴ The study found that after RESPONDS training, primary care clinicians were more confident in knowing how to proceed in a consultation when it was disclosed, (or if they suspected), that children were exposed to domestic violence and abuse, and the appropriate next steps to take. They had a greater awareness of current relevant service provision and referral routes. Training participants also reported increased willingness to engage directly with children and to discuss this appropriately with their non-abusive parent. REPROVIDE is the latest research programme into health impacts and practitioner responses to domestic abuse, which is funded from 2016 to 2021.⁵⁵ This research plans to improve how healthcare professionals respond to all adult patients and their children who experience or perpetrate domestic abuse.

In addition to this, Public Health England commissioned the charity, Against Violence and Abuse (AVA), to refresh their free e-learning modules to align with the NICE guidelines on domestic violence and NHS professionals, and provide free access to Level 1 and Level 2 training. Other programmes to assess and improve professionals' responses to domestic abuse within specialist healthcare settings include the Spotting the Signs toolkit in sexual health clinics, and the Promoting Recovery in Mental Health (PRIMH)⁵⁶ project in the domain of mental healthcare. Psychological Advocacy Towards Healing (PATH) is a randomised controlled trial to determine the effectiveness and cost-effectiveness of a psychological intervention delivered by domestic violence advocates.⁵⁷ The aim of this study is to assess the efficacy and cost-effectiveness of a novel psychological intervention specifically tailored for survivors of domestic violence and delivered by domestic violence advocates based in third sector organisations. Standing Together, a charity which brings communities together to end domestic abuse, was awarded funding in March 2016 from the 'Tampon Tax' by the UK Government to establish a Health Alliance for Domestic Abuse, to bring together those working across domestic abuse and health. This shows the increasing interest from senior policy-makers in how healthcare settings can provide a better response to domestic abuse victims.

Existing research has indicated that the mechanisms currently in place for early disclosure of domestic abuse in healthcare settings are particularly effective for reducing risk and improving victims' safety following support.⁵⁸ Certain barriers have, however, been highlighted, such as the presence of partners (or others) when seeking support, language barriers, and general time constraints.⁵⁹ These are among the factors found in healthcare settings which prevent successful identification of victims of abuse. It is evident that with these barriers in mind, further research – such as that undertaken by Themis – is necessary for identifying ways in which formerly missed opportunities can be learned from to ensure an earlier, quicker, and safer response to victims of domestic abuse.

Impact of domestic abuse on victims' health

Domestic abuse has detrimental implications for victims' health. The physical – and often more obvious – implications can be short-lived, or long-lasting. These can include: broken bones; sprains; cuts; bruises; digestive issues; eating problems; pain of the back, neck, abdomen, stomach or genital area; headaches; fainting; seizures; hypertension; urinary tract or vaginal infections; sexually transmitted diseases; and sexual dysfunction.⁶⁰ Although often less obvious, psychological implications of domestic abuse can pose an equally harmful threat to victims' health. A targeted sample of 260 women who had sought help from domestic abuse services within England and Wales completed baseline questionnaires as part of an intervention study.⁶¹ According to the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM), which is used in counselling services as a screening tool, over 70% of these women reported clinical levels of psychological distress. Their mean score (18) was almost four times higher than that of the general population.⁶² The study also indicated more than three-quarters of the women (77%) had been suffering post-traumatic stress disorder (PTSD), in addition to high levels of depression and anxiety – of which the severity was positively correlated to the severity of abuse experienced.

Agenda's *Hidden Hurt*⁶³ report on violence, abuse and other disadvantages in the lives of women, similarly evidences the overwhelming association between domestic abuse and mental health issues. The report illustrated that over half of women (54%) experiencing sexual and physical abuse – and a third (36%) experiencing extensive physical violence – meet the diagnostic criteria for at least one common mental disorder. Findings in earlier research of a strong bi-directional relationship between violent and abusive relationships and mental health issues highlight a need for interventions to address these issues together.⁶⁴ A recent research study suggested that the high prevalence of PTSD in their sample identified a need for interventions that target the trauma of domestic abuse to be available in health services. It also recommended that healthcare professionals should identify mental health difficulties or PTSD symptoms as potential indicators of domestic abuse.⁶⁵

Impact of domestic abuse on children

Studies have shown that violence can begin or escalate during or shortly after pregnancy.⁶⁶ A study published in 2001 found that 30% of domestic abuse begins in pregnancy while 40–60% of women experiencing domestic abuse are abused during pregnancy.⁶⁷ An estimated 130,000 children in the UK live in households with high-risk domestic abuse; that is, where there is a significant risk of harm or death.⁶⁸ Furthermore, 6% of all children are estimated to be exposed to severe domestic abuse between adults in their homes at some point in childhood.⁶⁹ Thousands more live with domestic abuse every single day – two studies reported that a quarter of young people had witnessed at least one episode of domestic abuse.⁷⁰ Research studies show a link between domestic abuse and child maltreatment,⁷¹ and domestic abuse has been shown to be a factor in the family background in two thirds of Serious Case Reviews.⁷² The Children and Family Court Advisory and Support Service (CAFCASS) reports that domestic abuse was present in 60% of cases that led to care applications in a 2011 sample.⁷³

Children's development can be affected by both direct and indirect exposure to abuse, and the impact of domestic abuse on victims' mental health is particularly relevant given the negative association between parental depression and children's cognitive and language development.⁷⁴ The term 'toxic trio' has been used to describe the interaction between domestic abuse, mental ill-health and substance misuse, which have been identified as common features in cases of child maltreatment.⁷⁵ SafeLives' analysis of our Children's Insights database found that exposure to domestic abuse causes serious physical and psychological harm to children. As measured by the children's caseworkers, at intake, 52% had behavioural problems, 60% felt responsible for the negative events, 52% had problems with social development and relationships, and 39% had difficulties adjusting at school.⁷⁶

In the same study, we found that only half (54%) of the children who were or had been exposed to domestic abuse, and only two-thirds (63%) of those exposed to severe domestic abuse, were known to children's social care prior to intake to the specialist children's service. This is concerning given the evidence that two-thirds were also directly harmed; 91% by the same perpetrator. Therefore, other statutory services – including health – have a role to play in ensuring children exposed to domestic abuse are being appropriately identified and referred for support.

UK Government policy

The first Government taskforce looking at the relationship between health and domestic abuse was launched in 2010, chaired by Professor Sir George Alberti. It concluded that “the NHS has a vital role to play in dealing with violence and abuse and its consequences, both short- and long-term.”⁷⁷ It recommended that NHS Commissioners should assess local needs and local services for victims of sexual abuse and ensure that appropriate commissioning arrangements were in place. The taskforce also recommended that Commissioners should ensure that “appropriately funded and staffed services” were put in place along locally agreed pathways. It is regrettable that more of the recommendations have not been seen through.

Early in 2016, the UK Government launched the second of two strategic ambitions, to End Violence Against Women and Girls (VAWG) (2016–2020). In line with SafeLives’ earlier research, the 2016–2020 VAWG strategy advocates an earlier, quicker and safer response to domestic abuse. Victims are to be identified *before* the point of crisis, securing their own (and their children’s) safety at the earliest possible stage.

Unlike previous governmental policy, the current 2016–2020 VAWG strategy recognises the importance of integrating domestic abuse within healthcare settings in particular. It acknowledges that “GPs, midwives, health visitors, mental health, drug and alcohol services, sexual health and Accident and Emergency staff are well placed to identify abuse”. Their ability to intervene early and direct victims towards appropriate statutory and non-statutory services is highlighted. Supporting the governmental VAWG strategy, this year’s NHS Mandate recognises the vital role of the NHS in tackling domestic abuse. This sets expectations upon NHS England to ensure the NHS helps to identify abuse early and provides or identifies the relevant support.⁷⁸

Over the past three years, the Public Health Outcomes Framework (PHOF) 2013–2016 has contributed to developing practices to integrate domestic abuse with healthcare. This is a framework aimed at reforming the public health system as a whole, situating public health within local government. Identifying domestic abuse as a key determinant of health, the PHOF administers responsibility to local authorities and local healthcare entities (GPs, A&E departments and hospitals) to recognise domestic abuse as a major public health issue, and protect those who are vulnerable.

The framework has this year been supported by the National Institute for Health and Care Excellence (NICE). NICE has developed a specific domestic violence and abuse Quality Standard, whereby the broader visions of the PHOF are expressed through four ‘quality statements’ designed to drive measurable improvements. These are: people

presenting to frontline staff with indicators of possible domestic abuse are asked about their experiences in a private discussion; people experiencing domestic abuse receive a response from trained staff; people experiencing domestic abuse are offered referral to specialist support services; and people who disclose that they are perpetrating domestic abuse are offered referral to specialist services.⁷⁹ The four practice-focused 'quality statements' closely reflect the earlier recommendations made by SafeLives' 2009 *Safety in Numbers* report, as well as the wider governmental VAWG strategy for integrating domestic abuse support within the realm of healthcare.

Conclusion

As stated by the WHO, domestic abuse is a public health emergency. From the terrible impact of domestic abuse on the immediate health of victims and their children, to the long-term implications of surviving or witnessing abuse, it is clear that the leadership of the NHS cannot afford to stand by. There are strong cost arguments for swift action too. The cost of drug abuse to the NHS is calculated at £488 million;⁸⁰ less than that of domestic abuse, yet the impact is recognised by decision-makers. At a time when the Government and health leaders are starting to increase the role that health can play in tackling domestic abuse, it makes sense for there to be strong leadership outside the traditional prism of criminal justice and local domestic abuse service provision.

There is a convincing case for the use of healthcare-based settings to identify and refer victims of domestic abuse, but more importantly, the evidence suggests that simply training staff to recognise signs of abuse and providing a referral pathway does not lead to effective identification and referral. As the IRIS model, Royal Free Foundation Trust and Saint Mary's Hospital, Manchester research suggests, locating specialist domestic abuse services within healthcare settings is proving to be much more effective at increasing referral rates. The Themis research provides a crucial piece in this puzzle, examining the effectiveness of the intervention itself in terms of safety and health of victims, as well as what makes a service work in practice.

