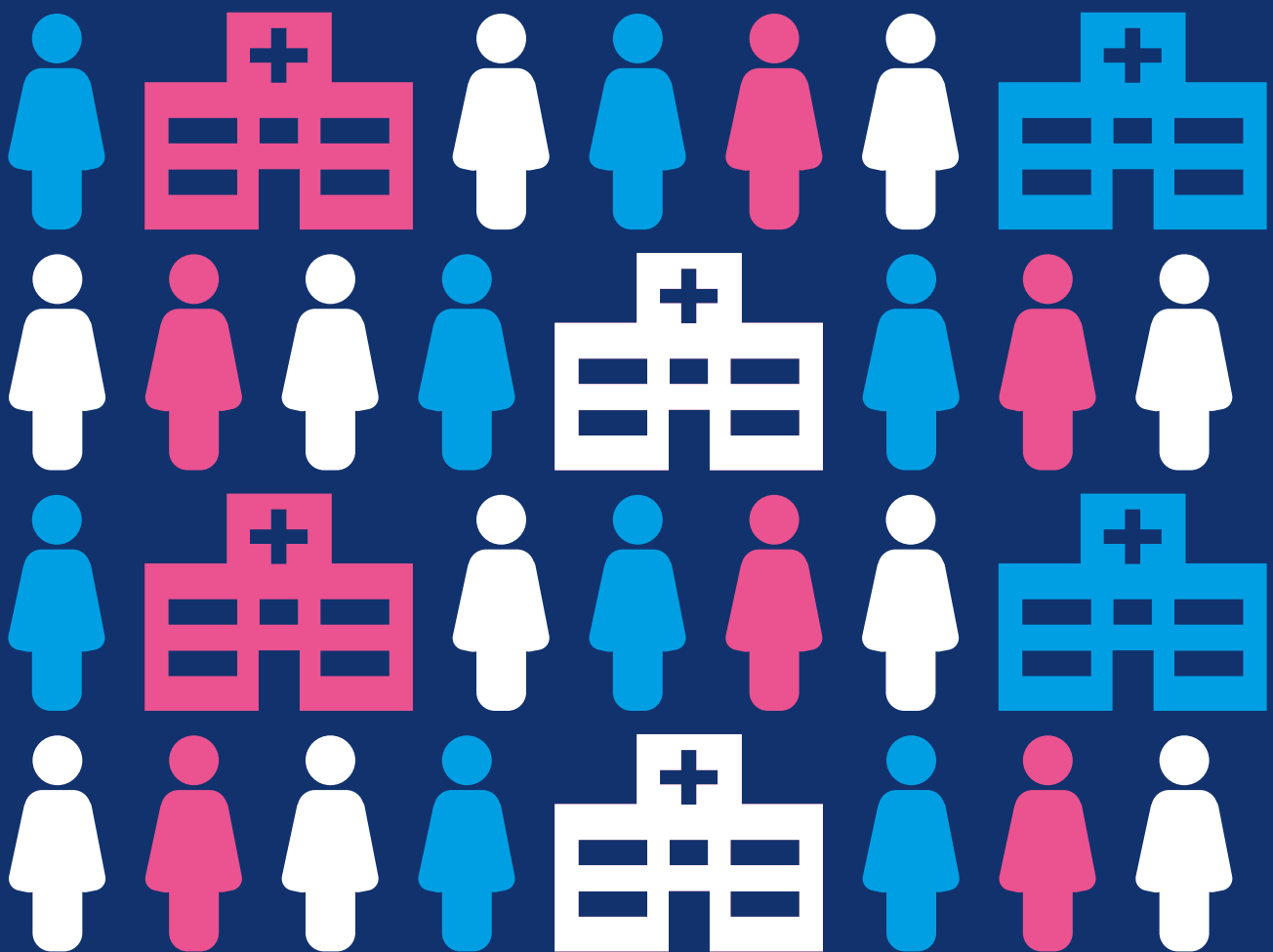


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# A Cry for Health

## Why we must invest in domestic abuse services in hospitals



Ending  
domestic  
abuse



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## Glossary

<b>A &amp; E</b>	Accident and Emergency Department in hospital (also known as Emergency Department)
<b>CI</b>	Confidence Interval (values between which there is 95% probability that the mean value for the population lies)
<b>DVA</b>	Domestic violence and abuse
<b>ED</b>	Emergency Department in Hospital, also known as A and E (Accident and Emergency)
<b>Idva</b>	Independent Domestic Violence Advisor
<b>Idsva</b>	Independent Domestic and Sexual Violence Advisor
<b>IQR</b>	Inter-Quartile Range (the middle 50% of values that extend from the largest of the bottom 25% to the smallest of the top 75%)
<b>Local surgery</b>	Local GP practice or Health Centre where clients can access a GP, Health Visitor or Practice Nurse
<b>Local practice</b>	As above
<b>Marac</b>	Multi-Agency Risk Assessment Conference
<b>Mdn</b>	Median (midway value, below which there are as many values for a variable as there are above)
<b>M</b>	Mean – average, the mathematical midpoint where the total sum of values is divided between the number of values
<b>N</b>	Total number of individuals in the sample
<b>n</b>	Number of individuals in a sub-sample of the main sample
<b>NS</b>	Not Significant (where a statistical test shows the finding had a 5% or more probability of appearing by chance)

# Executive summary

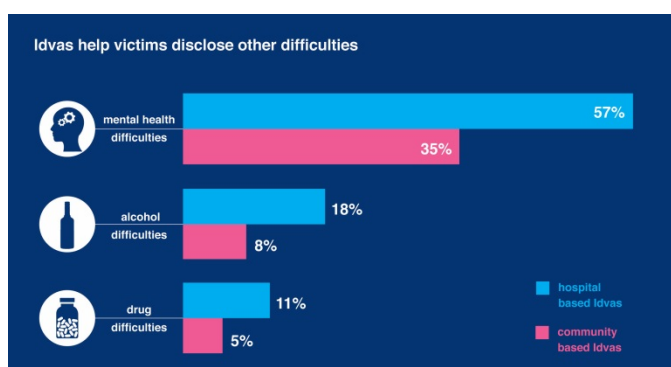
## Hospital-based specialist domestic abuse services

SafeLives' work is focused on ending domestic abuse and saving lives. We want to identify every family where there is domestic abuse as quickly as possible. We have previously reported that in the year before getting effective help, nearly a quarter (23%) of victims at high risk of serious harm or murder, and one in ten victims at medium risk, went to accident and emergency departments because of their injuries. In the most extreme cases, victims reported that they attended A & E 15 times. SafeLives has therefore made recommendations that there be more specialist domestic abuse services based in A & E.

A number of hospitals around the UK have adopted this approach and located specialist domestic abuse services in A&E as well as maternity units. SafeLives has conducted the first evaluation of hospital-based specialist domestic abuse services. The findings of this evaluation are the topic of this report.

### Hospital specialist domestic abuse services reach 'hidden' victims

We know that some groups of victims may be less visible to services or be given less priority. Our evaluation revealed that hospital Idvas were more likely to reach these groups of victims compared to local services. This included victims who disclosed high levels of complex or multiple needs related to mental health, drugs and alcohol, aged 55 or over, victims who do not have children living with them, victims from high income households and victims who remain in a relationship with their abuser.



## Hospital specialist domestic abuse services reach very vulnerable victims

Hospital Idvas were also more likely to engage with groups of victims who were very vulnerable due to a health issue. In addition to substance, alcohol and mental health issues, victims were more likely to be pregnant.

### 17% of victims identified in hospital were pregnant, compared to 6% of those in community settings

Hospital clients were also more likely to have ever been suicidal or to have self-harmed, and many were referred to the Idva after taking an overdose, because of despair at their predicament. (Nationally it is estimated that more victims die from suicide because of domestic abuse than are killed by their abuser.)

## Hospital Idvas have opportunity to identify victims earlier

Victims engaging with hospital Idvas seemed to be accessing effective support at an earlier point – hospital Idva clients had experienced abuse for an average of 6 fewer months than victims engaged with a local service.

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

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 associated forms of abuse (e.g. more physical and sexual abuse and less harassment and stalking).

**This indicates that, even for clients not identified by hospital staff, there is potential for hospitals to identify them earlier – as just under a third had visited A&E in the 6 months before first seeing their local Idva.**

## Why are victims engaged with hospital Idvas different?

The reason *why* hospital Idvas may be reporting **earlier** engagement with a **different** profile of victim compared to local services is likely two-fold:

- Prevalence of complex needs, vulnerabilities and unrecognised abuse in the hospital victim population may be higher than the victim population accessing local services, because victims are attending hospital primarily for urgent health issues which may or may not be related to the domestic abuse experienced.



- Victims may be more likely to disclose domestic abuse to the hospital Idva (compared to other agencies where disclosure may be perceived to have negative consequences). Victims may also be more likely to disclose other information due to the health setting e.g., alcohol/ drug related issues.

**Taken together, these influences mean that the hospital Idva has a unique opportunity to help victims in a context where they are much more likely to disclose.**

## Importance of hospital Idva to support screening

The National Institute for Health and Care Excellence (NICE) suggests that ‘people presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion.’<sup>1</sup>

Our findings strongly support this recommendation. **56% of hospital Idva clients had accessed A & E in the year before they received effective support from the hospital Idva.** These represent missed opportunities to intervene, especially important for victims hidden from other agencies (including men).

Health professionals highlighted being able to refer to the hospital Idva made asking about domestic abuse, in line with NICE recommendations, more likely to take place and with greater confidence that identification would result in a meaningful outcome for the victim.

## Hospital Idvas improve victim safety

Hospital Idvas reported that the safety of nearly two-thirds (64%) of victims was increased sustainably following their intervention. 9 out of 10 victims said they felt safer, with 58% feeling much safer after the intervention. Clients’ safety was more likely to be sustainably increased the more intensive the Idva intervention was.

Victims reported feeling more confident accessing support and

# 9 out of 10

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



<sup>1</sup> Quality Statement 1, NICE guidance, Domestic Violence and Abuse (Feb 2016).

empowered to make significant and meaningful changes to their life as a direct result of hospital Idva support.

There were indications that clients who had experienced severe abuse were more liable than those subject to non-severe abuse to be re-victimised in the 3 months after the Idva intervention, jeopardising their mental health recovery.

## **Embedding Idvas in the hospital**

Specialist domestic abuse services were most effective when they were:

- Embedded in the hospital
- Highly visible to health professionals working in the different hospital departments.

In practice, this means established referral routes, daily presence within the hospital, service coverage across shift patterns and regular involvement in training of all staff. The provision of clinical supervision for hospital Idvas should also be given priority so that Idvas feel well supported in the complex hospital work environment.

## **Establishing strong links between Hospital Idvas and the community**

Our findings also highlighted the importance of strong links between the hospital Specialist Domestic Abuse service and agencies acting within the wider community.

## **Hospital-based Idvas save public money**

Our evaluation included an analysis of the potential cost savings of Hospital Idva service provision.

An annual saving to the public purse of £2,050 per victim in health service use was estimated. This consisted of savings of £2,384 in hospital use balanced against rises of £98 in mental health service use, £64 in general practice use, and £74 in alcohol/drug service use.<sup>2</sup> An increased cost of £282 p.a. in social service use was also calculated.

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<sup>2</sup> All these figures are based on the average for a sample of 29 clients assessed pre- and post-Idva intervention, excluding 1 extremely atypical client who accounted for a disproportionate amount of hospital and ambulance use at both times (representing less than 1 in 2000 of the population).

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

### Introduction

In our ground-breaking 2009 report, *Safety in Numbers*<sup>3</sup>, SafeLives highlighted that physical and mental health problems are documented with a greater degree of frequency amongst 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, 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 from outreach workers. This year's Insights dataset (2015/16)<sup>4</sup> included 77% of victims at high-risk who had experienced abuse for 3 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 (on average 1.3 times) 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 cases<sup>5</sup> included 23% of victims at high-risk who had experienced abuse for 4 years on average. It found that 55% of victims visited their GP, on average 4.9 times. A smaller percentage of victims in the outreach dataset reported that they had attended A&E, 12%, as a result of the abuse but they had done so 1.5 times on average. Both the Idva and Outreach datasets

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<sup>3</sup> [http://www.safelives.org.uk/sites/default/files/resources/Safety\\_in\\_Numbers\\_full\\_report.pdf](http://www.safelives.org.uk/sites/default/files/resources/Safety_in_Numbers_full_report.pdf)

<sup>4</sup> Insights Idva National Dataset, 2015/16, Safelives, Unpublished

<sup>5</sup> Insights Outreach Dataset 2014/15, SafeLives, Unpublished

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.<sup>6</sup> 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 access 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, shame or embarrassment among victims, a fear of social services involvement, lack of interest from health professionals in wellbeing, lack of time of health professionals to deal with their disclosure, as well as a lack of domestic abuse awareness amongst healthcare professionals, mean that healthcare settings often fail to be recognised as opportunities to disclose, or access relevant support.<sup>7</sup> Over 70% of victims in one study did not know how to get help locally, and many women may not recognise health care services as potential providers of support.<sup>8</sup> Another common reason for not seeking formal help is the victims' belief that the abuse wasn't serious enough to warrant support.<sup>9</sup> The British Crime Survey found that four in five victims of domestic abuse don't tell the police.<sup>10</sup> 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.<sup>11</sup>

Citizen's Advice research in 2015<sup>12</sup> 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 personally close to them. The report argued that given 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

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<sup>6</sup> Crime Survey England and Wales 2014/15

<sup>7</sup> Kramer, Lorenzon and Mueller, 2004

<sup>8</sup> Lorenzon and Mueller 2004

<sup>9</sup> Fugate et al, 2005

<sup>10</sup> 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

<sup>11</sup> Safelives, 2015

<sup>12</sup> <https://www.citizensadvice.org.uk/Global/CitizensAdvice/Crime%20and%20Justice%20Publications/Linkinthechain.pdf>

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 £1.73bn (with mental health costs, estimated at an additional £176 million) according to research conducted by Sylvia Walby.<sup>13</sup> 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 NICE<sup>14</sup> 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 per call-out. This increases to £2200 for a patient who needs treatment for poisoning with major complications while treatment for other wounds or injuries with major complications costs £4231.

## **Identifying and supporting victims in healthcare settings**

Research in 2002 found that without a service to immediately refer onto, such as a hospital-based Idva service, the effectiveness of health professionals asking about domestic abuse is likely to be limited.<sup>15</sup> 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.<sup>16</sup> 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". 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

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<sup>13</sup> [http://www.lancaster.ac.uk/fass/doc\\_library/sociology/Cost\\_of\\_domestic\\_violence\\_update.doc](http://www.lancaster.ac.uk/fass/doc_library/sociology/Cost_of_domestic_violence_update.doc)

<sup>14</sup> <https://www.nice.org.uk/guidance/cg133/resources/costing-report-184853629>

<sup>15</sup> Ramsay et al, 2002

<sup>16</sup> <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4716185/>

to embedding the service successfully within the hospital which suggests an important learning point for commissioners.<sup>17</sup>

Another evaluation of Idva services at St Mary's Maternity Hospital 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.<sup>18</sup> The study also found that the speed 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 asking patients routinely 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 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 has found that improvements in antenatal enquiry for domestic violence and abuse developed through the 2004/5 BPDVP have improved 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.<sup>19</sup> 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".<sup>20</sup> More recently, the Royal College of Nursing has called for mandatory domestic abuse training.<sup>21</sup>

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<sup>17</sup> See page XX for guidance for commissioning a specialist domestic abuse service

<sup>18</sup> PATHway: an Independent Domestic Violence Advisory service at St Mary's Maternity Hospital, NHS Manchester, October 2010

<sup>19</sup> <http://eprints.uwe.ac.uk/19071/>

<sup>20</sup> <https://info.uwe.ac.uk/news/uwenews/news.aspx?id=2017>

<sup>21</sup> <http://www.nursingtimes.net/news/education/call-for-mandatory-domestic-abuse-awareness-training/7005752.article>

In a primary care setting, the *Identification and Referral to Improve Safety (IRIS)*<sup>22</sup> model has been recently implemented in 33 GP practices across England. The IRIS model is a training, support and referral programme to support GP's 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 (HARKS<sup>23</sup>) 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.<sup>24</sup> The study found that after RESPONDS training primary care clinicians were more confident in knowing how to proceed in a consultation when they suspected exposure of children to domestic violence and abuse or this was disclosed and the appropriate next steps. 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 2016-2021.<sup>25</sup> 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 *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)*<sup>26</sup> 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

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<sup>22</sup> <http://www.irisdomesticviolence.org.uk/iris/>

<sup>23</sup> 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.

<sup>24</sup> <http://www.bristol.ac.uk/primaryhealthcare/researchthemes/responds/about/>

<sup>25</sup> <http://www.bristol.ac.uk/primaryhealthcare/researchthemes/reprovide/about/>

<sup>26</sup> <http://avaproject.org.uk/ava-services-2/multiple-disadvantage/promoting-recovery-mental-health-primh/>

violence advocates.<sup>27</sup> The aim of this study is to assess the efficacy and cost-effectiveness of a novel psychological intervention specifically tailored for survivors of DVA and delivered by domestic violence advocates based in third sector organizations. 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 in 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 for early disclosure of domestic abuse in healthcare settings currently in place is are particularly effective for reducing risk and improving victims' safety following support.<sup>28</sup> Certain barriers have however been highlighted such as the presence of partners (or others) when seeking support, language barriers, and general time constraints.<sup>29</sup> These are amongst some 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 utilised 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 disease and sexual dysfunction.<sup>30</sup> 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 the UK, completed baseline questionnaires as part of an intervention study.<sup>31</sup> 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

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<sup>27</sup> <http://www.bristol.ac.uk/primaryhealthcare/researchthemes/path.html>

<sup>28</sup> Bair-Merritt et al, 2014; Coker et al, 2012

<sup>29</sup> Bacchus et al, 2010

<sup>30</sup> Campbell, 2002, Campbell et al, 2002, Coker et al, 2000

<sup>31</sup> Ferrari et al, 2014



population.<sup>32</sup> The study also indicated more than three quarters (77%) of the women had been suffering post-traumatic stress disorder 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*<sup>33</sup> report on violence, abuse and other disadvantages in the lives of women similarly evidences the overwhelming association between domestic abuse and mental health issues. This illustrated that over half (54%) of women 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 abuse and mental health issues highlights a need for interventions to address both violent and abusive relationships and mental health issues together.<sup>34</sup> 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, available in health services. The also recommended that health care professionals should identify mental health difficulties or PTSD symptoms as potential indicators of domestic abuse.<sup>35</sup>

## **Impact of domestic abuse on children**

Studies have shown that violence can begin or escalate during or shortly after pregnancy.<sup>36</sup> A study published in 2001 found around 30 per cent of domestic abuse begins in pregnancy while 40-60% of women experiencing domestic abuse are abused during pregnancy.<sup>37</sup> 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.<sup>38</sup> Furthermore, 6% of all children are estimated to be exposed to severe domestic abuse between adults in their homes at some point in childhood.<sup>39</sup> Thousands more live with domestic abuse every single

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<sup>32</sup> Connell et al, 2007

<sup>33</sup> <http://weareagenda.org/wp-content/uploads/2015/11/Hidden-Hurt-full-report1.pdf>

<sup>34</sup> Devries et al, 2013

<sup>35</sup> Ferrari et al, 2014

<sup>36</sup> Helton et al, 1987; Walby and Allen, 2004; Lewis, 2007

<sup>37</sup> Confidential enquiry into maternal and child health for England and Wales (2001) *Why mothers die 1997-1999*. London: RCOG Press.

<sup>38</sup> CAADA (2012), *CAADA Insights 1: 'A place of greater safety'*. Bristol: CAADA

<sup>39</sup> 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

day – two studies reported that a quarter of young people had witnessed at least one episode of domestic abuse.<sup>40</sup> Research studies show a link between domestic abuse and child maltreatment<sup>41</sup> and domestic abuse has been shown to be a factor in the family background in two thirds of Serious Case Reviews.<sup>42</sup> CAFCASS reports that domestic abuse was present in 60% of cases which led to care applications in a 2011 sample.<sup>43</sup>

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.<sup>44</sup> 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.<sup>45</sup> 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.<sup>46</sup>

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, which is concerning given the evidence that two-thirds were also directly harmed, 91% by the same perpetrator. There is a role, therefore, for other statutory services, including health, to ensure children exposed to domestic abuse are being appropriately identified and referred for support.

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<sup>40</sup> Radford et al, 2011 / Hamby et al, 2011

<sup>41</sup> For a review of the literature, see: Early Intervention Foundation (2014), 'Domestic violence and abuse review'. London: Early Intervention Foundation.

<sup>42</sup> 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.

<sup>43</sup> CAFCASS (2012), 'Three weeks in November ... three years on' Cafcass care application study 2012. London: CAFCASS.

<sup>44</sup> Sohr-Preston and Scaramella, 2006

<sup>45</sup> Department of Health, 2013

<sup>46</sup> <http://www.safelives.org.uk/sites/default/files/resources/Final%20policy%20report%20In%20plain%20sight%20-%20effective%20help%20for%20children%20exposed%20to%20domestic%20abuse.pdf>

## UK Government Policy

The first Government taskforce<sup>47</sup> 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.” 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 haven’t been seen through.

Earlier this year, 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 identified *before* the point of crisis, securing their own (and their children’s safety) at the earliest possible stage (VAWG, 2016).

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’ (VAWG, 2016:21). Their ability to intervene early and direct victims towards appropriate statutory and non-statutory services are 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 (NHS, 2016)

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 to reform 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

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<sup>47</sup> 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

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.<sup>48</sup> The four practice-focused 'quality statements' closely reflect the earlier recommendations made by SafeLives' Safety in Numbers (2009) report, as well as the wider governmental VAWG strategy - to integrate domestic abuse support within the realm of healthcare.

## Conclusion

As stated by the World Health Organisation, 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 National Health Service 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 £488m<sup>49</sup>, 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 St Mary's Maternity Hospital 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 which examines the effectiveness of the intervention itself in terms of safety and health of victims, as well as what makes a service work in practice.

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<sup>48</sup> <https://www.nice.org.uk/guidance/qs116>

<sup>49</sup> <http://www.nta.nhs.uk/uploads/why-invest-2014-alcohol-and-drugs.pdf>

# Chapter 3: Introduction to Themis – Aims, Need, Methods

## Aim

The aim of this study is to evaluate the model of domestic advocacy that bases Independent Domestic Violence Advisors (Idvas) in hospitals.

An **Idva** is a named professional case worker for victims of domestic abuse, who works to address the safety of 'high risk' victims 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.

## Need

The World Health Organisation (WHO) acknowledges domestic abuse as a public health issue (WHO 2013), and in the UK the Department of Health has included the need to address it within their strategic goals (Dept. of Health 2010). However, changes in the commissioning of services in the sector mean robust evidence is required on the effectiveness and cost-effectiveness of health-based domestic abuse interventions.

The hypothesis behind the research is that hospital-based Idva services reach a different demographic of victim, who might not access help via any other route. Also such services might provide an earlier point of intervention, potentially reducing the impact of the many health consequences associated with domestic abuse. This research could provide the evidence and opportunity to transform the health service response to domestic abuse.

A number of hospital-based domestic abuse services have been set up in recent years, operating in very different ways. Some have become well-established, operating successfully, whilst others have ceased to function or operate at minimal level. It was felt that by studying the different types of service, key features could be identified and 'best practice' guidelines drawn up.

## Method

This multi-site study included Idvas in five hospitals across England, operating different models of service delivery.

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

## Client interviews

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 clients 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 (two hospitals being in one area), a comparison group of local Idva clients was also recruited through the local domestic abuse service. Local Idvas work with high-risk clients referred to them by the police, the local Marac, other agencies and self-referred.

During the recruitment period, Idvas passed details of every eligible, consenting client to the SafeLives researcher, in order to conduct telephone interviews. Telephone interviews were conducted with participants at the start and end of the Idva intervention, and 3, 6, and 9 months afterwards (see data collection diagram at end of this chapter). These included standard measures of physical and mental health and questions about health service use.

- SF12v2 – Physical Composite Score and Mental Composite Score, adjusted for age and gender (Ware et al, 1995)
- SF6 – QALY – Quality-Adjusted Life-Years measurement (Brazier et al, 1998: Brazier et al, 2002)
- HADS - Hospital Anxiety and Depression Scale, Anxiety and Depression sub-scales (Zigmond and Snaith, 1983)
- Post-Traumatic Stress Disorder screen (Prins et al 2003)

The target was to conduct 65 interviews with hospital Idva clients and a similar number with local Idva clients, but the latter was not achieved, partly because recruitment at these sites started later. Initial interviews were conducted with 76 hospital Idva clients and 38 local Idva clients (see Appendix 1 for details of attrition and Chapter 4 for details of recruitment, representativeness and limitations). Fifteen willing clients were also interviewed face-to-face after the intervention, to discover their views of the hospital-based Idva service and find out about their help-seeking journey.

## Client Samples

There were two main samples used in the study, one containing two sub-samples:

1. The **Large Insights sample** for the study sites (hospital and local), consisting of Insights data collected over a 43-month period (April 2012 to October 2015), which overlapped with the Themis recruitment period (N=4236)
2. The **Full Themis sample** for the study sites (hospital and local), consisting of referral forms sent in by hospital and local Idvas over a 13-month recruitment period (October 2014 to October 2015, plus a further two months for follow-up interviews) (n=300).
  - i) The **Themis Insights sample** – clients in the Themis database for whom Insights data were available (n=198)
  - ii) The **Themis Interview sample** – clients in the Themis database who had been interviewed once or more often about their health and health service use (n=114). Samples used for analysis are the **Themis T1 Interview sample** (Insights data were available for 110 of these clients) and the **Themis T3 Interview sample** (insights data available for all of these clients).

Information on client demographics, complex health needs, levels of abuse and previous help-seeking, which had been collected through SafeLives' anonymised Insights data monitoring service, was analysed for all participating sites over a 43-month period (including the 13-month Themis fieldwork period).

## Staff interviews

Hospital staff and 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, clients' safety was paramount. Only those judged by Idvas as safe to take part, were recruited. After the interviews and with consent, any concerns about clients' safety from the abuser were referred to the Idva, and concerns about their mental health referred to their GP, requesting help<sup>50</sup>.

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<sup>50</sup> In one case confidentiality was breached, following the appropriate procedure, out of concern for one client's suicidality.

## Analysis

Insights data for all sites from 2012-2015 were analysed descriptively, and differences between hospital and local Idva clients were ascertained using appropriate tests. Categorical variables were tested using Chi-square (ensuring for differences in sample size). Differences and relationships were explored through both parametric and non-parametric means to ensure data validity, including: Mann-Whitney U, t-tests and Wilcoxon Signed Ranks tests for means and medians, as well as Spearman's Rho and Pearson's r for correlations. Factors relating to client outcomes were identified through a logistic regression model built on the basis of a correlation matrix.

Clients' 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 local Idva clients' mean health service use in the 6 months before the intervention, and comparing hospital clients' 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 1000 times.)

Qualitative semi-structured interviews with Idva clients were audio-recorded and analysed by the interviewer, whilst 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).

A case study approach was then used for the five different hospital sites. All sites were compared on the key quantitative and qualitative themes, to identify those where the Idva service was working most effectively. Profiles of two hospitals are then drawn, to show how the key elements of best practice can operate in different contexts.

## Data collection

The figure below indicates the data collection process along with approximate timings of each stage after the participants' intake to the Idva service:



First week

**Consent to (a) Insights and (b) health questionnaire sought by Idva**



First week

**Idva to fill out Insights Intake form and referral information and research participation online form**



First week & at approximately 3 months later

**SafeLives researcher to contact consenting participants to administer health questionnaire at intake to and exit from the service.**



Approx. 6, 9, and 12 months later

**SafeLives researcher to contact participants to administer health questionnaire at 3, 6 and 9 months after exit. Also conduct qualitative interviews with consenting participants at some point during this follow-up period.**

## Chapter 4: The Themis sample - Recruitment, interviews, representativeness and limitations

### Recruitment and interviews – target and actual numbers

Idvas at each site were asked to complete Themis referral forms for everyone who engaged with them. Some Idvas did so and some did not, largely because of time constraints. For instance, at one site they only completed forms for clients who were eligible to take part in Themis i.e. they were over 16, considered safe to take part, and had capacity. Some local Idvas were less motivated to complete the online forms because they did not see a study into the evaluation of hospital Idvas as being so relevant to them.

The conservative target for the number of T1 interviews, set at the start of fieldwork in September 2014, was 70 for hospital Idvas and 36 for local Idvas. The optimistic targets were 173 interviews for hospital Idvas and 72 for local Idvas (Table 4.1). Previously, when the recruitment period had been expected to be two years not 13 months, much higher targets had been set (see ‘Limitations’ later in this chapter).

Table 4.1: Target numbers for health interviews conducted with Idva clients at the different time-points

Time-point	Type of Idva client					
	Hospital		Local		All Idva clients	
	Conservative	Optimistic	Conservative	Optimistic	Conservative	Optimistic
T1 - No. Themis referral forms	186		120	240	306	426
T1 - Start of work with Idva (T1 interview)	70	173	36	72	106	245
T2 – End of work with Idva (Exit)	40	110	29	58	69	168
T3 – 3 months after Idva Exit (T3 interview)	30	66	23	46	53	112
T4 – 6 months after Idva Exit	16	36	18	36	34	72
T5 – 9 months after Idva Exit	6	14	0	0	6	14

Altogether 198 referral forms were submitted from hospital Idvas, and 102 from local Idvas. Of these, 104 hospital clients were eligible for the study and consented to take part, along with 50 local clients. However not all could be contacted by the Themis researcher. The actual number of T1 telephone health interviews was 76 for hospital clients and 38 for local clients (Table 4-2). Details of attrition are shown in Appendix 1 (Hospital and local sample attrition).

Table 4.2: Actual health interviews conducted with Idva clients at the different time-points

Time-point	Type of Idva client		
	Hospital	Local	All
T1 - No. Themis referral forms <b>(Full Themis sample)</b>	198	102	300
T1 – No. Themis referrals for whom Insights data were available <b>(Themis Insights sample)</b>	112	86	198
T1 - Start of work with Idva <b>(T1 interview sample)</b>	76	38	114
T2 – End of work with Idva (Exit)	37	3	40
T3 – 3 months after Idva Exit <b>(T3 interview sample)</b>	31	4	35
T4 – 6 months after Idva Exit	13	0	13
T5 – 9 months after Idva Exit	8	0	8

After T3, the number of interviews fell sharply because the 13-month recruitment period allowed fewer clients to progress as far as six or more months after exit from the Idva service. Therefore the data from the T4 and T5 interviews were not analysed. The data from T2 interviews reflected variable lengths of time (as Idva casework could last from one day to 31 months), and were also not analysed. Focus fell on clients' health and health service use at intake to the Idva service (T1) and 3 months after exit (T3), where there were comparable time periods for all clients.

**In summary**, the conservative targets were achieved for the hospital sample but only at T1 for the local sample, largely due to the late start to recruitment at several local sites (Table 4.4).

### Recruitment and interviews – differences between hospital sites

Although recruitment was ongoing at four of the hospital sites for 12-13 months, the number of referral forms submitted and interviews conducted, varied greatly between sites (Table 4-3 - Themis recruitment

and interviews at the five sites). The rate of submitting referral forms varied from 0.8 per month at one site to 8.7 at another. Over half (57%) of the total 198 hospital referral forms came from just one site (Site 4), as did 61% of the 76 T1 interviews, and 48% of the 31 T3 interviews.

Table 4.3: Themis recruitment and interviews at the five hospital sites

Themis database 2014-2015	Site 1	Site 2 <i>Service re-starting</i>	Site 3	Site 4	Site 5 <i>Service suspended</i>
<b>No. Themis referral forms 2014-15</b> (no. months' recruitment)	37 <i>(13 months)</i>	6 <i>(2 months)</i>	33 <i>(13 months)</i>	113 <i>(13 months)</i>	9 <i>(12 months)</i>
<b>No. T1 Themis interviews – at Idva Intake</b>	<b>19</b>	<b>3</b>	<b>8</b>	<b>46</b>	<b>0</b>
<b>No. T3 Themis interviews - 3 months after Idva Exit</b>	<b>11</b>	<b>1</b>	<b>4</b>	<b>15</b>	<b>0</b>

### Recruitment and interviews – differences between local sites

Recruitment started later at the four local Idva sites (one service covered two of the hospital site areas), because the hospital Idvas were prioritised for Themis training. In one case, recruitment only started two months before the end of the fieldwork period – because of organisational difficulties that the domestic abuse service was undergoing. At another, the same Idvas were dealing with hospital and local referrals, and so were trained with the other hospital Idvas at a much earlier stage.

The number of referral forms submitted by each site varied from 0.6 per month at one site to 12 per month at another (Table 4.4: Themis recruitment and interviews at the four local sites). This range reflected the differential motivation of the local Idvas, as well as the number of referrals received by each site.

Nearly half (44%) of the 102 referral forms came from just one site, run by the same service as the hospital Idva service that submitted 57% of the hospital referral forms. However the bulk of the T1 interviews were with clients from Sites 3 and 5. Very few T3 interviews were carried out, because the fieldwork period was shorter and fewer local Idva clients progressed that far (3 months post-Exit).

