Final Report of the Portsmouth Domestic Violence Early Intervention Project (EIP) Evaluation

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1. Introduction

This report provides a background to the evaluation and its design, and summarises some of the problems that have been encountered during its undertaking. Findings are presented alongside some of the key factors that have impacted on the establishment, implementation and continuation of the Early Intervention Project (EIP) model as a live intervention. We conclude by raising some issues for further consideration by EIP.

During the evaluation period EIP was a pilot project that aimed to: 'reduce repeat victimisation by providing support and information about the options available, to anyone experiencing domestic violence at the point of crisis'[1]. It sought to do this by training hospital staff to screen patients in order to identify if domestic violence was present in their lives and placing dedicated Project workers within the hospital setting to whom hospital staff can refer. Project workers offer a range of services including information on options, support, safety planning, referral, advocacy and liaison/accompaniment to other relevant services.

According to the original EIP service model, support workers were to be based in the Accident & Emergency Department of Queen Alexandra Hospital (QAH) on the outskirts of Portsmouth. The Project was to operate on a 24-hour basis and employ nine staff. However, once established, EIP had to be limited to daytime hours only, and employed four staff in total, based instead on the Aftercare ward in the Maternity Department of St. Mary's Hospital in central Portsmouth (for a full explanation see Section 3.1). EIP's services were initially made available to clients from A&E, Maternity and also the O&G Department in St. Mary's. Ongoing training sessions for health professionals on screening for, and handling disclosures of, domestic violence began in October 2001. Sessions were targeted at staff from the two main hospital departments participating in the intervention – A&E and Maternity – but staff from other relevant departments such as Paediatrics, were also involved.

A large amount of initial work was undertaken to forge relationships with all the relevant agencies in the Portsmouth area, without whose support the Project could not effectively respond to disclosures. These included: the Police Domestic Violence Unit, the local Women's Aid group, Victim and Witness Support, Housing Department and Social Services.

EIP was launched in June 2002, and in mid August 2002 the support element of the Project went 'live' with the opening of the EIP office in St. Mary's Hospital, following three weeks of EIP staff induction. Once these support structures had been established, hospital staff in the participating departments were then required to begin screening all women over the age of sixteen who attend the hospital, employing a 'sensitive questioning' protocol. Men are also screened, where domestic violence was suspected by hospital staff. In the Maternity Department screening is undertaken during at least one appointment, when the partner is not present. In A&E screening typically takes place at triage, but if that is not deemed safe, staff may attempt to 'create' a safe time to ask, for example whilst accompanying the patient to the toilet.

At the start of the project EIP workers were line managed 'in-house' by the Named Nurse for Child Protection in the Portsmouth Hospitals Trust (PHS) and also by the Domestic Violence Project Development Officer, who is based in Portsmouth City Council and reports to the City Crime and Disorder Officer. EIP is overseen by a Steering Group comprising representatives from Health Services, Victim Support, Witness Support, the Royal Marines, Portsmouth Refuge and the Police.

A full process evaluation is provided in Section 4 below.

[1] Extract from the original Early Intervention Project Bid Proposal, 2001.

2. Early Identification Of and Screening for Domestic Violence in Health Settings

There is growing consensus that health services have a key role to play in the identification, assessment and response to domestic violence. As the British Medical Association (1998) has argued, 'Intervention by the doctor is not just directly trying to stop the violence, but includes validation of the violence, medical treatment, information giving and support, and facilitating referral.' Whilst this approach is partly underpinned by the highlighting of co-ordinated, multi-agency responses as good practice in tackling social problems, it is also due to recognition that domestic violence constitutes a major public health issue. In the UK, the Department of Health has acknowledged that 'Domestic violence has considerable implications for the NHS – particularly in accident and emergency departments, primary care and in specialist settings such as maternity services. Health care costs incurred are considerable; personal costs even more so – perhaps especially if not acknowledged or recognised' (Department of Health, 1997: 23).