Chapter 3 – Who are the victims accessing help through hospital-based domestic abuse services?

Victims with unmet needs – complex needs

Hospital Idvas were more likely to reach victims who had strikingly more complex needs than community Idva victims, though this is likely to be as a result of a greater likelihood of disclosure rather than prevalence.

Need disclosed to Idva	Hospital	Community
Mental health difficulties	57%	35%
Alcohol misuse	18%	8%
Drug misuse	11%	5%
Financial difficulties	40%	30%
Additional vulnerability (physical disability including hearing and sight or learning difficulty)	12%	8%
'Toxic trio' (domestic abuse, mental health difficulties, alcohol/drug misuse)	20%	7%

Nearly twice as many hospital victims had self-harmed or planned/attempted suicide than victims in a community setting (43% compared to 23%).

By reaching victims with complex needs in the hospital setting, it is more likely that Idvas will be able to provide a more holistic service which enables victims to access support for their needs as well as their safety. Women who experience domestic violence have twice the level of usage of general medical services and between three and eight times the level of usage of mental health services. This was borne out by our findings which showed overall, at the start of the Idva intervention, hospital victims had slightly poorer physical health than the national population, and much worse mental health. Their anxiety score was twice the national average and their depression score 2.5 times worse. Overall quality of life was only three-quarters of the national average (0.6 compared to 0.8). Just under half (49%) screened positive for PTSD, this is eight times as many as in an inner-city community sample (6%).

If we look at the figures which compared victims in hospital with those in local community services, (at the point of Idva intake), hospital and community victims had similar rates of anxiety and PTSD. However, hospital victims had poorer physical health than community victims and were significantly more depressed, although these differences were not statistically significant. One in six hospital victims (16%) had been to A&E for an overdose in the six months before seeing the hospital Idva, compared to 1 in 38 (3%) before seeing the community Idva.

The identification of victims who had self-harmed or planned/attempted suicide is important because according to research by Sylvia Walby's research, an estimated one in eight of all suicides and suicide attempts by women in the UK is due to domestic abuse. This equates to just under 200 women dying from suicide each year and nearly 10,000 attempting suicide each year because of domestic abuse.⁸¹

We are more likely to hear that two women a week are killed by a current or ex-partner in England and Wales, but it is estimated many more take their own lives as a result of domestic abuse: every day almost 30 women attempt suicide as a result of experiencing domestic abuse, and every week three women take their own lives.⁸² By ensuring that domestic abuse is identified in a healthcare setting, specialist domestic abuse workers can help to make the victim safer, while health professionals are better able to understand the underlying causes of their ill-health.

Victims not visible to services

Hospital Idva victims at the five hospital sites were also more likely to be:

	Hospital	Community
Pregnant	17%	6%
Aged 55+	10%	7%
High-income households (£36,400+ per annum)	9%	4%

The increased prevalence of pregnant victims reflects the fact that some hospital Idvas had close links with maternity units. Given that the evidence shows domestic abuse of women increases during pregnancy, it is important that these victims are identified at the earliest opportunity within maternity services to prevent adverse birth outcomes, ranging from foetal loss, to early onset of labour, to an increase in maternal stress, which can lead to delayed foetal growth.⁸³

Half of hospital victims (51%) also had children living with them. We know that research studies show a link between domestic abuse and child maltreatment,⁸⁴ and domestic abuse has been shown to be a factor in the family background in two-thirds of Serious Case Reviews.⁸⁵

SafeLives' research⁸⁶ shows that 80% of older people (55+) who live with abuse are not visible to services, and of those who are, a quarter have lived with abuse for over 20 years. Given that older people are more likely to be users of NHS hospital services,⁸⁷ the fact that hospital Idva victims were

nearly 50% more likely to be aged over 55 suggests that this provides a setting in which we can increase services' ability to identify older victims.

Hospital Idvas also help more than twice as many victims from high-income households than community Idvas; reaching another demographic that is likely to be hidden from statutory services.⁸⁸

Reaching victims earlier and reaching those still in relationships

Our data showed that hospital victims' abusers were more likely:

	Hospital	Community
To be with their current partner	53%	31%
To be living with their partner, sometimes or all the time	48%	29%

We know that many victims do not want to contact statutory services about their abuse, so it is significant that the hospital victims we see in the research are more likely to still be with their partners. Our national Insights dataset shows that a majority of victims engaging with community-based Idva services have left or are leaving their relationship, which means there need to be more options provided for those who aren't yet ready to leave or for whom leaving is not an option (for example, familial abuse or child to parent abuse).

Hospital victims had also been abused for a shorter time (median 30 months) than community Idva victims (median 36 months), which shows that victims engaging with hospital Idvas were accessing support around six months earlier than those in community settings. This is important because we know that victims need help before they reach crisis point, which is when they call the police, for example. This is borne out by the data which show fewer hospital victims had called the police (58% compared to 77% of community Idva victims). This means that for too many families, the response to abuse remains an emergency one, focused on criminal justice action rather than becoming safe from abuse. As discussed on page 31, we know that four out of five victims don't tell the police about their abuse,⁸⁹ which means that a key route to accessing specialist domestic abuse services may remain closed to victims if they don't know how to, or don't want to, self-refer.

The data also showed that victims identified in hospital were more likely to disclose severe physical and sexual abuse in the three months prior to contact with the Idva service, and were more likely to have experienced abuse from multiple perpetrators than community Idva victims:

Abuse disclosed by victim	Hospital	Community
Severe physical abuse in three months before Idva intake	46%	41%
Severe sexual abuse in three months before Idva intake	14%	10%
Multiple perpetrators	14%	8%

However, more hospital Idva cases did not have a planned closure, meaning contact with the Idva stopped before casework was complete (13% for community victims, compared to 5% for hospital victims). This might reflect the earlier stage of change many hospital victims were at, often still living with their abuser, and sometimes only just beginning to realise that the partner's behaviour was abusive.

Abuser characteristics

The profile of abusers of hospital victims suggests that they are more likely to have been abusive to others (79% hospital, 67% community Idva victims), but that they are less likely to have a criminal record for domestic abuse⁹⁰ (36% hospital, 45% community Idva victims).

This perhaps suggests that the perpetrators who are being identified through the hospital-based Idva service are more likely to be serial offenders, and therefore a risk to victims, but less likely to have been identified already by criminal justice services.

Why might hospital-based Idva services be identifying hidden victims or unmet needs?

It is suggested that the hospital location also provides an opportunity to identify pregnant victims and safeguard children sooner, or to identify victims with children who are not receiving help.

“Sometimes repeat attenders at labour wards come in every week with non-specific things. Labour ward is for anyone after 22 weeks. Before that potentially [they] go to A&E”

Community Midwife Manager

“We try and encourage them [healthcare workers] to ask if there is a child at home. These children are hidden children... there is often a child behind the adult”

Named Nurse, Safeguarding Children

“This is the one [service] that is reaching people younger and earlier... safeguarding children more quickly. Sometimes in the case of a pregnant mum, even before they are born”

CEO DVA Organisation

Hospital staff highlighted how victims were more likely to seek out the service knowing it is easily accessible and can provide protection. Comments from Idvas concur with this, and further indicate that these victims are distinct from those seen in the community.

“I think patients may seek referral here because they feel it is a safe place they can come. They come [saying] ‘I know you have a service’. I don’t think there are many other places... Coming to hospital equals place of safety and expect confidentiality”

A&E Doctor

“We found people we were identifying through A&E were not known by other services”

Commissioner

“I think we are meeting people who are hidden from society”

Senior Hospital Idva

The red flags of domestic abuse

Hospital staff noted the signs that alert them to possible domestic abuse. These include subtle or hidden symptoms that can be signs of ill-treatment, such as functional disorders⁹¹ or pseudo-seizures,⁹² where the link has not been made. Idvas confirm that many victims they see in the hospital setting have complex issues and higher needs.

“Frequent attenders present with chronic pain, psychiatric presentations, overdoses, or almost fictitious disorders... they are a passport to see the doctor... very rarely do women turn up missing a couple of teeth or with a big black eye”

A&E Consultant

“Often injuries or aches and pains that don’t necessarily correlate with complaints of the patient... What’s important is to explore underlying problems”

Senior House Officer

“You think ‘Mm’... from ‘my partner hates me’ to ‘I can’t get any money for the taxi home because my partner has got my cash card’. Could be completely innocent or controlled”

Clinical Nurse Specialist

“A lot have mental health problems. A lot have personality disorders”

Hospital Idva

“Hospital victims – I think their needs are higher because [they] either come in with overdoses, attempted suicide, injuries or alcohol-related issues”

Senior Idva

Challenging the status quo

Both hospital staff and domestic abuse professionals drew attention to individuals who may not obviously be considered victims – those from a high-income background, for example, who were primarily identified in the hospital setting. This highlights the need to consider the possibility of domestic abuse in all individuals.

“Not always the partner that is the perpetrator... it can be [the] parent or child”

Clinical Nurse Specialist

“People need to remember that men can be victims of domestic violence as well... it can be more difficult for them to seek help or even acknowledge what’s going on because of the whole gender thing... There might be less awareness in the hospital regarding men”

Clinical Nurse Specialist

“Not forgetting [the] elderly population in this, [it’s] not just young people in classic situations. A number of elderly women don’t want to go home. Husbands don’t help them at home, [they are] not managing and [they] shout at them and they are frightened”

Practice Development Nurse

“Saw a lot of very wealthy middle-class women who suffered terrible domestic abuse from their husbands. One lady had hammer mark on forehead. Didn’t press charges [said] ‘No, I love him’”

A&E Matron

“[We see] different kinds of victims, for example, people with addictions, people who don’t speak English, transgender...”