Table 4.4: Themis recruitment and interviews at the four local sites

Themis database 2014-2015	Site 1 & Site 2	Site 3	Site 4	Site 5
<b>No. Themis referral forms 2014-15</b> (no. months' recruitment)	4 <i>(7 months)</i>	24 <i>(2 months)</i>	45 <i>(7 months)</i>	29 <i>(12 months)</i>
<b>No. T1 Themis interviews (Idva Intake)</b>	<b>3</b>	<b>13</b>	<b>7</b>	<b>15</b>
<b>No. T3 Themis interviews (3 months after Exit)</b>	<b>0</b>	<b>1</b>	<b>2</b>	<b>1</b>

### Representativeness of the Themis findings – compared to Large Insights sample

To assess how representative the Themis interview samples were, they were compared with the wider population of Idva clients at these sites - the Large Insights sample (Chapter 3). Insights data, collected by Idvas from all consenting clients, was used for this, as it covers demographic, health, abuse and help-seeking factors that may have affected clients' health and health service use, which were the focus of the Themis telephone interviews.

Differences between the Large Insights sample (April 2012-October 2015) and the Themis T1 Interview Insights sample (October 2014 - November 2015) and the T3 Interview Insights sample (for hospital clients only as the T3 local client sample was too small for analysis) were noted when they were 10% or more. As both samples were not on the same database, it was not possible to calculate the statistical significance of the differences. (The Large Insights database contained most of the clients in the Themis database, except those not consenting to Insights monitoring.)

There was a total of 692 hospital clients and 3544 local clients in the 43-month Large Insights sample, and 112 hospital clients and 86 local clients in the 13-month Themis Insights sample, i.e. those in the Full Themis sample for whom Insights data was available (Table 4.5). Smaller numbers were interviewed at T1 (Idva Intake) and at T3 (3 months post-Idva Exit); Insights data were available for all bar four hospital clients at T1.

Table 4.5: Comparison of hospital and local client numbers in the Themis Insights sample (2014-15) with those in the Large Insights sample (2012-15)

No. Idva clients	Large Insights sample (2012-15)	Full Themis sample (Themis referral forms) (2014-15)	Themis Insights sample (2014-15)	Themis T1 interview Insights sample (pre-intervention) (2014-15)	Themis T3 interview Insights sample (post-intervention) (2014-15)
Hospital clients	692	198	112	72	29
Local clients	3544	102	86	38	4
Total	4236	300	198	110	33

### Representativeness of the T1 and T3 Themis interview samples

Insights data for the Themis samples for 2014-15 (Full Themis sample consisting of all referral forms, T1 interview sample, T3 interview sample) were compared with those from the Large Insights sample for the same sites 2012-2015. Some differences may have been due to the change in some variables between 2012-2014 and 2014-2015.

Full details of these comparisons are available in Appendix 2. Overall, the smaller T1 and T3 interview samples were remarkably similar to the Large Insights sample. It was not possible to assess the statistical significance of differences between the Large Insights sample and Themis samples; variables where the difference was **10% or more** are noted below.

Demographically, there were no major differences in age, ethnicity, gender and sexuality.

Compared to hospital Idva clients in the Large Insights sample, members of the **T1 interview hospital sample** were:

- More likely to be employed
- More likely to have children in the household
- More likely to have experienced severe jealous and controlling behaviour, but less likely to have experienced severe physical or sexual abuse or been referred to Marac.
- More likely to be living with their abuser and to have been abused for a longer period of time
- Less likely to have contacted the police or GP in the last year
- More likely to have worked for longer with the Idva and for the Idva to have made more contacts on their behalf
- More likely to have been referred to the Idva by health agencies

Compared to local Idva clients in the Large Insights sample, members of the **T1 interview local sample** were:

- Less likely to live in a low-income household
- More likely to have financial problems

- More likely to have experienced any kind of severe abuse, but less likely to have been referred to a Marac, or for the abuse to have escalated in the last three months
- Less likely to be living with the abuser, but the abuse had carried on for longer
- Less likely to have consulted a GP in the past year
- More likely to have been referred to the Idva by the police

Compared to hospital Idva clients in the Large Insights sample, members of the **T3 interview hospital sample** were:

- More likely to be employed and have children in the household
- Less likely to have been pregnant at Idva Intake
- More likely to have had mental health problems at Intake and to have ever attempted or planned suicide
- More likely to have experienced severe harassment and stalking or severe jealous and controlling behaviour or any severe abuse at Idva Intake, but less likely to have experienced severe physical abuse or been referred to Marac
- More likely to have experienced abuse for longer
- Less likely to have contacted the police or a GP in the past year
- More likely to have been referred to the Idva by a healthcare worker
- More likely to have worked for longer with the Idva and for the Idva to have made more contacts on their behalf

Victims who will have been omitted from all the samples (Large Insights and T1 and T3 interview samples) will be those who:

- Chose **not to engage with the Idva**, whether because they felt too frightened or ashamed to do so, they did not believe they were being abused, or they did not feel they needed help. In some cases, the fact of being identified as being abused and being offered help could nevertheless provide an important future route to help.
- Chose to engage with the Idva on a **brief one-off basis**, and therefore less likely to have provided Insights data or been asked to participate in Themis.
- **Did not understand or speak English** sufficiently well to comprehend the consent form and verbal questions in the telephone health interview. (In one case, a client provided an English-speaking go-between for the first interview, but managed on her own during subsequent ones.)

Victims who will have been omitted from all the Themis samples will be those who:

- Were **ineligible for the study**, whether because they were aged under 16, or not felt to have capacity (perhaps because of alcohol or drug dependence), or believed unsafe to take part (this last could include victims still living with their abuser, who could not be safely contacted because of high risk and severely restricted access to private communication).

## General limitations

There are a number of limitations to the findings from this study.

### 1. Interview numbers

The numbers of local and hospital clients interviewed at T1 were considerably fewer than had been estimated, affecting the statistical power of the findings. As originally envisaged, with a fieldwork period of two years, it was estimated that 240 hospital clients and 180 local clients would be interviewed at T1. However, as the study had not been piloted, it was accepted in the Protocol that this could not be accurately predicted. Because of delays due to staffing change and the length of time required to obtain ethical approval of amended documents, the fieldwork period was reduced from two years to 15 months, including only 13 months to recruit new participants.

Interview numbers at subsequent time points were proportionately fewer, particularly, in the case of local clients, where recruitment started later.

### 2. Interview drop-out

Although it had been envisaged that everyone whom Idvas recruited to the study would be successfully interviewed by the Themis researcher, this proved not to be the case. Only three-quarters of those consented by Idvas (73% of those consented by hospital Idvas and 76% of those consented by local Idvas) were successfully interviewed at T1. In most cases this was because of difficulties in making contact with these clients, although a handful declined.

### 3. Timing of actual interviews

The T1 telephone interviews concerning health and health service use were meant to be conducted as soon as possible after the client's intake to the Idva service. According to the study Protocol, Idvas were to recruit eligible clients within their first three contacts with the client, and, if consent was given, pass details onto the Themis researcher within 24 hours via a secure database. The researcher then aimed to contact each participant as soon as possible, making three attempts before giving up. Although every effort was made to contact participants quickly, it often proved difficult and could take two or three weeks before a convenient time could be found for the interview. Sometimes a convenient time could not be found. Subsequent interviews could also be delayed.

The variable timing did not affect the health service use answers, as these were always geared to the expected periods (ie six months before Idva intake for T1, time between T1 and T2 for T2 which was variable, 3 months post-Exit for T3, 3-6 months post-Exit for T4, and 6-9 months post-Exit for T5). However the health questions had to be asked as per the time of the interview.



#### **4. Variable timing of T2 interviews**

T2 interviews were carried out at the end of the intervention, which could vary from 1 day to 31 months in length. This allowed pre- and post-Idva intervention data to be compared. The variable T1-T2 time was taken into account by controlling for case-length during the logistic regression to ascertain which were the key factors associated with increased and sustainable safety of clients.

#### **5. Site differences – Themis referral forms and recruitment**

Regardless of overall client numbers, Idvas at some sites recruited more clients than others. One hospital site recruited over half the hospital participants (accounting for 61% of T1 and 48% of T3 interviews). Participants were more evenly drawn from the local Idva sites, although one area contributed few.

Similarly the number of Themis referral forms also varied from one site to another. Some submitted them for nearly all referrals, as the Protocol stated, but where time was short, others only submitted forms for those eligible for Themis.

#### **6. Clients' recall of health service use**

Clients' recall of their health service use over the past six months (at T1) and 3 months (at T3) is unlikely to be completely accurate. One example of this was that seven hospital clients referred to the hospital Idva by the Emergency Department, did not mention any uses of an ED in the six months before contact with the Idva. On the whole, it would be expected that inaccurate recall would largely result in clients under-estimating rather than over-estimating use of health services (as the example demonstrates). As it is likely that such under-estimates are common across both hospital and local samples, it would not be expected to significantly affect the proportionate differences between health service use for hospital and local clients at T1.

However, when comparing hospital clients' service use at T1 and T3, it is likely that the underestimate of T1 use will be higher than T3 because of the longer period. This would mean that the reduced use of health services found at T3 could itself be an under-estimate. In other words, post-intervention cost savings in health service use may be higher than estimated in this report.

#### **7. Representativeness of the T1 and T3 Themis interview samples**

This is considered in detail in the preceding section.

# Chapter 5: Who are hospital Idva clients and how do they differ from local Idva clients?

## Introduction

First, a profile of hospital Idva clients will be drawn, based on SafeLives' Insights monitoring data collected at the start of the intervention (Idva intake) and, where possible, the end (Idva exit). Then the key ways in which hospital clients differ from local clients will be highlighted – in terms of demographics, complex needs, abuse, help-seeking, previous help, referral routes, and outcomes .

The Large Insights hospital sample consists of 692 consecutive clients at the five hospital sites, who accessed the Idva service between April 2012 and October 2015 and consented to anonymous Insights data collection. The Large Insights local sample consists of 3544 consecutive clients accessing the comparison Idva services in the same towns (connected largely with courts and Maracs) over the same period, who consented to Insights.

Full details of tables, including exact numbers of clients answering each question, can be found in the Appendix to this chapter, Appendix 3.

## Profile of hospital Idva clients (n=692)

Table 5-1: Profile of hospital clients - Demographics

Client demographics	Per cent
Gender – male	<b>5%</b>
Sexual orientation – heterosexual	<b>98%</b>
Black & Minority Ethnic	<b>15%</b>
Age – mean	<b>35.6 years</b>
High household income - £36,400 + p.a.	<b>9%</b>
Low household income - <£16,400 p.a.	<b>49%</b>
Employed	<b>34%</b>
Pregnant	<b>17%</b>
Children in household	<b>51%</b>
CYPS (Children & Young People's Services) involvement	<b>27%</b>

Table 5-2: Profile of hospital clients - Complex needs

Client – complex needs in the past year	Per cent
Mental health problems	<b>57%</b>
Alcohol problems	<b>18%</b>
Drug problems	<b>11%</b>
Any disability (physical or learning)	<b>12%</b>
Financial problems	<b>40%</b>
Any of the above	<b>74%</b>
Ever suicide plans/attempts	<b>36%</b>
Ever self-harmed	<b>37%</b>

Table 5-3: Profile of hospital clients – Current abuse

Client – Current abuse profile	Per cent
Severe physical abuse in past 3 months	<b>46%</b>
Severe sexual abuse in past 3 months	<b>14%</b>
Severe harassment & stalking in past 3 months	<b>30%</b>
Severe jealous & controlling behaviour in past 3 months	<b>47%</b>
Any severe abuse in past 3 months	<b>66%</b>
Two-plus types of severe abuse	<b>49%</b>
Any escalation (in severity or frequency) in past 3 months	<b>78%</b>
DASH Risk Indicator Checklist score (Mdn)	<b>Mdn - 10.0</b>
Assessed as 'High Risk' by Idva [ie DASH score = 10+]	<b>53%</b>
Reaches threshold for Marac [ie DASH score = 14+ or Idva assesses as 'very high risk']	<b>72%</b>

Table 5-4: Profile of hospital clients – Risk profile

Client – Risk profile	Per cent
Multiple perpetrators	<b>14%</b>
Previous exposure to abuse	<b>68%</b>
Abuser is current intimate partner	<b>53%</b>
Abuser is ex-intimate partner	<b>35%</b>
Client is living with abuser (partly/wholly)	<b>48%</b>
Length of abuse (Mdn)	<b>30.0 months</b>
Abuser has been abusive to other family member or previous partner	<b>79%</b>

## Comparison between hospital and local Idva clients

When comparing hospital and local Idva clients, only statistically significant results ( $p < 0.05$ ) are reported in this chapter, with Bonferroni adjustments for multiple comparisons. Detailed tables and test results can be found in the Appendix to this chapter, Appendix 3.

## Demographics

Hospital Idva clients at the 5 hospital sites were more likely to be:

- **Pregnant** (17% hospital, 6% local Idva clients)  
*[some hospital Idvas had close links with maternity units]*
- **With no children at home** (49% hospital, 33% local Idva clients)
- **Aged 55+ (borderline significant)** (10% hospital, 7% local Idva clients)
- **High-income households £36,400+p.a.** (9% hospital, 4% local Idva clients)

But there were no significant differences between the two groups as regards gender, sexuality, ethnicity – overwhelmingly female, heterosexual and white British.

## Complex Needs

Hospital clients had strikingly more complex needs than local Idva clients, indicating where strong multi-agency work is likely to be helpful.

More hospital clients had:

- **Mental health difficulties** (57% hospital, 35% local Idva clients)
- **Alcohol misuse** (18% hospital, 8% local Idva clients)
- **Drug misuse** (11% hospital, 5% local Idva clients)
- **Financial difficulties** (40% hospital, 30% local Idva clients)
- **Additional vulnerability –physical disability (incl. hearing & sight)/learning difficulty** (12% hospital, 8% local Idva clients)
- **Any of the above complex needs** (74% hospital, 58% local Idva clients)
- **‘Toxic trio’ (domestic abuse, mental health difficulties and alcohol/drug misuse)**(20% hospital, 7% local Idva clients)

More than twice as many hospital clients had **ever planned or attempted suicide** (36% hospital, 16% of local Idva clients), and nearly twice as many hospital clients had ever self-harmed, **or** planned or attempted suicide (43% hospital, 23% local Idva clients).

## Current Abuse Profile

Hospital clients were more likely than local Idva clients to have experienced:

- **severe physical abuse** (borderline significant) (46% hospital, 41% local Idva clients)
- **severe sexual abuse** (14% hospital, 10% local Idva clients)

## Risk Profile

Hospital clients were more likely to have experienced:

- **previous abuse** (68% hospital, 48% local Idva clients)
- abuse from **multiple abusers** (14% hospital, 8% local Idva clients)

Hospital and local clients were equally likely as to whether they had **tried to leave the abuser** in the past year (70% of hospital clients had, compared to 72% of local clients), and the number of times they had done so (Mdn of 1.00 for both groups).

Hospital clients had been abused for a **shorter time** (Mdn 30 months) than local Idva clients (Mdn 36 months).

## Abuser profile

Hospital clients' abusers were more likely:

- to be their **current intimate partner** (53% hospital, 31% local Idva clients)
- to be **living with them**, sometimes or all the time (48% hospital, 29% local Idva clients)
- to have been **abusive to others** (79% hospital, 67% local Idva clients)
- to have **financial problems** (55% hospital, 67% local Idva clients)

Their abuser was less likely:

- to be their **ex-partner** (35% hospital, 59% local Idva clients)
- **to have a criminal record for dva** (borderline significant) (36% hospital, 45% local Idva clients)

## Potential help-seeking in the past year

More hospital clients had been in contact with:

- Their **GP** for any reason (88% compared to 77% of local Idva clients)
- **Emergency Department** for dva (56% compared to 16% of local Idva clients)

But fewer hospital clients had called the **police** (58% compared to 77% of local Idva clients). More had also been in contact with their specialist dva service (24% compared to 18% of local clients) but this difference was not significant.

Hospital clients had made **more contacts** with all of the above in the past year (mean 9.2 compared to 6.7 for local Idva clients).

**Severity of abuse was associated with the number of attempts to leave and the number of help-seeking attempts**, for hospital and local clients considered together. The higher a victim's DASH Risk Indicator Score, the more contacts they had had with any of the above four services, either individually or combined (See table in Appendix 3 - Table A5-7).

### Referral routes

Most hospital Idva clients had been referred by **health services** (84% compared to 2% for local Idva clients), and **few by police** (9% compared to 45% of local Idva clients) or **self-referred** (2% compared to 23% for local Idva clients).

### Idva casework - Case length

Case length was **shorter** for hospital Idva clients (Mdn 1.7 months compared to 2.4 months for local Idva clients), and ranged from 1 day to 15 months (1 day up to 31 months for local Idva clients).

### Idva casework - Unfinished business

More hospital Idva cases did **not have a planned closure** (13% compared to 5% for local clients in 2012-15) i.e. contact with the Idva stopped before casework was complete. This might reflect the earlier stage of change many hospital clients were at, often still living with their abuser, and sometimes only just beginning to realise that the partner's behaviour was abusive (*which could leave hospital Idvas with more unresolved concerns about clients' safety, and greater need for clinical supervision*).

### Idva casework - Casework intensity

Despite the shorter average case-length, hospital Idvas worked **as intensively** for their clients (2012-15, n=2909):

- **similar no. of contacts** with/for their clients (Mdn of 8 for both hospital and local Idvas)

### Support enabled via Idva

The 5 types of support that clients were most likely to have been helped to access by both types of Idva were: safety planning, health and well-being, police, housing and Marac (Multi-Agency Risk Assessment Conference).

Hospital clients were significantly **more likely** to have been helped to access:

- **safety planning** (72% compared to 63% of local Idva clients)

- **health and well-being** services (67% compared to 56% of local Idva clients)  
*possibly because more hospital Idva clients had complex health needs*
- **police** (47% compared to 41% of local Idva clients)
- help with **housing** (45% compared to 31% for local Idva clients)

But hospital clients were **less likely** than local Idva clients to have been helped to access;

- **civil orders** (5% compared to 14% for local Idva clients)
- **criminal court** (1% compared to 4% for local Idva clients)

### How were risk and safety outcomes of hospital Idva clients different from local Idva clients?

Hospital and local clients had similar levels of improved safety from the abuse after Idva exit.

- Idvas reported **sustainable risk reduction** (i.e. moderate or significant risk reduction that is expected to be sustainable in the medium- or long-term) for similar numbers  
(64% hospital and 67% local clients)
- Nine out of 10 hospital and local clients felt their **quality of life had improved**, half by ‘a lot’  
(53% hospital, 49% local clients)
- Almost all clients felt confident to access help in future, with over half saying they felt ‘**very confident**’  
(56% hospital, 57% local Idva clients)
- Nine out of 10 hospital and local clients reported feeling safer, with just over half saying they felt ‘**much safer**’ (borderline significant difference between hospital and local clients)  
(58% hospital, 51% local clients)

For **hospital and local clients**, both measures of **improved safety** (client- and Idva-reported) increased if support was more intensive, controlling for gender, high-risk abuse and case-length, except where case-length was the correlating factor. (Full tables for this logistic regression can be found in Appendix 4.)

Idvas reported **increased safety** for **hospital and local clients** when:

- more interventions accessed (6+)
- longer period of support (ie case-length)
- more Idva contacts with or for client (5+)

Local Idva clients themselves also reported increased safety for all three of the above measures. But hospital clients only reported increased safety when there had been 5+ Idva contacts on their behalf.

Reduced safety from the abuse of hospital and local clients was more likely if:

- patients had ever had suicidal behaviour (ie plans/attempts)

For local clients, Idvas were more likely to report increased safety was more likely if:

- perpetrator had complex needs, particularly financial problems
- victim had experienced more severe physical abuse at Idva intake

For local clients, Idvas were more likely to report reduced safety if:

- client had alcohol or drug problems

The fact that hospital Idva clients had much higher rates of complex needs and suicidality, makes the equal 'success' rates of hospital and Idva clients – in terms of improved safety from abuse – notable.

## Post-Exit Abuse

Information on post-Exit abuse was only available from the small T3 Themis interview sample, i.e. Idva clients interviewed 3 months after the Idva intervention by the Themis researcher. Characteristics of this sample, compared to the Large Insights sample featured in the rest of this chapter, can be found in Chapter 4.

### Abuse following Exit from Idva intervention

Of the 31 hospital clients interviewed 3 months after Exit, 17 (55%) had experienced further abuse:

- 12 (39%) experienced **harassment and stalking** (an average of 8 times each)
- 9 (29%) experienced **jealous and controlling behaviour** (an average of 13 times each)
- 3 (10%) experienced **physical abuse** (1 episode each)
- 1 (3%) experienced **sexual abuse** (1 episode)

Although numbers were small, there were indications that whether a client was abused after Exit was associated with how much risk s/he had faced at Intake. Higher risk clients at Intake were more likely to have experienced post-Exit abuse:

- 81% of those who reached the **Marac threshold** at Intake, experienced post-Exit abuse, compared to 33% of those who had not (n=31)
- 78% of those deemed '**high-risk**' at Intake, had experienced post-Exit abuse, compared to 31% of those who were not (n=31).



## Chapter 6: Identifying domestic abuse victims in hospital

In this chapter, findings are drawn from the Full Themis sample - the 198 hospital clients and 102 local clients for whom Idvas had submitted Themis referral forms. These contained detailed questions on hospital referral source, previous help for the abuse, number of hours' help clients had received from their Idva, none of which were included in the Insights monitoring.

Detailed data tables (prefixed by A) can be found in Appendix 5. The Full Themis sample is compared to the Large Insights sample in Chapter 4.

### Which hospital departments and staff identified domestic abuse victims?

In the Full Themis sample, nearly nine out of 10 (86%) referrals to hospital Idvas came from **hospital departments** (Table A6-1).

The Emergency Department played a key role, accounting for 62% of all hospital referrals and over half of all 198 hospital Idva clients (54%) (Table A6-2). (In one hospital, there was an 8% cap on the number of referrals that could be taken from departments other than the Emergency Department.) This was followed by **maternity and ante-/neo-natal units** (16%), then **psychiatry/mental health** departments (7%), which often liaised closely with Emergency Departments, for instance in the case of drug overdoses.

**Nurses** had identified the greatest number of domestic abuse victims (45%), referring them to hospital Idvas, followed by **consultants/doctors/junior doctors** (18%), **midwives** (13%), and **psychiatrists/psychologists** (8%) (Table A6-3).

### Which hospital departments and staff were best at identifying 'hidden victims'?

Just over half of hospital (51%) and local Idva clients (52%) had **not** previously sought help for the abuse and could be regarded as hitherto '**hidden victims**' (Table A6-4, and Table A6-5).

Most of the 74 'hidden victims' identified in hospitals were identified by Emergency Departments (n=45), followed by maternity units (n=16). But, in relation to their total number of referrals, maternity departments identified proportionately more 'hidden victims' (62% of their referrals) than Emergency Departments (49%) or psychiatry (3 out of 10 referrals) (Table A6-6). **Possibly this is** because of national policy that all pregnant women should be screened for domestic abuse, and could be seen as evidence in favour of universal screening (though partner abuse rates are known to be higher among pregnant women anyway).

As regards which types of staff identified the most 'hidden victims', nurses hovered around the average (54% of their referrals had not previously sought help), with midwives identifying more (60%) as might be expected because of the screening policy, and consultants, doctors and junior doctors, fewer (41%) (Table A6-6). However, five of the six referrals made specifically by junior doctors were 'hidden victims'.

To some extent, Emergency Department nurses (followed by junior doctors) are the first healthcare workers that patients see (after ambulance crew and reception staff), so it is not surprising that they are more likely to identify domestic abuse victims. In addition, junior doctors may spend an hour taking patients' histories on admission to other wards, which means they are well-placed to receive such disclosures (if encouraged to do so by their senior consultant).

However there is scope for more victims to be identified earlier. In the Large Insights sample (N=4236), one in six local clients said they had visited an Emergency Department before being referred to a local Idva, indicating that there is potential for hospitals to identify them earlier. Similarly, there is also scope for earlier identification amongst hospital Idva clients, as 25 of the 76 in the Themis interview sample had visited Emergency Departments more than once in the 6 months before starting work with the hospital Idva.

### Who had victims previously sought help from?

Around half the Idva clients had sought help previously for this abuse (49% hospital Idva clients and 48% local Idva clients) (Table A6-4).

The proportion of clients seeking help from each source is listed below (and in Table A6-5: Sources of previous help sought for this abuse). Often clients had sought help from more than one organisation. Although hospital Idva clients had used health sources more frequently and police less frequently, the difference between hospital and local clients was not significant for any of the sources:

- The same/other **dva services** - refuge, outreach, Idva/Isva, helpline
  - (75% hospital clients, 72% local clients)
- **Police** (49% hospital clients, 62% local clients)
- **GP** (26% hospital clients, 9% local clients)
- **Community/mental health** (14% hospital clients, 4% local clients)
- **CYPS/Social Services** (14% hospital clients, 23% local clients)
- **Marac** (14% hospital clients, 17% local clients)
- **Housing** (12% hospital clients, 6% local clients)
- **Other** (11% hospital clients, 9% local clients)

Hospital Idva clients were more likely to have previously sought help from health services (which they used more – Chapter 5) than local Idva clients, who were more likely to have approached the police or CYPS /social services (perhaps because more had children at home, and more had been referred to the Idva by the police in the first place).

### **Intensity of work with clients**

Although analysis of the Large Insights sample (Chapter 5) showed hospital and local Idvas making the same Mdn number of contacts for/with their clients, the Full Themis sample showed that hospital Idvas worked more intensively with their clients than local Idvas:

- **More contacts** with/for clients (Mdn 12.0 contacts for hospital Idvas, 6.5 for local Idvas)
- **Longer hours on casework** (Mdn 8 hours for hospital Idvas, 3 for local Idvas)

# Chapter 7: What is different about hospital Idva clients?

## Introduction

In this section, the focus is on the 76 hospital Idva clients and 38 local Idva clients who agreed to the telephone health interview on at least one occasion (T1 Themis interview sample). Their physical and mental health and quality of life is compared. Then, for a smaller number of hospital clients who were available for follow-up (n=31), their health before and after the Idva intervention is considered (T3 Themis interview sample).

Only statistically significant results ( $p < 0.05$ ) are reported in this chapter, with Bonferroni adjustments for multiple comparisons. Full details of test results and tables are contained in Appendix 6.

## How did the health of hospital Idva clients compare to the national population?

Overall, at the start of the Idva intervention, hospital clients had slightly poorer physical health than the national population (mean Physical Composite Score = 49, compared to UK average 51), and much worse mental health (mean Mental Composite Score = 32, compared to UK average 52) [Table 7-1]. Their anxiety score (12) was twice the national average (6) and their depression score (10) 2.5 times higher than the national figure (4). Overall quality of life was only three-quarters the national average (0.6 compared to 0.8). Just under half (49%) screened positive for Post-Traumatic Stress Disorder (PTSD), 8 times as many as in an inner-city community sample (6% amongst women in south-east London - Frissa et al, 2013).

## How did the health of hospital Idva clients differ from local Idva clients?

At Idva Intake, hospital and local clients had similar rates of anxiety and PTSD. However hospital clients had poorer physical health than local clients and were more depressed (reflecting the fact that 1 in 6 had been to an Emergency Department because of an overdose in the 6 months before seeing the hospital Idva, compared to just 1 out of the 38 local Idva clients). However these differences were not significant once Bonferroni adjustments were applied for multiple comparisons.

Table 7-1: Comparing the health of hospital and local Idva clients at Idva Intake

<b>Health measure</b>	<b>Hospital Idva clients</b> (n=64 <sup>51</sup> ) <i>Mean score at Intake</i>	<b>Local Idva clients</b> (n=38) <i>Mean score at Intake</i>	<b>p</b>
<b>Physical health</b> (SF12 – PCS) <i>(higher score = better health)</i>	<b>49</b>	<b>55</b>	NS
<i>Mental health</i>			
<b>Overall mental health</b> (SF12–CS) <i>(higher score = better health)</i>	<b>32</b>	<b>32</b>	NS
<b>Anxiety</b> (HADS) <i>(high score = high anxiety)</i>	<b>12</b>	<b>11</b>	NS
<b>Depression</b> (HADS) <i>(high score = high depression)</i>	<b>10</b>	<b>8</b>	NS
<b>Post-Traumatic Stress Disorder</b> - proportion screening positive <i>(higher % = more with PTSD)</i>	<b>48%</b>	<b>53%</b>	NS
<b>Quality of Life</b> (SF-6D)	<b>0.59</b>	<b>0.63</b>	NS

### How did the health of hospital Idva clients change after the intervention?

Tracking 21 hospital clients over time, their mean health scores 3 months after Idva exit were compared with their scores at Idva Intake (Table 7-2). Their mental health improved; specifically, their overall mental health score increased and they became less anxious and depressed. The number screening positive for PTSD dropped from 13 (62%) to 10 (48%). The sample was too small for statistical significance of these changes to be assessed.

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<sup>51</sup> n=64 for HADS and PTSD, but 63 for questions based on SF12 which generated the PCS, MCS and Quality of Life scores (as 1 client did not answer all SF12 questions).

Table 7-2: Comparing health scores for hospital clients pre- and post-Idva intervention

Health measure	Hospital clients (n=21)	
	Before the Idva intervention Mean score	3 months after the Idva intervention Mean score
<b>Physical health</b> (SF12 – PCS) <i>(higher score = better health)</i>	<b>53</b>	<b>48</b>
<i>Mental health</i>		
<b>Overall mental health</b> (SF12 – MCS) <i>(higher score = better health)</i>	<b>31</b>	<b>39</b>
<b>Anxiety</b> (HADS) <i>(high score = high anxiety)</i>	<b>13</b>	<b>11</b>
<b>Depression</b> (HADS) <i>(high score = high depression)</i>	<b>10</b>	<b>8</b>
<b>Post-Traumatic Stress Disorder -</b> proportion screening positive <i>(higher % = more with PTSD)</i>	<b>62%</b>	<b>48%</b>
<b>Quality of Life</b> (SF-6D) <i>(higher score = better quality of life)</i>	<b>0.61</b>	<b>0.63</b>

### Might health changes after the intervention have been associated with post-Exit abuse?

Although clients' average mental health improved after Exit, there was considerable variation and indications that this might have been associated with whether further abuse had occurred since Exit (the sample was too small to take into account all possible factors that might have been related to these changes). Mental health improved much less for those subject to abuse in the three months after Exit, than for those who were free of it during this period (Table 7-3):

- The **overall mental health score** (Mental Composite Score) improved by an average of only 0.5 points for those subject to any post-Exit abuse, but by nearly 17 points for those who were not (median was used because of the small sample size and high variability).

Table 7-3: Health changes between Intake and 3 months after Exit, and whether further abuse had been experienced since Exit

Health score change at 3 months after Exit, compared to at Idva Intake (T3 minus T1)	Further abuse experienced in 3 months after Exit?	
	Yes (n=12) Mdn	No (n=9) Mdn
<b>SF12 Physical Composite Score change</b> (positive means improved health)	<b>+0.53</b>	<b>-6.16</b>
<b>Anxiety (HADS) score change</b> (negative = improved health)	<b>0.00</b>	<b>-4.00</b>
<b>Depression (HADS) score change</b> (negative means improved health)	<b>0.00</b>	<b>-6.00</b>
<b>SF12 Mental Composite Score change</b> (positive means improved health)	<b>+0.5</b>	<b>+16.7</b>
<b>QALY – Quality of Life – change</b> (positive means improved health)	<b>+0.01</b>	<b>+0.06</b>

Post-Exit abuse might, therefore, jeopardise a client’s mental health recovery. A larger study would be necessary to explore this.

# Chapter 8-1 What's different about hospital Idva clients? - Health Service Use

## Introduction

In this section, the focus is on the 76 hospital Idva clients and 38 local Idva clients who agreed to the telephone health interview on at least one occasion (T1 Themis interview sample). Their use of hospital services (in-patient, out-patient, Emergency Department [ED] and ambulance), local and mental health services and social care services is compared, excluding the ED visit/ambulance trip that led to the hospital Idva referral. Services associated with pregnancy are excluded (hospital ante-natal clinic and community midwife) so that data for all clients are comparable. Then, for a smaller number of hospital clients who were available for follow-up (n=31), their health service use before and after the Idva intervention is contrasted (T3 Themis interview sample).

Only statistically significant results ( $p < 0.05$ ) are reported in this chapter, with Bonferroni adjustments made for multiple comparisons. Full details of test results are contained in Appendix 7, and of the cost analysis in Appendix 8. As most health service uses are not normally distributed (with 0 as the majority value), non-parametric tests are used, and median values are shown (in addition to means).

## Pre-intervention use of hospital services

### How many victims had used hospital services before getting help from an Idva?

More hospital than local clients had used each of the hospital services in the six months before being referred to an Idva (Table 8-1a\_1). The difference was particularly high (and just significant, once the Bonferroni adjustment was made for multiple comparisons) for Emergency Department visits, perhaps not surprisingly as 54% of hospital clients had been referred to the Idva by the ED (Chapter 6).