2.1 How common is domestic violence?

Recently published findings from the British Crime Survey (BCS) 2001 (Walby and Allen, 2004) estimate that one in four (26%) women aged 16-59 have experienced at least one incident of non-sexual domestic abuse since the age of 16. Prevalence estimates for the year prior to when the 2001 BCS was administered are that six per cent of women were subject to non-sexual domestic. Extrapolating these figures to the general population suggests there were a total of 931,000 female victims of domestic violence that year.

2.2 Links between domestic violence and health

The health consequences of domestic violence are numerous and can range from adverse psychological effects to injury and death. UK research indicates that a high proportion (75%) of cases of domestic violence against women result in physical or mental injury (Walby and Allen, 2004). The health impacts of domestic violence are also confirmed by international studies. The American College of Emergency Physicians (2003) reports that domestic violence is the single largest cause of injury to women between the ages of 15 and 44 in the United States, more than muggings, car accidents, and rapes combined. An earlier study (Rand, 1997) estimated that current or ex-partners were responsible for inflicting 37 per cent of violence-related injuries among female patients presenting to hospital Emergency Rooms. A random sample study of 2,000 women in New Zealand found that women who have been abused have significantly worse physical health than women who have not, and a case-control study of 145 women in the USA reached similar conclusions (Davidson, et al, 2001). Victims of abuse are also much more likely to suffer longer-term physical and mental health conditions such as chronic pain, post-traumatic stress disorder, depression, self-harm, suicide attempts and problems in pregnancy (Plichta, 1992; WHO, 2002; Humphreys and Thiara, 2003). Although there is debate about whether pregnancy is a catalyst for the onset or intensification of domestic violence, links between the two have been identified in the research literature (see, for example, Mezey and Bewley, 1997, 2000; Hunt and Martin, 2001; WHO, 2002; Robinson, 2003; Royal College of Midwives, 2004).

That stigma and shame are major barriers to disclosure among women suffering domestic violence has been well documented (Dobash and Dobash, 1992). Recent findings from the BCS show that around a third of women who have suffered domestic violence since have probably never told anyone of the worst incident, and only 30 per cent of those sustaining some form of injury from domestic violence seek medical help (Walby and Allen, 2004). Nevertheless, other studies have found that abused women demonstrate higher levels of health care use than women with no history of abuse (see Rodriguez et al, 1999; Davidson et al, 2001). Additionally, women may come into contact with health professionals for reasons unrelated to the violence, such as during antenatal care (Craig, 2003), for obtaining contraception or in their role as carers of children or elders (Davidson et al, 2001). In

essence, virtually every woman in Britain uses the healthcare system at some point in her life, and for some women this may be their only point of contact with professionals in a position to recognise this situation and intervene.

2.3 Development of screening

Despite the potential for health professionals to identify victims of domestic violence, research has shown that they are far more reluctant to screen for it than for other recognised health-risk behaviours, such as smoking, alcohol consumption and sexual practices that may lead to a risk of contracting HIV and other STIs. This is still the case in the US, where provision of screening in health settings has existed for over a decade. In a survey of a nationwide, random sample of 610 US primary care physicians, only a minority (19%) reported screening new patients for domestic violence, compared with tobacco use (98%), alcohol abuse (90%) and HIV/STI risks (47%) (Gerbert et al, 2002). Other studies examining screening practices among a variety of health professionals also reveal low levels of routine screening, particularly where there are no obvious signs of injury. For example, a cross-sectional survey of 400 primary care physicians in California found that routine screening of patients with injuries occurred in most (79%) cases, but far less often (9-11%) during new patient visits or check-ups. Those physicians surveyed tended to attribute this to perceived patient-related, rather than physician-related barriers, such as patients' fear of retaliation by the perpetrator, fear of police involvement and lack of disclosure (Rodriguez et al, 1999).