Hospital Idva

“And much older women who might end up at A&E in their 60s/70s and for the first time ever someone will ask her that question. Because very, very often those victims have never been anywhere near the police”

CEO, DVA Organisation

Chapter 4 – The role of a hospital-based Independent Domestic Violence Advisor

Idvas are a crucial part of community domestic abuse provision. They represent the voice of victims at the highest risk and are a single point of contact for them, addressing their needs and ensuring that statutory agencies act quickly to make them safe.

Hospital Idvas are domestic abuse workers who have an Idva (Independent Domestic Violence Advisor) qualification (Open College Level 3) and take referrals mainly from hospitals.

- Hospital-based Idvas (and Independent Domestic and Sexual Violence Advisors, Idsvas) can either be seconded into the hospital from an established community-based Idva service, or they can be part of a specific hospital-only commissioned service.
- On top of the Idvas' normal range of skills such as knowledge and empathy, they need to be confident in the hospital setting, good at networking with all levels of hospital staff, and skilled and flexible trainers.
- A background in mental health or other complex needs is helpful.
- The exact role of the Idva will depend on the agreement with the hospital but, in general, staff will fill out a referral form after they have gained consent from the patient, which will be passed on to the Idva, or staff may phone the Idva with the necessary details. The Idva can then respond accordingly.
- The Idva will complete a Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment and refer to Marac as usual if the victim is at high risk. If the victim has left the hospital, the Idva will arrange to meet them, either at the hospital, at the victim's home (if safe to do so), or in another private place (for example, a GP surgery).
- If a victim is assessed as being at standard or medium risk, the Idva will signpost them to other specialist domestic abuse services in the community.
- If the victim is identified out-of-hours and is at high risk, they may be kept in overnight so that the Idva can support them in the morning.
- Even if there is no disclosure or consent, if staff are concerned for the safety of the patient, they can notify the Idva, who can carry out checks on the hospital register or contact the Multi-Agency Safeguarding Hub (MASH) or Public Protection Unit (PPU).

Where were Idvas based and for how long?

Site 1 – One part-time Idva (four hours a week during weekdays in office hours) not based on hospital premises.

Site 2 – One part-time Idva (two days a week), not known how much time was spent on hospital premises or which days.

Site 3 – Two full-time Idvas based in the hospital with seven-day cover mostly during office hours.

Site 4 – One full-time Idva based in the hospital working weekdays mostly during office hours.

Site 5 – No specialised hospital Idvas at time of the study. Referrals from hospitals were made and then allotted to different Idvas.

In some other hospitals, another model is used – domestic abuse workers handle most cases referred by hospital staff, who refer high-risk cases to the qualified Idvas.

Coverage depended partly on the size of the hospital (Site 3 was substantially bigger than Site 4), but also on operational factors – for example, the extent of funding for the Idva service, commitment of the hospital to the Idva service, and whether a suitable office was provided in the hospital.

A day in the life of a hospital-based Idva

8.30am Listened to messages on phone. Four referrals in A&E. One overdose transferred to Medical Assessment Unit (MAU). Will still be in on Monday for me to visit. Also one patient kept in A&E overnight for me to see first thing.

9.00am Picked up referrals from A&E. Two inpatients: one home awaiting my call; one positive disclosure, no consent given for support. Staff very upset by this as was “a nasty assault”. Clarified no children or not a vulnerable adult. Support given to that member of staff. Telephone to MAU to let them know I’m aware of victim, please hold until I get there. They are also waiting for the psychiatric ward, but have no free beds, so patient shouldn’t be there if no medical need. Bleeped psychiatric ward to let them know I haven’t accessed patient yet, but if they get there before me please ask domestic violence questions.

9.45am Took patient in A&E from cubicles into private room, made comfortable. Female victim, physical assault from partner, sustained head injury, facial lacerations, fractured jaw, bruising to torso, and broken ribs. During our interview, disclosed regular attempted strangulation. Victim has two children who are with maternal grandparents. Victim agreed to refuge with children. Her parents able to take them.

10.50am Bleep from Maternity ward delivery suite – one of my ladies has arrived by ambulance and is asking for me. Said I’ll get there as soon as I can.

Talked to doctor about case with disclosure of repeated strangulation; more tests ordered due to this. Identified appropriate refuge space, unfortunately out of county. Victim agreed for short term, while other safety procedures can be put in place. Victim agreed to make a statement after meeting our in-house police officer and understanding the process.

Wrote up notes, completed children safeguarding forms and Marac referral.

11.20am Telephone call to MAU. Psychiatrist with patient, asked for them to call me when finished.

11.35am Visited Maternity ward delivery suite, met with my lady who is very anxious that ex-partner is going to turn up. Reassurance given by myself and midwife. Ward is locked, password system is in place. Patient's anxiety is having an impact on labour. Agreed to visit later. Patient has no birthing partner.

12.00pm Coffee. Psychiatrist called. Patient took overdose following argument with partner, described them as “very controlling and makes threats of physical violence”. Has experienced two previous abusive relationships and traumatic childhood. Has consented to speak with me. Psychiatrist referring to self-harm counsellor but nothing else as mental health reactionary to abuse. Patient expecting my call this week.

Completed ward round for delivery suite and Maternity ward. Recognised a name on the board, looked at notes. Partner is a well-known perpetrator in our service. Telephone call to Domestic Abuse Unit. Confirmed that partner is a domestic abuse serial and serious perpetrator (DASSP), and that he had been to Marac four months ago with an ex-partner as the victim. Telephone call to community midwife. They were never able to ask about domestic abuse within the relationship as he was always there. Telephone call to social care. They weren't aware of the pregnancy. They have worked with the victim previously with her other child. Safeguarding children referral form completed. Wrote up notes.

12.30pm Child protection conference for existing client. Sandwich in car.

2.00pm Visit for existing client.

3.30pm Bleeped by A&E. 78-year-old admitted with head injury. Disclosed he had been hit by his daughter (carer) with his walking stick as he was being too slow. After further questioning, disclosed other physical, emotional and financial abuse. A&E will find him a bed somewhere under welfare need, but he has consented for me to talk with him. Completed Risk Identification Checklist (RIC). Referral to vulnerable adult team. Marac referral. Wrote up notes.

5.00pm Checked emails and admin.

6.00pm Finished.

Victims' views of Idvas

Initial validation by a sympathetic Idva was crucial and precious to victims, which is in line with the type of feedback that community-based Idvas often receive. Victims supported by the hospital-based Idva also: gained confidence to access support in the future; could be empowered to make radical changes (for example, give evidence to police, ask perpetrator to leave, and/or move to new area); and could be enabled to access services more quickly (such as mental health and alcohol/drug services) or to access services that were not otherwise available (such as an immediate police response if they are a high-risk client).

“Hospital [Idva] has been helping me and referring me to places. Everything is getting sorted out. I have been waiting years to get help with my depression. My doctor now is a waste of space. He weren't interested”

Victim of domestic abuse

“Up until this point, I was trying so hard to get help but now I have had so much support and I know it's still there all the time. It has been wonderful, absolutely wonderful... My confidence is coming back. I feel like now I can be there for the children. And my mum, it has gone right round the family. I have seven children and grandchildren. It has touched the entire family. You have no idea what a mess you have been in and how it's affecting the entire family... I don't know what would have happened without that support. I think we would have seen somebody die”

Victim of domestic abuse (Abuse by teenage daughter to mother and sister)

“She's helped me so much with getting him to go to the [perpetrators'] course. Helped me write letters. She's been absolutely amazing. She is still working with me. I feel she's the only person I can be honest to”

Victim of domestic abuse

- Some victims would have liked earlier support, for example, at an earlier hospital visit, such as when giving birth. Some required longer support than offered, particularly if further harassed by the perpetrator or dealing with a family fall-out from the abuse – for example, child behavioural problems or children taken into foster care.
- One male victim greatly appreciated the help from his female Idva but would have preferred a male Idva, claiming he would have been better able to “relate to a man's way of thinking”. He had felt that the police, and especially social services, were more sceptical than they would have been towards a female victim.

- Some victims didn't recognise they had been abused at first, and the Idva could raise awareness, giving skilled help in recognising healthy and unhealthy relationships.

"I didn't really think it was abuse. I thought it was quite normal. It was psychological – I didn't recognise it. I couldn't see it till it got really out of hand"

Victim of abuse

"You look back and think 'How did all that happen? How did you not realise that this wasn't living?' and carrying on like it was normal"

Victim of abuse

"Now, because I don't think anyone has taken it seriously, I feel I'm having to give up my home. I can't live like this. I have been pushed into an impossible situation. I can't live in fear for the rest of my life"

74-year-old woman abused for 40 years

Staff training in domestic abuse compared to hospital-based domestic abuse services

It could appear tempting for over-stretched services to invest in training, rather than incurring the cost of employing domestic abuse professionals directly in hospital. However, this would not be an effective or cost-effective alternative. This is demonstrated through SafeLives' consultancy research, which involved interviewing clinicians in one County Council area in 2015, and found the following:

- Generic safeguarding training failed to equip practitioners to safely and competently address the needs of people who have experienced domestic violence.
- When training did take place, there were not always supporting policies, standard operating procedures or pathways in place.
- Even Level 3 safeguarding training covered a very wide breadth and thus failed to deliver the necessary depth of understanding of domestic abuse.

- There were widespread variations in access to training. For example, in some organisations Level 3 safeguarding training was delivered to all clinical staff, whereas in others, only registered staff were trained to Level 3.
- Without a thorough understanding of the nature and dynamic of domestic violence, it was possible for clinicians to follow a process but potentially increase the risk to the victim.

Moreover, while there was a desire to ask patients about domestic abuse, A&E and midwifery clinicians suggested that there were barriers to doing so where there was not a rapid and robust referral mechanism once there had been a disclosure. It confirmed the Themis qualitative findings that busy clinicians, who may only have a 10-minute consultation, are unlikely to ask about domestic abuse if there is no referral pathway, or if that pathway would require them to spend much non-clinical time on the patient's behalf.