Table 8-1a\_1 No. of hospital and local clients using hospital services

Hospital service	No. clients using this service in the 6 months pre-intervention				p
	Hospital clients (n=76)		Local clients (n=38)		
	n	Per cent	n	Per cent	
In-patient nights	26	34%	5	13%	NS
Out-patient appointments	28	37%	10	26%	NS
Emergency Department visits	41	54%	11	29%	$p < 0.0125$
Ambulance trips to A&E	25	33%	6	16%	NS



## How did hospital and local Idva clients differ in their use of hospital services?

Hospital clients' total use of hospital services (in-patient nights, out-patient appointments and Emergency Department visits) was significantly more than local clients' in the 6 months before Idva Intake (Table 8-1a\_2). This could be partly because of their poorer physical health and worse depression (Chapter 7), and partly because the main source of hospital Idvas' referrals was from hospital staff (86% of this sample) (Chapter 6).

Once the Bonferroni adjustment was applied for the components of hospital use (reducing the  $p < 0.05$  level to  $p < 0.0125$ ) the difference was significant for in-patient nights and Emergency Department visits, but not for outpatient appointments or ambulance trips. Hospital clients had made significantly more use of all three hospital services than local clients ( $p < 0.05$ ).

Table 8-1a\_2: Six-month pre-intervention use of hospital services by hospital and local Idva clients (*full sample*)

Hospital service	No. clients using this service in the 6 months pre-intervention				p
	Hospital clients (n=76)		Local clients (n=38)		
	Mdn	Mean	Mdn	Mean	
In-patient nights	0.0	3.7	0.0	0.3	$p < 0.0125$
Out-patient appointments	0.0	1.3	0.0	0.5	NS
Emergency Department visits	1.0	1.4	0.0	0.4	$p < 0.0125$
Total no. hospital uses	2.0	6.3	1.0	1.2	$p < 0.0125$
Ambulance visits to Emergency Department	0.0	1.0	0.0	0.2	NS

## ED and Ambulance 'Outlier'

One client had used the ED and ambulance 30 times in the six-month period, each time following an overdose (one-third of these visits were related to domestic abuse). Out of 76 hospital clients, she alone accounted for 29% of their 103 ED visits and 40% of their 75 ambulance trips. This high usage continued after she exited the Idva service. In the next three months she visited the ED a further 26 times, 21 times by ambulance. This high rate of ED use (60-plus times a year) is very unusual. The UK College of Emergency Medicine (2014) estimates 1-2% of ED attendances are by 'frequent attenders' (threshold from 5 to 12 visits a year, according to different studies – Kennedy et al 2004), and describes those attending 30 or

more times a year as 'very high frequency attenders'. Although a precise figure for the UK is not available, a US study of frequent ED attenders (Ruger et al 2004) found that 0.05% patients visited ED more than 20 times a year. The proportion attending as often as this one patient will therefore be very small, less than one in 2000.

Because inclusion of this client skewed hospital clients' mean ED and ambulance use (and health service costs are calculated on the basis of means), findings for hospital use are reported both including and excluding this extreme 'outlier' client.

When the outlier is excluded from the hospital sample, the mean of their ED use dropped from 1.4 to 1.0, and that of their ambulance use dropped from 1.0 to 0.6 (Table 8-1a\_3). Excluding the outlier, did not affect the significance of differences between hospital and local clients for the different types of hospital use, except that hospital clients' higher rate of in-patient nights just slipped from significance.

Table 8-1a\_3: Six-month pre-intervention use of hospital services by hospital and local Idva clients (excluding extreme outlier)

Hospital service	No. clients using this service in the 6 months pre-intervention				p
	Hospital clients (n=75)		Local clients (n=38)		
	Mdn	Mean	Mdn	Mean	
In-patient nights	0.0	3.6	0.0	0.3	NS
Out-patient appointments	0.0	1.3	0.0	0.5	NS
Emergency Department visits	1.0	1.0	0.0	0.4	p<0.0125
Total no. hospital uses	2.0	5.9	1.0	1.2	p<0.0125
Ambulance visits to Emergency Department	0.0	0.6	0.0	0.2	NS

## Pre-intervention use of local and mental health services

### How many victims had used local and mental health services before getting help from an Idva?

Very similar proportions of hospital and local Idva clients had used local and mental health services in the previous six months (Table 8-1a\_4). Over half had seen a nurse at their local surgery and more than three-

quarters had seen a GP. The only major difference was that hospital clients were more likely to have seen someone in mental health services (counsellor, psychiatrist, psychologist, psychiatric nurse, crisis team); 43% had, compared to 26% of local Idva clients. One-third had had contact with social care services.

While more than nine out of 10 victims had seen a doctor or nurse at their local surgery/practice in the six months before accessing the Idva service, only 1 local Idva client had been referred by one of these staff to the Idva service (3% of local clients interviewed, and just 0.05% of 3430 local Idva clients in the large Insights database), and 9 hospital clients (12% of hospital clients interviewed and 6% of the 683 hospital clients in the large Insights database). This reflects the fact some hospital Idvas have developed training and referral links with local health centres. This shows the untapped potential of local health centre staff to identify and refer many more victims of domestic abuse at an earlier stage, provided there is capacity in local domestic abuse services.

Full data on local and mental health service use was not available for one hospital client, so the hospital client sample was 75 in this section

Table 8-1a\_4: No. of hospital and local clients using local and mental health services

Local and mental health service	No. clients using this service in the 6 months pre-intervention				<i>p</i>
	Hospital clients (n=75 <sup>52</sup> )		Local clients (n=38)		
	No.	<i>Per cent</i>	No.	<i>Per cent</i>	
GP	65	<b>87%</b>	29	<b>76%</b>	NS
Nurse/Health Visitor at Local Surgery	42	<b>56%</b>	21	<b>55%</b>	NS
<b>Local Surgery</b> (both of the above)	68	<b>91%</b>	36	<b>95%</b>	NS
Mental health	32	<b>43%</b>	10	<b>26%</b>	NS
Alcohol/drug misuse	7	<b>9%</b>	3	<b>8%</b>	NS
<b>Total no. local health uses (all of the above)</b>	71	<b>95%</b>	37	<b>97%</b>	NS
Social Services/					

<sup>52</sup> Full data on local and mental health service use was not available for one hospital client.

Local and mental health service	No. clients using this service in the 6 months pre-intervention				<i>p</i>
	Hospital clients (n=75 <sup>52</sup> )		Local clients (n=38)		
Social Care	25	<b>33%</b>	12	<b>32%</b>	NS
Specialist DVA service	12	<b>16%</b>	5	<b>13%</b>	NS

### How much did hospital and local Idva clients use local and mental health services?

Although similar proportions of hospital and local clients had used local and mental health services in the six months before accessing an Idva, the rate of use was higher for hospital clients. This only achieved significance for contacts with all the local and mental health services combined (Table 8-1a\_5).

- The median number of all local and mental health services was 8 for hospital clients, compared to 4.5 for local clients.

The extreme 'outlier' client who increased median rates of some hospital service use (ED and ambulance), did not affect the medians for local and mental health service use, so she is not excluded from this section.

Table 8-1a\_5: Six-month pre-intervention frequency of use of local and mental health services by hospital and local Idva clients (full sample)

Local and mental health service	No. clients using this service in the 6 months pre-intervention				p
	Hospital clients (n=75)		Local clients (n=38)		
	Mdn	Mean	Mdn	Mean	
<b>GP</b>	4.0	6.5	2.0	3.4	NS
<b>Nurse/Health Visitor at Local Surgery</b>	1.0	3.9	1.0	1.7	NS
Local Surgery (both of the above)	6.0	10.4	3.0	5.1	NS
<b>Mental health</b>	0.0	5.7	0.0	1.6	NS
<b>Alcohol/drug misuse</b>	0.0	0.8	0.0	0.2	NS
<b>Total no. local health uses (all of the above)</b>	8.0	16.9	4.5	6.9	p<0.0125
<b>Social Services/ Social Care</b>	0.0	4.1	0.0	2.7	NS
<b>Specialist domestic abuse service</b>	0.0	1.1	0.0	1.0	NS

### How closely was health service use associated with health?

As might be expected, clients' level of health service use (both all hospital use and all local and mental health service use) before the intervention was significantly associated with their overall health (SF6-QALY) at the start of the intervention. This was true for both all hospital use, and all local and mental health service use, and for all clients considered together as well as for hospital and local Idva clients considered separately, whether or not the extreme outlier user of hospital services was included (Appendix 7: Table A8-1a\_6a and b).

## Change in health service use pre- and post-intervention –hospital services

### Did use of hospital services change after the Idva intervention?

The number of **hospital uses** pre- and post-intervention was compared for 31 hospital clients (including the outlier) for a 3-month period (Table 8-1a\_7). Uses during the 6-month pre-Idva period were halved to match the 3-month pre-Idva period. Caution must be used in interpreting these results because of the small size of the sample (n=31), but they can be regarded as indicative.

Table 8-1a\_7 No. hospital uses pre- and post-Idva intervention for hospital clients (*full sample*)

Hospital service	Average no. times used by hospital Idva clients in 3 months (n=31)				p
	(half of)Pre-Idva		Post-Idva		
	Mdn	Mean	Mdn	Mean	
<b>In-patient nights</b>	<b>0.0</b>	2.3	<b>0.0</b>	0.4	NS
<b>Out-patient appointments</b>	<b>0.0</b>	0.4	<b>0.0</b>	2.1	NS
<b>Emergency Department visits</b>	<b>0.5</b>	0.9	<b>0.0</b>	1.0	NS
<b>Total no. hospital uses</b>	<b>1.0</b>	3.6	<b>0.0</b>	3.6	NS
<b>Ambulance visits to Emergency Department</b>	<b>0.0</b>	0.8	<b>0.0</b>	0.7	NS

When the extreme ‘outlier’ as regards use of hospital services was excluded, the median use of Emergency Department before the intervention dropped from 0.5 to 0.3, and of inpatient nights after the intervention dropped from 0.4 to 0.0 (the outlier had been the only inpatient during this period). The drop in inpatient nights from pre- to post-intervention was significant statistically (Table 8-1a\_8).

Using the Bonferroni adjustment, a 95% confidence level requires  $p < 0.0125$  for 4 single-service variables, and  $p < 0.05$  for the combined hospital use variable.

Table 8-1a\_8: No. hospital uses pre- and post-Idva intervention for hospital clients (*excluding extreme outlier*)

Hospital service	Average no. times used by hospital Idva clients in 3 months (n=31)				p
	(half of)Pre-Idva		Post-Idva		
	Mdn	Mean	Mdn	Mean	
<b>In-patient nights</b>	<b>0.0</b>	2.3	None		p<0.0125
<b>Out-patient appointments</b>	<b>0.0</b>	0.4	<b>0.0</b>	1.3	NS
<b>Emergency Department visits</b>	<b>0.3</b>	0.4	<b>0.0</b>	0.2	NS
<b>Total no. hospital uses</b>	<b>0.8</b>	3.1	<b>0.0</b>	1.5	NS
<b>Ambulance visits to Emergency Department</b>	<b>0.0</b>	0.3	<b>0.0</b>	0.1	NS

Only one client was hospitalised post-Idva, compared to 11 pre-Idva. The mean number of outpatient appointments increased from 0.4 in pre-Idva to 1.3 in the post-Idva period. 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.

### Change in health service use pre-and post-intervention – Local and mental health services

For the 30 hospital clients asked at Idva Intake and 3 months after Idva Exit, there were no significant differences in use of local and mental health services (number of pre-Idva uses was halved so that the period was equivalent to the 6-month post-Idva period) (Table 8-1a\_9). This perhaps illustrates the long-lasting effects of domestic abuse on victims' health.

Caution must be used in interpreting these results because of the small size of the sample (n=30), but they can be regarded as indicative.

Using the Bonferroni adjustment, a 95% confidence level requires p<0.008 for 6 single-service variables and p<0.025 for the two combined-use variables.

Table 8-1a\_9 No. local and mental health service uses pre- and post-Idva intervention for hospital clients (including outlier)

Local and mental health service	Average no. times used by hospital Idva clients in 3 months (n=30)				p
	(half of)Pre-Idva		Post-Idva		
	Mdn	Mean	Mdn	Mean	
<b>GP</b>	1.8	3.4	3.0	3.3	NS
<b>Nurse/Health Visitor at Local Surgery</b>	0.5	1.2	0.0	0.8	NS
Local Surgery (both of the above)	2.8	4.5	3.0	4.0	NS
<b>Mental health</b>	0.0	3.2	0.0	4.1	NS
<b>Alcohol/drug misuse</b>	0.0	0.5	0.0	0.8	NS
Total no. local health uses (all of the above)	4.0	8.3	5.5	10.5	NS
<b>Social Services/ Social Care</b>	0.0	1.9	0.0	3.3	NS
<b>Specialist domestic abuse service</b>	0.0	0.9	0.0	0.2	NS

## Costs of health service use

This section is a brief summary of the full cost analysis, which can be found in Appendix 8 (to Ch. 8-1b).

### How much do hospital Idva clients cost in health service use compared to local Idva clients – before the Idva intervention?

In the six months before accessing the Idva service, hospital clients cost on average £2463 each in use of hospital, ambulance, local and mental health services, whereas local Idva clients cost £533 (Table 8-1a\_10). This means that, if the costs are doubled to cover a 12-month period, hospital Idva clients have used more than four times (£4926) the value of health services in a year compared to local Idva clients (£1066) before starting work with their Idva.

However the small size of the sample meant that the 95% Confidence Intervals (between which we can be 95% sure that the mean for the population of these clients lies) was large; for hospital clients it lay between £3608 and £6666 per annum, and for local clients between £746 and £1426 p.a.). This is a significant



difference between the two groups, and indicates there could be a particular benefit to health services (particularly hospitals) in identifying and referring hospital patients to Idva services.

As pointed out earlier in this chapter, one hospital client had used ED services and ambulances far more than others, and was in fact in a very small minority nationally (probably less than 0.5%); omitting this extreme ‘outlier’ from the hospital sample, chiefly reduced hospital costs, and to a lesser extent mental health service costs (Table 8-1a\_10). On the basis of this figure, pre-intervention hospital clients cost on average £4,496 p.a. in health service use (95% Confidence Interval £3,292 to £5,954 p.a.), compared to £1,066 for local clients (95% Confidence Interval £746 to £1,426 p.a.).

Table 8-1a\_10: Health service costs for six months pre-Intervention

Health service cost	Mean costs in pounds (£) for six-month pre-Intervention period		
	Hospital client sample including outlier (n=76)	Hospital client sample excluding outlier (n=75)	Local client sample (n=38)
Hospital services (including ambulance)	1532	1393	226
Local surgery	408	396	214
Mental health services	457	393	81
Drug/alcohol services	66	66	12
<i>Total health costs</i>	<i>2463</i>	<i>2248</i>	<i>533</i>

Social service costs for hospital clients averaged £216 per client for the six months, and £145 for local Idva clients.

### How much did health service costs change before and after the hospital Idva intervention?

It should be noted that these results are based on a small sample (n=30), and as such can only be regarded as indicative.

The health service costs were calculated for the sample of 30 who were measured both pre- and post-Idva intervention, for all health services (Table 8-1a\_11). The analysis was run with and without the outlier, who had proportionately more influence on this small sample than on the 76-strong hospital sample analysed in the previous section. (She alone accounted for 54% ED visits and 64% ambulance trips at pre-intervention, and all inpatient nights, 81% ED visits and 91% of ambulance trips at post-intervention.) Service use for the three-month post-intervention period was doubled so that it was equivalent to the six-month pre-intervention period for the purposes of comparison.

Table 8-1a\_11: Health service costs for Pre- and Post- Intervention periods

Health service cost	Costs in pounds (£) for hospital clients measured pre- and post-intervention (6-month periods)			
	Pre-intervention including outlier (n=30)	Post-intervention including outlier (n=30)	Pre-intervention excluding outlier (n=29)	Post-intervention excluding outlier (n=29)
Hospital services (including ambulance)	1906	1303	1569	377
Local surgery	324	329	292	324
Mental health services	683	679	537	635
Drug/alcohol services	81	116	83	120
<i>Total health costs</i>	<i>2994</i>	<i>2427</i>	<i>2481</i>	<i>1456</i>

Including the outlier, the overall health cost saving after the hospital Idva intervention was £568 for the six-month period, and £1136 for a full year. When the outlier (with her high hospital service use both pre- and post-intervention) was excluded, the overall cost saving was £1,025 for the six-month period, and £2050 for a full year.

The analysis of uncertainty conducted through bootstrapping showed that conclusions when the outlier was excluded were robust at a 95% Confidence Interval (£364 to £4060), as there was a cost saving after the intervention, even at the lower confidence level. When the outlier was included, there was less certainty (95% Confidence Interval from minus £770 to plus £1870 p.a.).

In summary, when the outlier was excluded, the health cost reduction after the hospital Idva intervention was £2,050 per patient per year (95% Confidence Interval £364 to £4,060 p.a.). This consisted of:

- **Saving in hospital service use** (ie inpatient, outpatient and Emergency Department) £2,184 per patient p.a.
- **Saving in ambulance use** £200 p.a.
- **Rise in local surgery use** (GP, practice nurse, nurse practitioner, Health Visitor) £64 per patient p.a.
- **Rise in mental health services use** of £196 per patient p.a.
- **Rise in drug/alcohol services use** of £74 per patient p.a.

Higher use of mental health and alcohol/drug support services post-Idva may be because clients are in a better position to prioritise their own health, rather than simply survive in the abusive relationship. These post-intervention figures are based on the first three months, and are likely to reduce over time, further increasing the post-intervention health cost savings.

### Assumptions on the health cost findings

No assumptions were made as to how much of any change in costs was due to the Idva intervention. Most hospital clients referred by hospital staff (23 of the 30), are identified at a point when they are already accessing a hospital service and may be in a poorer state of health than local Idva clients – although no significant differences were found in the health of the two groups (Chapter 6-1). The fact that 77% were referred by a hospital department would have boosted the sample's pre-intervention hospital use to an extent, although it was not possible to ascertain how much because it was not clear from the data which hospital use had led to the referral. (However, if 23 hospital uses were subtracted from the total for the T1 period, this would have reduced the average hospital use of the 30-strong sample for a three-month period at T1 from 3.1 (Table 8-1a\_9) to 2.7, which is still higher than the 1.5 hospital uses for the local sample.)

Whereas it might be assumed that health service use would drop in time anyway after using the hospital service, whether or not a victim was referred to the hospital Idva, it might equally be assumed that health service use could have risen without Idva referral, as domestic abuse tends to escalate over time, with increasing impacts on health.

### Social services

**Before** - In the 6 months before seeing the hospital Idva, the 30 victims who were measured both 'before' and 'after' the Idva intervention, had, on average, used £198 worth of social services.

**After** - In the 6 months after exiting the Idva service (figures for the 3-month post-intervention were doubled), clients had on average used £339 of social services.

This represents an **annual increase in social service cost of £282 per victim<sup>53</sup>**, once they had accessed the hospital Idva service. It is often only after accessing the Idva service that victims who are parents, are referred to social services. The prime aim is usually to safeguard children, so the cost associated with the

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<sup>53</sup> However, the analysis of uncertainty conducted through bootstrapping showed that conclusions were not robust at a 95% CI, at the lower confidence level: costs could have dropped.

intervention stopping the abuse could be seen as an investment in the children's future emotional health, which should reap future health cost savings.

Sometimes this intervention is short-term, sometimes it results in children being removed to foster care, if the mother is not believed to be keeping her children safe from living in a household where there is domestic abuse. Interviews with mothers showed that some had not felt adequately supported by police to keep their children safe (Chapter 9).

### **Cost of Hospital Idva services:**

- One hospital Idva service cost £40,000 p.a. in staffing and £720 in clinical supervision (2015/16) for the equivalent of one full-time Idva who worked with 97 cases during the year. This averaged a cost of £417 in Idva service per client.
- Another hospital Idva service cost £90,000 a year (including clinical supervision, publicity materials and so on) for two full-time staff, who worked with 286 cases a year (2015-16). This averaged at a cost of £315 per client. This may be lower than the other service because on this site there was a shorter, six-week time limit on cases, after which cases had to be passed onto local domestic abuse services.

### **Cost-benefit of the hospital Idva service**

These findings indicate that there could be a substantial cost saving in health service use once victims have accessed the hospital Idva service. If the average cost of a hospital Idva is £365 per client (average of the two services quoted above), this cost could be more than offset by the average £2050 estimated annual reduction in health service use per client (excluding the extreme outlier client).

Taking account of the small sample, even if the lowest limit applies (of the 95% range within which we can be confident this figure lies), this is a cost reduction of £364 per client per year. Even at this most conservative estimate, this indicates that the intervention would at the very least be cost-neutral for the NHS.

For hospitals themselves, the intervention could be seen as particularly cost-effective as the health costs that dropped after intervention were entirely those of the hospital services. Omitting ambulance services (which are funded by separate healthcare trusts), the average drop in hospital service use after the intervention was still large (£2,184 as opposed to £2384 p.a. per client).

It is not known how much of this health service use drop was a result of the intervention. Clients themselves estimated that domestic abuse-related healthcare dropped by £356 a year, on average, after the intervention (excluding the extreme outlier client). This applied particularly to hospital use.

### Proportion of health service use attributed by clients to domestic abuse – Hospital vs. local clients

Idva clients were asked what proportion of health service use they attributed, partially or wholly, to domestic abuse. Differences between hospital and local clients were striking. Overall, hospital clients attributed just over one-third (35%) of their health service use to domestic abuse, compared to 60% for local clients, perhaps reflecting their generally poorer state of health (Table 8-1a\_12). In particular, this applied to their use of hospital and mental health services. But nearly all their use of alcohol/drug services was perceived to be related to domestic abuse, compared to only a sixth of that by local clients. As regards use of local surgeries, in both cases, patients perceived that a similar substantial proportion (45% for hospital clients and 41% for local clients) was related to domestic abuse. (When the hospital outlier client was excluded, results were similar to the full sample – see A8-1a\_12 in Appendix 7.)

In contrast, more social service use was attributed to domestic abuse for hospital clients (85%) than local ones (63%)

Table 8-1a\_12: Client-perceived domestic abuse-related health service costs for the six-month pre-intervention period

Health service cost	Client-perceived domestic abuse-related health service costs in pounds (£) for 6 months <i>(% of all health service costs)</i>	
	<b>Hospital client sample including outlier (n=75)</b>	<b>Local client Sample (n=38)</b>
Hospital services (including ambulance)	329 (22% of total)	146 (65% of total)
Local surgery	184 (45% of total)	88 (41% of total)
Mental health services	289 (63% of total)	81 (100% of total)
Drug/alcohol services	64 (97% of total)	2 (17% of total)
<i>Total health costs (% domestic-abuse related of total health costs)</i>	866 (35% of total)	317 (60% of total)
Social worker/Child & Family Support worker	184 (85% of total)	91 (63% of total)

## Proportion of health service use attributed by hospital clients to domestic abuse – Pre-Idva vs Post-Idva

When the pre-Idva and post-Idva periods are compared for hospital clients, the health costs that were perceived by the patient to be partly or wholly related to domestic abuse differed according to whether the extreme outlier client was included or excluded. If she was included, the total client-perceived domestic abuse-related health costs rose by an average of £672 over a six-month period (Table 8-1a\_13). As previously, when this small pre- and post-intervention sample is considered, the extreme outlier had a disproportionate effect. When she was excluded, these health costs fell by £178 (£356 over a full 12 months).

This is a considerably smaller fall than the total post-intervention reduction in health service costs stated in the previous section, which might indicate that patients underestimate health conditions due to or aggravated by domestic abuse. Or it might indicate that their health is anyway at a low ebb at the time of the hospital visit when they are referred to the hospital Idva.

After the intervention, the proportion of health service use they attribute to domestic abuse rose from 43% to 61% (excluding the extreme outlier client). The main difference when excluding the outlier client is that the client-perceived domestic abuse-related hospital costs drop much more in the post-intervention period (to 6% of all hospital services used compared to 74% of these when she is included).

The cost of social service use attributed to domestic abuse more than doubled after the intervention (from £147 to £318 for a six-month period), and the proportion attributed to domestic abuse rose from 74% to 94%.

Table 8-1a\_13 – Client-perceived domestic abuse-related health service costs pre- and post-intervention for hospital clients (6-month period)

Health service cost	Domestic abuse-related health service costs in pounds (£) for hospital clients measured pre- and post-intervention (for 6-month period) <i>(% of all health service costs)</i>			
	<b>Pre-intervention including outlier (n=30)</b>	<b>Post-intervention including outlier (n=30)</b>	<b>Pre-intervention excluding outlier (n=29)</b>	<b>Post-intervention excluding outlier (n=29)</b>
Hospital services (including ambulance)	475 (25% of all)	961 (74% of all)	328 (21% of all)	23 (6% of all)
Local surgery	172 (53% of all)	143 (44% of all)	177 (61% of all)	147 (45% of all)
Mental health services	456 (67% of all)	636 (94% of all)	471 (88% of all)	591 (93% of all)
Drug/alcohol services	81 (100% of all)	116 (100% of all)	83 (100% of all)	120 (100% of all)
<i>Total domestic-abuse related health costs</i>	<i>1184 (40% of all)</i>	<i>1856 (77% of all)</i>	<i>1059 (43% of all)</i>	<i>881 (61% of all)</i>
Social worker/Child & Family Support worker	147 (74% of total)	318 (94% of total)	-	-

## Chapter 8-2: Emergency Department and Ambulance Use

In this section, the use of hospital Emergency Departments (EDs) and of ambulance trips to EDs are analysed in their own right in relation to domestic abuse. This gives a better picture of how EDs and ambulances are used by victims of domestic abuse. Full details of all the tables can be found in Appendix 8.

### Use of Emergency Department (ED) by clients before Idva intervention

More hospital (54%) than local (29%) Idva clients had used an Emergency Department (Accident and Emergency or, rarely, a walk-in Minor Injuries Unit) in the six months leading up to referral to the Idva (Table A8-2\_1). This reflects the fact that ED staff were responsible for referring half the hospital clients to the hospital Idva.

Of those who had attended ED, sometimes more than once:

- over two-thirds of both hospital and local clients had attended ED at least once because of **domestic abuse** (71% hospital clients, 82% local clients)
- two-thirds of local clients had attended ED at least once because of **physical injury** by their abuser, compared to fewer than a third of hospital clients (29% hospital clients, 64% local clients)
- over a quarter of hospital clients (29%) had visited ED at least once after taking an **overdose**, compared to far fewer (9% ) local clients.

### Extreme outlier hospital client

In the six months before accessing the Idva service, the 76 hospital clients made a total of 103 visits to ED and the 38 local clients made a total of 14 visits. However, as explained in the previous section, one hospital client alone accounted for 29% of hospital clients' ED visits and 38% of their ambulance journeys to ED. Such a rate of ED and ambulance use is very unusual, less than one in 2000 people, according to the literature. The analysis was therefore carried out both including and excluding this 'extreme outlier' client, who substantially skewed the results for the hospital sample.

Only the findings **excluding the extreme outlier** are presented here, with detailed tables of the sample both including and excluding the outlier shown in the Appendix to this chapter (Appendix 9).

### Uses of ED by clients before the Idva intervention (omitting extreme outlier client)

During the 6 months leading up to Idva Intake, 75 hospital clients made a total of 73 visits to ED, whereas the 38 local clients only used EDs 14 times altogether (Table A8-2\_3).



- Half of hospital client (51%) Emergency Department visits and more than 5 out of 6 (86%) of those by local clients were related to **domestic abuse**
- **Physical injuries by the abuser** accounted for only 18% of hospital client ED visits but nearly two-thirds (64%) of local client ED visits
- More than 1 in 5 hospital client ED visits followed the client taking an **overdose** (22%), compared to 7% of local client ED visits
- Almost all **overdose attendances** by hospital and local Idva clients at ED were related to domestic abuse (90%)

### Higher suicidality of hospital Idva clients

Hospital Idvas help clients who are much more likely than local Idva clients to have mental health difficulties, and more than twice as likely to have ever planned or attempted suicide (Chapter 5), analysis of the Large Insights sample showed. Echoing this, the much higher proportion of hospital than local clients interviewed for this study who attended ED after an overdose (16% compared to 3%) is further evidence of the powerful potential of hospital staff to identify and refer to hospital Idvas the more depressed and suicidal victims, who may otherwise remain hidden and be at higher risk of death.

In a national report on the costs of domestic abuse in Britain, Sylvia Walby (2004) estimated 27 victims a day made suicide attempts and 3.6 victims a week committed suicide - higher than the number killed by their abuser each week (Chapter 3). U.S. researchers Stark and Flitcraft (1995) showed a temporal connection between women visiting ED to get treatment for injuries then being admitted for attempted suicide. They concluded that domestic abuse may be the single most important cause of female suicidality.

### Untapped potential of hospital ED staff to identify domestic abuse victims

Eighteen of the 76 hospital clients had been to an ED more than once, 11 for conditions related to domestic abuse. This means there was the theoretical possibility for 24% of hospital Idva clients to have been identified earlier by ED staff, particularly the 14% who said their earlier visit was because of domestic abuse (injury, overdose or aggravation of an existing physical or mental health condition). Similarly, 11 of the 38 (29%) local Idva clients had visited an ED in the six months before referral to a local Idva, 7 (18%) because of domestic abuse; however none had been referred to an Idva by hospital staff.

The non-referral of domestic abuse victims to a hospital Idva does not necessarily reflect on hospital staff, because the hospital Idva service was not present in some sites for some of the time. However it does show the potential for many victims of domestic abuse to be identified earlier by ED staff (just as victims could be identified earlier by other healthcare staff, in the hospital, local GP practice and mental health staff, given sufficient training and Idva resources)

## Ambulance Use by clients before Idva intervention

More hospital than local Idva clients had attended ED by ambulance (37% compared to 16%) in the six months before being referred to an Idva (A8-2\_4). Again, this reflects the fact that ED staff had referred half the hospital clients to the hospital Idva.

Of those who had travelled to ED by ambulance:

- 4 out of 5 hospital and local clients had done so at least once because of **domestic abuse** (79% hospital clients, 83% of local clients)
- more local than hospital clients had done so at least once because of **physical injury** by their abuser (29% of hospital clients, 67% local clients)
- more hospital than local clients had done so at least once after taking an **overdose** (43% hospital clients, 17% local clients)

## Ambulance uses by clients before the Idva intervention (omitting extreme outlier client)

During the 6 months leading up to Idva Intake, 75 hospital clients used ambulances to visit ED a total of 50 times, whereas the 38 local clients only used them 6 times altogether (Table A8-2\_6).

- At least half the ambulance uses for both hospital (52%) and local clients (83%) were related to **domestic abuse**, considerably more for local clients
- **Physical injuries by the abuser** accounted for 1 in 6 of hospital client ambulance uses (16%) but two-thirds of local client ambulance uses (67%)
- Nearly a quarter of hospital client ambulance uses followed the client taking an **overdose** (24%), compared to 17% for local clients

## Potential for ambulance crews to identify domestic abuse victims

In over half the cases where a victim attended the Emergency Department for a condition related to domestic abuse (injury, overdose, or existing physical/mental complaint worsened by the stress of the abuse), they travelled there by ambulance (63% of all 49 domestic-abuse related ED visits by hospital and local clients<sup>54</sup>). 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 they may be more willing to disclose. This was the case for 29% of clients later referred to a hospital Idva and 13% clients later referred to a local

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<sup>54</sup> Excluding the extreme outlier client.

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.

## Chapter 9: Getting Help – Clients’ help-seeking journey and views of the hospital Idva service

Fifteen hospital Idva clients across three sites (large city, medium city and small town in rural area) were interviewed after they had exited the Idva service. Fourteen 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.

Clients 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 the abuse triggered off physical health problems, which prompted the visit to the hospital Emergency Department (ED), which led to referral to the hospital Idva.

### Summary

#### Clients’ views on Hospital Idvas

- Initial **validation** by a sympathetic Idva was crucial and precious to victims. They gained confidence to **access support** in the future, could be **empowered** to make radical changes (eg give evidence to police, ask perpetrator to leave, move to new area), and could be enabled to **access services** more quickly (eg mental health and alcohol/drug services) or that were not otherwise available (eg immediate police response to a call from a high-risk client).
- Some victims would have liked **earlier support** (eg at earlier hospital visit such as giving birth). Some required **longer support** than offered, particularly if further harassed by the perpetrator or dealing with family fall-out from the abuse (eg child behaviour problems or children taken into foster care).
- Some victims didn’t recognise they had been abused at first, and the Idva could **raise awareness**, giving skilled help in recognising healthy/unhealthy relationships.
- Victims’ **wider families** were often also traumatised through a ‘ripple effect’ and, by helping the client, the Idva could indirectly benefit a wider circle of people.

## Clients' views on previous help-seeking from agencies

- Few victims talked to **health professionals** (GPs and Emergency Department) about the abuse before getting help from the hospital Idva because –
  - their partner always accompanied them to appointments
  - the victim didn't realise it was abuse or
  - they felt 'dismissed' by the GP because of their alcohol problem
- **GPs** often provided valuable support, but only when made aware of, or able to ask about the abuse.
- **Social services** were generally seen as 'unhelpful', perhaps because their focus was on the child, not the victim. Sometimes children were taken into foster care because their mother was not believed to be keeping them safe, adding substantially to the victim's trauma.
- **Police** evoked a mixed response. They could offer immediate respite from the abuse and had helped obtain non-molestation orders. On the other hand, in one case they had put a victim in danger (by breaking a promise not to tell the perpetrator that the victim was their source of information), and in other cases had not enforced non-molestation orders (giving social services grounds for taking her children into foster care, one mother believed).
- **Specialist dv services** were found to be generally helpful.
- **Friends and family** were usually helpful once they knew about the abuse. But partners often isolated the victim eg by not allowing them their own phone, by proxy violence (attacking a friend's partner and threatening further attacks if the victim kept in contact with her friend), or persuading the victim to move away from family and friends.
- The only **male victim** interviewed, concerned about his own and his daughter's safety from his wife's physical violence, had felt both police and social services were more sceptical than they would have been towards a female victim. Although he found the hospital Idva very helpful, he would have preferred a male Idva.