A number of studies concur about the reasons for uneven implementation of screening protocols by healthcare providers. In their synthesis of research findings Moracco et al (2003) provide a useful list of barriers commonly identified by practitioners at both the individual and system levels. Individual factors include:

- Concern about offending patients
- Personal discomfort about discussing the topic
- A feeling of powerlessness to do anything about the problem
- Frustration with patients who return to their abusers
- Belief that abuse is not a medical problem
- Lack of awareness about violence against women

System-level factors include:

- Inadequate training
- Lack of time during patient visits
- Lack of privacy
- Underestimation by providers of the prevalence of violence among their female patients

Notwithstanding the reservations of some practitioners and academics, there are indications that screening in health settings is accepted, both by women who have been victims of abuse, and those who have not. In a large-scale study of women attending general practices in Northern Ireland, 78 per cent of those who had ever had a sexual relationship said they would not mind being asked by their doctor about violence in relationships and, while a proportion were unsure, only seven per cent said they would object; similar levels of agreement (77%) were registered among those in the sample who had experienced domestic violence (Bradley et al, 2002). Gielen et al (2000) argue that the perspective of women themselves should inform screening policies and protocols.

The rationale for universal screening is thus based on

> *the high prevalence [of domestic violence], the high association with an array of health problems, the low level of suspicion and inquiry on the part of physicians, abused women's general unwillingness to volunteer information, and the high level of patient acceptance of direct physician inquiry. Furthermore, screening incurs minimal costs and risks to patients, while offering significant potential benefits* (Rodriguez et al, 1999).

In the UK this has been taken up by the Department of Health, which has produced guidelines on 'a possible approach to routine enquiry' to be used in specific healthcare contexts (Department of Health, 2000). A number of professional bodies in the health sector have also recommended universal routine screening of all female services users about domestic violence.[2]

2.4 Examples of screening projects – UK and international

Two recent UK studies have reported high rates of detection following the introduction of a screening tool in different healthcare settings. In Watts et al's study (2002), based in the Obstetrics and Gynaecology (O&G) Department of a London Teaching Hospital, 17.2 per cent of women screened reported lifetime abuse and 5.2 per cent reported abuse in the previous year. The same intervention in the Accident and Emergency (A&E) department at a later point recorded 24.5 per cent for lifetime abuse and 19.7 per cent for physical violence in the previous year (Watts et al, 2000 and 2002). Mezey and Bewley's study of the screening of women receiving obstetric care from Guy's and St Thomas' Hospital in London reported broadly similar findings – 13.4 per cent for lifetime abuse and 6.4 per cent for abuse in the previous year (Mezey and Bewley, 2000). Mezey and Bewley also found that asking specific screening questions produced a significantly higher rate of detection than not asking direct questions. In addition, both of these studies explored women's reactions to being asked about domestic violence by a health professional. In both cases routine screening for domestic violence was accepted by a majority, providing it was conducted in safe conditions and with the necessary support systems in place (Mezey and Bewley, 2000; Watts et al 2000). At the start of this evaluation EIP was one of a number of health-based early identification and screening projects being piloted in the UK.

There are also international examples of domestic violence screening pilots in health settings. In New South Wales, Australia, of 999 women screened in Antenatal, Emergency, Alcohol and Drugs and Mental Health Services, 11 per cent disclosed experiencing domestic violence in the previous year, and 30 per cent of these requested assistance in the form of information or referral to a specialist service. The Queensland Domestic Violence Initiative, which piloted routine screening in antenatal and emergency departments, found that of 2,912 women screened, seven per cent disclosed domestic violence, with the highest detection rates evident in Gynaecology outpatients and Emergency Departments. Thirteen per cent of those who disclosed accepted an offer of help (Queensland Health, 2001). In both pilots the vast majority (95% and 97% respectively) of women who completed an evaluation survey accepted the screening.