Chapter 5 – What creates an effective hospital- based domestic abuse service?

The Idva as a healthcare professional

The qualitative evidence from the interviews that follow demonstrate the Idva as a professional in the domestic abuse sector and highlight the knowledge and specialism involved in carrying out the role. Respondents convey the benefits that an Idva's expertise can bring to hospital staff and the organisation as a whole, which include: education and training; being a main point of referral and support to staff; and using their specialist knowledge to help save time for hospital employees; and preventing crises, making it cost-effective for the NHS overall. The wide-ranging and demanding nature of the hospital Idva role is also highlighted.

Establishing quality standards

Idvas highlighted the importance of guidance and training in enabling hospital staff to ask questions about domestic abuse. This expertise was recognised by hospital staff, who explained how this gave them confidence to support victims and equipped them to make enquiries about domestic abuse:

"Having [the Idvas] here and being able to discuss with them and having confidence to be able to question patients in terms of domestic and sexual violence – it is an incredible service"

A&E Lead Nurse

"For something that's quite a complex and emotive subject it is really nice to have a person when we know we have concerns... sometimes we have a hunch and we have somebody to say 'Can I just run it past you?'"

Hospital Midwife

"We train people to be brave enough to ask. Don't be frightened to ask the question because if the answer is 'Yes', it is OK because we are here"

Idva Team Leader

Although training is a key aspect of the Idva role, interviewees commented on the sheer scale of training in a large organisation with a constant turnover of staff. One respondent commented: *"It is like painting the Forth Bridge"* (**Commissioner**). Hospital staff noted their already difficult training schedules and Idvas mentioned how continuous training challenges their working practice:

“A&E has a high turnover of medical staff... sustaining, training people to understand the importance of asking questions... needs constant work or structures that enable that”

Team Leader Mental Health

“Every 6 to 9 months nurses and doctors turn over... we do some training and awareness work with one lot and we have got them leaving and moving on”

Idva Services Manager

Opening Pandora's Box

Respondents talked of the value of having the Idva as a clear pathway for referrals, and how this encourages staff to 'ask the question', knowing that they have support and a means of action. Idvas noted the concern practitioners have in dealing with a disclosure of domestic abuse without clear pathways into support:

“Having an Idva means we have a very clear pathway of referral, which is very important... very big difference between identifying and knowing there is something they can do. We have [the] opportunity to take action at that point, even if just to send [an] email”

A&E Consultant

“Knowing that we are on site [is beneficial]. [A] lot of practitioners [are] worried about disclosures. ‘We have opened a can of worms. What can we offer?’”

Senior Idva

Saving time, saving money

Hospital staff recognised that the expertise of the Idvas saved them time and hence made them economically worthwhile to the organisation. Domestic abuse professionals note the need to evidence savings, and one Commissioner cited the savings a hospital Idva service can make:

“We do leave lots of work up to them... they do so much more with patients [than] we could ever dream of doing because of time. Their role is so important, I don't know what we would do without them”

A&E Consultant

“It is really helpful to have input from an Idva... One of my nurses spent a whole day and I spent a whole afternoon trying to find one refuge”

Consultant Psychiatrist

“Evidence would need to show a reduction in repeat attendances to hospital... because victims, when suffering from domestic abuse, they keep turning up at A&E. If we can show a reduction in that, it can prove its worth... It would have to be [an] economic argument”

City Council Commissioner

“We can extrapolate the money saved by hospital Idva service, so we kept it [the Idva service] – it’s a ‘Spend to save’ agenda”

Commissioner

The Idva-plus role

The hospital Idvas’ role differs from the community Idvas’ role, requiring some additional skills. On top of their usual demanding repertoire of knowledge, skills and empathy, they need familiarity with the hospital setting, confidence to walk into wards and liaise with staff, and they need to be skilled and flexible trainers. In addition, their needs for clinical supervision may be higher than community Idvas. If based in A&E, they are working in a setting where trauma is routine and often graphic. They face the challenge of working with more victims who have complex needs (including some whose partners are offenders, causing them to fear repercussions from approaching anyone for help), and with more victims who are at an earlier stage of change, who are more likely to return to the abuser.

“[Hospital Idvas] need therapeutic counselling because of the cumulative emotional stress of the job. This emotional strain is not so high in other Idva roles”

CEO, DVA Organisation

Out of sight, out of mind

The Idva needs to be seen and embedded in the hospital setting. Building relationships and networking are essential for the service to be successful. Also key is the need for the service to be visible and able to cope with the challenges associated with this, bearing in mind the size of the organisation and possible consequences of being prominent.

Building relationships

Hospital staff noted how networking and building relationships with hospital teams is crucial to achieving positive outcomes. Domestic abuse professionals corroborate this by highlighting how self-confidence and the ability to make contacts are important personal attributes for an Idva, and how Idvas may need support to do this.

“They (Idvas) have lunch in the staff room. They socialise with the team. That is where the success really comes from. They are not seen as a separate and aloof service that we just refer to”

A&E Nurse

“[It is] important to build rapport with hospital staff. Having [a] recognisable face... hospital Idvas need confidence to network and introduce themselves”

Idva Team Leader

“I felt really lonely just being there in the beginning. Trying to find people to introduce myself [to]. It still is lonely”

Hospital Idva

Putting down roots

Further to building relationships, staff mentioned that having an Idva based in the hospital setting prompted their awareness of the service. Idvas without a hospital base to engage with victims noted how this negatively impacted on their practice.

“Domestic violence is in your mind because we walk past their door. Having them here is a constant reminder to us”

A&E Consultant

“If I had [an] office – that might help...”

Hospital Idva

“I can’t really see anybody here... [I’ve] not got a private room to see people in”

Hospital Idva

The visibility of the Idva

Hospital staff stressed the need for the Idva to be visible and accessible in order for them to remember to use the service. As indicated in the previous section, this can pose problems for Idvas if they do not have a base in the hospital to operate from. However, a more prominent presence can cause challenges for Idvas in prioritising their workload.

“They go around the department every day and speak to the staff... check for referrals. If they are not visibly there we don’t remember to use the service because [the] department is very busy”

Alcohol Nurse

“[The] fact that she’s instantly accessible. [The] role is very, very, very busy and it is constant... Medical staff expect if she is there, to be able to talk to her, get information from her, for her to act. Whereas [it] gives that role less time to prioritise... [it] is a real challenge of the role”

CEO, DVA Organisation

Another consideration of being ‘seen’ in the hospital setting is that patients also become aware that the service is there. This may be beneficial for victims as it creates an additional self-referral pathway, but there also needs to be consideration of the implications of being aware of the service and how this will be managed.

“In the past, we would get multiple victims turn up numerous times in A&E. They might be just to see us. Walk into reception: ‘I’m here to see [XYZ] services’. [A] couple came out of the blue”

Senior Idva

“The question is whether to publicise... there is risk to the client if word gets out that we are running the study; a relative or friend see Idva with client and identify. It can put client and service at risk...”

Research Nurse

The scale of the task

A concern of both hospital staff and professionals was how to raise awareness internally of the domestic abuse service, given the large size of the hospital organisation. Idvas noted the importance of reaching all departments and staff highlighted the need for this to be organised and promoted for successful implementation and outcomes.

“The sheer scale of the place. All the different wards knowing about us and how to refer to us... I think we are missing quite a lot of opportunities”

Hospital Idva

“For any new Idva, going into any hospital, there has to be a plan... you have got to sell yourself... to get across what you are there for, in an easy-to-understand way. If just the Idva, [they] can be [the] lone voice in [a] massive organisation”

Adult Safeguarding Lead

One Idva noted how the support of senior hospital staff can act as a bridge between hospital teams and the service.

“For a hospital Idva service to run properly and be accepted by hospital staff, you need a medical champion – the higher up the better. Junior doctors want to impress them – they don’t want to miss stuff. So if the senior medic says this is important, then they’ll look for it”

Senior Idva

Following NICE guidelines

NICE published quality standards in February 2016 setting out how health staff should ask about domestic abuse. Quality Statement 1 suggests that “services should ensure that they can provide a safe and private environment in which people feel able to disclose that they are experiencing domestic violence and abuse.”⁹³

Our research highlighted a number of issues with asking victims about domestic abuse. For example: whether to make a targeted ask; the disparity between staff who do or don’t ask; concerns about asking; and effective ways of asking about domestic abuse in a private space.

Asking about domestic abuse

Responses from hospital staff indicated a difference in opinion about whether all patients should be asked about domestic abuse, or whether enquiries should be targeted in line with NICE guidelines. Some consider that consistent questioning removes the taboo, whereas others have reservations about whether they should be building an evidence case, and whether this is sustainable or a priority for their role. Domestic abuse professionals who were interviewed mostly advocated asking all patients, but noted the varying practices for screening across hospitals.

“Routine enquiry is good because [it] gets rid of [the] fear of asking... we will pick up ones we wouldn't suspect and hopefully pick things up earlier and more subtly. It loses the supposed stigma in asking about these things”

A&E Consultant

“We do targeted enquiry... general screening is not as successful. The evidence shows we should ask certain risk groups”

A&E Consultant

“I don't know that [universal enquiry] is sustainable long-term... also not main priority of our roles. Our role is focused assessment, not screening”

Emergency Medicine Consultant

“The evidence is saying we should actually ask it, and ask it with confidence. Not ‘I am really sorry, I have got to ask this’. Without an apology, as if it is a normal thing to ask”

Council Commissioner

While advocating asking everyone, some hospital staff felt that workload pressures and lack of resources prevent this.

“I actually think we should ask everybody... but our workload is too onerous... if we had more resource I think I would routinely screen everybody and I think we could pick up people. If we only screen people we think are at risk, we already miss half the people”

A&E Consultant

“If we were serious about really looking for this, we would find things we don't want to find. Unfortunately... we haven't even marshalled resources to deal with what we already see, so why triple our workload?”