## Help-Seeking

Clients were asked about their informal help-seeking from family and friends, more formal help-seeking requested or received from agencies such as the police and healthcare practitioners, and also if they had at any time asked for help from specialist organisations dealing with domestic abuse (other than the hospital Idva service).

### Family and friends

Most said they had found it difficult, at least for some time, to talk to family and friends about the abuse they were receiving. Generally speaking, once they were able to talk to family and friends, they did find they were offered emotional and practical support.

One mentioned, for example, that she had been unable to seek help from family and friends as she was effectively isolated from them. Her partner had 'poisoned my mind against my family' and convinced her that they did not care about her so for several years they had no contact (Participant 3008749). It was only after he had attacked her on the street in front of witnesses and was subsequently jailed that she was able to get in touch with her family and to tell them about the abuse she had been experiencing. Once he was released from jail however, she was persuaded to return to him, and was again isolated because he refused to allow her to see her family. She was not allowed to have her own phone, but from time to time she was able to get hold of a phone and text 'help' to her sister when she was being physically attacked, so that her family knew to call the police. Now that the relationship is over, she is receiving practical and emotional support from her family.

Other participants were isolated from family and friends by their partners. Participant 5008189 was forced to stop seeing one friend because the friend's partner was attacked by the participant's partner. She was told that the attacks would continue unless she stayed away from the friend. Participant 4008764 was persuaded to move away from her local area and thus away from her support network of friends. She was also sworn to secrecy about an event in the partner's past. When the strain of keeping the secret became too much for her and she did finally tell a friend, the friend was annoyed that she had not said anything before, and the participant found herself still more isolated. She was unable to tell her family what was going on, because it would have meant disclosing her partner's past and she commented that 'if my mum – if my family ever found out, they would disown me'.

The isolation was not always obviously caused or facilitated by the partner/perpetrator. For example, Participant 1083097 found that friends were concerned about her relationship long before she recognised for herself that there were any problems. They passed on their concerns to a Safeguarding Officer, who in

turn spoke to the partner's Probation Officer. However the participant was annoyed at what she perceived as unwarranted interference and would not have anything further to do with her friends.

Participant 1089622 had already been estranged from her family. It was only when she decided to try and re-establish the relationship that the partner seemed to behave more badly. Previously, he had already done his best to isolate her from friends – calling her female friends names and not allowing her to have male friends. It seems, therefore, that he was unhappy at her decision to rebuild family relationships – perhaps with good reason (from his perspective) as they were subsequently able to support her through a court case in which he was convicted of physically abusing her. Similarly, Participant 1080307 found that once she decided to return to study after having been a full-time mother, the more she was out of the house and meeting other people, 'the more insecure he got'.

Other participants found they were reliant to some extent on informal support. Participant 1088059, for example, had their support when she was leaving the relationship. A sister who was also in a violent relationship recommended the Freedom Programme, so Participant 1088059 attended that. The abuse does not seem to have been a surprise to her family as she commented that 'everyone knew what [he] was like' and that 'He's a lovely person but he's got that violent streak'. Another (Participant 2008262) found that after having been in a series of abusive relationships, although her family knew about the abuse in the latest relationship, they did not seem particularly concerned. Nevertheless, one of her adult children was actively involved in seeking formal help for her (calling the police) and has been practically and emotionally supportive since the relationship has ended and the participant has been working on sorting out other issues in her life.

Some participants found that although family might have been aware and even concerned about potential abuse, they were less able to provide the type of support that might have been most useful. Participant 3082295, for example, was warned about her partner by her family and (and also friends/colleagues who warned her 'he doesn't look you can trust on him' [*sic.*]). When she came to stay with her family, they refused to allow the partner to stay also, which meant that she was seeing him in secret. Her relationship with her parents seemed quite fraught perhaps in part as a result of that (although subsequent events did indicate that they were right to be concerned). Another found that her parents were unable or unwilling to support her in ending the relationship, perhaps for cultural reasons as divorce was seen as culturally unacceptable (Participant 3083198). In another case, although the family members were aware of the abuse, they struggled to know what to do because the perpetrator was a young person with mental health problems rather than a partner (Participant 1083124).

As with Participant 3008749 mentioned above, family and friends were not always at first aware that the abuse was going on and it was only right at the end, that they found out. Some may have suspected however. Participant 3083229 did not tell any of his family about what was happening; however his father

saw his partner hit him with a tea towel and advised him to leave the relationship. Now the relationship is over, they are being financially and emotionally supportive.

## Police

More formal help-seeking sources for the participants included the police. Whereas attitudes to the support received from family were generally positive and appreciative, attitudes to the police were considerably more mixed. Some participants simply saw the police as a means to obtain immediate respite from abuse. For example, the police were called on a number of occasions for Participant 3008749, and on these occasions they would remove her partner from the house overnight. However, she would never make a statement against him. When he was being prosecuted for attacking her in front of witnesses, she refused to go to court to give evidence. This was partly because of nervousness at the whole prospect of giving evidence but also 'I knew I still loved him so I didn't want to see him because I didn't know how I'd feel if I did see him'.

Other participants felt that they had reason to be disillusioned about the extent to which they might receive effective support from the police. For example, Participant 5008189 was attacked outside work and called the police but asked them to ensure that they did not divulge to the participant that she was the one to call them. She was scared of the consequences, especially as her partner hated 'grasses'. They agreed but subsequently when interviewing her partner, told him exactly what she had said. Generally speaking, she was too scared to call the police as she felt that they would not protect her and this lack of faith in the ability to offer protection was echoed by Participant 1089622 who said that the police were 'no good'. She had received involvement from the police on several occasions and they had apparently helped her to get a non-molestation order on her ex-partner. However, the partner would wait outside family members' houses and outside her child's school and although the police were called, Participant 1089622 said they never did anything. There was social worker involvement and eventually her child was taken into care because it was said that the child's safety could not be guaranteed. The participant blamed this solely on the police's failure to protect her (and she says the judge backed her up in that supposition). 'But everything the court has asked me to do, I'm doing and I've been doing that from day one. [...] I've been doing my best to keep him away. The police have let me down [...]'.

The same lack of faith in the police was expressed by Participant 3082295. She had been suspected of harming her own child, but had subsequently been exonerated. She had finally been able to completely separate from her partner and was confident that he did not know where she was staying. However one day she returned home to find him in her room in a shared house. With the help of her housemates, she was able to get away and go to the police, but they suspected that she must have given her address directly to the participant and accused her of wasting their time. She said that 'this is not the way to speak



with victims of domestic abuse'. She felt that if he turned up again, she would not bother to call the police, even though she also felt that she would be in real physical danger.

A few other participants also expressed concerns. Participant 3083198 for example found that although when the police were called and would try to defuse the situation by suggesting that her partner left the family home for the night, as soon as they left, he would return and demand to be let back in. She was also suspicious that her partner was somehow interfering in police investigations because he knew an ex-police officer (although this suspicion did not seem to be based on concrete evidence). Participant 4008764 had involvement with the police mostly because of concerns about her partner's part, then because of relationship issues. However, when she did try to talk to the police because she was concerned that her partner might be in danger of repeating some of his past (criminal) behaviours, she was told by a police officer 'I don't know who to believe, you or him' – a statement which she found distressing. On the other hand, when the relationship was completely over, the police did give her helpful advice, including notifying her child's school that he was not allowed to pick the child up.

Others, however, found the police to be more supportive. Participant 1088059 found them to be helpful and understanding and they assisted with getting a non-molestation order against her partner. When Participant 1080307 called the police about a particular situation, she found they gave her 'reassurance' and were 'very kind'. Participant 3086562 called the police because 'I wanted to teach him a lesson, more than anything'. Again, they offered to help her with obtaining a non-molestation order although she declined the offer. Participant 3083229 rang police (as well as social services) when his wife hit their daughter. He found that the police were helpful although a little sceptical (because the perpetrator was female), and said they were certainly more supportive than social services. Another survivor, Participant 2008262 had experienced police involvement across a number of abusive relationships and was not always happy about the way they handled things. In one (previous) relationship in particular, she complained about their apparent support for the perpetrator, and said she received a letter of apology. However, she said that in an earlier relationship, the specialist DVA police officer was 'brilliant'. And in this final abusive relationship, they had been 'nice to me'. They wanted her to co-operate with a prosecution, but she would not give evidence.

There were, therefore, somewhat mixed reactions to police involvement. On the one hand, the police were seen as providing a necessary but reactive service. The usefulness of police in terms of preventing abuse before it happened or being able to offer longer-term protection to survivors was seen as limited. Awareness that police involvement could mean pressure to take further action against the perpetrators was an additional barrier to participants, who often simply wanted the abuse to go away. They were reluctant to

support any further action for different reasons - some were afraid of the consequences of police action, some still loved the perpetrator, and some simply did not want the hassle.

### GP and other medical services

Another type of formal support for survivors of domestic abuse is from medical services, particularly their GP. However, few of the Themis participants had actually spoken to their GP or other medical professionals openly about the abuse they were experiencing, and certainly not before the stage at which an Idva became involved.

Participant 3008749, for example, suffered from a range of conditions requiring frequent GP visits but never seems to have disclosed the abuse. As her partner did not work, he always accompanied her to GP appointments, and she was never given the opportunity to be alone with the GP. If she had, she feels that she might have tried to say something. Another survivor, Participant 5008189, had gone to the GP for injuries sustained as a result of abuse (e.g. dislocated finger) and for problems with sleeping but had not disclosed what was happening. She commented that 'I think it's because I didn't see it [...] I just didn't see how much abuse he'd put me through'. If she had been asked, she may well have said something. Also, Participant 1083097 was having stomach pains while pregnant after her partner 'was being really mean to me'. She was taken to hospital and was asked what had happened but didn't want to tell them about his behaviour because he was in the room with her. She thinks that if she had been asked while on her own, she would have said something.

Most participants found that once their GP was made aware, they were supportive. For example, Participant 1088059 has been on anti-depressants and it seems that she did disclose the abuse to the GP at some stage. She found the GP to be supportive – to the extent of weekly then monthly phone calls to check up on her. Participant 1081062 never talked to GP at the time the physical abuse was going on (while still in relationship) but her GP has since implied that they were suspicious that something was happening, but were never able to get her on her own.

On the other hand, Participant 3083229 had physical injuries which he says really needed stitching. He never sought medical advice at the time and says did not tell his GP what was happening at home. Participant 2008262 felt particularly unsupported by her previous GP who she says was 'horrible' and 'just dismissed' her (the participant had alcohol problems and seems to have been 'dismissed' because of that). After registering with a new GP, she felt much more supported.

The important role that health professionals have to play in identifying and contributing to the prevention of abuse, not least because of the impact of abuse on the physical and emotional health of survivors and

perpetrators (see e.g. Feder et al, 2011), has been well noted. Although this was not a primary focus of these interviews, Themis participants seem to support the fact that GPs can provide valuable support – but only when they are made aware of or are able to ask about abuse.

### Other agencies and services

Some participants were involved with other agencies or services (including social services), either prior to the Idva involvement or as a result of it. Participant 3008749, for example, was involved with various other agencies including drug support. She suspected that her drug worker was aware of the abuse she was experiencing, but, as at GP surgeries, her partner was always with her. On the one occasion when she was on her own, the drug worker tried to talk to her about abuse and suggested that if she ever needed support and advice, she could call. However as the participant did not have her own phone, she was never able to call the worker.

Participant 1089622 was involved in couples counselling with the perpetrator and he also took part in a domestic violence perpetrator's programme (DVPP) at the instigation of social services. However the course facilitator was concerned about his behaviour and phoned the participant several times a week to check she was safe because they could see that he was being 'manipulative' while on the course. The same participant also had ongoing support from Women's Aid (starting from a previous abusive relationship). She found them helpful, and also Victim Support who became involved after the final incident (physical assault).

Another survivor, Participant 3082295, had prior involvement with domestic violence agencies in her home country, having stayed in a refuge after leaving her first relationship. In the UK, she has also had support but the situation was complicated by her legal status – especially when she was under suspicion of harming one of her children, and her police were holding her documents. Her legal situation was still not resolved at the time of interview. She had referred herself to a Domestic Violence support service and had also been seeing a counsellor. When she first saw her counsellor, she could not speak to her. 'It was enough, just bringing me to a sitting room and ask me "did you want to speak or are you OK?" and that was enough for me to cry'.

A number of participants had been involved with social services and generally speaking had found them unhelpful (perhaps because they focus on the child's safety rather than the adult's). Participant 1089622 had had social services involvement for a number of years (including prior to this last relationship). She felt they were 'out to get' her and had provided her with no support but were simply focused on an excuse to take her child away. Participant 3083229 contacted social services himself because of concern about the

risk of abuse to his child from his partner. He was helped to work out an evacuation plan but when he told them that he was scared to leave, because of the potential consequences, he felt that they were sceptical: “Oh, you are a man, put up with it”.

Whereas specialist domestic violence services were usually seen as helpful, social services were generally viewed with more suspicion and as not necessarily willing or able to support the wider family.

## Idva services

All the Themis participants in the qualitative strand had contact with the Idva service based at hospital sites 1, 3 or 4 for varying lengths of time, ranging from one or two phone calls to more intensive visits and supports. As discussed below, referral pathways for most were similar although there were one or two variations. Although the amount of support required varied, participants were unanimous in their appreciation of the service provided by the Idvas across all three areas.

## Lessons Learned

The primary lesson to be learned from the Themis interviews conducted across the three sites, is that the Idva service makes a real, positive difference to those who receive it.

Certainly for the women we spoke to (perhaps less so for the one male survivor), the service empowered them to make in some cases quite radical changes to their lives, and even where big changes were not made, they were given more confidence because of the knowledge that such support existed.

Some participants (e.g. Participant 3008749) felt that if they had been provided with a chance to talk to an Idva at an earlier stage, they would have been able to make changes then.

Some may have needed further support, because they did not seem to have been able to make the most of the support they were being offered at the time (e.g. Participant 4008764) , or because of subsequent events, such as the partner trying to make further contact (e.g. Participant 3008749).

Several participants (e.g. 3008749, and 5008189) had never previously tried to get support because of not really recognising what was happening was abuse. Participant 5008189 stated that ‘I was blind to it [...] You don’t realise it is domestic abuse, you think it’s normal ..’ Perhaps on the same lines, Participant 1089622 noted that ‘I think some people when they’re asked if they want Idva services or people like that involved, some people are quite reluctant, I bet. .. I personally think it’s a good idea to like have support there but if

you don't know, because I think at first I said 'no' actually, but then when I thought about it, it is good'. It may be therefore that Idva services need to be somewhat persistent in their offer of help and also in helping would-be clients recognise their experiences as abusive.

Allied to this is the issue of timing when support is offered. One participant (3082295) suggested that for her, the best time might have been when she was in hospital after the birth of second child and was scared and depressed at the thought of having two children as a single mother and with little money. Participant 1081062 also noted that the support needed depends very much on the stage the survivor is at.

The way Idvas talk and listen to clients is of paramount importance and seems to have been especially appreciated by all the Themis participants. As Participant 2008262 noted, 'you've got to make someone feel you are going to listen to them, they're not a nuisance. I think that's really important'.

## Conclusion

As mentioned throughout this report, the Idva service appears to have been an invaluable experience for all the Themis participants. Perhaps an additional important point to note is that it is not just the survivors themselves who have benefitted. In many cases, the wider family has gained from the Idva support – either indirectly because of the support provided to the survivor or more directly because the Idva was able to talk to them as well, such as for the parents of Participant 1083232. The fact that the Idva was able to speak to her parents as well 'made it better for all of us, not just me because in a situation like that, it wasn't just me going through it'. Given the known impacts of domestic violence and other forms of abuse on the health of victims/survivors as noted above, the benefits of the Idva service extend not only to the individuals concerned but presumably would have wider implications in terms of cost-saving for the NHS.

## Quotes from client interviews

### I didn't recognise it was abuse

"Didn't really think it was abuse. Thought it was quite normal. Psychological. I didn't recognise it. Couldn't see it till it got really out of hand. Terrorised me." (3008107 – *she first disclosed to GP*)

"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." (1083124)

"I don't think I would have admitted it was a domestic abuse situation. It just felt my ex- was just a nasty man. Then (hospital Idva) went through one of her questionnaires after I had moved. (I was) on the border of being high-risk. Quite shocking." (1083201)

74-year old woman abused for 40 years. "Now because I don't think anyone has taken it seriously, I feel I am 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." (1083570- HADS anxiety = 17, depression = 14)

### Value of hospital Idva

"Hospital (Idva) has been helping me and referring me to places. Everything getting sorted out. I have been waiting years to get help with my depression. My doctor now is waste of space. He weren't interested." (1080936: HADS anxiety = 14, depression = 14)

"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. Any 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." (1083124 – abuse by teenage daughter)

"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 still is working with me. I feel she's the only person I can be honest to." (1083557)

### Male client's view on hospital Idva and other professionals (3083229)

"Nice lady. Felt like she was a mum. She was listening. She was really listening and understand what I was talking about. That actually felt nice. At least there is someone there that knows. I would have preferred it to have been a man. Because he would have been able to relate on a man's way of thinking. (Idva) fulfilled everything for me. She was helpful. I have never met one man in this whole process. Massive feminist state here. Feels like odds stacked against me. In case conference – about 20 people there. I was the only man."

# Chapter 10: Providing Help

Forty-nine hospital staff and 15 hospital Idvas, Idva managers and commissioners were interviewed across the five hospital sites. A list of staff interviewed, identified only by role to preserve confidentiality, along with the themes drawn from the qualitative analysis, are listed in Appendix 10.

## Summary

### Hospital staff & hospital Idvas/Idsvas

- Hospital Idva should be seen as the equivalent of a **healthcare professional** (equivalent of alcohol or mental health specialist nurse). Their role is to train, advise, support and motivate hospital staff in the important area of domestic abuse, which affects physical and mental health so much. (*However they would need management by a dva specialist.*)
- Idva should be **embedded** in hospital and **highly visible**, with reach to all hospital departments.
- Views on whether **dva screening** should be routine or targeted, varied. Asking everyone allows for **unexpected disclosures** (including from men).
- Staff vary in their willingness to **ask the question about dva**. A filter question can be useful (especially if the patient does not recognise the behaviour as abuse), alongside general alertness to signs of fear and control. Also staff should be aware that perpetrators, too, may be open to seeking help.
- ‘Carpe diem – seize the day!’ Timing is crucial. Idvas based in hospital can talk to a victim during a **golden ‘window of opportunity’** when they are most likely to disclose, and can therefore be offered help at a much earlier opportunity.
- Hospital Idvas can reach **victims hidden** from other agencies, eg due to alcohol or drug abuse.
- At its best, the hospital Idva service can work **seamlessly** with other hospital professionals, sharing information and maximising chances to help victims.
- A hospital Idva needs to be an **Idva-plus**. On top of the Idva’s normal range of skills, 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. Their needs for clinical supervision may be higher because of the traumatic setting (if based in ED), and the challenge and worry of working with more clients with complex needs and at an earlier stage of change.

# Thematic Analysis

## Methodology

The data collected from the interviews was transcribed by the researcher. The transcribed data was read and re-read several times and during this process the initial thoughts and ideas were noted down. Following this codes were assigned to the data that the researcher considered important to the research questions. All initial codes relevant to the research questions were incorporated into sub-themes using thematic maps to aid the generation of final themes as suggested by Braun and Clarke (2006).

The sub-themes were re-considered in relation to the initial codes and several were merged into final themes. Each final theme was defined and named to give a clear indication of the essence of the theme and accompanied extracts that clearly identified issues within the theme and presented a logical example of the point being made.

Finally, a framework of the final quotes was used to look at any differences within the themes from different hospital locations or staff roles.

## Analysis

A thematic analysis was applied to transcripts from 49 interviews with hospital staff across five hospitals and 15 interviews with Idvas (or Idvas – Independent Domestic and Sexual Violence Advisors), Idva service managers and Commissioners across all the sites (see Appendix 10). Eight themes were produced from interaction with the data from hospital staff and six themes were produced from interaction with the data from Idvas, Commissioners and Service Managers (See Appendix 10).

These were grouped into six superordinate themes to give more overarching topics, representing the meaning of several themes, from both hospital staff and domestic abuse specialist perspectives: The final six themes are: “The Idva as a healthcare professional”; “Out of sight, out of mind”; “To ask or not to ask the question”; “Carpe Diem, seize the day”; “Finding the hidden victims”; and “Working together to tackle domestic abuse”.

These final themes are viewed as central in determining the impact of an Idva in a hospital setting, considering what facilitates or impedes a domestic abuse service and hospital co-location, and advises on information that assists the recognition of domestic abuse by staff.



## Theme 1: “The Idva as a healthcare professional”

This theme demonstrates the Idva as a professional in the domestic abuse sector, and highlights the knowledge and specialism involved in carrying out the role. The topics within the theme convey the benefits this expertise can bring to hospital staff and the organisation as a whole. These include education and training, being a main point of referral and support to staff; and through their know-how by time-saving to hospital employees and prevention of crises, is most likely a cost-effective service to the NHS. 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 staff to tackle the question of domestic abuse. This expertise was recognised by hospital staff and, importantly, equipped them to make enquiries about domestic abuse, and gave them confidence to support victims:

*“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 I think.”*

**(ED 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 enormity of training in a large organisation with a constant turnover of staff with one respondent commenting: *“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 6-9 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 can refer the patient for help. Idvas noted the concern practitioners have in dealing with a disclosure of domestic abuse:

*"Having 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 opportunity to take action at that point, even if just send email"* (ED Consultant)

*"If we didn't have service...people would just stop screening. No point asking question if not going to do something about it...like opening a nasty cut and not doing anything about it"* (Alcohol Nurse)

*"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?'"* (Hospital Idva)

## Saving time, saving money

Hospital staff recognise that the Idvas' expertise saves their time and hence, is economically worthwhile to the organisation. Domestic abuse professionals note the need to evidence savings, with one Commissioner supporting the savings a hospital Idva service can make:

*"We do leave lot 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"* (ED Consultant)

*"Really helpful to have input from Idva...[previously] one of my nurses spent whole day and I spent whole afternoon trying to find one refuge"* (Consultant Psychiatrist)

*"Evidence would need to show a reduction in repeat attendances in hospital...because victims when suffering from domestic abuse, they keep turning up at A&E. If we can show reduction in that, it can prove it is worth...It would have to be an economic argument"* (Commissioner)

*"We can extrapolate the money saved by hospital Idva service, so kept it. 'Spend to save' agenda"* (Commissioner)

## The Idva-plus role

Hospital Idvas' role differs from local Idvas' role inasmuch as – 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 local Idvas. If based in an Emergency Department, they are working in a setting where trauma is routine and often graphic. They face the challenge of working with more clients who have complex needs (including some, whose partners are offenders and they may strongly fear repercussions from approaching anyone for help), and with more who are at an earlier stage of change, who are more likely to return to the abuser, with the attendant dangers for them and concerns for their Idva.

*“Can’t have little shy, retiring type because they do have to be visible. (In addition to Idva training) they also have to be good trainers, acceptable to clinicians ...and have got to put up with some really horrendous cases, because they will see nasty injuries and can really be quite traumatised...”*

**(Commissioner)**

## Theme 2: “Out of sight, out of mind”

This theme encapsulates the need for the Idva to be seen and embedded in the hospital setting for the service to be successful. The topics within the theme consider the necessity for networking and building relationships with staff and having a hospital base. Also key is the need for the service to be visible and 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 the 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 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”* **(ED Nurse)**

*“[It is] important to build rapport with hospital staff. Having [a] recognisable face...hospital Idvas need confidence to network and introduce selves.”* **(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 clients, 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” (ED Consultant)*

*“All of them want me to be there more often – to be visible. But I can’t just loiter” (Hospital Idva)*

This respondent again mentioned later in the interview:

*“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 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. In addition to this, 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. 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 clients become aware that the service is there. This may be beneficial for victims but there are also considerations of being alerted to the facility.

*"In the past, we would get multiple clients turn up numerous times in A&E. They might be just to see us. Walk into reception: 'I'm here to see (service name) services'. Couple came out of the blue."*

**(Senior Idva)**

*"Whether to publicise...risk to client if word gets out we are running the study or relative, friend see Idva with client and identify. Can put client and service at risk...[we] don't want too much publicity"*

**(Research Nurse)**

## The scale of the task

A main concern of both hospital staff and professionals was how to make people aware of the service in a large organisation. Idvas noted concerns that they are reaching all departments, and staff highlighted the need for this to be organised and promoted.

*"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, can be lone voice in massive organisation"* **(Adult Safeguard 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)**

## Theme 3: "To ask or not to ask the question"

This theme depicts the issues associated with asking clients about domestic abuse. The topics within the theme include whether to screen routinely, the disparity between staff in enquiring, the concern of asking, and examples of effective ways to ask about domestic abuse.

### Making screening routine

Responses from hospital staff indicated ambivalence in whether to routinely screen for domestic abuse. Some consider that consistent questioning removes the taboo; others have reservations about whether evidence supports routine screening, and whether this is sustainable or a priority of their roles. Domestic

abuse professionals noted the varying practices for screening across hospitals but advocate routine enquiry.

*“Routine enquiry is good because gets rid of [the] fear of asking...picks up ones we wouldn’t suspect, hopefully picks things up earlier and more subtly. Loses supposed stigma in asking about these things” (ED Consultant)*

*“[Do] targeted enquiry...general screening not as successful...evidence shows... [should only ask] certain risk groups” (ED 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” (Consultant, Emergency Medicine)*

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

Although advocating regular screening, some hospital staff consider workload and lack of resources are preventing 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” (ED Consultant)*

*“If we were serious about really looking for this we would find things we don’t want to find. Unfortunately [there is] institutional implicit avoidance [of] trying to see how deep the rabbit hole goes, because 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 responses indicate there are hospital employees who are cautious about asking clients due to the difficulty of enquiring, or the outcome of dealing with a disclosure. As indicated earlier, Idvas note the concern amongst hospital staff about ‘opening a can of worms’, and this may be linked to their apprehension. 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."

**(Hospital Idva)**

"People would find hospital Idva in corridor and tell them quite powerful stuff. Obviously nursing staff are mainly female. Quite high incidence of abuse...feeling was, quite lot of people were feeling uncomfortable because it brought up a lot for themselves" **(Consultant ED)**

"[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 between individuals and departments regarding the importance of asking about domestic abuse. Idvas noted this disparity even from 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] not 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, don't do anything about it" **(ED Sister)**

"Dental, they have been quite un-cooperative. '[They say we] don't need link nurse and don't see much dv.' About 30% [of] assaults we get through are facial/dental injuries." **(Hospital Idva)**

"[Idva has] only had 2-3 referrals from [maternity ward in hospital] since June 2013. Few from community midwives and couple from Maternity discharge planning team" **(Hospital Idva)**

### The best way to ask

Staff acknowledged the training given by the Idvas in how to ask the question about domestic abuse to the client. They suggested that effective ways of asking concentrate on engaging around the issue rather than a direct question.

"Asking around (the issue)...you get a sense of their world...gaining someone's trust and showing interest...from that...'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'" **(ED 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 that has come off our Idva here...empowered...from taboo to routine” (ED Consultant)*

## Theme 4: “Carpe diem, seize the day”

This theme demonstrates the importance of acting immediately when a patient discloses domestic abuse. The topics within this theme relate to reaching the victim at the ‘point of crisis’ and when they are motivated to disclose. 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 to the victim so they do not lose the opportunity to engage the client. 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 here...when someone starts to open up we really want to hit right there and then...[you can say] we have got specialist people here to give really good advice, options, pathways” (Senior Nurse, ED)*

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

*“[You’ve] got to find windows of opportunity. Window stays open for about 4 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 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 in hospital at a crisis point or with an injury may act as a motivating factor in the ‘stages of change’. 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 Idsva)*



*“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, said” (Consultant Psychiatrist)*

## **Sowing the seed**

Whilst 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 the victim (perhaps on an everyday product) 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)*

*“(Giving the [everyday product] ) 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 bit of a better deed than just send them back to some awful sort of situation” (Senior Nurse, ED)*

## **Theme 5: “Finding the hidden victims”**

This theme encapsulates how clients are identified in the hospital setting, and how they may differ from victims seen in the community. The topics within the theme consider the importance of the hospital as a safe location, discovering clients who are unknown to other services, signs that alert hospital staff to possible abuse, the link to complex needs, and clients located in the hospital setting who are not evidently thought of as victims.

## The safe location

Hospital staff highlight how clients seek out the service knowing it is easily accessible and can provide protection. Comments from Idvas concur with this, and further indicate these clients are distinct from those seen in the community.

*"I think patients may seek referral here [because we've got Idva service]. They feel it is a safe place they can come. They come [saying] "I know you have a service" because I think there are not many places...because coming to hospital equals place of safety and expect confidentiality"* (ED 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)

It is suggested the hospital location also provides an opportunity to identify pregnant women and safeguard children sooner, or to identify unknown 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"* (Senior Midwife)

*"Try and encourage them to ask if there is a child at home. Because these children, hidden children...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)

## The red flags of domestic abuse

Hospital staff note 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 disorders<sup>55</sup> or pseudo-seizures<sup>56</sup> where the link has not been made. Idvas confirm that many clients they see in the hospital setting have complex issues and higher needs.

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<sup>55</sup> A functional disorder is 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.

<sup>56</sup> A pseudo-seizure may occur as a psychological reaction to severe trauma or stress.

*“Frequent attenders...chronic pain, psychiatric presentations, overdoses, almost fictitious disorder...a passport to see the doctor ...very rarely about woman turning up missing couple of teeth and 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 ED 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” (Senior Nurse, ED)*

*“A lot have mental health problems. A lot have personality disorders.” (Hospital Idva)*

*“Hospital clients – I think their needs are higher because either come in with overdose, attempted suicide, injuries of alcohol-related issue.” (Senior Idva)*

## **Disguising to disclose**

Hospital staff spoke of perpetrators who are reluctant to leave the client. Staff note ways they have devised to facilitate disclosure, or situations where they can get victims alone if they feel they want to disclose (not all are revealed here). Also considered are ways staff can disseminate information to aid disclosure.

*“‘Dot on the pot’ if you suspect domestic abuse. Ask for a ‘routine’ urine sample and give them a urine pot...in the female toilets [there is a] roll of small dots. If they want to talk to someone, put on underneath side of urine pot. Then endeavour to get them on their own” (ED sister)*

*“No, we are all quite good at lying! ‘We are going up to [the] ward now and having breakfast’...because normally quite busy and don’t have any cubicles, we can say ‘not much room in here I am going to have to ask you to wait outside’ ” (ED Nurse)*

*“In [area], nurses in A&E and Maternity give out cards to say ‘is this you?’. If yes, go to dva services. If you give out in Maternity you get people admitting to violence at home after two years [where it is] more than four years in the community.” (Commissioner)*

## Challenging the stereotype

Both hospital staff and domestic abuse professionals drew attention to clients who may not obviously be thought of as victims being identified in the hospital setting. This highlights the need for awareness to consider the possibility of domestic abuse in all individuals.

*“Not always partner that is the perpetrator...can be parent or child” (Senior Nurse, ED)*

*“And for people to remember that men can be victims of domestic violence as well...more difficult for them to seek help or even acknowledge what’s going on because of the whole gender thing...might be less awareness in the hospital re. men” (Senior ED Nurse)*

*“Not forgetting elderly population in this, 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” (Senior ED Nurse)*

*“Saw 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’ ” (Senior ED Nurse)*

*“[We see] different kinds of clients, 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 clients have never been anywhere near the police” (CEO, DVA Organisation)*

## Theme 6: “Working together to tackle domestic abuse”

The final theme considers how hospital staff, departments and agencies can work together to identify and assist victims of domestic abuse. The topics within the theme include alerting professionals to possible victims, how a hospital location can make services more easily accessible to victims, the issues of sharing information and what Idvas can do to encourage a good working relationship with hospital staff.

## Flagging and tagging

Hospital staff noted how 'flagging' cases can inform staff and other services to vulnerable patients. Idvas note the benefits of this and show that in hospitals where this is not practised, how it can hinder partnership working.

*"Now [you] must document on hospital record. Now computerised record, box you tick. If suspect domestic violence but not disclosed, document that you asked. Continue monitoring and surveillance. Lot of what we do is fact-finding and info-sharing"* (Senior ED Nurse)

*"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"* (ED 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 can put flags on patient records. If Marac clients – flag, put referral to Idva on them. Here, unless there is a child or open SOVA [Safeguarding of Vulnerable Adults] they wouldn't be able to do that... [not being] on the system makes it [a] lot more difficult for partnership working."* (Hospital Idva Services Manager)

## Fast-Tracking

Idvas comment 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, this also enables children to be referred to services immediately or plans 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 [service] – we are in the same building."* (Senior Idva)

*"We are identifying more dv 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 directly"* (Hospital Idva)

*"Lot of clients are pregnant, do lot [of] good work with post-natal and some ante-natal and labour wards to plan for birth and afterwards"* (Hospital Idva)

## Working and sharing

Hospital staff note the unease of sharing information with Idvas, and how setting them up with secure email, for example, can ease co-operation.