2.5 Issues in the implementation of screening

Though screening for domestic violence has been advocated at government level and endorsed by a number of relevant professional bodies, it remains controversial, with key concerns centring on the abilities and compliance of practitioners in implementing it and a lack of proven impact on outcomes for victims. These issues are often over-emphasised to the exclusion of the positive achievements of successful screening programmes. For example, the authors of a systematic review of 20 mainly North American studies and surveys on screening in healthcare settings (Ramsay et al, 2002) identified a range of positive results from such interventions: they increased rates of identification of domestic violence, typically two-fold; between half and three-quarters of patients surveyed thought screening was

[2] Including the British Medical Association, the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists.

acceptable; and, where domestic violence was detected, referral to other agencies increased. However, they concluded there was insufficient evidence to recommend the widespread implementation of screening programmes, since: lower proportions of doctors and nurses were in favour and there was scant evidence to show that screening interventions affected outcomes such as decreased exposure to violence. Despite this, the authors maintain that the prevalence and severity of domestic violence warrants a response from health services, which should be located within a co-ordinated response from local authorities and the police.

Training for health professionals in domestic violence and screening protocols are undoubtedly essential elements in initiating a screening programme, but appear to be insufficient in ensuring consistent implementation by individual practitioners, who may remain ambivalent. One response to this position is that a distinction should be made between screening and routine enquiry, whereby procedures are not necessarily standardised but questions are routinely asked in certain settings (Bradley et al, 2002; Taket et al, 2003). However, there are examples of more radical approaches. In one US Emergency Department, when the introduction of mandatory screening by nurses of all adult patients, accompanied by training and formal quality assurance feedback, did not bring about a significant improvement in screening levels, a second intervention was piloted involving a formal disciplinary process for non-compliance with the mandatory screening policy. This led to an increase in screening rates from 29.5 per cent to 72.8 per cent (see Moracco et al, 2003).

The latter point, that screening should not take place in a vacuum, has been taken up by Davidson et al (2001), who argue that screening should not be undertaken in a context where appropriate complementary interventions do not exist. They ask: 'Will the identification of violence without adequate plans to provide help and support for women, and contact with appropriate agencies, be helpful to women or demoralising?' (Davidson et al, 2001: 120). EIP is one of a new generation of interventions that links both routine screening and new support services.

3. Evaluation Design and Implementation

The evaluation aimed to assess the impact and effectiveness of both the screening process and the EIP intervention itself in terms of reducing repeat victimisation. Specifically it sought to investigated whether: use of EIP reduces repeat visits to A&E and incidents of domestic violence reported to the police; whether it empowers its clients; and its impact on other local services.

This was a prospective, multi-methodological evaluation to assess process and outcome issues using quantitative and qualitative methods. It also included an action research element using interim reports to feed back findings during the research process. Data collection included the following elements:[3]

- The creation of a relational database which enabled EIP staff and evaluators to monitor and track cases. For evaluation purposes data was analysed (following anonymisation) for two interim and this final report.
- Questionnaires and focus groups with hospital staff to assess the training input on domestic violence, and referral to EIP.
- Focus groups with EIP and hospital staff to explore implementation issues.
- Telephone interviews with multi-agency partners to assess their perception of EIP, including its effectiveness.
- Questionnaires/telephone interviews and focus groups with service users focused on their use and assessment of EIP and other related domestic violence services, and to establish the need for further services.
- A small number of in-depth case studies involving service users, EIP staff and any other relevant agencies, to explore the complexities of domestic violence and interventions designed to address it.

3.1 Preparation of research tools and protocols

EIP was officially launched, approximately two months later than planned, on the 7th of June 2002 and after a number of further postponements the Project went live on the 12th of August 2002 (see Section 4). As Table 3.1.1 below illustrates, a significant amount of the work for the evaluation took place prior to the actual launch date, beginning in November 2001. Despite being considerably longer than intended, the preparatory phase was relatively smooth, undoubtedly enhanced by the co-operative working relationship that developed from the outset between the evaluation team and the EIP Project Development Officer.

Table 3.1.1 provides a brief synopsis of all the major research tasks that were undertaken for the evaluation. These are described below in more detail.