Consultant Psychiatrist

The fear of asking

Staff indicate that there are some hospital employees who are cautious of asking patients about domestic abuse. This can be due to the difficulty of asking the question, or a fear of the outcome and potential of having to deal with a disclosure. Idvas note a common concern among hospital staff of 'opening a can of worms'. A further indication that emerged was the likelihood that there will be staff who have experienced or are dealing with domestic abuse themselves.

"I think staff are uncomfortable about asking unless it clearly relates to an injury or relationship issue... [They think] 'if I ask about their relationship, that will open up a whole can of worms, and I am not comfortable with that and haven't got the time'"

Team Leader Mental Health

"Some people feel really uncomfortable asking. [We] often do case studies: if we find someone who has disclosed, [we] look at last attendance. Go to staff, 'why didn't you ask?' No explanation given"

Senior Hospital Idva

"People would find a hospital Idva in the corridor and tell them quite powerful stuff. Obviously nursing staff are mainly female. Quite [a] high incidence of abuse... feeling was [that] quite lot of people were feeling uncomfortable because it brought up a lot for themselves"

A&E Consultant

"[Idva]... used to get a lot of disclosures from hospital staff... if you had experienced it and had survived or just got on with it, you might be less sympathetic in asking that question"

Idva Team Leader

Staff who don't ask

Hospital staff and Idvas also highlight the inconsistency across individuals and departments regarding the importance of asking about domestic abuse. Idvas note this disparity is also present in departments that have been advised to routinely screen.

"Some wards and departments are very much geared up to be aware of domestic violence... might get other wards where [domestic abuse] is not a huge issue... less part of the culture to ask about"

Clinical Nurse Specialist

“Some, especially male nurses, won't ask because they feel awkward... one said 'you just know, it is just obvious'... one won't ask because she wouldn't like to be asked herself. Ambulance staff don't ask... if they do, [they] don't do anything about it”

A&E Sister

“Dental have been quite unco-operative. They say that they don't see much domestic violence but about 30% [of] assaults we get through are facial/dental injuries”

Idva

“[Idva has] only had two to three referrals from [maternity ward in hospital] since June 2013. Few from community midwives and [a] couple from maternity discharge planning team”

Hospital Idva

The best way to ask

Staff acknowledged that the training given by Idvas about how to ask patients the question about domestic abuse was beneficial. Some of the most effective ways of asking concentrated on engaging around the issue rather than direct questioning.

“Asking around [the issue]... you can get a sense of their world. Gaining someone's trust and showing interest from that comment: 'I am cold at home... I'm not allowed to put the heating on because John won't let me. He says I am lazy”

A&E Practice Development Nurse

“Do you think there are any problems at home? We have seen these injuries that have been based on domestic violence in the past. Is there anything you would like to tell me?’ You are not putting words in their mouth but empowering them to say it. A lot of that has come from our Idva here – empowered [us] to move from taboo to routine”

A&E Consultant

The golden window of opportunity

When a patient discloses domestic abuse, it is important to act immediately. Victims in the hospital setting are often at the 'point of crisis' and motivated to disclose. Once again, the importance of co-location is emphasised as it aids immediacy and promotes engagement.

In the right place, at the right time

Hospital staff and Idvas noted the benefits of co-location in order to have an immediate response for the victim so they do not lose the opportunity to engage with them. Staff noted how they would benefit from an out-of-hours service or helpline.

“Key thing is, sometimes, I think we should have [Idvas] here as much as we are... when someone starts to open up, we really want to respond right there and then...[you can say] we have got specialist people here to give really good advice, options, pathways”

Clinical Nurse Specialist

“[A] woman in her 70s... disclosed a lot of abuse... by Monday morning, she denied everything. Even an on-call system for advice would be nice out of hours”

A&E Sister

“[You’ve] got to find windows of opportunity. The window stays open for about four hours and [you’ve] got to do everything you can within it”

Idva Service Manager/Commissioner

“We are catching people at point of crisis, at the time. Otherwise, they have gone home and been reluctant to engage. We are getting there earlier”

Hospital Idva

The motivation to change

Domestic abuse professionals note that presenting at a hospital setting at crisis point or with an injury may act as a motivating factor in the ‘stages of change’.⁹⁴ Hospital staff also recognise a client’s moment of bravery and an impulse to make change.

“Some, because injured, are very motivated. [It] drives them through stages of change. [It] can lead to emergency accommodation or injunction”

Senior Idva

“Because often that person will have momentary ‘weakness’... in truth, that is a moment of bravery followed by deep anxiety about what they have done and said”

Consultant Psychiatrist

Sowing the seed

While the hospital setting can identify victims earlier, a client may not always be ready to engage. However, the initial contact gives professionals a chance to identify and pass covert information to a victim for further consideration.

“For me, meeting someone and advising them of their options... is a move in the right direction. I am happy with that... at some point when they are ready, then they know that there are options”

Hospital Idva

“When we close, we make sure they know who they can contact if it happens again. Knowing they can call us if they need to is really helpful”

Hospital Idva

“[Our intervention]⁹⁵ gives them that bit of time. Quite often when we see people, there is so much happening. From a slightly personal point of view, you always feel slightly better that you have done a bit of a better deed than just send them back to some awful sort of situation”

Clinical Nurse Specialist

Working together to tackle domestic abuse

Hospital staff, departments and agencies need to work together to identify and assist victims of domestic abuse. This can range from alerting professionals about possible victims, to how the hospital location can make services more easily accessible to victims; from the issues of sharing information, to what Idvas can do to encourage a good working relationship with hospital staff.

Flagging and tagging

Hospital staff noted how ‘flagging’ cases can alert staff and other services to vulnerable patients. Idvas promote the benefits of this and show hospitals where flagging is not practiced how this can hinder partnership working.

“Now [you] must document on a hospital record. Now it’s a computerised record, box you tick. If you suspect domestic violence but it’s not disclosed, [you must] document that you asked. Continue monitoring and surveillance. A lot of what we do is fact-finding and info-sharing”

Lead Nurse for Safeguarding

“Repeat attendances at A&E as a result of the abuse will come up on the system... number of times in before, red alert, under Idvas. Red flag goes straight to Idvas – alert”

A&E Nurse

“In past jobs we haven’t had info because people have been anonymous, talking to us on the phone. Here, if people don’t want to engage, we can flag to hospital and GP and Marac without consent and feel we are more effective really”

Hospital Idva

“They [another hospital] can put flags on patient records. If Marac victims – flag, put referral to Idva on them. Here, unless there is a child or open SOVA⁹⁶ they wouldn’t be able to do that... [not being] on the system makes it [a] lot more difficult for partnership working”

Hospital Services Manager

Fast-tracking

Idvas comment on how being in the hospital environment gave them the ability to have prompt access to other services and the ability to fast-track patients to appropriate interventions. Due to the emphasis put on safeguarding within hospitals and co-location, children can be referred to services immediately and plans can be put in place to protect new-borns.

“[There is a] lot more close liaison with other specialists, which can be harder to do in community-based [services] – we are in the same building”

Senior Idva

“We are identifying more domestic violence victims because we are here and therefore we are identifying more children... we [have] really good links with child protection on site in case children are abused”

Hospital Idva

“A lot of victims are pregnant, we do lots [of] good work with post-natal and some antenatal and labour wards to plan for birth and afterwards”

Hospital Idva

Working and sharing

Hospital staff note the unease of sharing information and how setting up Idvas with secure email, for example, can help overcome barriers.

“Info-sharing and confidentiality... I think there is always that level of discomfort and making sure you are disclosing only what needs to be disclosed. This is one of the biggest barriers”

A&E Consultant

“Previously the Idva had already worked on faxed referral process and went to email address but wasn’t secure for NHS address... so I created nhs.net email address for referrals to be sent so that Idvas could use. So staff [could] email Idva and send referrals confidently – owned by Trust, so that staff never worry”

Adult Safeguarding Lead

Some Idvas note how co-location has assisted in forming good working relationships, whereas hospital staff highlight how operational differences between groups can hinder multi-agency working.

“I think co-location is critical... there is real information-sharing... being physically there makes such a difference. Amount of contact I have now and good relationships I have now with other professionals [is working well]”

Idva Team Leader

“Trying to marry services that are chalk and cheese”

Adult Safeguarding Lead

“Different thresholds for what would they [agencies] think is important. I spend quite a lot of time building up good networks. Sometimes people say... ‘we are on different planets’”

Lead Nurse for Safeguarding

Some staff mentioned how they would like feedback from the Idva on what happens with referrals to encourage a good working relationship.

“I’d like a bit more knowledge of what happens next... [I] make initial referral and never really find out what happens next... doesn’t help motivate me to make referrals”

Consultant Psychiatrist

“Nice for the staff... what was the outcome? Nice to have a bit of feedback”

A&E Sister

Chapter 6 – Checklist for Commissioners of hospital-based domestic abuse services

- Idvas need to have **strong links with community-based provision** and be trained in community-based interventions to ensure they can refer victims appropriately. Idvas who have a mental health background would be particularly suited to working within this setting.
- Hospital Idvas should be valued and **integrated within hospital staff** – they need to be set up with an email, ID with access to wards, an appropriate room, access to hospital register/patient records, and an appropriate hospital manager (such as the Safeguarding Lead). Without access to medical notes on the hospital's database, it is difficult for Idvas to monitor key risk indicators that could be used to assess risk and share with Marac. These indicators could include repeat attendance, other types of attendance for other symptoms or injuries, or other mental health, physical health or drug/alcohol factors.
- Good **clinical supervision** for Idvas helps them to feel well supported in the complex hospital work environment. Within A&E, and the hospital generally, Idvas are far more exposed to the very visible effects of abuse, compared with community-based Idvas who may see clients after they have received medical care. Consideration should be given to whether an Idva needs an 'honorary' NHS contract so that they are given a salary band within the hospital which further embeds them into the structure.
- Think about the number of Idvas needed to cover a **seven-day service**. The number of victims visiting a hospital peaks on Friday and Saturday evenings (and in some cases on Sunday or Monday when victims come into a service having waited over the weekend). Commissioning a 24/7 service could help to ensure that victims receive support when they need it. Idvas should not be 'lone workers' and the number of Idvas employed should reflect the number of hospital patients, so caseloads can be managed appropriately.
- The service commissioned should be **sustainably funded** over the long-term rather than a 'one-off' – to ensure it successfully embeds in the hospital. The Commissioner should pay particular attention to how they hold the hospital accountable for how it embeds the Idva service, and ensure there is attendance at steering group meetings to help make the most of the service.
- The Lead Consultant in A&E/Maternity needs to be on board with the service right from the start, and every ward/department should have a **Senior Domestic Abuse Champion** who helps the Idva to make links with departments. Buy-in from safeguarding teams is particularly important.
- **Expectations** of the Idva need to be defined from the start, particularly in relation to staff training and referrals. Training in particular is demanding on Idvas given the number of staff in a hospital setting, and extra support needs to be planned to enable them to fulfil this vital part of the role. Hospital Idvas need to have a high level of confidence in order to carry out training at all staff levels in the hospital, and to make links with all departments.