*“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” (ED Consultant)*

*“Previously 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 to that Idvas could use. So staff 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 needing to develop associations.

*“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” (Idva Team Leader)*

*“Trying to marry services that are chalk and cheese” (Safeguarding of Vulnerable Adults worker)*

*“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 Children and Adults)*

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” (ED Sister)*

# Chapter 11: What makes a hospital Idva service work well?

## The five hospital Idva services

The five hospitals were all based in England and varied greatly in size and setting, from large to small, metropolitan to rural. Also varying greatly were the Idva services based in the hospitals - in institutional identity (managed by hospital staff or an outside domestic abuse service), location of office base, number of workers and hours of operation. In addition, these services could be constrained formally by specifications laid down by domestic abuse commissioners (in terms of which departments they could take referrals from and how long they could work with clients before passing them onto a local Idva service), institutionally (access to office space, the hospital computer system, identity badge), and informally by the quality of relationships between hospital staff and hospital Idvas. Some hospital Idvas were actually Idsvas (Independent domestic and sexual abuse advisors), but all are termed Idvas in this chapter to preserve the sites' anonymity.

In order to protect the identities of the hospitals, they will be identified as Sites 1, 2, 3, 4 and 5. In this chapter 'what works well' themes gleaned from the 64 interviews (49 with hospital staff and 15 with hospital Idvas, dva service managers and commissioners) are considered alongside quantitative information (number of referrals, outcomes) for each site.

## Key themes

The key themes influencing the effectiveness of a hospital Idva service (ie how well-accepted by hospital staff and how busy with clients), were that the service was:

- **Championed by key senior staff** in the wards the service was primarily working with
- **Highly visible** (office base & Idvas' presence in the hospital wards/staffroom)
- **Institutionally integrated** (Idvas have hospital staff 'badge', access to NHS emails and hospital computer system, able to 'flag and tag' cases) in order to overcome structural barriers (MOZAIC research)
- **Providing ongoing training**, as hospital staff turnover is high and the level of training given to hospital staff was related to the level of referrals from them to hospital Idvas
- **Adequately and sustainably funded**, so that candidates of adequate calibre can be attracted and retained
- Backed by **clinical supervision** to help prevent Idva burn-out, given the intrinsically traumatic setting of an Emergency Department, the more complex cases (particularly where mental health and substance abuse problems are also present), and greater danger to clients (more suffering

severe abuse and more still living with their abusers). Colleague support is also needed, to prevent isolation.

- Staffed by Idvas with an **outgoing, confident personality**, who can build **good relationships** with all levels of hospital staff - from consultants to receptionists, in the different wards/departments ... in addition to the knowledge, experience and empathy required for their casework with individuals.

It must be stressed that these features affected how well the *service* worked as a whole, not how well a particular Idva worked with her clients. There was no evidence other than to suggest that all Idvas worked well with clients; the hospital and policy context affected the number and source of their referrals, and the length of casework.

### **Comparison of hospital sites**

The key features of the five sites are highlighted in Table 11-1, which shows that the hospital Idva service in Sites 3 and 4 exhibited most of the key features for a successful service in 2015. One of these was a large hospital, one much smaller. Idva services at all sites were fully operational when Themis was planned, but by 2015 the service at Site 2 had largely ceased, only re-starting towards the end of the fieldwork period. At Site 5, the service was suspended during the whole period of fieldwork, with any referrals from hospitals going through the main Idva team. This demonstrates the fluidity of hospital Idva services – if an Idva leaves, they may not be replaced (particularly if the service was not well-accepted, referrals were low and they felt isolated, or funding was not available), and the service may be suspended, at least temporarily.



Table 11-1: Presence of key features at the five sites – 2015

	Site 1	Site 2 <i>Service re-starting</i>	Site 3	Site 4	Site 5 <i>Service suspended</i>
<b>Highly visible</b> <i>(central/frequent)</i>	X	?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	-
<b>Institutionally integrated</b>	X	?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	-
<b>Championed by key Emergency Department (ED)/Maternity staff</b>	ED	?ED Mat	ED	ED Mat	-
<b>Sustainably funded</b>	X	X	<input checked="" type="checkbox"/>	X	-
<b>Idva involved in regular training of many staff</b>	X	?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	-
<b>Idva is confident / outgoing in hospital</b>	X	?	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	-
<b>Clinical supervision available for Idva</b>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	-

The number of cases dealt with by each of the five hospital Idva services varied greatly, not always according to the size of the hospital. A low number could reflect a low rate of referral in that hospital or a break in continuity of the hospital Idva service. Also, Insights forms were not completed for all referrals. In some hospitals, Idvas completed one for almost every victim who engaged with them, but in others, they were only completed for a minority. This was for a number of reasons: not all clients could be contacted or chose to engage with the Idva, some only wanted a brief one-off consultation, some were very unwell and unable to answer the Insights questions, and some did not consent to Insights. For instance, at Site 3, although Idvas only completed Insights forms for 5.3 clients a month, they actually worked with 23.1 clients a month, many on a one-off basis (Table 11-2).

Nevertheless, it is interesting to compare some key points from the Insights data for the different sites. Over a 43-month period (from April 2012 to October 2015), the number of Insights forms submitted for each site ranged from 94 to 248 (Table 11-2). Sites 1 and 2 are considered together, because the service was in abeyance at Site 2 for much of the recruitment period, and figures were submitted jointly for these neighbouring sites.

Table 11-2: Key features of referrals to the hospital Idva service at the five sites

Insights database 2012-2015 (43 months)	Site 1	Site 2 <i>Service re- starting</i>	Site 3	Site 4	Site 5 <i>Service suspended</i>
<b>No. Insights Intake forms</b>	94 (43 months)		228* (43 months)	248 (43 months)	122 (43 months)
<b>Average no. Insights Intakes/month</b>	2.2		5.3	5.8	2.8

\* Actually, in just 12 months (2014-15) there were 365 referrals, of which 277 (76%) engaged with the Idvas, an average of 23.1 a month.

The two sites where the key factors were mostly present (Sites 3 and 4) showed the highest number of Insights Intake forms completed for referrals to the hospital Idva service 2012-15, averaging 5.3 and 5.8 per month (Table 11-2).

Table 11-3: Themis recruitment and interviews at the five hospital sites

Themis database 2014-2015	Site 1	Site 2 <i>Service re- starting</i>	Site 3	Site 4	Site 5 <i>Service suspended</i>
<b>No. Themis referral forms 2014-15</b>	37	6	33	113	9
(no. months' recruitment)	(13 months)	(2 months)	(13 months)	(13 months)	(12 months)
<b>No. T1 Themis interviews (Idva Intake)</b>	19	3	8	46	0
<b>No. T3 Themis interviews (3 months after Exit)</b>	11	1	4	15	0

Table 11-3 shows the number of Themis referral forms submitted for each site, along with the number of Themis Intake and post-Exit telephone health interviews conducted. Although each site was supposed to submit a Themis referral form for every referral received, they did not all manage to do so, particularly Site 3 (which was very busy and only submitted forms for clients who were eligible for Themis<sup>57</sup>). Site 4 submitted over half (57%) of the 198 Themis referral forms from all hospital sites, and their clients

<sup>57</sup> In a sample month (January 2015) when Site 3 Idvas **did** submit Themis forms for **every** referral received, 20 forms were sent in; for four of these clients, Insights Intake forms were also submitted, and two were interviewed for Themis.

accounted for 61% (46 out of the 76) of hospital clients interviewed at Idva Intake (T1), and 48% (15 out of 31) of those interviewed three months post-Exit.

Local policy (in the form of Domestic and Sexual Violence and Abuse Commissioner's service specifications) affected Idva casework in two ways – length of casework and source of referrals. One hospital service adhered to guidance of a six-week limit for high-risk cases (during which time, their cases would be taken to Marac – the Multi-Agency Risk Assessment Committee), and shorter periods for lower-risk cases. At all sites, clients still needing help after the hospital Idva intervention, were referred to local Idva services. At one hospital, the Idvas were primarily attached to the ED, and restricted in the number of clients they could take from other wards (8% of all victims who engaged with the Idva).

Networking also played a key role. Where the Idva had good relationships with staff in a particular ward or department, there were more training opportunities and referrals to the Idva. Where there were poor relationships, training opportunities were fewer and referrals few. This underlines the importance of a hospital Idva feeling comfortable in the hospital setting and confident enough to make relationships with all levels of staff. Their ability to help clients access specialist health care (such as with mental health, alcohol or drug problems) could also be enhanced by knowing the particular health pathways involved.

The effect of policy and good relationships with staff is illustrated by the proportion of referrals from Maternity departments. This varied greatly - from 21% at Site 4, where the hospital Idva had very close links with the maternity wards (visiting almost daily), to 10% for the site where there were not close links, and less than 1% for the Idva service where policy precluded more than 8% referrals from all non-ED sources.

Table 11-4: Outcomes of the 5 hospital Idva services – for Insights cases (n=537 maximum)

Insights database 2012-2015 (43 months)	Site 1	Site 2 <i>Service re- starting</i>	Site 3	Site 4	Site 5 <i>Service suspended</i>
<b>No. Insights Exits</b>		50	213	200	74
<b>Length of casework - Mdn in months</b>		2.5	1.1	3.2	2.5
<b>No. contacts with/for client – Mdn</b>		10	10	8	8
<b>1+ type of severe risk @ Intake</b> - only for those who exited during this period		83%	82%	54%	47%
<b>2+ types of severe risk @ Intake</b> - only for those who exited during this period		56%	74%	34%	30%
<b>Moderate/substantial &amp; sustainable risk reduction*</b>		65%	58%	73%	57%
<b>Substantial &amp; sustainable risk reduction*</b>		62%	28%	37%	21%
<b>Client felt much safer*</b>		66%	50%	73%	32%

\*Clients were referred to other local domestic abuse services, where needed.

Client outcomes between the different sites are summarised in Table 11-4 (full statistical details, of inter-quartile range and 95% Confidence Interval, are available in Appendix 10). The median length of casework was between 2.5 and 3.2 months, except for 1.1 months at the site where policy prescribed shorter casework (maximum 6 weeks for high-risk clients). In the other sites, Idvas could be working with clients for up to 15 months. Despite this difference, the median number of contacts made with or on behalf of a client did not vary much between the sites (ranging between 8 and 10), even where the median case-length was only one month. Similarly, the median number of hours spent on a client's casework in the smaller Themis sample (n=69) was similar, ranging from 8 to 11, excluding the site with details of only 1 case (Table 11-5).

Table 11-5: Outcomes of the 5 hospital Idva services – for Themis referrals (n=69)

Themis database 2014-2015 (15 months)	Site 1	Site 2 <i>Service re- starting</i>	Site 3	Site 4	Site 5 <i>Service suspended</i>
<b>No. hours spent on casework (Mdn)</b>	11 <i>n=16</i>	<i>[not available]</i>	8 <i>n=8</i>	8 <i>n=44</i>	4 <i>n=1</i>

A key outcome of the hospital Idva intervention (whether the Idva perceived risk had reduced sustainably and at least moderately for victims), was achieved for over half of clients from all sites – ranging between 57% and 73%. Significantly more clients at site 4 experienced such a moderate risk reduction than at site 3 (see Appendix to Chapter 9 for the relevant 95% Confidence Intervals), which could be linked to the longer period of casework at site 4. At all sites, clients considered still at risk would have been referred onto local domestic abuse services for continuing support, with their consent. Potential disadvantages of this strategy were that the client had to establish a relationship with another domestic abuse worker, and there could be a delay in the transfer.

Differences between sites were more apparent at a higher threshold - of substantial (as well as sustainable) risk reduction. This was achieved for 21% to 37% clients at four of the sites, and a significantly higher 62% at Site 1.

It was notable that, where Idvas had completed Insights Intake and Exit forms, more clients at sites 1, 2 and 3 had experienced severe risk at Intake than at sites 4 and 5 (four-fifths compared to half). This was also true for those experiencing two or more types of severe risk at Intake – significantly more clients at sites 1, 2 and 3 had experienced these than those at sites 4 and 5.

Where client-perceived safety was concerned, nine out of 10 clients at all sites felt safer after the intervention. However, considering those who felt ‘much safer’, a difference emerged. Significantly more clients at site 4 felt ‘much safer’ than at sites 3 and 5. The lower proportion at site 3 may be associated with more clients having experienced severe abuse at Intake (74% had experienced two or more types of severe abuse) coupled with the shorter period of casework. As stated, any clients still at risk at any of the sites would have been referred onto other local domestic abuse services.

## Hospital Idva service – CASE STUDY 1 (2014-15)

- Large metropolitan hospital
- **No. hospital staff:** 7,000
- Busy **Emergency Department** – 70,000 patients p.a.
- **Hospital Idva service** - 5 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, as staff are Trust employees (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 dva 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
- **No. Idvas:** two full-time, covering seven days a week 9am-5pm
- **No. hospital staff trained in dva 2014-15:** 271
- **No. referrals 2014-15:** 365 (Commissioner's target = 300 from ED, 25 from other wards)
- **Dva 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 follow guidelines to work with high-risk cases for 4-6 weeks, medium-risk cases for 2 weeks and standard risk cases for 1 week or 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, recently, online joint Care Plans.

### Profile

This service is **well-embedded**, with Idvas championed by senior ED staff and enjoying good relationships with staff there 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 dva, and Emergency Nurse Practitioners 1 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** (Multi-agency risk assessment conference) rose from 11 to 70 a year.

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

## Hospital Idva service – CASE STUDY 2 (2014-15)

- Smaller rural hospital
- **No. hospital staff:** 3,000
- **Emergency Department** – 42,000 patients p.a.
- **Hospital Idva service** - 3 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 honorary NHS contract, enabling them to have an NHS badge, access to NHS emails and ability to 'flag and tag' cases on hospital computer system. (However, when second Idva was employed, it took 6 months to get her NHS honorary contract arranged.)
- **Visibility:** very high – although based in room outside main hospital building, the Idva visited the ED and Maternity wards very regularly. Idva can see patients in pleasant quiet room in ED and Maternity.
- **Publicity:** leaflets and posters (after approval by six panels)
- **No. Idvas:** one full-time equivalent (two job-sharing), Monday to Friday office hours
- **No. hospital staff trained in dva:** 2014-15 - 200 (plus 35 GPs) 2015-16 - 120 (plus 27 GPs)
- **No. cases Idvas worked with 2015-16:** 97
- **Dva screening policy in ED:** To ask all patients where possible dva 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 contact on her regular ward visits, Maternity use . However Idva does not necessarily know level of risk or other medical details (eg whether mental health or substance use difficulty) or social services involvement.
- **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 relations. 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.

Also it 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 dva during their Safeguarding Initial Training. Full-day refresher training on dva is also offered, though this is optional. Maternity staff can be trained in half-hour handover period, with between 3 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 **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.

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### Three 'don'ts' (Features of less successful hospital Idva services)

- No Idva base in the hospital, or an inappropriate room far from ED and Maternity. This can lead to the hospital Idva feeling isolated and not valued.
- No effective information-sharing, eg of hospital notes and no detail in referral form. In such cases the hospital Idva can be at a considerable disadvantage because she does not know any background information on the client. This not only makes casework more difficult but can, in rare cases, be a source of risk.
- No continuous training. 'It should be like painting the Forth bridge!' Training needs to be continuous, not only because of frequent staff turnover, but to keep the issue uppermost in hospital staff's minds. When training stops, referrals stop.

# Chapter 12: Lessons Learned

## For commissioners

- The provision of a Hospital-based special domestic abuse service meaningfully builds capacity for the response to domestic abuse in an area, helping to make victims and their families safer.
- Hospital Idvas save the public purse money due to significant reductions in use of hospital and local health services following Hospital Idva intervention.
- Hospital Idva services reinforce systems and services that are already in place. For example, professionals are more likely to screen in accordance with NICE guidelines if there is a specialist domestic abuse service in their Hospital.
- Sustainable funding is necessary in order to attract confident, high-calibre Idvas, who can network and train all levels of staff.

## For hospital Idva services

- Embed your service within the Hospital with strong referral routes, IT access, a daily presence, service coverage across shifts, and support from senior Clinical staff.
- Consider ways to increase service visibility across the departments of the Hospital and reinforce screening by health professionals.
- Involve Hospital Idva in training all staff about domestic abuse – regularly, in order to cope with high staff turnover.
- Ensure staff are given additional training in how to respond to victims with complex needs (e.g., mental health, alcohol and substance misuse).
- Ensure staff are given additional training in how to respond to the specific needs of hidden and very vulnerable victims (e.g., older victims, pregnant victims and victims with poor health).
- Make links with the local specialist domestic abuse service and consider opportunities for shared training and opportunities to train each other.
- Ensure that Idva staff have adequate Clinical supervision to feel well- supported in the complex Hospital work environment.

## **For hospital staff**

- 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 local domestic abuse service.
- Ensure that you engage in asking every patient presenting with indicators of domestic abuse as recommended by NICE and make a referral if a victim of domestic abuse is identified.
- Consider a domestic abuse awareness raising campaign. Being asked about domestic abuse and Hospital Idva engagement may be the first time victims recognise their experience as domestic abuse.

## **For other Idva services**

- If the hospital(s) in your area do not have an Idva service, make sure that referral routes are established and known to Health Professionals across hospital departments.
- The use of a health questionnaire (with appropriate training) may be a helpful way of identifying and understanding the complex needs of clients. This would facilitate appropriate referral to health services.
- Make links with the local hospital service to take advantage of shared training opportunities as well as opportunities to train each other.

## **For police and all Idva services**

- Investigate ways in which clients can be given more effective protection against further abuse. Idvas to give clients clear advice about reporting further abuse. Police to ensure enforcement of court orders protecting victims of domestic abuse.

# Conclusions

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 getting 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 (e.g., over 55 years old) and very vulnerable victims (e.g. pregnant) 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 local 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 effective help was then accessed. Missed opportunities to intervene are likely to result in later identification when a situation may have escalated.

Once victims have been identified, Hospital Idvas provide effective help to improve safety for victims and their families. 9 out of 10 victims engaged with a Hospital Idva said they felt much 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 specialist 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 specialist 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 specialist 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 ask about abuse (as recommended by NICE) and confidently make a referral to the domestic abuse service.

Strong referral routes in and out of a Hospital specialist 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 (e.g., issues with mental health and/ or substance and alcohol misuse). These findings provide additional support for SafeLives' investigation of a One Front Door approach (a single place for all referrals of adults and children where there are concerns about domestic abuse, child safeguarding, substance misuse and mental health).

**This indicates that, even for clients referred to local Idvas, there is potential for hospitals to identify them earlier – as just under a third had visited A&E in the 6 months before first seeing their local Idva.**

# Recommendations

- There should be more specialist domestic abuse services based in Hospital settings, particularly A&E and maternity units.
- Hospital Idvas should receive additional training on the complex needs of 'hidden' and vulnerable victims.
- NICE guidelines for asking every patient presenting with indicators of domestic abuse should be applied comprehensively – the presence of hospital domestic abuse services makes this much more likely.
- The Idva team should be embedded in the hospital and highly visible, with reach to all hospital departments and relevant professionals (e.g., lead safeguarding nurse), and full involvement in domestic abuse training.
- Hospital Idva services should be embedded in the local via relationships with outside agencies (e.g., Housing).
- If no Idva service is available within the Hospital then a strong referral route to a local domestic abuse service must be established.
- Safety planning should be implemented for every victim referred to a special domestic abuse service, wherever it is located.
- Hospitals need to engage in campaigns designed to raise awareness of domestic abuse.
- SafeLives will investigate the potential of a One Front Door approach to increase identification

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## Appendix 1 – Appendix to Chapter 3 - Introduction

### Themis sample – Attrition (comparison between hospital and local clients)

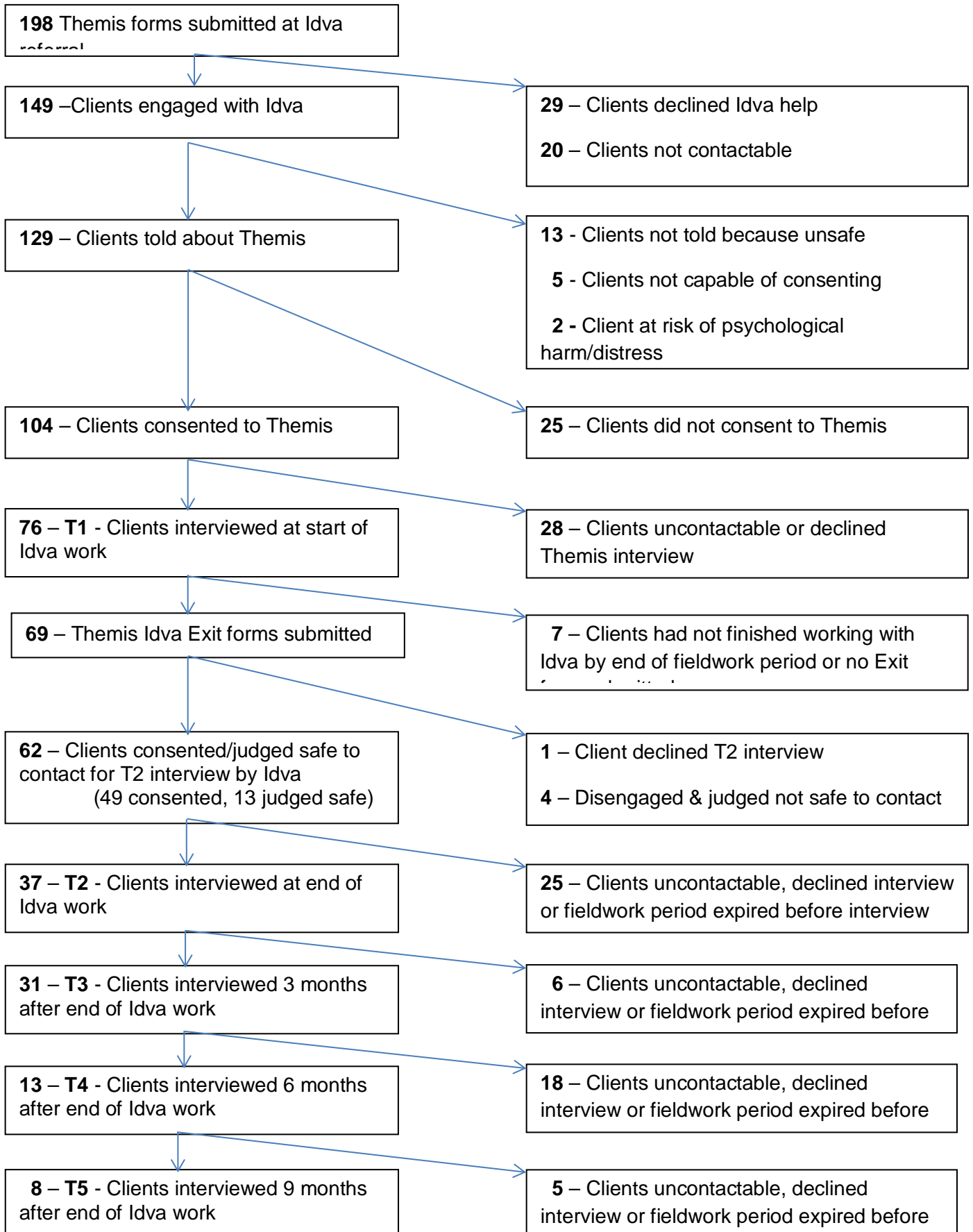
HOSPITAL IDVA CLIENTS
<b>198</b> – Themis forms submitted at Idva intake
<b>149</b> – Clients engaged with Idva
<b>129</b> – Clients told about Themis
<b>104</b> – Clients consented to Themis
<b>76</b> – <b>T1</b> -Clients interviewed at start of Idva work <i>38% of forms submitted</i> <i>73% of those consenting to Themis</i>
<b>69</b> – Themis Idva Exit forms submitted
<b>62</b> – Clients consented/judged safe to contact for T2 interview by Idva (49 consented, 13 judged safe)
<b>37</b> – <b>T2</b> -Clients interviewed at end of Idva work <i>19% of forms submitted</i> <i>49% of those interviewed at T1</i>
<b>31</b> – <b>T3</b> -Clients interviewed 3 months after end of Idva work <i>16% of forms submitted</i> <i>41% of those interviewed at T1</i>
<b>13</b> – <b>T4</b> -Clients interviewed 6 months after end of Idva work <i>7% of forms submitted</i> <i>17% of those interviewed at T1</i>
<b>8</b> - <b>T5</b> -Clients interviewed 6 months after end of Idva work

LOCAL IDVA CLIENTS
<b>102</b> - Themis forms submitted at Idva intake
<b>89</b> – Clients engaged with Idva
<b>84</b> – Clients told about Themis
<b>50</b> – Clients consented to Themis
<b>38</b> – <b>T1</b> -Clients interviewed at start of Idva work <i>37% of forms submitted</i> <i>76% of those consenting to Themis</i>
<b>25</b> – Themis Idva Exit forms submitted
<b>21</b> - Clients consented/judged safe to contact for T2 interview by Idva (17 consented, 4 judged safe)
<b>3</b> – <b>T2</b> -Clients interviewed at end of Idva work <i>3% of forms submitted</i> <i>8% of those interviewed at T1</i>
<b>4</b> – <b>T3</b> -Clients interviewed 3 months after end of Idva work <i>4% of forms submitted</i> <i>11% of those interviewed at T1</i>
<b>0</b> – <b>T4</b> -Clients interviewed 6 months after end of Idva work <i>0% of forms submitted</i> <i>0% of those interviewed at T1</i>
<b>0</b> - <b>T5</b> -Clients interviewed 6 months after end of Idva work

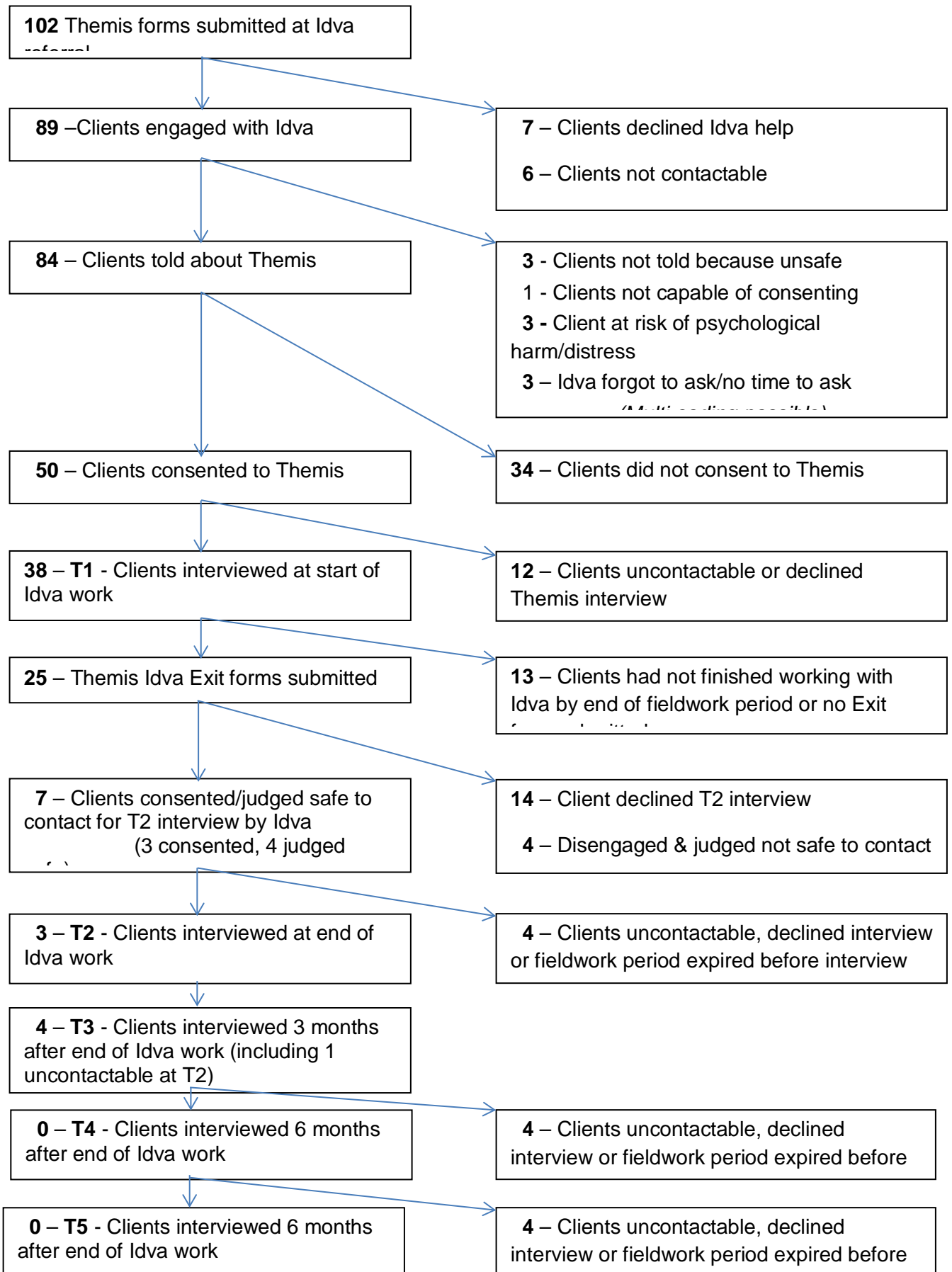
Recruitment of local Idva clients started later. As a result, fewer were interviewed at each stage.

N.B. The period between T1 and T2 (start and end of Idva intervention) varied from one day to 31 months.

## HOSPITAL IDVA CLIENTS – Detailed Attrition



## LOCAL IDVA CLIENTS – Detailed Attrition



## Appendix 2 Appendix to Chapter 4 – Representativeness

### Representativeness of the Themis findings – compared to Large Insights sample

To assess how representative the Themis sample was, the samples interviewed before and after the intervention were compared with the wider population of Idva clients at these sites - the Large Insights sample (Chapter 3). Insights data, collected by Idvas from all consenting clients, was used for this, as it covers demographic, health, abuse and help-seeking factors that may have affected clients' health and health service use, which were the focus of the Themis telephone interviews.

Differences between the Large Insights sample (April 2012-October 2015) and the Themis T1 Interview Insights sample (October 2014 - November 2015) and the T3 Interview Insights sample (for hospital clients only as the T3 local client sample is too small for analysis) are noted when they are 10% or more – **in red** when the proportion in the Themis sample is 10% or more higher, **in blue** when it is 10% or more lower. As both samples were not on the same database, it was not possible to calculate the statistical significance of the differences. (The Large Insights database contained most of the clients in the Themis database, except those not consenting to Insights monitoring.)

There was a total of 692 hospital clients and 3544 local clients in the 43-month Large Insights sample, and 112 hospital clients and 86 local clients in the 13-month Themis Insights sample, i.e. those in the Full Themis sample for whom Insights data was available (Table A4.1). Smaller numbers were interviewed at T1 (Idva Intake) and at T3 (3 months post-Idva Exit); Insights data were available for all bar four hospital clients at T1.

Table A4.1: Comparison of hospital and local client numbers in the Themis Insights sample (2014-15) with those in the Large Insights sample (2012-15)

No. Idva clients	Large Insights sample (2012-15)	Full Themis sample (Themis referral forms) (2014-15)	Themis Insights sample (2014-15)	Themis T1 interview Insights sample (pre-intervention) (2014-15)	Themis T3 interview Insights sample (post-intervention) (2014-15)
Hospital clients	<b>692</b>	198	112	<b>72</b>	29
Local clients	<b>3544</b>	102	86	<b>38</b>	4
Total	<b>4236</b>	300	198	<b>110</b>	33

## Representativeness – Demographics

The hospital sample interviewed at Idva intake and at post-intervention was similar demographically to the Large Insights hospital sample (in terms of gender, age, sexuality, ethnicity, household income), except they were more likely to be employed and to have children living in their household (Table A4.2: Comparison of hospital Idva clients at Themis sites for the different samples - Demographics). Additionally, the T3 hospital sample contained fewer women who were pregnant at Idva Intake.

Table A4.2: Comparison of hospital Idva clients at Themis sites for the different samples - Demographics

Demographic variable at Idva intake	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Gender - male	5% (32/677)	4% (4/112)	4% (3/71)	3% (1/29)
Non-heterosexual orientation	2% (12/636)	6% (7/112)	6% (4/71)	3% (1/29)
Black or Minority Ethnic	15% (104/689)	8% (9/111)	11% (8/70)	14% (22/29)
Age – mean (years)	35.6 (n=686)	36.8 (n=112)	38.7 (n=71)	36.2 (n=29)
Age 55-plus	10% (71/686)	10% (11/112)	11% (8/71)	3% (1/29)
High household income (£36,400+ p.a.)	9% (21/224)	14% (14/98)	17% (11/64)	8% (2/25)
Low household income (<£16,400p.a.)	49% (109/224)	44% (43/98)	44% (28/64)	40% (10/25)
Employed	34% (101/301)	39% (44/112)	44% (31/71)	45% (13/29)
Pregnant (of women)	17% (109/692)	18% (19/108)	9% (6/68)	4% (1/28)
Children in household	51% (353/692)	63% (71/112)	65% (46/71)	69% (20/29)

The local Idva sample interviewed at intake was similar demographically to the Large Insights local Idva sample, except they were less likely to be living in low-income households (Table A4.3: Comparison of local Idva clients at Themis local sites for the different samples - Demographics).