Table 3.1.1 – Research Tasks

Task
Prior to Project going 'live'
Negotiations with EIP management on evaluation needs and protocols
Development of pro formas to be used by hospital and EIP staff
Design of the Training Evaluation Questionnaire and dissemination to hospital staff
Design of Health Professionals Responses Questionnaire and dissemination to hospital staff
Design and development of the EIP Database
Ethics Committee application process

[3] The majority of the initial data collection design was undertaken by Ruth Breslin.

Design of the Service User Questionnaire

Once Project went 'live' on 12th August 2002

Amendments to pro formas following live usage
'Beta testing' of the EIP Database using live data
Installation of the EIP Database
EIP staff training on the EIP Database
EIP Staff Focus Group/interviews
Dissemination of the Service User Questionnaire
Multi-agency Telephone Interviews
Hospital Staff Focus Groups
Service User Focus Group
Service User interviews

3.2 Work with EIP management

From the outset the evaluation team and the EIP Project Development Officer (PDO) have worked together to ensure that the various elements of the evaluation have been undertaken successfully. This involved meetings, telephone calls and emails, in a process of ongoing dialogue and consultation. Negotiations were always open and fruitful, and all necessary evaluation protocols were in place when the Project went 'live'. The PDO commented on and approved all paper data collection materials and facilitated the dissemination of the Training Evaluation Questionnaires and the organisation of interviews and focus groups.

3.3 Ethics Committee approval

Because this evaluation was classified as a form of research taking place on-site within the National Health Service, it required ethical approval from the Isle of Wight, Portsmouth and South East Hampshire Local Research Ethics Committee. This process involved completing a twelve-page application form, furnishing the Committee with drafts of all research tools (which therefore had to be prepared well in advance of the Project's actual start date), appearing before the Committee to present the evaluation team's 'case', and responding to the Committee's further correspondence. Obtaining final approval was a lengthy process, which began in April 2002 and was not completed until the end of June 2002 (see Section 3.11.2 below).

3.4 EIP database and pro formas

The EIP Database is a dual-purpose tool, designed to enable detailed record keeping by EIP itself, and to ensure the evaluators had access to accurate data about EIP service provision. It was designed to record information on all clients who disclose domestic violence in the participating hospital departments, whether they choose to access EIP or not. It contains information about:

- the client;
- the perpetrator;
- hospital visit(s) when domestic violence was disclosed;
- client contact(s) with EIP;
- client needs and intentions and use of other services;
- the support, referral and accompaniment services provided by EIP;
- how the client's situation has changed between hospital and EIP contacts.

Although originally designed by the evaluation team, the database and the data it contains are the property of EIP, and the intention was that Project staff would continue to use it beyond the evaluation phase. In order to protect confidentiality, only EIP staff can access the information the database contains (aside from the evaluation team who received an anonymised version, from which clients' names had been removed, from EIP staff upon request). In addition, the database is only accessible from the PC within the EIP office, which is password protected via each individual staff member's computer account.

It was the responsibility of all EIP staff to enter the data collected on the paper pro formas (see below) onto the database at regular intervals, and to keep it up-to-date. Following an extended period of development (see Section 3.11.3), which included 'beta testing'[4] with real data from EIP, the database, accompanied by a dedicated User Manual, was installed on the PC in the EIP office in November 2002 and Ruth Breslin provided training on its usage over two sessions in November 2002 and January 2003.

The paper pro formas were designed to collect all of the relevant data for the EIP Database. The Patient Details (PD) pro formas are used by hospital staff to record details of any domestic violence disclosures that they receive. These pro formas are then passed on to EIP staff, whether the client chooses to access EIP or not, so that screening and all disclosures of domestic violence can be monitored. The Client Details (CD) pro formas are used by EIP staff to record a wide range of information about the client, the contacts made with them and the take-up of the support/services EIP provides.