- The first six months of the role need to **focus on setting up** the service, instituting policies and training, not taking referrals.
- All hospitals should have a domestic abuse policy in place for both patients and staff. Hospitals should be ready for high rates of **disclosure by hospital staff**, and recognise the challenges posed by disclosures from staff whose perpetrator is also employed by the Trust, particularly in relation to potential access to confidential information.
- Idvas need to be **embedded in the hospital**, ideally with an office in the A&E department, and highly visible with reach to all hospital departments. For example, the service could be advertised on payroll slips, on the intranet, on every ward, in waiting rooms and in toilet cubicles through posters and leaflets.
- All staff need **mandatory domestic abuse training**, ideally delivered by the Idva as part of safeguarding training at Level 1, and at any other training opportunities. Domestic abuse training should be part of the hospital induction.
- Hospital staff asking about domestic abuse should follow **NICE guidelines**. The presence of hospital Idvas makes this much more likely in practice.
- SafeLives estimates that one full time Idva costs **approximately £50,000**. This includes salary costs as well as associated costs, such as management and administration overheads, training and accreditation to ensure quality. It also includes clinical support to ensure an effective service can be delivered. Safe caseloads range between 65 and 85 for Idvas and outreach workers; typically Idvas are expected to support victims at high risk and some medium-risk cases (likely to require less intensive support). While all hospital Idvas will take referrals at all levels of risk, only some will go on to provide support to victims at all levels of risk. However, hospital Idvas will spend up to 25% of their time training other members of clinical staff, so their caseloads need to be commensurately smaller.⁹⁷

Chapter 7 – Understanding the impact of hospital- based domestic abuse services

Increased safety

After an intervention by hospital-based domestic abuse services, according to the Themis Insights dataset, 9 out of 10 hospital and community victims reported feeling safer, with just over half (58% hospital, 51% community victims) saying they felt “much safer”. Similarly, 9 out of 10 hospital and community victims felt their quality of life had improved, half by “a lot” (53% hospital, 49% community victims).

Almost all victims felt confident to access help in future, with over half saying they felt “very confident” (56% hospital, 57% community victims). Idvas reported sustainable risk reduction (that is, moderate or significant risk reduction that is expected to be sustainable in the medium- to long-term) for similar numbers (64% hospital, 67% community victims).

For **hospital and community victims, improved safety** reported by Idvas increased if support was more intensive.⁹⁸ This includes:

- **more interventions accessed (6+);**
- **a longer period of support (i.e. case length); and**
- **more Idva contacts (5+).**

Improved safety from the abuse **dropped if patients had ever had suicidal behaviour** (i.e. plans/attempts).

For **community victims**, increased Idva-reported **safety was more likely** if:

- **the perpetrator had financial problems; or**
- **the victim had experienced more severe physical abuse at Idva intake.**

For **community victims**, improved Idva-reported safety was **less likely if the victim had alcohol or drug problems.**

In terms of improvements in reported safety, victims saw similar ‘success’ rates whether they accessed hospital or community Idvas. When we take into account the higher rates of complex needs and suicidality among hospital victims, these similar success rates are a notable finding.

A chance to identify victims earlier

Hospital victims had used all hospital services⁹⁹ more than community victims in the six months before Idva intake (perhaps partly because of their poorer physical health and worse depression, and partly because hospital Idvas are mostly picking up referrals from hospital staff). The difference was significant for inpatient nights and A&E visits, but not outpatient appointments. They had also used ambulances more often to get to the A&E.

A&E use

In the six months before they started working with an Idva, just over half of the hospital victims (N=41) had attended an A&E at least once (or, rarely, a walk-in Minor Injuries Unit), compared to less than a third of community victims. This reflects the fact that 38 of these hospital Idva victims had been referred to the Idva by the A&E; whereas none of the community Idva victims were referred by these means.

- **More hospital Idva victims** had attended an A&E (54% compared to 29% community victims).
- More hospital victims said they had visited A&E because of **domestic abuse** (38% compared to 18% of community victims).
- More hospital victims had visited A&E for **mental health reasons**, largely overdoses and self-harm, for which they would be considered for physical *and* mental health treatment (22% compared to 3% of community victims).
- One in six hospital victims (16%) had been taken to A&E after an **overdose**, compared to just one of the community victims (3%), perhaps reflecting hospital victims' higher rate of depression.

Altogether, in the six months before accessing the Idva service, the 76 hospital victims made 103 visits to A&E (averaging 1.4 visits each), and the 38 community victims made 14 visits (averaging 0.4 visits each).

However, if an extreme outlier is omitted from the hospital sample (whose weekly A&E and ambulance use represented less than 0.05% of the UK population and strongly skewed results for this sample), 75 hospital clients had made 73 visits to A&E (averaging 1.0 visits each). The following findings exclude this outlier.

Community Idva victims showed a very different pattern of A&E attendance from victims referred by hospital Idvas. Fewer had been to A&E before starting to get help from an Idva, and nearly all attendances were for physical health reasons. Even so, the fact that 29% had been to A&E

in the six months before accessing a community Idva, and that almost all of their visits (86%) were related to domestic abuse – nearly two-thirds (64%) specifically because of injuries by the abuser – indicates the important potential for hospitals to identify these victims earlier.

It may also have been possible to identify some hospital victims earlier: 18 of the 41 (44%) hospital victims who had visited A&E in the six months before referral had visited more than once.

There is considerable potential, then, for hospital A&Es to identify victims of domestic abuse earlier – patients they are already identifying who have visited previously, and those they are not identifying, who later come to the notice of the police who then refer them to a community Idva. Not all victims would be prepared to disclose, but at least they would know where to go for help when they needed it.

Ambulance use

- At least half of the ambulance uses for both hospital and community victims were related to domestic abuse; considerably more for community victims (83% compared to 52%).
- Only one in six (16%) ambulance uses by hospital victims were because of physical injury by the abuser, compared to four in six by community Idva victims.
- Well over half of the ambulance uses were for physical health reasons, particularly for community Idva victims.
- Mental health (predominantly overdose) was a more common reason for ambulance use by hospital victims: accounting for one in three for hospital victims and one in six for community victims.

In two-thirds of the cases where a victim attended A&E for a condition related to domestic abuse (injury, overdose, or existing physical/mental complaint worsened by stress of the abuse), they travelled there by ambulance (63% of all 49 domestic abuse-related A&E visits by hospital and community victims). This puts ambulance crews in a potentially key position to identify domestic abuse victims, particularly as they see them soon after the health crisis, when victims may be more willing to disclose. This was the case for 29% of all victims later referred to a hospital Idva, and 13% of victims later referred to a community Idva. In some cases, the victim is not transported to hospital – in which case, the ambulance crew may be the only healthcare staff that victims see after an incident.

Ambulance crew should be included in domestic abuse training and understand the referral pathway for highlighting disclosure and the need for domestic abuse questions to be asked.

Use of hospital service post- Idva intervention

The number of hospital services used pre- and post-intervention was compared for 30 hospital victims (excluding the outlier) over a three-month period.¹⁰⁰ Caution must be exercised when interpreting these results because of the small size of the sample, but they can be regarded as indicative.

Before accessing support from an Idva, hospital victims had spent, on average, two nights as an inpatient in the past three months. Post-intervention, no victims had spent time in hospital as an inpatient. This emerged as a significant difference. Interestingly, the number of outpatient appointments increased by 30% post-Idva intervention. This may have been because victims had been put in touch with hospital services after accessing the Idva, particularly those related to mental health and substance misuse.

For the 30 hospital victims asked at Idva intake and three months after Idva exit, there were no significant differences in the use of community services and mental health services.¹⁰¹ This perhaps illustrates the long-lasting effects of domestic abuse on victims' health.

Cost-benefits of the hospital Idva service

Despite the long-term impact domestic abuse has on health, this analysis identified that there could be a cost saving in health services once victims have accessed the hospital Idva service. On average, an individual accessing the hospital Idva service costs £4,000 in healthcare services during the six months before and after the Idva intervention. After receiving support, costs were reducing by 41% per client, equivalent to an estimated £2,050 annual reduction in health service use per client. Community Idva victims cost £1,066 per annum in their use of hospital, local and mental health services.

This study cannot identify how much of this drop in health service use was a result of the Idva intervention, however it does identify that the reduction in costs is largely based on the use of hospital services.

In a separate pilot of the Idva service at Saint Mary's Hospital, Manchester, the evaluation team calculated that the 28 cases referred to Maracs as part of the pilot saved the public sector £170,800, compared with the costs of £50,591 to the health service of employing a full-time Idva.¹⁰²

Specific service savings

The health cost saving after a hospital Idva intervention is £2,050 per patient, per year. This consists of:

- **Saving in hospital service use** (i.e. inpatient, outpatient, A&E) of £2,184 per patient, per annum
- **Saving in ambulance use** of £200 per patient, per annum
- **Rise in local surgery use** (i.e. GP, practice nurse, nurse practitioner, health visitor) of £64 per patient, per annum
- **Rise in mental health service use** of £196 per patient, per annum
- **Rise in drug/alcohol service use** of £74 per patient, per annum

There is also a **rise in social services costs** (social worker and child and family support worker) of £282 per patient, per annum.