Table A4.3: Comparison of local Idva clients at Themis sites for the different samples - Demographics

Demographic variable at Idva intake	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Gender - male	4% (125/3506)	1% (1/86)	0% (0/38)	0% (0/4)
Non-heterosexual orientation	2% (55/3515)	2% (2/86)	3% (1/38)	0% (0/4)
Black or Minority Ethnic	17% (610/3523)	16% (14/86)	18% (7/38)	0% (0/4)
Age – mean (years)	34.9 (n=3529)	33.2 (n=86)	33.1 (n=38)	(37.0) (n=4)
Age 55-plus	7% (258/3529)	5% (4/86)	3% (1/38)	(25%) (1/4)
High household income (£36,400+ p.a.)	4% (51/1166)	3% (2/80)	5% (2/37)	(25%) (1/4)
Low household income (<£16,400p.a.)	55% (644/1166)	46% (37/80)	43% (16/37)	(25%) (1/4)
Employed	38% (593/1545)	42% (36/86)	45% (17/38)	(75%) (3/4)
Pregnant (of women)	6% (198/3379)	4% (3/85)	3% (1/38)	0% (0/4)
Children in household	67% (2380/3544)	74% (64/86)	76% (29/38)	(75%) (3/4)

### Representativeness – Complex Needs and Disability

The hospital sample interviewed at Idva intake was similar in terms of complex needs and disability to the Large Insights hospital sample (Table A4.4: Comparison of hospital Idva clients at Themis sites for the different samples – Complex needs and disability). However the sample interviewed at T3 were more likely to have experienced mental health problems at Intake and to have ever attempted or planned suicide.

Table A4.4: Comparison of hospital Idva clients at Themis sites for the different samples - Complex needs and disability

Past-year complex needs and disability at Idva intake	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Mental health problems	57% (377/667)	57% (63/110)	61% (42/69)	79% (22/28)
Alcohol problems	18% (116/644)	19% (20/105)	19% (12/65)	16% (4/25)
Drug problems	11% (71/637)	7% (7/100)	10% (6/62)	8% (2/24)
Disability	12% (75/626)	15% (16/110)	16% (11/70)	18% (5/28)
Financial problems	40% (264/660)	40% (45/112)	39% (28/71)	48% (14/29)
Any of the above – ie any complex problem	74% (500/675)	74% (83/112)	76% (54/71)	86% (25/29)
'Toxic trio' – mental health, drug/alcohol problem and domestic abuse	20% (126/632)	20% (22/111)	19% (13/70)	18% (5/28)
Ever planned/attempted suicide	36% (235/645)	42% (46/109)	45% (31/69)	48% (13/27)

The local Idva sample interviewed at Idva intake (T1) was similar in terms of complex needs and disability to the Large Insights local Idva sample, except they were more likely to have had financial problems (Table A4.5: Comparison of local Idva clients at Themis sites for the different samples – Complex needs and disability).

Table A4.5: Comparison of local Idva clients at Themis sites compared for the different samples - Complex needs and disability

Past-year complex needs and disability at Idva intake	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Mental health problems	35% (1206/3474)	35% (29/82)	41% (15/37)	(0%) (0/4)
Alcohol problems	8% (268/3482)	10% (8/82)	11% (4/37)	0% (0/4)
Drug problems	5% (167/3483)	7% (6/82)	8% (3/37)	0% (0/4)
Disability	8% (277/3480)	15% (13/85)	16% (6/38)	0% (0/4)

Past-year complex needs and disability at Idva intake	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Financial problems	30% (1040/3457)	41% (34/84)	42% (16/38)	(50%) (2/4)
Any of the above – ie any complex problem	58% (1981/3447)	64% (54/84)	63% (24/38)	(50%) (2/4)
'Toxic trio' – mental health, drug/alcohol problem + domestic abuse	7% (238/3453)	10% (8/81)	11% (4/37)	0% (0/4)
Ever suicidal	16% (559/3437)	9% (7/81)	8% (3/36)	(25%) (1/4)

### Representativeness – Current Severe Abuse

Fewer clients in the Themis hospital sample interviewed at Idva intake had suffered severe physical or sexual abuse or reached the Marac threshold, compared to the Large Insights sample, but more had suffered severe jealous and controlling behaviour (Table A4.6: Comparison of hospital Idva clients at Themis sites for the different samples – Current Abuse).

Table A4.6: Comparison of hospital Idva clients at Themis sites for the different samples – Current Abuse

Current Abuse (in past 3 months)	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Severe physical abuse	46% (317/683)	40% (44/111)	33% (23/70)	25% (7/28)
Severe sexual abuse	14% (93/655)	6% (7/109)	4% (3/69)	11% (3/28)
Severe harassment and stalking	30% (202/672)	36% (40/112)	39% (28/71)	48% (14/29)
Severe jealous & controlling behaviour	47% (319/683)	59% (66/112)	61% (43/71)	69% (20/29)
Any severe abuse	66% (443/676)	72% (81/112)	73% (52/71)	79% (23/29)
Any escalation in severity or frequency of abuse in past 3	78% (517/663)	82% (92/112)	83% (59/71)	72% (21/29)



months				
Mdn DASH risk score	10.0 (n=648)	12.0 (n=112)	11.0 (n=71)	12.0 (n=29)
Reaches Marac threshold	72% (326/455)	55% (61/112)	51% (36/71)	52% (15/29)

Regarding the post-intervention T3 hospital sample, fewer had suffered severe physical abuse or reached the Marac threshold, but more had suffered severe harassment and stalking, jealous and controlling behaviour and any severe abuse.

The local Themis sample interviewed at Idva intake was similar in terms of abuse to the Large Insights local Idva sample, except they were more likely to have experienced any severe abuse but less likely to have experienced escalation in frequency or severity of abuse over the last three months (Table A4.7: Comparison of local Idva clients at Themis sites for the different samples – Current Abuse).

Table A4.7: Comparison of local Idva clients at Themis sites compared for the different samples – Current Abuse

Current Abuse (in past 3 months)	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Severe physical abuse	41% (1438/3537)	47% (40/86)	42% (16/38)	(0%) (0/4)
Severe sexual abuse	10% (358/3442)	9% (7/79)	3% (1/33)	(0%) (0/4)
Severe harassment and stalking	34% (1175/3511)	44% (38/86)	34% (13/38)	(25%) (1/4)
Severe jealous & controlling behaviour	47% (1163/3527)	61% (52/86)	55% (21/38)	(25%) (1/4)
Any severe abuse	65% (2274/3512)	78% (66/85)	76% (28/37)	(25%) (1/4)
Any escalation in severity or frequency of abuse in past 3 months	78% (2712/3476)	67% (58/86)	53% (20/38)	(25%) (1/4)
Mdn DASH risk score	10.0 (n=3342)	13.0 (n=86)	12.5 (n=38)	11.5 (n=4)
Reaches Marac threshold	74% (1723/2320)	62% (53/86)	50% (19/38)	(25%) (1/4)

## Representativeness – Risk profile

More clients in the Themis hospital sample interviewed at Idva intake were living with the abuser and had been abused for a longer time compared to the Large Insights sample (Table

A4.8: Comparison of hospital Idva clients at Themis sites for the different samples – Risk profile). The post-intervention T3 hospital sample had also been abused for longer than the Large Insights sample.

Table A4.8: Comparison of hospital Idva clients at Themis sites for the different samples – Risk profile

Risk profile	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Client living with abuser	41% (285/360)	48% (54/112)	52% (37/71)	35% (10/29)
Length of abuse in months (Mdn)	30.0 (n=685)	36.0 (n=112)	38.0 (n=71)	36.0 (n=29)

Compared to the Large Insights local Idva sample, local clients who were interviewed for Themis had been abused for longer, and fewer were living with their abuser at Idva intake (Table A4.9: Comparison of local Idva clients at the four Themis local sites – Risk profile).

Table A4.9: Comparison of local Idva clients at Themis sites for the different samples – Risk profile

Risk profile	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Client living with abuser	27% (936/3536)	22% (19/86)	13% (5/38)	(25%) (1/4)
Length of abuse in months (Mdn)	36.0 (n=3535)	36.0 (n=86)	48.0 (n=38)	(75.0) (n=4)

## Representativeness – Help-seeking

Fewer clients in the Themis hospital sample interviewed at Idva intake and post-intervention (T3) had called the police in the past year or seen their GP for any reason, compared to the Large Insights sample (Table A4.10: Comparison of hospital Idva clients at Themis sites for the different samples – Help-seeking). However, similar proportions of the T1 and T3 Interview samples had accessed their hospital Emergency Department in the past year.

Table A4.10: Comparison of hospital Idva clients at Themis sites for the different samples – Help-seeking

Help-seeking in the past year	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Visited ED because of domestic abuse	56% (372/665)	59% (66/112)	59% (42/71)	55% (16/29)
Police	58% (387/671)	39% (44/112)	34% (24/71)	28% (8/29)
Accessed other specialist domestic abuse support	24% (64/272)	19% (21/112)	23% (16/71)	38% (11/29)
Attended GP for any reason	88% (427/488)	74% (83/112)	75% (53/71)	69% (20/29)
Total no. of contacts with all the above (Mdn)	8.0 (n=188)	8.0 (n=112)	8.0 (n=71)	9.0 (n=29)

The local Themis sample interviewed at Idva intake was similar to the Large Insights local Idva sample, regarding their help-seeking in the past year, except that fewer had seen their GP for any reason (Table A4.11: Comparison of local Idva clients at Themis sites for the different samples – Help-seeking).

For both hospital and local clients interviewed, the median number of help-seeking and GP contacts were similar to those in the wider samples of Idva clients.

Table A4.11: Comparison of local Idva clients at Themis sites for the different samples – Help-seeking

Help-seeking in the past year	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Visited ED because of domestic abuse	16% (559/3409)	19% (16/86)	24% (9/38)	(0%) (0/4)
Police	77% (2677/3482)	73% (63/86)	74% (28/38)	(75%) (3/4)
Accessed other specialist domestic abuse support	18% (266/1447)	16% (14/86)	13% (5/38)	(0%) (0/4)
Attended GP for any reason	77% (2482/3217)	71% (61/86)	61% (23/38)	(75%) (3/4)

Help-seeking in the past year	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Total no. of contacts with all the above in past year (Mdn)	5.0 (n=1318)	5.0 (n=86)	4.5 (n=38)	(4.5) (n=4)

### Representativeness – Referral route

More clients in the T1 and T3 hospital interview samples had been referred by health (including hospitals) than in the Large Insights sample – 97% compared to 84% (Table A4.12: Comparison of hospital Idva clients at Themis sites for the different samples – Referral route).

Table A4.12: Comparison of hospital Idva clients at Themis sites for the different samples – Referral route

Referral route	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Health	84% (572/683)	96% (107/112)	97% (69/71)	100% (29/29)
Police	9% (60/683)	2% (2/112)	0% (0/71)	0% (0/29)
Self	2% (14/683)	1% (1/112)	1% (1/71)	0% (0/29)
Marac	<1% (3/683)	1% (1/112)	0% (0/71)	0% (0/29)
Domestic and sexual abuse services	1% (6/683)	0% (0/112)	0% (0/38)	0% (0/29)
CYPS (Children & Young People's Services)	1% (6/683)	0% (0/112)	0% (0/38)	0% (0/29)
Housing & other	1% (9/683)	1% (1/112)	1% (1/71)	0% (0/29)

More of the local Themis sample who were interviewed at Idva intake had been referred by police, compared to the Large Insights local Idva sample (Table A4.13: Comparison of local Idva clients at Themis sites for the different samples – Idva casework).

Table A4.13: Comparison of local Idva clients at Themis sites for the different samples – Idva casework

Referral route	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Health	2% (84/3430)	4% (3/86)	3% (1/38)	(0%) (0/4)
Police	45% (1528/3430)	63% (54/86)	68% (26/38)	(100%) (4/4)
Self	23% (803/3430)	13% (11/86)	16% (6/38)	(0%) (0/4)
Marac	5% (166/3430)	8% (7/86)	3% (1/38)	(0%) (0/4)
Domestic and sexual abuse services	5% (176/3430)	6% (5/86)	3% (1/38)	(0%) (0/4)
CYPS (Children & Young People's Services)	8% (260/3430)	6% (5/86)	5% (2/38)	(0%) (0/4)
Housing & other	11% (379/3430)	1% (1/86)	3% (1/38)	(0%) (0/4)

### Representativeness – Length, intensity and closure of Idva casework

Hospital Idvas had worked with clients in the Themis T1 and T3 interview samples for twice as long as those in the Large Insights sample (Table A4.14: Comparison of hospital Idva clients at Themis sites for the different sites – Idva casework). They also recorded more contacts with their clients (the interpretation of this question varied between Idvas – some also included all contacts made with or on behalf of the client). However, fewer hospital clients in the T1 sample had had their cases closed in a planned way with the client, with more ending in an unplanned way (for instance the Idva being unable to contact the client again, despite several attempts).

Table A4.14: Comparison of hospital Idva clients at Themis sites for the different sites – Idva casework

Idva casework	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Length of casework (Mdn in months) excl. one-offs <sup>58</sup>	1.7 (n=521)	3.8 (n=87)	3.5 (n=59)	3.5 (n=29)
No. contacts (Mdn)	8.0 (n=533)	12.0 (n=87)	12.0 (n=59)	14.0 (n=29)
Planned closure	87% (460/531)	74% (64/87)	73% (43/59)	79% (23/29)

There were no major differences between the local Themis sample interviewed at Idva intake and the Large Insights local Idva sample, as far as Idva casework was concerned. (Table A4.15: Comparison of local Idva clients at Themis sites for the different sites – Idva casework).

Table A4.15: Comparison of hospital Idva clients at Themis sites for the different sites – Idva casework

Idva casework	Large Insights sample Per cent (n/total)	Themis Insights sample Per cent (n/total)	T1 Themis interview Insights sample (pre-intervention) Per cent (n/total)	T3 Themis interview Insights sample (post-intervention) Per cent (n/total)
Length of casework (Mdn in months) excl. one-offs <sup>59</sup>	2.3 (n=2259)	2.2 (n=42)	2.1 (n=11)	(1.8) (n=4)
No. contacts (Mdn)	8.0 (n=2376)	6.5 (n=42)	6.0 (n=11)	(4.5) (n=4)
Planned closure	95% (2251/2372)	91% (38/42)	91% (10/11)	(100%) (4/4)

<sup>58</sup> Excluding 15 hospital Idva cases closed on the same day, which were also excluded from the logistic regression in Ch. 4 (none are in the Themis sample).

<sup>59</sup> Excluding 111 local Idva cases closed on the same day, which were also excluded from the logistic regression in Ch. 4 (none are in the Themis sample).

The fact that the hospital Themis sample differed from the Large Insights sample as regards Idva casework, whereas this was not the case with the local Themis sample, raises the question as to whether hospital Idvas recruiting for Themis made more contacts with such clients and worked with them for longer, because of taking part in this evaluation of their work. The study was not aimed at evaluating local Idvas' work, and their casework length and contacts more closely reflected the Large Insights sample of local Idva clients.

## Appendix 3 - Appendix to Chapter 5 - Differences between hospital and local Idva clients

The statistical level of  $p < 0.05$  is the chosen level for significance, with appropriate Bonferroni adjustments being made when a group of variables are being tested. In this Appendix the raw probability variables are stated when they are  $p = 0.05$  or less. When the Bonferroni-adjusted level of significance equivalent to  $p < 0.05$  is reached, or when a variable considered alone reaches  $p < 0.05$ , this is indicated in red.

### Client Demographics

Using the Bonferroni adjustment, for a 95% confidence level with 11 variables,  $p$  must be **<0.005** for the difference between hospital and local clients to be significant.

Table A5-1a: Comparison of hospital and local clients – Demographics

Demographic	Hospital clients		Local clients		X <sup>2</sup>	p=
	No. (out of total)	Per cent	No. (out of total)	Per cent		
Gender – male	32/677	<b>5</b>	125/3506	<b>4</b>	2.119	NS
Sexual orientation - heterosexual	12/636	<b>2</b>	55/3515	<b>2</b>	0.352	NS
Black & Minority Ethnic	104/689	<b>15</b>	610/3523	<b>17</b>	2.018	NS
Age 55-plus	71/686	<b>10</b>	258/3529	<b>7</b>	7.371	NS (0.007)
High household income (£36,400+ p.a.)	21/224	<b>9</b>	51/1166	<b>4</b>	9.568	<b>p=0.002</b>
Low household income (<£16,400 p.a.)	109/224	<b>49</b>	644/1166	<b>55</b>	3.268	NS
Employed	101/301	<b>34</b>	593/1545	<b>38</b>	2.502	NS
Pregnant (of women)	109/653	<b>17</b>	198/3379	<b>6</b>	91.288	<b>p&lt;0.001</b>
Children in household	353/692	<b>51</b>	2380/3544	<b>67</b>	65.916	<b>p&lt;0.001</b>
Current involvement with CYPS (Children	165/603	<b>27</b>	904/3242	<b>28</b>	0.069	NS



and Young People's Services)						
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Table A5-1b: Comparison of hospital and local clients – Demographics (continuous variable)

Demographic	Hospital clients (n=686)				Local clients (n = 3529)				t	p
	Mean	SD	CI		Mean	SD	CI			
Age (in years)	<b>35.6</b>	13.1	34.6	36.6	<b>34.9</b>	11.8	34.5	35.3	1.269	NS

### Client Complex Needs

Using the Bonferroni adjustment, for a 95% confidence level with 9 variables, p must be **<0.006** for the difference between hospital and local clients to be significant.

Table A5-2: Comparison of hospital and local clients - Complex needs

Client complex need at pre-intervention	Hospital clients		Local clients		X <sup>2</sup>	p=
	No. (out of total)	Per cent	No. (out of total)	Per cent		
Mental health problem	377/667	<b>57</b>	1206/3474	<b>35</b>	112.683	p<0.001
Alcohol problem	116/644	<b>18</b>	268/3482	<b>8</b>	68.518	p<0.001
Drug problem	71/637	<b>11</b>	167/3483	<b>5</b>	39.910	p<0.001
Financial problem	264/660	<b>40</b>	1040/3457	<b>30</b>	25.180	p<0.001
Disability	75/626	<b>12</b>	277/3480	<b>8</b>	10.945	p<0.001
Any of the above problems	500/675	<b>74</b>	1981/3447	<b>58</b>	64.943	p<0.001
'Toxic trio' ie mental health, alcohol/drug problems & domestic abuse	126/632	<b>20</b>	238/3453	<b>7</b>	111.989	p<0.001
Ever planned/attempted suicide	235/645	<b>36</b>	559/3437	<b>16</b>	141.016	p<0.001
Ever planned/attempted suicide OR self-harmed	294/686	<b>43</b>	798/3535	<b>23</b>	123.242	p<0.001

### Current abuse profile

Using the Bonferroni adjustment, for a 95% confidence level with 10 variables, p must be **<0.005** for the difference between hospital and local clients to be significant.

Table A5-3a: Comparison of hospital and local clients – Current abuse



Current abuse (in past 3 months)	Hospital clients		Local clients		X <sup>2</sup>	p=
	No. (out of total)	Per cent	No. (out of total)	Per cent		
Severe physical abuse	317/683	<b>46</b>	1438/3537	<b>41</b>	7.810	NS (p=0.005)
Severe sexual abuse	93/655	<b>14</b>	358/3443	<b>10</b>	8.116	<b>p=0.004</b>
Severe harassment & stalking	202/672	<b>30</b>	1175/3511	<b>34</b>	2.964	NS
Severe jealous & controlling behaviour	319/683	<b>47</b>	1163/3527	<b>47</b>	0.045	NS
Any severe abuse	443/676	<b>66</b>	2274/3512	<b>65</b>	0.153	NS
Two-plus types of severe abuse	328/665	<b>49</b>	1571/3482	<b>45</b>	3.978	NS (p=0.046)
Any escalation in severity or frequency of abuse in past 3 months	517/663	<b>78</b>	2712/3476	<b>78</b>	0.001	NS
'High-risk' abuse	363/689	<b>53</b>	2050/3539	<b>58</b>	6.466	NS (p=0.011)
Reaches Marac threshold	326/455	<b>72</b>	1723/2320	<b>74</b>	1.351	NS

Table A5-3b: Comparison of hospital and local clients – Current abuse (continuous variable)

Current abuse	Hospital clients (n=648)		Local clients (n = 3342)		Z	p
	Mdn	IQR	Mdn	IQR		
DASH Risk score	<b>10.0</b>	4	<b>10.0</b>	5	-2.258	NS (0.024)

### Risk profile

Using the Bonferroni adjustment, for a 95% confidence level with 4 variables, p must be **<0.013** for the difference between hospital and local clients to be significant.

Table A5-4a: Comparison of hospital and local clients – Risk profile

Risk profile	Hospital clients		Local clients		X <sup>2</sup>	p=
	No. (out of total)	Per cent	No. (out of total)	Per cent		
Multiple perpetrators	98/685	<b>14</b>	275/3538	<b>8</b>	30.425	<b>p&lt;0.001</b>
Previous exposure to	195/28	<b>68</b>	659/1372	<b>48</b>	39.277	<b>p&lt;0.001</b>

Risk profile	Hospital clients		Local clients		X <sup>2</sup>	p=
	No. (out of total)	Per cent	No. (out of total)	Per cent		
abuse	5					
Has attempted to leave in the past year	421/604	<b>70</b>	2276/3158	<b>72</b>	1.402	NS

Table A5-4b: Comparison of hospital and local clients – Risk profile (continuous variable)

Risk profile	Hospital clients (n=685)		Local clients (n = 3535)		Z	p
	Mdn	IQR	Mdn	IQR		
Length of abuse (in months)	<b>30.0</b>	60	<b>36.0</b>	72	-2.426	NS (0.015)

### Abuser profile

Using the Bonferroni adjustment, for a 95% confidence level with 10 variables, p must be <0.005 for the difference between hospital and local clients to be significant.

Table A5-5: Comparison of hospital and local clients – Abuser profile

Abuser profile	Hospital clients		Local clients		X <sup>2</sup>	p=
	No. (out of total)	Per cent	No. (out of total)	Per cent		
Abuser is current intimate partner	362/689	<b>53</b>	1084/3541	<b>31</b>	123.257	<b>p&lt;0.001</b>
Abuser is ex-intimate partner	239/689	<b>35</b>	2096/3541	<b>59</b>	140.048	<b>p&lt;0.001</b>
Client is living (wholly/ partly) with abuser	332/692	<b>48</b>	1034/3536	<b>29</b>	92.882	<b>p&lt;0.001</b>
Abuser has been abusive to other family member or previous partner	154/195	<b>79</b>	749/1118	<b>67</b>	11.096	<b>p&lt;0.001</b>
Abuser has financial problems	112/202	<b>55</b>	813/1209	<b>67</b>	10.673	<b>p&lt;0.001</b>
Abuser has alcohol problems	107/236	<b>45</b>	714/1468	<b>49</b>	0.886	NS
Abuser has drug problems	99/246	<b>40</b>	611/1460	<b>42</b>	0.223	NS
Abuser has mental health problems	111/227	<b>49</b>	559/1295	<b>43</b>	2.576	NS
Abuser has complex health need or financial	205/259	<b>79</b>	1180/1451	<b>81</b>	0.674	NS

Abuser profile	Hospital clients		Local clients		X <sup>2</sup>	p=
	No. (out of total)	Per cent	No. (out of total)	Per cent		
problems						
Abuser has criminal record for domestic violence	109/300	<b>36</b>	702/1568	<b>45</b>	7.297	NS (p=0.007)

### Potential help-seeking in the past year

Using the Bonferroni adjustment, for a 95% confidence level with 5 variables, p must be <0.01 for the difference between hospital and local clients to be significant.

Table A5-6a: Comparison of hospital and local clients – Potential help-seeking in the past year

Potential help-seeking in the past year	Hospital clients		Local clients		X <sup>2</sup>	p=
	No. (out of total)	Per cent	No. (out of total)	Per cent		
Saw GP for any reason	427/488	<b>88</b>	2482/3211	<b>77</b>	26.257	p<0.001
Attended Emergency Department as a result of the abuse	372/664	<b>56</b>	559/3404	<b>16</b>	493.758	p<0.001
Called the police	387/671	<b>58</b>	2677/3480	<b>77</b>	107.846	p<0.001
Accessed specialist domestic abuse support (other than current Idva service)	64/272	<b>24</b>	266/1444	<b>18</b>	3.845	NS (p=0.050)

Table A5-6b: Comparison of hospital and local clients – Potential help-seeking in the past year (continuous variable)

Potential help-seeking in the past year	Hospital clients (n=188)				Local clients (n = 1318)				t	p
	Mean	SD	CI		Mean	SD	CI			
Total no. contacts with all of the above help services	<b>9.2</b>	6.5	8.3	10.1	<b>6.7</b>	7.1	6.3	7.0	4.667	p<0.001

### Severity of abuse and potential help-seeking and attempts to leave

Using the Bonferroni adjustment, for a 95% confidence level with 6 variables, p must be <0.008 for the correlation between the DASH score and help-seeking attempts to be significant.

Table A5-7: Correlation between severity of abuse (DASH score) and potential help-seeking and attempts to leave

Potential help-seeking and attempts to leave in the past year	Hospital and local Idva clients		
	<i>N</i>	<i>r</i>	<i>p</i>
No. GP visits (any reason)	3504	0.096	p<0.001
No. Emergency Department visits	3839	0.152	p<0.001
No. police reports	3914	0.154	p<0.001
Accessed specialist domestic abuse support (other than current Idva service)	1502	0.097	p<0.001
No. contacts with other domestic abuse service	1322	0.111	p<0.001
No. of attempts to leave	3583	0.173	p<0.001

### Previous help for this abuse (using data collected from Themis referrals only)

Using the Bonferroni adjustment, for a 95% confidence level with 8 variables, p must be <0.006 for the difference between hospital and local clients to be significant.

Table A5-8: Previous help for this abuse

Previous help for this abuse	Hospital clients		Local clients		χ <sup>2</sup>	p
	No. (out of total)	Per cent	No. (out of total)	Per cent		
Clients who have had previous help for this abuse	85/172	<b>49</b>	47/98	<b>48</b>	0.053	NS
Source – domestic abuse services	64/85	<b>75</b>	34/47	<b>72</b>	0.138	NS
Source – police	42/85	<b>49</b>	29/47	<b>62</b>	1.839	NS
Source – GP	22/85	<b>26</b>	4/47	<b>9</b>	5.774	NS (p=0.016)
Source – Children and Young People’s (CYPS) services/ social services	12/85	<b>14</b>	11/47	<b>23</b>	1.814	NS
Source – Marac	12/85	<b>14</b>	8/47	<b>17</b>	0.198	NS
Source - Community health or mental health	13/85	<b>15</b>	2/47	<b>4</b>	3.661	NS
Source – Housing	10/85	<b>12</b>	3/47	<b>6</b>	0.987	NS

## Referral routes to the Idva

No Bonferroni adjustment was needed as this was only one variable.

Table A5-9: Referral routes to hospital and local Idvas

Primary referral route to the Idva	Hospital clients (n=283)		Local clients (n=2430)		X <sup>2</sup>	p
	No.	Per cent	No.	Per cent		
Health	572	84%	84	2%	2830.93	p<0.001
Police	60	9%	1528	45%		
Self	14	2%	803	23%		
Domestic abuse and sexual violence services	6	1%	176	5%		
Marac	3	<1%	166	5%		
Children and Young People's Services (CYPS)	6	1%	260	8%		
Specialist services	13	2%	34	1%		
Other	7	1%	299	9%		

## Idva Casework

Using the Bonferroni adjustment, for a 95% confidence level with 3 variables, p must be <0.017 for the difference between hospital and local clients to be significant.

Table A5-10a: Comparison between hospital and local Idva clients for Idva casework (Insights data)

	Hospital clients		Local clients		Z	p
	Mdn	IQR	Mdn	IQR		
<b>Case length</b> – in months (n=2780)	1.7	2.7	2.4	3.1	4.816	p<0.001
<b>No. contacts</b> with/on behalf of client (n=2909)	8.0	9	8.0	11	-1.716	NS

Table A5-10b: Comparison between hospital and local Idva clients for Idva casework (Insights data)

Idva casework	Hospital clients (n=531)		Local clients (n=2372)		X <sup>2</sup>	p
	No.	Per cent	No.	Per cent		
<b>Unplanned closure of case</b>	71	13%	121	5%	48.042	p<0.001

Idva casework (n=2903)	Hospital clients (n=531)		Local clients (n=2372)		$\chi^2$	<i>p</i>

Using the Bonferroni adjustment, for a 95% confidence level with 3 variables, *p* must be **<0.017** for the difference between hospital and local clients to be significant.

Table A5-11a: Comparison between hospital and local Idva clients for Idva casework (Themis data)

	Hospital clients		Local clients		Z	<i>p</i>
	Mdn	IQR	Mdn	IQR		
No. contacts with/on behalf of client (n=129)	<b>12.0</b>	17.3	<b>6.5</b>	6.3	-3.481	<b>p&lt;0.001</b>
No. hours' work for client (n=94)	<b>8.0</b>	10.8	<b>3.0</b>	3.0	-5.407	<b>p&lt;0.001</b>

Table A5-11b Comparison between hospital and local Idva clients for Idva casework (Themis data)

Idva casework	Hospital clients (n=87)		Local clients (n=42)		$\chi^2$	<i>p</i>
	No.	Per cent	No.	Per cent		
<b>Unplanned closure of case</b> (n=129)	23	<b>26%</b>	4	<b>9%</b>	4.896	No (p=0.027)

Using the Bonferroni adjustment, for a 95% confidence level with 12 variables, *p* must be **<0.004** for the difference between hospital and local clients to be significant.

Table A5-12: Support enabled by Idva

Support enabled via Idva	Hospital clients (n=692)		Local clients (n=3544)		$\chi^2$	<i>p</i>
	No.	Per cent	No.	Per cent		
Safety planning	499	<b>72%</b>	2214	<b>63%</b>	23.355	<b>p&lt;0.001</b>
Health and well-being	463	<b>67%</b>	1994	<b>56%</b>	26.924	<b>p&lt;0.001</b>
Police	322	<b>47%</b>	1463	<b>41%</b>	6.547	NS (p=0.011)
Housing	309	<b>45%</b>	1084	<b>31%</b>	51.902	<b>p&lt;0.001</b>
Marac	235	<b>34%</b>	1117	<b>32%</b>		NS
Children	168	<b>24%</b>	853	<b>24%</b>		NS
Finance/benefits	119	<b>17%</b>	469	<b>13%</b>	7.606	NS (p=0.006)

Support enabled via Idva	Hospital clients (n=692)		Local clients (n=3544)		X <sup>2</sup>	p
	No.	Per cent	No.	Per cent		
Civil orders	36	5%	491	14%	39.786	p<0.001
Probation	17	3%	159	5%	5.990	NS (p=0.014)
Criminal court	4	1%	146	4%	21.260	p<0.001
Immigration	8	1%	68	2%		NS
Honour-Based Violence issues	3	<1%	15	<1%		NS

### Risk and safety outcomes

Using the Bonferroni adjustment, for a 95% confidence level with 4 variables, p must be <0.013 for the difference between hospital and local clients to be significant.

Table A5-13: Risk and safety outcomes

Safety and wellbeing outcomes	Hospital clients		Local clients		X <sup>2</sup>	p
	No. (out of total)	Per cent	No. (out of total)	Per cent		
Idva reported sustainable risk reduction	303/477	64%	1521/2272	67%	2.069	NS
Client felt much safer	250/435	58%	1092/2142	51%	6.104	NS (p=0.013)
Client said quality of life had improved 'a lot'	229/436	53%	1043/2141	49%	2.101	NS
Client felt very confident to access help in future	247/440	56%	1211/2138	57%	0.038	NS

### Post-Exit abuse and 'High risk' clients

Using the Bonferroni adjustment, for a 95% confidence level with 2 variables, p must be <0.025 for the difference between hospital and local clients to be significant.