Higher use of mental health and alcohol/drug support services post-Idva may be because victims are in a better position to prioritise their own health, rather than simply survive in an abusive relationship. The rise in social services costs may be due to this agency often only getting involved with a family once a victim with children starts to receive Idva help.

Conclusion

Specialist domestic abuse services that are co-located within mainstream services, in this case hospitals, are likely to be a crucial part of a system that effectively responds to domestic abuse as quickly as possible to get the response right first time, for every family.

Hospital Idvas have a unique role to play in the response to domestic abuse in an area. The addition of a hospital Idva team to an area means 'hidden' victims (those aged 55+, for example) and vulnerable victims

(those who are pregnant or suicidal) are more likely to be identified and receive effective help.

Hospital-based services support earlier identification of victims of abuse. For example, in our evaluation, victims identified by the hospital Idva had experienced an average of 30 months of abuse, whereas victims identified by a community Idva had experienced an average of 36 months of abuse.

Victims attend hospital for health reasons that may or may not be related to abuse. This is a window of opportunity to raise awareness and recognition of domestic abuse. Victims reported that the hospital Idva helped them to recognise that their experiences were domestic abuse and so prompted them to seek help. Missed opportunities to intervene are likely to result in later identification when a situation may have escalated and the impact on the victim and their family's health and welfare has increased.

Once victims have been identified, hospital Idvas provide effective help to improve safety for victims and their families. Nine out of 10 victims engaged with a hospital Idva said they felt safer following intervention. Our findings reinforce SafeLives' longstanding recommendation that all victims engaged with a domestic abuse service receive safety planning alongside other interventions.

Hospital domestic abuse services are most effective when they are embedded in both the hospital and the community. Within the hospital, this means day-to-day visibility, established referral routes across departments, and support from senior clinical staff. Within the community, links to outside agencies (including local domestic abuse services) improves outcomes for victims. Generally, good clinical supervision for Idvas helps them to feel well supported in the complex hospital work environment.

The presence of a well-embedded domestic abuse service has value over and above the direct services to victims that it provides. Health professionals throughout the hospital are more likely to engage in asking patients about domestic abuse (as recommended by NICE) and confidently make a referral to the domestic abuse service.

Strong referral routes in and out of a hospital domestic abuse service make an enormous difference to the likelihood of a victim receiving effective help from all relevant agencies. This is especially important for victims with complex needs who are more likely to be identified in hospital and who need additional health referrals (for example, those with mental health or substance misuse issues).

Basing Idvas in hospitals could deliver cost savings, but new research with a larger sample size would need to be commissioned to confirm this.

The health service has an obligation to safeguard adults and children in its care – hospital-based domestic abuse services are one effective way of fulfilling this role for victims of domestic abuse and their children.

Appendix A – Estimated number of staff within each hospital site who may have experienced domestic abuse in the previous year

Site	Total number of staff	Percentage of female staff	Number of female staff	Female staff estimated to have experienced domestic abuse in previous year	Number of male staff
1	8,395	75%	6,313	525	2,082
2	7,282	78%	5,651	475	1,631
3	4,489	84%	3,774	300	715
4	1,584	78%	1,250	100	334
5	6,730	78%	5,249	425	1,481
Total number	28,480	78%	22,237	1,825	6,243
Average number of staff across all sites	5,696	78%	4,447	365	1,249

Appendix B – Overview of hospital- based Idva services involved in Themis

Hospital Idva service – Case study 1

Type of hospital	Large metropolitan hospital
Number of staff	7,000
Emergency Department (ED)	70,000 patients per annum
Hospital Idva service	Five years old
Cost of Idva service 2014–15	£90,000
Funded by	NHS England, Local Clinical Commissioning Group, City Council Public Health
Idvas employed by	Hospital Trust
Institutional integration	Full (staff are Trust employees with NHS badges, access to NHS emails and hospital computer system, able to 'flag and tag' cases and receive real-time alerts when patients with a history of domestic violence or abuse attend the ED).
Visibility	Very high – based in room in ED, Idvas regularly use staffroom.
Publicity for service	Posters widespread in hospital – other materials include mousemats.
Number of Idvas	Two full-time, covering seven days a week 9am–5pm

Number of hospital staff trained in domestic violence and abuse 2014–15	271
Number of referrals 2014–15	365 (Commissioner's target = 300 from ED, 25 from other wards)
Domestic violence and abuse screening policy in ED	Patients from a number of high-risk groups are screened for domestic abuse, along with those reluctant to explain how their injuries occurred, or whose partner seems overbearing or unwilling to let them speak. In one consultant's words: "Think about it for everybody, and if you have to think twice, ask."
Method of referral	Often face-to-face by calling into Idvas' room, by phone, or (out-of-hours) by online referral form (including risk assessment). This gives Idvas information about the level and type of risk, which is supplemented by access to the patient's online hospital notes.
Casework length	By agreement with their Commissioner, Idvas work with high-risk cases for 4 to 6 weeks, medium-risk cases for two weeks, and standard risk cases for one week or in a one-off consultation.*
Information sharing	Idvas are regarded as part of the hospital team, with whom confidential information can be shared.
'Toxic trio' work	There are close links with the alcohol and drug misuse and mental health teams, with joint meetings commonly held and online joint Care Plans.

* SafeLives recommends that Idvas work with high-risk cases for 3–6 months and 6–12 months for medium-risk cases.

Profile

This service is **well-embedded**, with Idvas championed by senior ED staff and enjoying good relationships with staff in ED and in the psychiatric liaison unit. They are gradually spreading their reach throughout the hospital, appointing link nurses in other wards who can train those staff. There is good continuity – one of the Idvas has worked at the hospital since the service began.

Idvas here are regarded as having an equivalent level of **expertise** to Clinical Nurse Specialists – who are recognised as an important level of healthcare staff in this hospital (they specialise in alcohol misuse, drug misuse or mental health).

All ED staff receive at least 20 minutes' **training** on domestic violence and abuse, and Emergency Nurse Practitioners receive one hour. Idvas spend a third of their time training hospital staff – tutoring on Adult Safeguarding and Child Protection courses, along with study days on domestic violence, and updates on topics such as Female Genital Mutilation, Child Sexual Exploitation, and 'Honour-Based' Violence.

In the hospital seven days a week, Idvas are on hand to give **informal advice** to staff who are unsure about making a referral. They give staff feedback on cases that have been referred to them, and reassure staff who ask a patient about domestic abuse but are met with a denial, that by asking, they have signalled to the client that help is available, if and when they do feel ready to disclose.

When the Idva service was introduced at this hospital, the level of referrals of high-risk domestic abuse cases to Marac rose from 11 to 70 a year.

Hospital staff would like an **evening Idva service**, even if on-call.

Case study 2

Type of hospital	Smaller rural hospital
Number of staff	3,000
Emergency Department (ED)	42,000 patients per annum
Hospital Idva service	Three years old
Cost of Idva service 2014–15:	£40,720
Funded by	Primary Care Trust initially, then a charitable trust
Idvas employed by	Third sector domestic abuse organisation
Institutional integration	High – Idvas have an honorary NHS contract, enabling them to have an NHS badge, access to NHS emails and ability to ‘flag and tag’ cases on the hospital computer system. (However, when second Idva was employed, it took six months to get her an honorary NHS contract.)
Visibility	Very high – although based in a room outside the main hospital building, the Idva visited the ED and Maternity wards very regularly. Idva can see patients in a pleasant, quiet room in ED and Maternity.
Publicity for service	Leaflets and posters (after approval by six panels).
Number of Idvas	One full-time equivalent (two job-sharing), Monday to Friday office hours
Number of hospital staff trained in domestic violence and abuse 2014–15	200 (plus 35 GPs); 120 in 2015–16 (plus 27 GPs)
Number of referrals 2014–15	97
Domestic violence and abuse screening policy in ED	To ask all patients where possible domestic violence and abuse indicators are present.

Method of referral	ED staff mostly use paper forms, Psychiatric Liaison mostly use phone during office hours, Maternity mostly use phone or tell Idva face-to-face on her regular ward visits. However, Idva does not necessarily know level of risk or other medical details (for example, whether mental health or substance misuse difficulty are present) or social services involvement.
Casework length	Not known
Information-sharing	This is enabled by the Idva having an honorary NHS contract.
'Toxic trio' work	If patient has substance abuse or mental health issues, information is shared with these staff and services, with whom there are good relationships. Sometimes the Idva accompanies the client to their first appointment.

Profile

The service is now working very well and there is good continuity – one of the Idvas has worked at the hospital since the service began.

However, the Idva service took a while to bed in, possibly because the Idvas are not hospital employees. For instance, it took two years before the Idva was allocated an office base in the hospital grounds. It took six months before the second job-share worker obtained her honorary NHS contract, enabling her to have an NHS badge, email and access to the computer system. Six panels had to meet to approve a domestic abuse poster for the hospital.

It also took six months of educating and training hospital staff before the service could get off the ground, which is normal for hospital Idva services.

Training can be arranged very flexibly, for instance at the start of the morning shift (8am). ED staff are given a 45-minute training session on domestic violence and abuse during their initial Safeguarding Training. Full-day refresher training on domestic violence and abuse is also offered, though this is optional. Maternity staff can be trained in a half-hour handover period, with between three and 15 members of staff involved, and there is online e-learning.

There are very **close relationships** with both ED and Maternity staff. This includes joint working with Maternity staff, compiling joint care plans for when the mother returns home with her baby.

Hospital staff would like an **evening and weekend service**, even if on-call or telephone advice.

There can sometimes be difficulties in **liaison** between the hospital and the organisation employing the hospital Idvas.