Table A5-14: Post-Exit abuse and 'high risk' at Intake

Post-Exit abuse and severity of risk at Intake	'High Risk' at Intake (n=18)		Not 'High Risk' at Intake (n=13)		X <sup>2</sup>	p
	No.	Per cent	No.	Per cent		
Post-Exit abuse	14	78%	4	31%	6.850	p=0.009

Table A5-15: Post-Exit abuse and above Marac threshold at Intake

Post-Exit abuse and severity of risk at Intake	Reached Marac threshold at Intake (n=16)		Not at Marac threshold at Intake (n=15)		X <sup>2</sup>	p
	No.	Per cent	No.	Per cent		
Post-Exit abuse	13	81%	5	33%	7.300	p=0.007

## Appendix 4 – Appendix to Chapter 5 – Factors affecting risk and safety outcomes for hospital and local clients

What factors reflect feeling safer at exit for hospital clients? Regression findings:  
Model 1

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)		
							Lower	Upper	
Step 1 <sup>a</sup>	Interventions	.037	.128	.085	1	.770	1.038	.808	1.334
	Contacts	.044	.030	2.150	1	.143	1.045	.985	1.109
	InsightsCaseLength	.585	.174	11.304	1	.001	1.794	1.276	2.523
	Suicide at T1	-.967	.429	5.086	1	.024	.380	.164	.881
	AnyAbuse escalating in severity & frequency at T1	.276	.444	.388	1	.534	1.318	.552	3.147
	Physical abuse at T1	-.062	.455	.019	1	.891	.940	.385	2.291
	Harrasment and stalking at T1	-.598	.434	1.903	1	.168	.550	.235	1.286
	Jealous and controlling behaviour at T1	.771	.520	2.199	1	.138	2.162	.780	5.988
	Victim substance misuse at T1	.173	.561	.095	1	.758	1.189	.396	3.567
	Victim mental health T1	-.019	.441	.002	1	.965	.981	.413	2.328
	Perpetrator substance misuse	.072	.577	.016	1	.900	1.075	.347	3.330
	Perpetrator mental health	-.902	.573	2.474	1	.116	.406	.132	1.248
	Perpetrator financial issues	-.041	.638	.004	1	.949	.960	.275	3.355
	Constant	.885	.709	1.556	1	.212	2.423		

n = 413; Model statistics: -2LL = 203.72, X<sup>2</sup> = 181.38, df = 13, p < .001, Nagelkerke R<sup>2</sup> = .19, % classified correctly = 91%



**What factors reflect feeling sustainable risk reductions at exit for hospital clients?  
Regression findings: Model 2**

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)	
							Lower	Upper
Sum_Intervention	.417	.055	56.666	1	.000	1.517	1.361	1.691
Q105	.037	.015	6.448	1	.011	1.038	1.008	1.067
CaseLengthinMonths	.099	.048	4.270	1	.039	1.104	1.005	1.212
SuicideBeh2	-.205	.224	4.328	1	.033	.814	.525	1.263
ESCALATION_SFsj	-.125	.235	.281	1	.596	.883	.557	1.399
PhysAbuse_binary	-.018	.224	.006	1	.936	.982	.634	1.522
HarStalk_binary	-.309	.212	2.128	1	.145	.734	.485	1.112
JCB_binary	.393	.288	1.859	1	.173	1.482	.842	2.608
SubstancesNew	-.628	.294	4.548	1	.033	.534	.300	.950
MentalHealth2	-.308	.219	1.973	1	.160	.735	.478	1.130
Perp_substnc_misusesj	.300	.295	1.031	1	.310	1.350	.756	2.409
Q62	.347	.322	1.159	1	.282	1.414	.752	2.659
Q63	-.217	.337	.413	1	.520	.805	.416	1.559
Constant	-2.151	.348	38.206	1	.000	.116		

n = 413; Model statistics: -2LL = 714.25, X2 = 182.36, df= 13, p< .001, Nagelkerke R2 = .33, % classified correctly = 71%

### What factors reflect feeling safer at exit for local? Regression findings: Model 3

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)		
							Lower	Upper	
Step 1 <sup>a</sup>	Sum_Intervention	.229	.056	16.957	1	.000	1.257	1.127	1.401
	Q105	.067	.018	14.447	1	.000	1.070	1.033	1.107
	CaseLengthinMonths	.092	.043	4.511	1	.034	1.096	1.007	1.194
	SuicideBeh2	-.084	.251	.111	1	.739	.920	.562	1.506
	ESCALATION_SFsj	.105	.182	.331	1	.565	1.111	.777	1.588
	PhysAbuse_binary	.337	.170	3.932	1	.047	1.401	1.004	1.954
	HarStalk_binary	.068	.165	.169	1	.681	1.070	.774	1.480
	JCB_binary	.080	.205	.153	1	.696	1.084	.724	1.621
	SubstancesNew	-.476	.358	1.765	1	.184	.621	.308	1.254
	MentalHealth2	-.055	.186	.088	1	.767	.946	.657	1.364
	Perp_substnc_misusesj	.400	.241	2.743	1	.098	1.491	.929	2.394
	Q62	-.310	.260	1.421	1	.233	.733	.441	1.221
	Q63	-.303	.310	.956	1	.328	.739	.402	1.356
	Constant	.206	.281	.536	1	.464	1.229		

n = 2124; Model statistics: -2LL = 1164.35, X2 = 96.79, df= 13, p< .001, Nagelkerke R2 = .12, % classified correctly = 91%

**What factors reflect feeling sustainable risk reductions at exit for local clients?  
Regression findings: Model 4**

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B)		
							Lower	Upper	
Step 1 <sup>a</sup>	Sum_Intervention	.559	.026	466.533	1	.000	1.749	1.663	1.840
	Q105	.034	.007	21.896	1	.000	1.034	1.020	1.049
	CaseLengthinMonths	.047	.020	5.708	1	.017	1.048	1.008	1.089
	SuicideBeh2	-.261	.135	3.757	1	.053	.770	.592	1.003
	ESCALATION_SFsj	.017	.107	.024	1	.877	1.017	.824	1.254
	PhysAbuse_binary	-.254	.099	6.569	1	.010	.776	.639	.942
	HarStalk_binary	-.004	.092	.002	1	.967	.996	.832	1.193
	JCB_binary	-.168	.121	1.942	1	.163	.845	.667	1.071
	SubstancesNew	-.544	.214	6.456	1	.011	.580	.381	.883
	MentalHealth2	-.129	.102	1.591	1	.207	.879	.719	1.074
	Perp_substnc_misusesj	-.197	.123	2.566	1	.109	.821	.645	1.045
	Q62	-.077	.143	.289	1	.591	.926	.700	1.226
	Q63	-.406	.168	5.851	1	.016	.666	.480	.926
	Constant	-2.031	.151	181.575	1	.000	.131		

n = 2124; Model statistics: -2LL = 3669.03, X2 = 1120.27, df= 13, p< .001, Nagelkerke R2 = .36, % classified correctly = 76%

## Appendix 5 - Appendix to Chapter 6 – Identifying victims in hospital

The data source for this chapter was the Full Themis sample (n=300).

### Sources of referral to hospital and local Idvas

Table A6-1: Primary referral route

Source of referral to Idva	Hospital clients (n=198)		Local clients (n=102)	
	No.	Per cent	No.	Per cent
Hospital	170	86%	1	1%
Non-hospital health	18	9%	3	3%
Police	2	1%	58	57%
Self	3	2%	15	15%
Marac	1	<1%	8	8%
Children and Young People's Services	1	<1%	7	7%
Domestic abuse and sexual violence services	0	0%	6	6%
Housing	1	<1%	1	1%
Other specialist services	2	1%	0	0%
Other	0	0%	3	3%

### Sources of hospital referrals to hospital Idvas

Table A6-2: Hospital department referrals to hospital Idva

Source of hospital referral to Idva	Hospital clients (n=170)	
	No.	Per cent
Emergency Department (A&E)	106	62%
Maternity, ante- and neo-natal units	27	16%
Psychiatry / mental health	12	7%
Paediatrics	4	2%
Gynaecology	1	<1%
SARC (Sexual Assault Referral Centre) at hospital	1	<1%
Other hospital department	19	11%

## Which hospital staff referred clients to hospital Idvas?

Table A6-3: Hospital staff referrals to hospital Idva

Source of hospital referral to Idva	Hospital clients (n=164)	
	No.	Per cent
Nurse	74	45%
Doctor/Junior Doctor (F1/F2)	23	14%
Midwife	21	13%
Psychologist / Psychiatrist	13	8%
Consultant	7	4%
Ward sister	6	4%
Other	20	12%

## Previous help for this abuse

Table A6-4: Previous help sought for this abuse

Previous help sought	Hospital clients (n=172)		Local clients (n=98)	
	No.	Per cent	No.	Per cent
<i>Clients who have previously sought help for this abuse</i>	85	49%	47	48%

Table A6-5: Sources of previous help sought for this abuse

Previous help sought for this abuse	Hospital clients (n=85)		Local clients (n=47)	
	No.	Per cent	No.	Per cent
Source – domestic abuse services	62	<b>73%</b>	34	<b>72%</b>
Source - police	42	<b>49%</b>	29	<b>62%</b>
Source – GP	22	<b>26%</b>	4	<b>9%</b>
Source – Children and Young People’s (CYPS)services/social services	12	<b>14%</b>	11	<b>23%</b>
Source - Marac	12	<b>14%</b>	8	<b>17%</b>
Source - Community health or mental health	13	<b>15%</b>	2	<b>4%</b>
Source - Housing	10	12%	3	<b>6%</b>
Source - Other	10	12%	4	<b>9%</b>

## Which hospital departments were best at identifying 'hidden victims'?

Table A6-6: Hospital departments identifying 'hidden victims' and those who had previously sought help

Hospital department	Hospital Idva clients					
	Victims who have previously sought help		'Hidden victims'		All clients	
	No.	Per cent	No.	Per cent	No.	Per cent
Emergency department (A&E)	47	51%	45	49%	92	100%
Maternity, ante-/neo-natal units	10	38%	16	62%	26	100%
Psychiatry / mental health	7	(70%)	3	(30%)	10	100%
Paediatrics	2	(67%)	1	(33%)	3	100%
Gynaecology	0	(0%)	1	(100%)	1	100%
SARC (Sexual Assault Referral Centre) at hospital	0	(0%)	1	(100%)	1	100%
Other hospital department	8	53%	7	47%	15	100%

## Which hospital staff were best at identifying 'hidden victims'?

Table A6-7: Hospital departments identifying 'hidden victims' and those who had previously sought help

Hospital staff	Hospital Idva clients					
	Victims who have previously sought help (n=74)		'Hidden victims' (n=74)		All clients (n=148)	
	No.	Per cent	No.	Per cent	No.	Per cent
Nurse	29	46%	34	54%	63	100%
Doctor/Junior Doctor (F1/F2)	13	62%	8	38%	21	100%
Midwife	8	40%	12	60%	20	100%
Psychologist / Psychiatrist	8	67%	4	33%	12	100%
Consultant	3	(50%)	3	(50%)	6	100%
Ward sister	3	(60%)	2	(40%)	5	100%
Other	7	39%	11	61%	18	100%

## Appendix 6 - Appendix to Chapter 7 – Health

### Comparing hospital and local Idva clients with the national population

Table A7-1a: Comparing health of hospital and local Idva clients at Idva Intake with health of national population (continuous measures)

Health measure at Idva Intake	Hospital Idva clients (n=64 <sup>60</sup> ) Mean score at Intake (95% CI)	Local Idva clients (n=38) Mean score at Intake (95% CI)	Mean for adult UK population
<b>Physical health</b> (SF12 – PCS)	<b>49</b> (46 to 53)	<b>55</b> (52 to 59)	<b>51</b> <sup>61</sup>
<b>Mental health</b>			
Overall poor mental health (SF12 – MCS)	<b>32</b> (29 to 35)	<b>32</b> (28 to 36)	<b>52</b> <sup>62</sup>
Anxiety (HADS – anxiety)	<b>12</b> (11 to 13)	<b>11</b> (10 to 13)	<b>6</b> <sup>63</sup>
Depression (HADS – depression )	<b>10</b> (9 to 11)	<b>8</b> (6 to 9)	<b>4</b> <sup>64</sup>
Overall Quality of Life (SF-6D)	<b>0.59</b> (0.56 to 0.62)	<b>0.63</b> (0.59 to 0.67)	<b>0.80</b>

Table A7-1b: Comparing health of hospital and local Idva clients at Idva Intake with health of national population (categorical measure)

Health measure at Idva	Hospital clients (n=64)	Local clients (n=38)	UK national population
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<sup>60</sup> N=64 for HADS and PTSD, but 63 for questions based on SF12, as 1 client did not answer all SF12 questions, which generated PCS, MCS and Quality of Life scores.

<sup>61</sup> Gandek et al, 1998

<sup>62</sup> Gandek et al, 1998

<sup>63</sup> Crawford et al, 2001.

<sup>64</sup> Crawford et al, 2001

Intake	Per cent	Per cent	Per cent
<b>Post-Traumatic Stress Disorder</b> – proportion screening positive	<b>62%</b>	<b>48%</b>	<b>6%<sup>65</sup></b> (inner-city sample)

### Comparing hospital Idva clients with local Idva clients

The difference in health scores between hospital and local Idva clients are detailed for the 64 hospital clients (63 for measures involving SF12 and SF6) and 38 local clients surveyed at Intake along with results of the statistical tests applied. Once Bonferroni adjustments were made, differences which had been significant (at  $p < 0.05$ ) for physical health and depression, no longer met the  $p < 0.008$  level required.

Table A7-1c: Comparing health of hospital and local Idva clients at Idva Intake (continuous measures)

Health measure	Hospital clients (n=64)				Local clients (n = 38)				t	p
	Mean	SD	CI		Mean	SD	CI			
<b>Physical health</b> (average) (SF12 – PCS)	<b>49</b>	12.8	46	53	<b>55</b>	10.6	52	59	-2.443	NS (p=0.017)
<b>Poor mental health</b>										
Overall poor mental health (SF12 – MCS)	<b>32</b>	12.2	29	35	<b>32</b>	11.4	28	36	0.033	NS
Anxiety (HADS – anxiety)	<b>12</b>	5.1	11	13	<b>11</b>	4.6	10	13	0.909	NS
Depression (HADS – depression)	<b>10</b>	5.2	9	11	<b>8</b>	4.9	6	9	1.987	NS (p=0.05)
Quality of Life (SF-6D)	<b>0.59</b>	0.12	0.56	0.62	<b>0.63</b>	0.11	0.59	0.67	-1.580	NS

Table A7-1d: Comparing health of hospital and local Idva clients at Idva Intake (categorical measure)

Health measure	Hospital clients (n=64)		Local clients (n=38)		X <sup>2</sup>	p
	No.	Per cent	No.	Per cent		

<sup>65</sup> Frissa et al, 2013.



Health measure	Hospital clients (n=64)		Local clients (n=38)		X <sup>2</sup>	p
<b>Post-Traumatic Stress Disorder</b> – proportion screening positive	40	<b>62%</b>	18	<b>48%</b>	0.168	NS

### Comparing hospital Idva clients pre- and post- Idva intervention

The changes in health scores between pre- and post-Idva intervention are detailed for the 21 hospital Idva clients surveyed at both times. Statistical tests were not appropriate because of the small sample size.

Table A7-2a: Comparing health scores for hospital clients pre- and post-Idva intervention (continuous measures)

Health measure	Hospital clients (n=21)							
	Pre-Idva intervention				3 months post-Idva intervention			
	Mean	SD	CI		Mean	SD	CI	
<b>Physical health (SF12-PCS)</b>	<b>53</b>	11.5	48	59	<b>48</b>	11.4	42	53
<b>Mental health</b>								
Overall mental health (SF12-MCS)	<b>31</b>	12.4	26	37	<b>39</b>	12.8	33	45
Anxiety (HADS)	<b>13</b>	4.8	11	15	<b>11</b>	6.3	8	14
Depression (HADS)	<b>10</b>	5.5	9	12	<b>8</b>	6.0	5	11
<b>Overall quality of life (SF-6D)</b>	<b>0.61</b>	0.1	0.56	0.65	<b>0.63</b>	0.2	0.56	0.70

Table A7-2b: Comparing health scores for hospital clients pre- and post-Idva intervention (categorical measure)

Health measure	Hospital clients (n=21)							
	Pre-Idva intervention				3 months post-Idva intervention			
	N	Per cent	CI		N	Per cent	CI	
<b>Post-Traumatic Stress Disorder</b> – proportion screening positive	13	<b>62%</b>	41%	83%	10	<b>48%</b>	43%	53%

For the 21 members of the hospital sample whose health scores were compared pre-and post-intervention, the only major difference at pre-intervention (compared to all 63 hospital clients interviewed at that time – Table 6a-1) was that:

- More hospital clients screened positive for **PTSD** at Intake (62% compared to 48% in the full hospital sample at Intake).
- 

### Were individuals' mental health changes between pre- and post-Idva intervention associated with post-intervention abuse?

Table A7-3 Pre- and post-intervention health changes, and whether further abuse had been experienced since Exit (hospital Idva clients)

Health change at 3 months post-Idva Exit, compared to at Idva Intake (T3 minus T1)	Further abuse experienced in 3 months after Exit?									
	Yes (n=12)					No (n=9)				
	<i>Mdn</i>	<b>Mean</b>	SD	<i>CI</i>		<i>Mdn</i>	<b>Mean</b>	SD	<i>CI</i>	
<b>SF12 Physical Composite Score change</b> ( <i>positive means improved health</i> )	+0.5	<b>-3.0</b>	11.3	-10.2	+4.2	-6.2	<b>-9.6</b>	13.7	-20.1	+1.0
<b>SF12 Mental Composite Score change</b> ( <i>positive means improved health</i> )	+0.5	<b>+2.8</b>	9.2	-3.0	+8.7	+16.7	<b>+14.9</b>	17.1	+1.8	+28.1
<b>Anxiety (HADS) score change</b> ( <i>negative means improved health</i> )	0.0	<b>-0.4</b>	4.1	-3.1	+2.2	-4.0	<b>-3.7</b>	3.8	-6.6	+0.7
<b>Depression (HADS) score change</b> ( <i>negative means improved health</i> )	0.0	<b>-0.8</b>	3.1	-2.7	+1.2	-6.0	<b>-4.2</b>	6.4	-9.1	+0.7
<b>QALY – Quality of Life – change</b> ( <i>positive means improved health</i> )	+0.01	<b>-0.01</b>	+0.08	-0.14	+0.14	+0.06	<b>+0.06</b>	0.14	-0.12	+0.28

## Appendix 7 - Appendix to Chapter 8-1a – Health service use

### Pre-intervention use of hospital services by hospital and local clients (full sample)

Once Bonferroni adjustments were made, to achieve the requisite 95% confidence level, the p level drops from  $p < 0.05$  to  $p < .0125$  for these 4 variables.

**Table A8-1a\_1: No. of hospital and local clients using hospital services (full sample)**

Hospital service	No. clients using this service in the 6 months pre-intervention				X <sup>2</sup>	p
	Hospital clients (n=76)		Local clients (n=38)			
	No.	Per cent	No.	Per cent		
In-patient nights	26	34%	5	13%	5.671	NS (p=0.017)
Out-patient appointments	28	37%	10	26%	1.263	NS
Emergency Department visits	41	54%	11	29%	6.382	p=0.012
Ambulance trips	25	33%	6	16%	3.744	NS (p=0.053)

### Pre-intervention use of hospital services – differences between hospital and local Idva clients (including and excluding extreme outlier)

The raw probability value of the combined variable (total hospital use) for hospital, compared to local Idva clients is valid in its own right, and lies well within the  $p < 0.05$  significance level. But to achieve the 95% level of confidence ( $p < 0.05$ ) for its three components (in-patient nights, out-patient appointments and Emergency Department visits), and for the ambulance use variable, Bonferroni adjustment reduced the threshold to  $p < 0.0125$ . In the full sample, hospital clients had higher rates of total hospital use, in-patient and Emergency Department use than local clients, but not of outpatient appointments or ambulance use.

**Table A8-1a\_2: Six-month pre-intervention frequency of use of hospital services by hospital and local Idva clients (full sample)**

Hospital service	No. clients using this service in the 6 months pre-intervention						Z	p
	Hospital clients (n=76)			Local clients (n=38)				
	Mdn	Mean	IQR	Mdn	Mean	IQR		
In-patient nights	0.0	3.7	2.8	0.0	0.3	0.0	-2.582	p=0.010
Out-patient appointments	0.0	1.3	2.0	0.0	0.5	1.0	-1.612	NS
Emergency Department	1.0	1.4	1.0	0.0	0.4	1.0		

<b>visits</b>							-2.710	<b>p=0.009</b>
<b>Total no. hospital uses</b>	<b>2.0</b>	6.3	6.0	<b>1.0</b>	1.2	1.3	-3.170	<b>p=0.001</b>
<b>Ambulance visits to Emergency Department</b>	<b>0.0</b>	1.0	1.0	<b>0.0</b>	0.2	0.0	-1.963	NS (p=0.038)

In the sample excluding the extreme outlier, the total number of hospital uses is still significantly more for hospital than local clients, as is the number of Emergency Department visits. However, without the outlier, hospital clients' number of in-patient nights just falls short being significantly more than local clients.

**Table A8-1a\_3: Six-month pre-intervention frequency of use of hospital services by hospital and local Idva clients (excluding extreme outlier)**

Hospital service	No. clients using this service in the 6 months pre-intervention						Z	p
	Hospital clients (n=75)			Local clients (n=38)				
	Mdn	Mean	IQR	Mdn	Mean	IQR		
<b>In-patient nights</b>	<b>0.0</b>	3.6	2.0	<b>0.0</b>	0.3	0.0	-2.492	NS (p=0.013)
<b>Out-patient appointments</b>	<b>0.0</b>	1.3	2.0	<b>0.0</b>	0.5	1.0	-1.662	NS
<b>Emergency Department visits</b>	<b>1.0</b>	1.0	1.0	<b>0.0</b>	0.4	1.0	-2.620	<b>p=0.009</b>
<b>Total no. hospital uses</b>	<b>2.0</b>	5.9	6.0	<b>1.0</b>	1.2	1.3	-3.170	<b>p=0.002</b>
<b>Ambulance visits to Emergency Department</b>	<b>0.0</b>	0.6	1.0	<b>0.0</b>	0.2	0.0	-1.963	NS (p=0.050)

## Pre-Intervention use of local and mental health services by hospital and local DVA clients

Table A8-1a\_4 shows the raw significance values of the tests. To achieve the 95% level of confidence for these results ( $p < 0.05$ ), Bonferroni adjustment reduced the threshold to  $p < 0.008$  for the six separate service variables, and  $p < 0.025$  for the two combined variables. None achieved significance.

**Table A8-1a\_4: No. of hospital and local clients using local and mental health services in the six months pre-intervention (full sample)**

Local and mental health service	No. clients using this service in the 6 months pre-intervention				X <sup>2</sup>	p
	Hospital clients (n=75 <sup>66</sup> )		Local clients (n=38)			
	No.	Per cent	No.	Per cent		
GP	65	87%	29	76%	1.932	NS
Nurse/Health Visitor at Local Surgery	42	56%	21	55%	0.006	NS
<b>Local Surgery</b> (both of the above)	68	91%	36	95%	0.570	NS
Mental health	32	43%	10	26%	2.887	NS
Alcohol/drug misuse	7	9%	3	8%	0.065	NS
<b>Total no. local health uses</b> (all of the above)	71	95%	37	97%	0.435	NS
Social Services/ Social Care	25	33%	12	32%	0.035	NS
Specialist DVA service	12	16%	5	13%	0.159	NS

<sup>66</sup> Full data on local and mental health service use was not available for one hospital client.

Table A8-1a\_5 shows the raw significance values of the tests. To achieve the 95% level of confidence for these results ( $p < 0.05$ ), Bonferroni adjustment reduced the threshold to  $p < 0.008$  for the six separate service variables, and  $p < 0.025$  for the two combined variables. Total local and mental health service use achieved significance.

**Table A8-1a\_5: Six-month pre-intervention frequency of use of local and mental health services by hospital and local Idva clients (full sample)**

Local and mental health service	No. clients using this service in the 6 months pre-intervention						Z	p
	Hospital clients (n=75 <sup>67</sup> )			Local clients (n=38)				
	Mdn	Mean	IQR	Mdn	Mean	IQR		
<b>GP</b>	<b>4.0</b>	6.5	6.0	<b>2.0</b>	3.4	4.3	-2.501	NS (p=0.012)
<b>Nurse/Health Visitor at Local Surgery</b>	<b>1.0</b>	3.9	3.0	<b>1.0</b>	1.7	2.0	-0.652	NS
<b>Local Surgery (both of the above)</b>	<b>6.0</b>	10.4	9.0	<b>3.0</b>	5.1	4.5	-2.416	NS (p=0.016)
<b>Mental health</b>	<b>0.0</b>	5.7	4.0	<b>0.0</b>	1.6	1.0	-1.834	NS
<b>Alcohol/drug misuse</b>	<b>0.0</b>	0.8	0.0	<b>0.0</b>	0.2	0.0	-0.345	NS
<b>Total no. local health uses (all of the above)</b>	<b>8.0</b>	16.9	16.0	<b>4.5</b>	6.9	9.3	-2.693	<b>p=0.007</b>
<b>Social Services/Social Care</b>	<b>0.0</b>	4.1	2.0	<b>0.0</b>	2.7	2.0	-0.332	NS
<b>Specialist domestic abuse service</b>	<b>0.0</b>	1.1	0.0	<b>0.0</b>	1.0	0.0	-0.269	NS

<sup>67</sup> Full data on local and mental health service use was not available for one hospital client.

## Health service use and clients' overall health

**Table A8-1a\_6a: Clients' overall state of health at Idva intake and their six-month pre-intervention use of health services (full sample)**

Using the Bonferroni adjustment, a 95% confidence level requires  $p < 0.025$  for 2 variables. The hospital sample both with and without the

Health service in six months before Idva intervention	Correlation with poorer overall health (SF6-QALY)					
	Hospital clients (n=63)		Local clients (n=38)		All clients (n=101)	
	r	p	r	p	r	p
<b>All hospital use</b> (inpatient, out-patient, ED)	-0.349	0.005	-0.411	0.010	-0.426	<0.001
<b>All local and mental health service use</b> (GP, Nurse/ Health Visitor at local surgery, mental health, alcohol/drug services)	-0.329	0.008	-0.459	0.004	-0.400	0.01

**Table A8-1a\_6b: Clients' overall state of health at Idva intake and their six-month pre-intervention use of health services (excluding extreme outlier)**

Health service in six months before Idva intervention	Correlation with poorer overall health (SF6-QALY)					
	Hospital clients (n=62)		Local clients (n=38)		All clients (n=101)	
	r	p	r	p	r	p
<b>All hospital use</b> (inpatient, out-patient, ED)	-0.342	0.006	-0.411	0.010	-0.421	<0.001
<b>All local and mental health service use</b> (GP, Nurse/ Health Visitor at local surgery, mental health, alcohol/drug services)	-0.314	0.013	-0.459	0.004	-0.391	<0.001

## Change in health service use pre- and post-intervention – hospital services

**Table A8-1a\_7: No. hospital uses pre- and post-Idva intervention for hospital clients (full sample)**

Using the Bonferroni adjustment, a 95% confidence level requires  $p < 0.0125$  for the 4 single-service variables.

Hospital service	Average no. times used by hospital Idva clients in 3 months (n=31)						Z	p
	(half of)Pre-Idva			Post-Idva				
	Mdn	Mean	IQR	Mdn	Mean	IQR		
In-patient nights	0.0	2.3	1.5	0.0	0.4	0.0	Z = -2.139	NS (p=0.032)
Out-patient appointments	0.0	0.4	0.5	0.0	2.1	1.0	Z= -1.425	NS
Emergency Department visits	0.5	0.9	0.5	0.0	1.0	0.0	Z = -1.216	NS
Total no. hospital uses	1.0	3.6	3.0	0.0	3.6	1.0	Z= -1.008	NS
Ambulance visits to Emergency Department	0.0	0.8	0.5	0.0	0.7	0.0	Z= -0.952	NS

**Table A8-1a\_8: No. hospital uses pre- and post-Idva intervention for hospital clients (excluding extreme outlier)**

Using the Bonferroni adjustment, a 95% confidence level requires  $p < 0.0125$  for the 4 single-service variables.

Hospital service	Average no. times used by hospital Idva clients in 3 months (n=31)						Z	p
	(half of)Pre-Idva			Post-Idva				
	Mdn	Mean	IQR	Mdn	Mean	IQR		
In-patient nights	0.0	2.3	0.8	None			Z = -2.812	p=0.005
Out-patient appointments	0.0	0.4	0.6	0.0	1.3	1.0	Z= -1.103	NS
Emergency Department visits	0.3	0.4	0.5	0.0	0.2	0.0	Z = -1.809	NS
Total no. hospital uses	0.8	3.1	2.6	0.0	1.5	1.0	Z= -1.462	NS
Ambulance visits to	0.0	0.3	0.5	0.0	0.1	0.0	Z= -1.674	NS



Hospital service	Average no. times used by hospital Idva clients in 3 months (n=31)						Z	p
	(half of)Pre-Idva			Post-Idva				
	Mdn	Mean	IQR	Mdn	Mean	IQR		
Emergency Department								

**Table A8-1a\_9: No. local and mental health service uses pre- and post-Idva intervention for hospital clients** (full sample, minus case where no data for local and mental health service use)

Using the Bonferroni adjustment, a 95% confidence level requires  $p < 0.008$  for 6 single-service use variables and  $p < 0.025$  for the two combined service variables.

Local and mental health service	Average no. times used by hospital Idva clients in 3 months (n=30)						Z	p
	(half of)Pre-Idva			Post-Idva				
	Mdn	Mean	IQR	Mdn	Mean	IQR		
GP	1.8	3.4	2.0	3.0	3.3	4.0	Z=-0.195	NS
Nurse/Health Visitor at Local Surgery	0.5	1.2	1.1	0.0	0.8	1.0	Z=-0.505	NS
Local Surgery (both of the above)	2.8	4.5	4.5	3.0	4.0	6.3	Z=-0.432	NS
Mental health	0.0	3.2	2.1	0.0	4.1	5.0	Z=-1.164	NS
Alcohol/drug misuse	0.0	0.5	0.0	0.0	0.8	0.0	Z=-0.730	NS
Total no. local health uses (all of the above)	4.0	8.3	8.5	5.5	10.5	8.9	Z=-0.309	NS
Social Services/Social Care	0.0	1.9	2.6	0.0	3.3	1.0	Z=-0.210	NS
Specialist domestic abuse service	0.0	0.9	0.0	0.0	0.2	0.0	Z=-0.356	NS

## Health and social service costs

The following tables are based on the cost analysis reported in Appendix 7 (to Chapter 8-1b).

**Table A8-1a\_12: Client-perceived domestic abuse-related health service costs for six-month pre-intervention period**

Health service cost	Client-perceived domestic abuse-related health service costs in pounds (£) for 6 months ( <i>% of all health service costs</i> )		
	Hospital client sample <u>including outlier</u> (n=75)	Hospital client sample <u>excluding outlier</u> (n=74)	Local client Sample (n=38)
Hospital services (including ambulance)	329 (22% of total)	317 (23% of total)	146 (65% of total)
Local surgery	184 (45% of total)	181 (46% of total)	88 (41% of total)
Mental health services	289 (63% of total)	294 (55% of total)	81 (100% of total)
Drug/alcohol services	64 (97% of total)	65 (98% of total)	2 (17% of total)
<i>Total health costs (% domestic-abuse related of total health costs)</i>	866 (35% of total)	857 (38% of total)	317 (60% of total)
Social worker/Child & Family Support worker	184 (85% of total)	-	91 (63% of total)

**Table A8-1a\_13: Client-perceived domestic abuse-related health service costs pre- and post-intervention for hospital clients (6-month period)**

Health service cost ( <i>% of all health costs</i> )	Client-perceived domestic abuse-related health service costs in pounds (£) for hospital clients measured pre- and post-intervention (for 6-month period) ( <i>% of all health service costs</i> )			
	Pre-intervention <u>including outlier</u> (n=30)	Post-intervention <u>including outlier</u> (n=30)	Pre-intervention <u>excluding outlier</u> (n=29)	Post-intervention <u>excluding outlier</u> (n=29)
Hospital services (including ambulance)	475 (25% of all)	961 (74% of all)	328 (21% of all)	23 (6% of all)
Local surgery	172 (53% of all)	143 (44% of all)	177 (61% of all)	147 (45% of all)
Mental health services	456 (67% of all)	636 (94% of all)	471 (88% of all)	591 (93% of all)
Drug/alcohol services	81 (100% of all)	116 (100% of all)	83 (100% of all)	120 (100% of all)
<i>Total domestic-abuse</i>	1184 (40% of all)	1856 (77% of all)	1059 (43% of all)	881 (61% of all)

<i>related health costs</i>	<i>all)</i>	<i>all)</i>		
Social worker/Child & Family Support worker	147 (74% of total)	318 (94% of total)	-	-

## Appendix 8 - Appendix to Chapter 8-1b - Cost analysis – Method

Elisabetta Fenu – Lead Health Economist, National Guideline Centre, Royal College of Physicians

We conducted a cost analysis alongside the study to evaluate the possible savings to the health and social care system generated by the use of Independent Domestic Violence Advisor (Idva) services located within hospital settings.

Health care and social resource use data were collected from participants through questionnaires.

### Unit costs

Table A8-1b\_1 reports the unit costs that were attached to the resource use data. (References are listed at the end of this Appendix.)

**Table A8-1b\_1 - Unit costs**

Health care resource collected	Cost	Source
GP surgery consultation	£49.02	PSSRU 2015
GP home visit	£32.49	PSSRU 2015
GP phone consultation	£20.23	PSSRU 2015
Practice Nurse consultation	£12.14	Based on the cost per hour of face to face contact (£47) and average consultation time of 15.5 minutes (PSSRU 2015)
Community Psychiatric Nurse	£38	Average cost of face to face contact in district nursing services (PSSRU 2015)
Psychiatrist	£107	Based on the cost per hour (£107) and assumption of one hour for duration of consultation (PSSRU 2015)
Clinical Psychologist	£212	NHS Reference Costs 2013/14 – Cost of consultant-led outpatient attendance for clinical psychology
Health Visitor	£54	Average cost of face to face contact in health visiting services (PSSRU 2015)
Counsellor	£45.83	Based on the cost per hour of counselling services in primary care (£55) and average consultation time of 55 minutes (PSSRU 2014 )
Psychotherapist	£156	NHS Reference Costs 2013/14 – Cost of consultant-led outpatient attendance for clinical psychotherapy
Family therapist	£156	Same as psychotherapist (assumption)
Drug/alcohol support	£78	NHS Reference Costs 2013/14 – Addition services attendance
In-patient stay per night	£275	Mean cost per bed day - NHS reference costs 2013/2014

Health care resource collected	Cost	Source
Outpatient appointments	£111	Mean cost of all outpatient attendances - NHS reference costs 2013/2014
A&E attendance	£124	Weighted average of all emergency medicine attendances - NHS reference costs 2013/2014
Ambulance trip	£231	Cost for see and treat and convey (currency code ASS02) - NHS reference costs 2013/2014
Social worker/Child and Family support worker	£53	Based on the average between cost per hour of a social worker (£55) and family support worker (£51) - PSSRU 2015. Assumption of one hour for duration of consultation.

Average health and social care services consumptions per patient and the relative average cost per patient are reported in this section. Health care resource use data were available for 76 individuals from the hospital sample and 38 from the local sample. Data for one individual in the hospital sample were excluded from the main analysis as this case was judged to be an extreme outlier (for an explanation of why this client was regarded as an extreme outlier for health service use, see second page of Chapter 8-2-1).

However, they were included in a sensitivity analysis. For another individual, data on the community health and social services use were not available and only hospital data were considered for this individual.

## Resource use difference between local and hospital sample

We assessed the difference in resource use and costs between the hospital-based Idva sample and the local Idva sample in the six months prior to being referred to the Idva service. In a sensitivity analysis of the health costs, we also included the outlier.

The results of this analysis are reported in Table A8-1b\_2 for the health care costs (excluding outlier), Table A6-2-1b\_3 for the social costs (full sample), and Table A8-1b\_4 for the health care costs (full sample).

**Table A8-1b\_2 – Difference in resource use and costs between hospital and local sample at T1 (excluding outlier)**

Health care resource	Mean use per individual – hospital T1	Mean cost per individual – hospital T1	Mean use per individual – local T1	Mean cost per individual – local T1	Difference cost (hospital vs local)
GP surgery consultation	4.9	239	2.9	142	97
GP home visit	0.0	0	0.0	-	0
GP phone consultation	1.3	27	0.5	10	17
Practice Nurse consultation	2.0	24	0.7	9	15
Community Psychiatric Nurse	0.9	33	0.0	1	32
Psychiatrist	0.4	45	0.0	3	42
Clinical Psychologist	0.8	160	0.0	-	160

Health care resource	Mean use per individual – hospital T1	Mean cost per individual – hospital T1	Mean use per individual – local T1	Mean cost per individual – local T1	Difference cost (hospital vs local)
Health Visitor	2.0	106	1.0	53	53
Counsellor	3.0	138	1.5	69	69
Psychotherapist	0.1	17	0.0	-	17
Family therapist	0.0	-	0.1	8	-8
Drug/alcohol support	0.9	66	0.2	12	54
In-patient stay per night	3.6	997	0.3	94	903
Outpatient appointments	1.3	142	0.4	50	92
A&E attendance	1.0	118	0.4	46	72
Ambulance trip	0.6	136	0.2	36	100
<b>TOTAL (95% CI)</b>		<b>£2,250 (£1,646 to £2,977)</b>		<b>£533 (£373 to 713)</b>	<b>£1,717</b>

**Table A8-1b\_3 – Difference in social service use and costs between hospital and local sample at T1 (full sample)**

Health care resource	Mean use per individual – hospital T1	Mean cost per individual – hospital T1	Mean use per individual – local T1	Mean cost per individual – local T1	Difference cost (hospital vs local)
Social worker/Child and Family support worker	4.08	216	2.74	145	71
<b>TOTAL (95% CI)</b>		<b>£216 (£113 to £346)</b>		<b>£145 (£32 to £300)</b>	<b>£71</b>

**Table A8-1b\_4 – Difference in health care resource use and costs between hospital and local sample at T1 – full sample**

Health care resource	Mean use per individual – hospital T1	Mean cost per individual – hospital T1	Mean use per individual – local T1	Mean cost per individual – local T1	Difference cost (hospital vs local)
GP surgery consultation	5.16	253	2.89	142	111
GP home visit	0.01	0	0.00	0	0
GP phone consultation	1.32	27	0.50	10	17
Practice Nurse consultation	1.96	24	0.74	9	15
Community Psychiatric Nurse	0.89	34	0.03	1	33

Health care resource	Mean use per individual – hospital T1	Mean cost per individual – hospital T1	Mean use per individual – local T1	Mean cost per individual – local T1	Difference cost (hospital vs local)
Psychiatrist	0.83	88	0.03	3	86
Clinical Psychologist	0.85	181	0.00	0	181
Health Visitor	1.93	104	0.97	53	52
Counsellor	2.99	137	1.50	69	68
Psychotherapist	0.11	17	0.00	0	17
Family therapist	0.00	0	0.05	8	-8
Drug/alcohol support	0.84	66	0.16	12	53
In-patient stay per night	3.64	1002	0.34	94	908
Outpatient appointments	1.26	140	0.45	50	91
A&E attendance	1.33	165	0.37	46	119
Ambulance trip	0.98	225	0.16	36	189
<b>TOTAL (95% CI)</b>		<b>£2,464 (£1,804 to £3,333)</b>		<b>£533 (£373 to 713)</b>	<b>£1,931</b>

On average, individuals in the hospital sample incurred higher health and social service costs than those in the local sample.

### Domestic abuse-related resource use difference between local and hospital sample

Clients were asked whether their service use was related partly or wholly to domestic abuse. This was a subjective measure.

The results of this analysis are reported in Table A8-1b\_5 for the health care costs (excluding outlier), Table A8-1b\_6 for the social costs (full sample), and Table A8-1b\_7 for the health care costs (full sample).

**Table A8-1b\_5 – Difference in domestic abuse-related health care use and costs between hospital and local sample at T1 – excluding outlier**

Health care resource	Mean use per individual – hospital T1	Mean cost per individual – hospital T1	Mean use per individual – local T1	Mean cost per individual – local T1	Difference cost (hospital vs local)
GP surgery consultation	2.6	129	1.3	63	65
GP home visit	0.0	-	-	-	-
GP phone	0.8	17	0.3	6	10

Health care resource	Mean use per individual – hospital T1	Mean cost per individual – hospital T1	Mean use per individual – local T1	Mean cost per individual – local T1	Difference cost (hospital vs local)
consultation					
Practice Nurse consultation	0.5	6	0.5	6	-0
Community Psychiatric Nurse	0.9	33	0.0	1	32
Psychiatrist	0.4	42	0.0	3	39
Clinical Psychologist	0.8	160	-	-	160
Health Visitor	0.5	29	0.2	13	16
Counsellor	1.3	59	1.5	69	-10
Psychotherapist	0.0	-	-	-	-
Family therapist	0.0	-	0.1	8	-8
Drug/alcohol support	0.8	65	0.0	2	63
In-patient stay per night	0.4	103	0.2	65	38
Outpatient appointments	0.2	25	0.1	12	13
A&E attendance	0.7	84	0.3	39	45
Ambulance trip	0.5	105	0.1	30	74
<b>TOTAL (95% CI)</b>		<b>£856 (£629 to £1,108)</b>		<b>£317 (£194 to £463)</b>	<b>£539</b>

**Table A8-1b\_6 – Difference in domestic abuse-related social service use and costs between hospital and local sample at T1 – full sample**

Health care resource	Mean use per individual – hospital T1	Mean cost per individual – hospital T1	Mean use per individual – local T1	Mean cost per individual – local T1	Difference cost (hospital vs local)
Social worker/Child and Family support worker	3.47	184	1.71	91	93
<b>TOTAL (95% CI)</b>		<b>£184 (£79 to £317)</b>		<b>£91 (£33 to £181)</b>	<b>£93</b>

**Table A8-1b\_7 – Difference in domestic abuse-related health care resource use and costs between hospital and local sample at T1 – full sample**

Health care resource	Mean use per individual – hospital T1	Mean cost per individual – hospital T1	Mean use per individual – local T1	Mean cost per individual – local T1	Difference cost (hospital vs local)
GP surgery consultation	2.69	132	1.29	63	69
GP home visit	0.00	0	0.00	0	0
GP phone consultation	0.85	17	0.32	6	11
Practice Nurse consultation	0.47	6	0.47	6	0
Community Psychiatric Nurse	0.85	32	0.03	1	31
Psychiatrist	0.39	41	0.03	3	38
Clinical Psychologist	0.75	158	0.00	0	158
Health Visitor	0.53	29	0.24	13	16
Counsellor	1.27	58	1.50	69	-11
Psychotherapist	0.00	0	0.00	0	0
Family therapist	0.00	0	0.05	8	-8
Drug/alcohol support	0.83	64	0.03	2	62
In-patient stay per night	0.38	105	0.24	65	40
Outpatient appointments	0.26	29	0.11	12	17
A&E attendance	0.70	86	0.32	39	47
Ambulance trip	0.47	109	0.13	30	79
<b>TOTAL (95% CI)</b>		<b>£868 (£639 to £1,118)</b>		<b>£317 (£194 to £463)</b>	<b>£</b>

On average, individuals in the hospital sample incurred higher client-perceived domestic abuse-related health and social service costs than those in the local sample.

### Resource use difference between pre- and post-intervention periods in the hospital sample

Resource use data were available at initial referral (T1) and at 3 months after exit from the Idva service (T3) for 31 individuals of the hospital sample. We compared the costs in the six months before individuals received the intervention with the costs in the following three months (at T3 follow-up time) to ascertain any potential cost savings generated by the intervention. Values collected at T3 were adjusted for the different follow-up time (the previous three months compared to the previous six months for T1), and therefore observed resources use was multiplied by 2; figures reported in the tables below reflect this change.



The results of this analysis are reported in Table A8-1b\_8 for the health care costs (excluding outlier), Table A8-1b\_9 for the social care costs (full sample), and Table A8-1b\_10 for the health care costs (full sample).

**Table A8-1b\_8 – Difference in health care resource use and costs between T1 and T3 – hospital sample (excluding outlier)**

Health care resource	Mean use per individual – T1	Mean cost per individual – T1	Mean use per individual – T3	Mean cost per individual – T3	Difference (T1-T3)
GP surgery consultation	4.0	198	5.3	261	-£63
GP home visit	0.0	0	0.0	0	£0
GP phone consultation	1.8	37	1.2	24	£13
Practice Nurse consultation	1.5	19	1.1	14	£5
Community Psychiatric Nurse	0.7	28	1.7	63	-£35
Psychiatrist	0.5	50	0.9	100	-£50
Clinical Psychologist	1.5	325	1.7	353	-£28
Health Visitor	0.7	38	0.5	25	£13
Counsellor	2.0	92	2.1	98	-£6
Psychotherapist	0.3	42	0.0	0	£42
Family therapist	0.0	0	0.1	21	-£8
Drug/alcohol support	1.1	83	1.5	120	-£37
In-patient stay per night	4.5	1238	0.0	0	£1,238
Outpatient appointments	0.8	93	2.7	296	-£203
A&E attendance	0.9	107	0.4	50	£57
Ambulance trip	0.6	131	0.1	31	£100
<b>TOTAL (95% CI)</b>		<b>£2,481</b>		<b>£1,456</b>	<b>£1,025 (£182 to £2,030)</b>

**Table A8-1b\_9 – Difference in social services use and costs between T1 and T3 – hospital sample (full sample)**

Health care resource	Mean use per individual – T1	Mean cost per individual – T1	Mean use per individual – T3	Mean cost per individual – T3	Difference (T1-T3)
Social worker/Child and Family support worker	3.7	£198	6.4	£339	- £141 (-£381 to - £82)
<b>TOTAL (95% CI)</b>		<b>£198</b>		<b>£339</b>	<b>- £141 (-£381 to - £82)</b>

The health care cost savings accrued after individuals received the intervention were £1,025 on average per individual. The analysis of uncertainty conducted through bootstrapping showed that conclusions are robust at a 95% CI, as costs were lower after the intervention even at the lower confidence interval.

Assuming the same cost savings were observed throughout a full year, if the cost of hospital-based Idva was no more than £2,050 per patient per year, this intervention would be cost neutral to the NHS.

**Table A8-1b\_10 – Difference in health care resource use and costs between T1 and T3 – hospital sample – full sample**

Health care resource	Mean use per individual – T1	Mean cost per individual – T1	Mean use per individual – T3	Mean cost per individual – T3	Difference (T1-T3)
GP surgery consultation	4.7	232	5.5	269	-£37
GP home visit	0.0	0	0.0	0	£0
GP phone consultation	1.8	36	1.2	23	£13
Practice Nurse consultation	1.5	19	1.1	13	£6
Community Psychiatric Nurse	0.8	29	3.3	125	-£96
Psychiatrist	1.5	155	0.9	97	£58
Clinical Psychologist	1.7	369	1.6	342	£27
Health Visitor	0.7	37	0.5	24	£13
Counsellor	2.0	90	2.1	95	-£5
Psychotherapist	0.3	40	0.0	0	£40
Family therapist	0.0	0	0.1	20	-£20
Drug/alcohol support	1.0	81	1.5	116	-£35
In-patient stay per	4.5	1242	0.8	231	£1,011

Health care resource	Mean use per individual – T1	Mean cost per individual – T1	Mean use per individual – T3	Mean cost per individual – T3	Difference (T1-T3)
night					
Outpatient appointments	0.8	90	4.3	473	-£383
A&E attendance	1.8	224	2.1	256	-£32
Ambulance trip	1.5	350	1.5	343	£7
<b>TOTAL (95% CI)</b>		<b>£2,994</b>		<b>£2,426</b>	<b>£568 (-£385 to £935)</b>

### Domestic abuse-related resource use difference between pre- and post-intervention periods in the hospital sample

Clients were asked whether their service use was related partly or wholly to domestic abuse. This was a subjective measure.

The results of this analysis are reported in Table A8-1b\_11 for the health care costs (excluding outlier), Table A8-1b\_12 for the social costs (full sample), and Table A8-1b\_13 for the health care costs (full sample).

**Table A8-1b\_11 – Difference in domestic violence-related health care resource use and costs between T1 and T3 – hospital sample (excluding outlier)**

Health care resource	Domestic violence-related – Mean use per individual – T1	Domestic violence-related – Mean cost per individual – T1	Domestic violence-related – Mean use per individual – T3	Domestic violence-related – Mean cost per individual – T3	Difference (T1-T3)
GP surgery consultation	2.3	114	2.3	114	-£0
GP home visit	0.0	0	0.0	0	£0
GP phone consultation	1.6	32	0.7	13	£19
Practice Nurse consultation	0.2	2	0.1	2	£0
Community Psychiatric Nurse	0.7	27	1.7	63	-£36
Psychiatrist	0.4	43	0.9	93	-£50
Clinical Psychologist	1.5	325	1.7	353	-£28
Health Visitor	0.5	29	0.3	18	£11
Counsellor	1.7	76	1.3	61	£15
Psychotherapist	0.0	0	0.0	0	£0
Family therapist	0.0	0	0.1	21	-£21
Drug/alcohol support	1.1	83	1.5	120	-£37
In patient stay per night	0.5	147	0.0	0	£147

Health care resource	Domestic violence-related – Mean use per individual – T1	Domestic violence-related – Mean cost per individual – T1	Domestic violence-related – Mean use per individual – T3	Domestic violence-related – Mean cost per individual – T3	Difference (T1-T3)
Outpatient appointments	0.3	30	0.1	15	£15
A&E attendance	0.5	66	0.1	8	£58
Ambulance trip	0.4	85	0.0	0	£85
<b>TOTAL (95% CI)</b>		<b>£1,059</b>		<b>£881</b>	<b>£178 (-£98 to £446)</b>

**Table A8-1b\_12 – Difference in domestic abuse-related social resource use and costs between T1 and T3 – hospital sample (full sample)**

Health care resource	Domestic violence-related – Mean use per individual – T1	Domestic violence-related – Mean cost per individual – T1	Domestic violence-related – Mean use per individual – T3	Domestic violence-related – Mean cost per individual – T3	Difference (T1-T3)
Social worker/Child and Family support worker	2.8	£147	6.0	£318	-£171
<b>TOTAL (95% CI)</b>		<b>£147</b>		<b>£318</b>	<b>-£171 (-£457 to £61)</b>

Over a six-month period, there was a £178 decrease in what clients perceived were domestic abuse-related health care services use. However, the analysis of uncertainty conducted through bootstrapping showed that conclusions were not robust at a 95% CI.

**Table A8-1b\_13 – Difference in domestic abuse-related health care resource use and costs between T1 and T3 – hospital sample (full sample)**

Health care resource	Domestic violence-related – Mean use per individual – T1	Domestic violence-related – Mean cost per individual – T1	Domestic violence-related – Mean use per individual – T3	Domestic violence-related – Mean cost per individual – T3	Difference (T1-T3)
GP surgery consultation	2.3	111	2.3	111	£0
GP home visit	0.0	0	0.0	0	£0
GP phone consultation	1.5	31	0.6	13	£18
Practice Nurse consultation	0.2	2	0.1	2	£0
Community Psychiatric Nurse	0.7	26	3.3	125	-£99

Health care resource	Domestic violence-related – Mean use per individual – T1	Domestic violence-related – Mean cost per individual – T1	Domestic violence-related – Mean use per individual – T3	Domestic violence-related – Mean cost per individual – T3	Difference (T1-T3)
Psychiatrist	0.4	41	0.8	90	-£49
Clinical Psychologist	1.5	315	1.6	342	-£27
Health Visitor	0.5	28	0.3	17	£11
Counsellor	1.6	74	1.3	59	£15
Psychotherapist	0.0	0	0.0	0	£0
Family therapist	0.0	0	0.1	20	-£20
Drug/alcohol support	1.0	81	1.5	116	-£35
In patient stay per night	0.7	186	0.8	231	-£45
Outpatient appointments	0.3	29	1.8	201	-£172
A&E attendance	0.8	104	1.7	216	-£112
Ambulance trip	0.7	156	1.4	313	-£157
<b>TOTAL (95% CI)</b>		<b>£1,184</b>		<b>£1,855</b>	<b>£671</b>

## References to Appendix 8 (Chapter 8-1)

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## Appendix 9 – Appendix to Chapter 8-2 Emergency Department and Ambulance Use

### Use of Emergency Department (ED) by clients before Idva intervention

Table A8-2\_1: No. hospital and local Idva clients using Emergency Department (full sample)

All hospital clients (76 clients)		Type of Emergency Department (ED) use	All local clients (38 clients)	
N	Per cent		N	Per cent
41	54%	Clients who attended an Emergency Department	11	29%
29	38%	Clients whose ED visits were related to domestic abuse	9	24%
28	37%	Clients attending for physical health reasons	10	26%
12	16%	Clients attending after injury by abuser	7	18%
17	22%	Clients attending for mental health reasons	1	3%
12	16%	Clients attended Emergency Department after overdose	1	3%
40/70	57%	<i>Clients who had ever made suicide plans/attempts (Insights questionnaire)</i>	3/36	8%

Table A8-2\_2: No. attendances by hospital and local clients at Emergency Departments (full sample)

No. ED visits by Hospital clients (n=103)		Type of Emergency Department (ED) use	No. ED visits by Local clients (n=14)	
N	Per cent		N	Per cent
103	100%	<b>All visits to ED</b>	14	100%
47	46%	Visits related to domestic abuse	12	86%
13	13%	Visits because of physical injuries by abuser <sup>68</sup>	9	64%
52	50%	Visits for mental health reasons	1	7%
46	45%	Visits to ED after overdose	1	7%

<sup>68</sup> Including one case where the client was the perpetrator who had injured herself after attacking her partner. They were both receiving help to prevent this happening again.

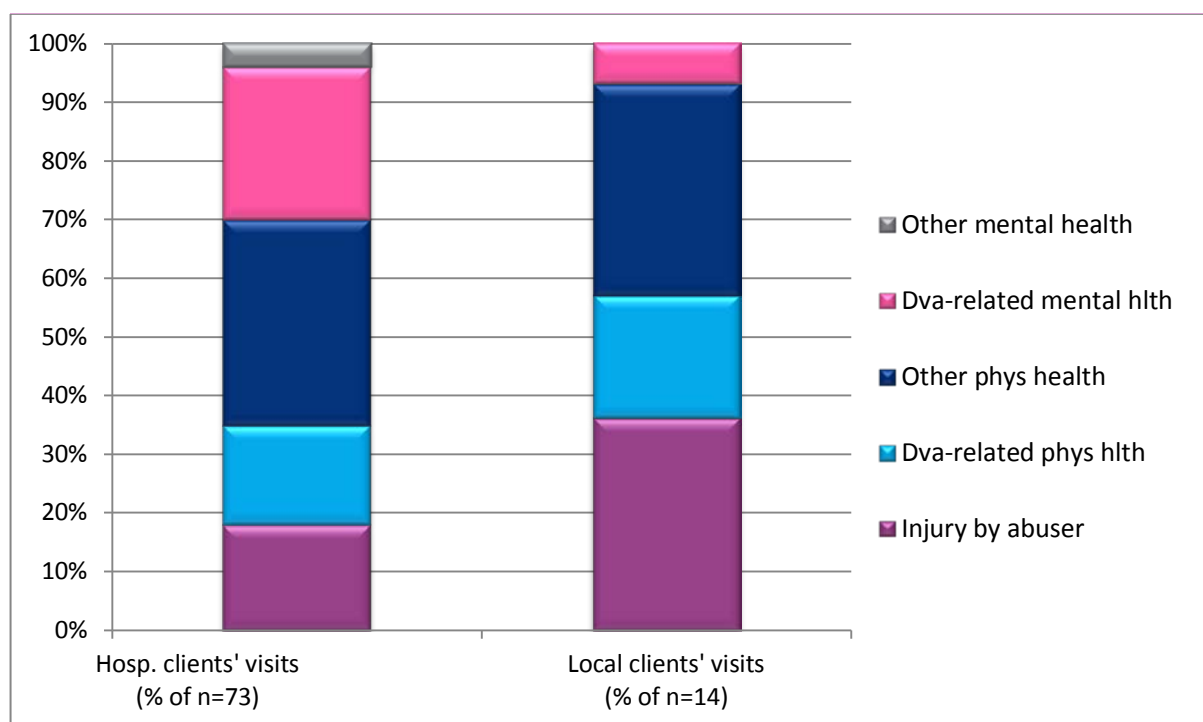
48	47%	Visits to ED after overdose or self-harm	1	7%
18/51	35%	Physical health visits related to domestic abuse	11/13	85%
29/52	56%	Mental health visits related to domestic abuse	1	(100%)

Table A8-2\_3: No. attendances by hospital and local clients at Emergency Departments (excluding outlier client)

No. ED visits by Hospital clients (excl. outlier) (n=73)		Type of Emergency Department (ED) use	No. ED visits by Local clients (n=14)	
N	Per cent		N	Per cent
73	100%	<b>All visits to ED</b>	14	100%
37	51%	Visits related to domestic abuse	12	86%
13	18%	Visits because of physical injuries by abuser <sup>69</sup>	9	64%
22	30%	Visits for mental health reasons	1	7%
16	22%	Visits to ED after overdose	1	7%
18	25%	Visits to ED after overdose or self-harm	1	7%
18/51	35%	Physical health visits related to domestic abuse	11/13	85%
19/22	86%	Mental health visits related to domestic abuse	1/1	[100%]

<sup>69</sup> Including one case where the client was the perpetrator who had injured herself after attacking her partner. They were both receiving help to prevent this happening again.

Fig. A8-2\_1 Reasons for Emergency Department attendances in 6 months before Idva Intake – Hospital and Local clients (*excluding hospital client outlier*)



### Ambulance Use by victims before Idva Intake

Table A8-2\_4: No. hospital and local Idva clients using Ambulances to attend Emergency Department (full sample)

All hospital clients (76 clients)		Feature of Clients' Ambulance Use to Emergency Department (ED)	All local clients (38 clients)	
n	Per cent		n	Per cent
28	37%	Clients taken to ED by ambulance	6	16%
22	29%	Clients whose ambulance trips were related to domestic abuse	5	13%
15	20%	Clients taken by ambulance for physical health reasons	5	13%
8	11%	Clients taken by ambulance after injury by abuser <sup>70</sup>	4	11%

<sup>70</sup> Including one case where the client was the perpetrator who had injured herself after attacking her partner. They were both receiving help to prevent this happening again.



16	21%	Clients taken by ambulance for mental health reasons	1	3%
12	16%	Clients taken by ambulance after overdose	1	3%

Table A8-2\_5: No. ambulance uses by hospital and local clients to attend Emergency Departments (full sample)

No. of Ambulance uses by Hospital clients (n=80 uses)		Type of Ambulance use	Local client Ambulance uses (n=6 uses)	
n	Per cent		n	Per cent
80	100%	Total no. ambulance uses	6	100%
36	45%	Uses related to domestic abuse	5	83%
1.0		Average no. ambulance trips for all clients in group	0.2	
8	10%	Uses because of physical injuries by abuser <sup>71</sup>	4	67%
31	39%	Physical health uses (including injuries)	5	83%
10	13%	Physical health uses related to domestic abuse (including injuries)	4	67%
49	61%	Mental health uses	1	17%
26	33%	Mental health uses related to domestic abuse	1	17%
22	28%	Ambulance uses after overdoses	1	17%

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<sup>71</sup> Including one case where the client was the perpetrator who had injured herself after attacking her partner. They were both receiving help to prevent this happening again.

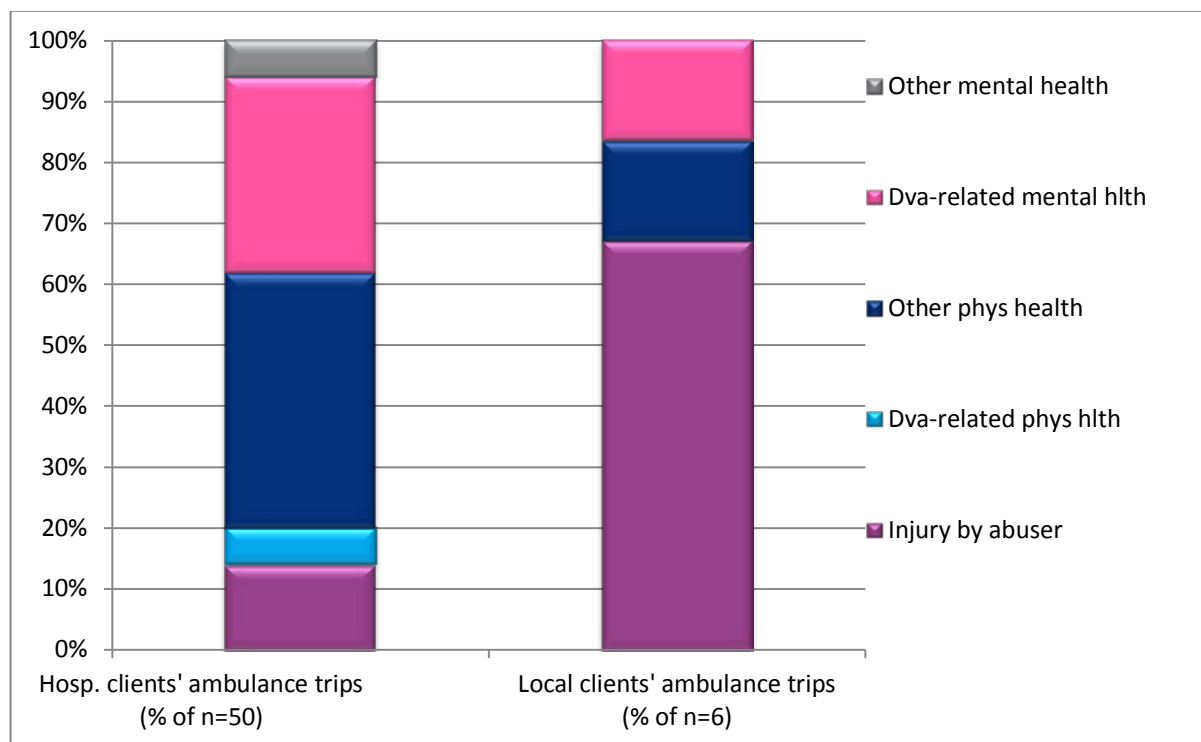
Table A8-2\_6: No. ambulance uses by hospital and local clients to attend Emergency Departments (excluding outlier client)

No. of Ambulance uses by Hospital clients (excl. outlier) (n=50 uses)		Type of Ambulance use	No. of Ambulance uses by Local clients (n=6 uses)	
			n	Per cent
50	<b>100%</b>	Total no. ambulance uses	6	<b>100%</b>
26	<b>52%</b>	Uses related to domestic abuse	5	<b>83%</b>
<b>0.6</b>		Average no. ambulance trips for all clients in group	<b>0.2</b>	
8	<b>16%</b>	Uses because of physical injuries by abuser <sup>72</sup>	4	<b>67%</b>
31	<b>62%</b>	Physical health uses (including injuries)	5	<b>83%</b>
10/31	<b>32%</b>	Physical health uses related to domestic abuse (including injuries)	4/5	<b>80%</b>
19	<b>38%</b>	Mental health uses	1	<b>17%</b>
16/19	<b>84%</b>	Mental health uses related to domestic abuse	1/1	<b>[100%]</b>
12	<b>24%</b>	Ambulance uses after overdoses	1	<b>17%</b>

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<sup>72</sup> Including one case where the client was the perpetrator who had injured herself after attacking her partner. They were both receiving help to prevent this happening again.

Fig. A8-2\_2: Reasons for ambulance use to ED in the 6 months before Idva Intake – Hospital and Local clients (*excluding hospital client outlier*)



## Appendix 10- Appendix to Chapter 10 – Providing help

Table A10\_1: Hospital staff interviewed at the 5 sites

Hospital staff role	No. of interviews
Emergency Medicine Consultants	7
Emergency Medicine junior doctors, house officers	3
Emergency Medicine nurses/sisters	12
Safeguarding Children/Adults Named Nurses	6
Psychiatrists	3
Mental health nurses	8
Alcohol/drug nurses	1
Midwives and midwife managers	6
Other medical staff	1
Research and human resources staff	2
<b>Total</b>	<b>49</b>

**Table A10\_2: Sources of themes generated by staff interviews**

Themes - Idva/Commissioner/Service Manager	Themes - Hospital staff
“Location, Location, Access”	“Utilising the Idva expertise”
“Out of sight, out of mind”	“The visibility of the Idva”
“Training to ask the question”	“To ask or not to ask about domestic abuse”
“Institutional Advocacy: the benefits of co-location to joined up working”	“The red flags of domestic abuse”
“Sowing the seed”	“Uncovering domestic abuse”
“Spend to save”	“Striking while the iron’s hot”
“Idva-plus role”	“Working together to tackle domestic abuse”
	“Untypical domestic abuse”

## Appendix 11- Appendix to Chapter 11 – Hospital case studies

### Comparing hospital Idva service outcomes at the five sites

Table A11-4: Outcomes of the 5 hospital Idva services – for Insights cases (n=537 maximum for all sites)

Insights database 2012-2015 (43 months)	Site 1	Site 2 Service re-starting	Site 3	Site 4	Site 5 Service suspended
<b>No. Insights Exits</b>		50	213	200	74
<b>Length of casework - Mdn in months (Inter-quartile range)</b>		<b>2.5</b> (4.4)	<b>1.1</b> (0.9)	<b>3.2</b> (3.3)	<b>2.5</b> (2.4)
<b>No. contacts with/for client – Mdn (Inter-quartile range)</b>		<b>10</b> (9)	<b>10</b> (7)	<b>8</b> (11)	<b>8</b> (12)
<b>1+ type of severe risk @ Intake - only for those who exited during this period (95% Confidence Interval)</b>		<b>83%</b> n=38 of 46 (72% to 94%)	<b>82%</b> n=172 of 209 (77% to 87%)	<b>54%</b> n=105 of 196 (47% to 61%)	<b>47%</b> n=34 of 73 (36% to 58%)
<b>2+ types of severe risk @ Intake - only for those who exited during this period</b>		<b>56%</b> n=25/45	<b>74%</b> n=148/201	<b>34%</b> n=67/196	<b>30%</b> n=22 of 73

Insights database 2012-2015 (43 months)	Site 1	Site 2 Service re- starting	Site 3	Site 4	Site 5 Service suspended
(95% Confidence Interval)		(42% to 71%)	(68% to 80%)	(27% to 41%)	(20% to 41%)
<b>Moderate/substantial &amp; sustainable risk reduction*</b>		<b>65%</b> n=22 of 34	<b>58%</b> n=118 of 204	<b>73%</b> n=124 of 171	<b>57%</b> n=39 of 68
(95% Confidence Interval)		(49% to 81%)	(51% to 65%)	(66% to 80%)	(45% to 69%)
<b>Substantial &amp; sustainable risk reduction*</b>		<b>62%</b> n=21 of 34	<b>28%</b> n=56 of 204	<b>37%</b> n=63 of 171	<b>21%</b> n=14 of 68
(95% Confidence Interval)		(46% to 78%)	(22% to 34%)	(30% to 44%)	(11% to 31%)
<b>Client felt much safer*</b>		<b>66%</b> n=27 of 41	<b>50%</b> n=81 of 162	<b>73%</b> n=121 of 167	<b>32%</b> n=21 of 65
(95% Confidence Interval)		(52% to 81%)	(42% to 58%)	(66% to 80%)	(21% to 43%)

\*Clients were referred to other local domestic abuse services, where needed.