Endnotes

1. Office for National Statistics (ONS) (2016), Crime Survey England and Wales 2014–15. Please note that the ONS is currently reviewing its national datasets following criticism that its cap on violent crimes per victim was underestimating the extent of domestic abuse
2. HM Inspectorate of Constabulary (HMIC) (2015), Increasingly everyone's business: A progress report on the police response to domestic abuse
3. Victims at high risk are those who are likely to be seriously harmed or murdered by their partner. SafeLives has developed a DASH risk checklist for the identification of high-risk cases of domestic abuse, stalking and 'honour'-based violence www.safelives.org.uk
4. SafeLives (2015), Insights Idva National Dataset 2013–14
5. SafeLives (2015), Getting it right first time: policy report
6. Ibid.
7. SafeLives (unpublished), Insights Idva National Dataset 2015/16
8. Ibid.
9. SafeLives Children's Insights Dataset 2014; based on a sample of 877 children's cases collected by specialist support services
10. Department of Health (2011) http://webarchive.nationalarchives.gov.uk/20130107105354/www.dh.gov.uk/en/MediaCentre/Pressreleasesarchive/DH_113837
11. Walby, S. (2009), The cost of domestic violence: up-date 2009
12. SafeLives (2015), Safety in numbers report, www.safelives.org.uk
13. SafeLives (2015), Getting it right first time: policy report, www.safelives.org.uk
14. Ramsay et al. (2002)
15. The full evaluation can be found on the SafeLives' website, www.safelives.org.uk
16. Walby, S. (2004), The cost of domestic violence. Women and Equality Unit
17. This is the median. The mean was 63 months for hospital victims and 63.3 months for community victims.
18. SafeLives (2015), All Welcome, www.safelives.org.uk

19. NICE (2016), Quality Statement 1, NICE guidance, Domestic Violence and Abuse
20. www.nice.org.uk/guidance/ph50/resources/domestic-violence-and-abuse-multiagency-working-1996411687621
21. See Appendix A
22. Crime Survey of England and Wales 2012/13 (2014), Why the victim did not tell the police about the partner abuse experienced in the last year
23. Confidential enquiry into maternal and child health for England and Wales (2001), Why mothers die 1997–1999
24. www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-alerts-policy.pdf
25. Walby, S. (2009), The cost of domestic violence: up-date 2009
26. www.devon.gov.uk/de/text/cost_of_dv_report_sept04.pdf
27. All these figures are based on the average for a sample of 29 Idva victims assessed pre- and post-Idva intervention.
28. Data provided by the Care Quality Commission (CQC). We have been unable to obtain figures for the number of acute hospitals in England. There were 181 A&E Departments in 2012 www.whatdotheyknow.com/request/address_of_major_ae_departments and 152 Midwifery Units in 2013 www.nao.org.uk/wp-content/uploads/2013/11/10259-001-Maternity-Services-Book-1.pdf
29. A more detailed checklist for Commissioners of hospital-based domestic abuse services can be found in **Chapter 6** of this report.
30. www.who.int/bulletin/volumes/89/1/10-085217/en
31. Department of Health (2010), Responding to violence against women and children – The role of the NHS
32. In one case, confidentiality was breached, following the appropriate procedure, out of concern for one client's suicidality.
33. SafeLives (2015), Safety in numbers report, www.safelives.org.uk
34. SafeLives (unpublished), Insights Idva National Dataset, 2015/16
35. SafeLives (unpublished), Insights Outreach Dataset 2014/15
36. Crime Survey England and Wales 2014/15
37. Kramer, Lorenzon and Mueller (2004)
38. Lorenzon and Mueller (2004)
39. Fugate et al (2005)
40. Crime Survey of England and Wales 2012/13 (2014), Why the victim did not tell the police about the partner abuse experienced in the last year
41. SafeLives (2015)

42. www.citizensadvice.org.uk/Global/CitizensAdvice/Crime%20and%20Justice%20Publications/Linkinthechain.pdf
43. www.lancaster.ac.uk/fass/doc_library/sociology/Cost_of_domestic_violence_update.doc (link points to a direct download)
44. www.nice.org.uk/guidance/cg133/resources/costing-report-184853629
45. Ramsay et al. (2002), op. cit.
46. www.ncbi.nlm.nih.gov/pmc/articles/PMC4716185
47. See **Chapter 6** for guidance on commissioning a specialist domestic abuse service.
48. NHS Manchester (2010), PATHway: an Independent Domestic Violence Advisory service at Saint Mary's Hospital
49. <http://eprints.uwe.ac.uk/19071>
50. <https://info.uwe.ac.uk/news/uwenews/news.aspx?id=2017>
51. www.nursingtimes.net/news/education/call-for-mandatory-domestic-abuse-awareness-training/7005752.article
52. www.irisdomesticviolence.org.uk/iris
53. HARKS is a mnemonic for Humiliate, Afraid, Rape, Kick and Safety and is triggered by Read-coded symptoms and conditions associated with domestic abuse. HARKS is a reminder to ask about domestic abuse and is a safe way to record data.
54. www.bristol.ac.uk/primaryhealthcare/researchthemes/responds/about
55. www.bristol.ac.uk/primaryhealthcare/researchthemes/reprovide/about
56. <http://avaproject.org.uk/ava-services-2/multiple-disadvantage/promoting-recovery-mental-health-primh/>
57. www.bristol.ac.uk/primaryhealthcare/researchthemes/path.html
58. Bair-Merritt et al. (2014); Coker et al., (2012)
59. Bacchus et al. (2010)
60. Campbell (2002); Campbell et al. (2002); Coker et al. (2000)
61. Ferrari G., Agnew-Davies R., Bailey J., Howard L., Howarth E., Peters T.J., Sardinha L., Feder G.S. Domestic violence and mental health: A cross-sectional survey of women seeking help from domestic violence support services. *Global Health Action*, 8 February 2016 (29890), 1654–9716
62. Connell et al. (2007)
63. <http://weareagenda.org/wp-content/uploads/2015/11/Hidden-Hurt-full-report1.pdf>
64. Devries et al. (2013)
65. Ferrari et al. (2014)
66. Helton et al, (1987); Walby and Allen, (2004); Lewis, (2007)

67. Confidential enquiry into maternal and child health for England and Wales (2001), Why mothers die 1997–1999
68. CAADA (2012), CAADA Insights 1: A place of greater safety
69. Radford, L., Corral, S., Bradley, C., Fisher, H., Basset, C., Howatt, N. and Collishaw, S. (2011), Child abuse and neglect in the UK today. London: NSPCC
70. Radford et al. (2011); Hamby et al. (2011)
71. For a review of the literature, see: Early Intervention Foundation (2014), Domestic violence and abuse review.
72. Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C. and Megson, M. (2011), New learning from serious case reviews: a two year report for 2009–11. London: Department for Education
73. CAFCASS (2012), 'Three weeks in November ... three years on' CAFCASS care application study 2012
74. Sohr-Preston and Scaramella (2006)
75. Department of Health (2013)
76. SafeLives (2014), In plain sight, www.safelives.org.uk
77. Responding to violence against women and children – the role of the NHS: The report of the Taskforce on the Health Aspects of Violence Against Women and Children, March 2010
78. NHS (2016)
79. www.nice.org.uk/guidance/qs116
80. www.nta.nhs.uk/uploads/why-invest-2014-alcohol-and-drugs.pdf
81. Walby, S. (2004), The cost of domestic violence. Women and Equality Unit
82. Walby, S. and Allen, J. (2004), Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. London: Home Office
83. <http://online.liebertpub.com/doi/pdf/10.1089/jwh.2010.2051>
84. For a review of the literature, see: Early Intervention Foundation (2014), Domestic violence and abuse review. London: Early Intervention Foundation
85. See **Chapter 2** for the policy context for more detail on the impact on children living with domestic abuse.
86. SafeLives (2015), All Welcome, www.safelives.org.uk
87. Of the 18.7 million adults admitted to hospital in 2015, around 7.6 million (41%) were aged 65 or over. www.ageuk.org.uk/Documents/EN-GB/Factsheets/Later_Life_UK_factsheet.pdf?dtrk=true
88. While there is little research on the use of services by higher-income victims, there is anecdotal evidence that they remain hidden: www.thedailybeast.com/articles/2013/02/28/domestic-violence-among-the-wealthy-hides-behind-veil-of-silence.html

89. Crime Survey of England and Wales 2012/13 (2014), Why the victim did not tell the police about the partner abuse experienced in the last year
90. This is based on the victims' knowledge and may be an underestimation because perpetrators often hide previous criminal behaviour from new partners.
91. A physical disorder in which the symptoms have no known or detectable organic basis but are believed to be the result of psychological factors such as emotional conflicts or stress.
92. A pseudo-seizure may occur as a psychological reaction to severe trauma or stress.
93. www.nice.org.uk/guidance/qs116/chapter/Quality-statement-1-Asking-about-domestic-violence-and-abuse
94. SafeLives (2013), Themis practice briefing, page 1
95. Information about methods of communicating covertly with victims is concealed in this report to ensure they remain effective in the long-term.
96. Safeguarding of Vulnerable Adults
97. Descriptions and analysis of two models of hospital-based Idva services can be found at Appendix B
98. Controlling for gender, high-risk abuse and case length, except where case length was the correlating factor.
99. That is, inpatient, outpatient and A&E, but excluding antenatal services.
100. Number of uses at Idva intake was halved, to make the period equivalent to the three-month post-Idva period.
101. Number of uses at Idva intake was halved, to make the period equivalent to the three-month post-Idva period.
102. NHS Manchester (2010), PATHway: An independent domestic violence advisory service at Saint Mary's Maternity Hospital

SafeLives

CAN Mezzanine,
32–36 Loman St,
London, SE1 0EH

Suite 2a, Whitefriars
Lewins Mead
Bristol, BS1 2NT

0117 403 3220
info@safelives.org.uk
safelives.org.uk

Charity no: 1106864
Company no: 5203237

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