An early version of the PD pro forma was used as part of the domestic violence training provided to health professionals by Portsmouth Training Consortium Ltd (PTC). The final version of both PD and CD pro formas was made available to hospital staff from the participating hospital departments and EIP staff prior to the live date. Shortly after EIP went live, slight amendments were made to both sets of pro formas upon the request of the EIP team – these changes were also incorporated into the design of the database.

3.5 Service user questionnaire

Whilst the EIP Database collects a wide range of factual data about EIP's clients, much of which can be aggregated, a specific questionnaire was also designed to gather more in-depth information about clients' experiences and assessments of service provision. In five separate sections the Service User Questionnaire explored the following issues:

- being asked about domestic violence by a member of medical staff;
- contacting EIP;
- using EIP's services;
- using other domestic violence services;
- taking part in the evaluation.

In order to ensure both client safety and confidentiality, the Ethics Committee requested that the Service User Questionnaire should not be sent out by the evaluation team. The evaluation team agreed that it would not have access to the names and addresses of EIP clients unless they provide these details directly to the team themselves. Responsibility for disseminating the questionnaires therefore rested with EIP staff.

[4] A form of testing that is typically carried out on any newly developed piece of software using live data to assess its reliability and user-friendliness.

A specific protocol was negotiated with EIP staff, which set out exactly *when* these questionnaires should be disseminated and *to whom*. A member of the evaluation team met with EIP staff and the PDO in January 2003, and the following protocol was agreed.

- Questionnaires should *not* be sent to any client who has not supplied a safe postal address.
- Questionnaires *should* be sent to *all* clients who have *ever* accessed EIP and have provided safe contact details.
- Questionnaires *should* be sent to *all* clients who have disclosed domestic violence within the participating hospital departments and provided safe contact details, to ensure that those who choose *not* to contact / access EIP are included in the evaluation.
- Questionnaires should *not* be sent to clients whilst EIP is working with them on a regular basis. EIP staff are asked to use their own best judgement as to the most appropriate time to send / give out questionnaires to these clients.

In addition, there was short period of a few months, where the Project was running with only one full time member of staff. No questionnaires were distributed during this period.

Since EIP went live 131 clients (of 259 with whom the project has had contact) have received Service User Questionnaires and 29 had been returned by July 2004 – an acceptable response rate (22%) for an evaluation of this type.

3.6 Service user interviews

The original intention was to identify potential service user interviewees through their volunteering for contact with the evaluation team via the return form attached to the Service User Questionnaire. Whilst most (n=21) service users who returned questionnaires said they would be prepared to participate in an interview, it proved impossible to contact the majority of them. Several had moved home, others had changed their telephone numbers and only four of the 21 were in contact with EIP when the evaluation team tried to organise interviews with them. Only five were interviewed with an additional two taking part in a focus group. Towards the end of the evaluation EIP staff made contact with a small number of clients to ask if they would be prepared to take part in an interview, even though they had not returned a service user questionnaire. Three agreed to do so but it proved impossible to contact one of these clients. In total seven interviews with service users were conducted. These interviews, together with information from the database, form the basis of the case studies (see Section 5.7).

3.7 Training evaluation questionnaire

An integral component of EIP is the training that hospital staff in participating hospital departments receive on handling disclosures of domestic violence, which is provided by PTC and led by the EIP Project Development Officer. An appraisal of this training was therefore essential to the evaluation, and a short questionnaire was designed for this purpose. The questionnaire asked hospital staff to assess the training overall, and in particular whether it equipped them with the knowledge and tools they needed to respond to disclosures of domestic violence and refer to EIP.

Between October 2001 and June 2004 PTC trained 146 individuals, the majority of whom were health workers, across 17 separate training courses. Each course was approximately two and a half hours long and comprised the following elements: Defining Domestic Abuse; Coping with Disclosure; Asking the Question, Record Keeping and Confidentiality.

In April 2002 the evaluation team posted a questionnaire to each participant who was trained in 2001, prior to the start of the evaluation. Participants trained from 2002 onwards, were given the questionnaire, by a member of PTC at the end of their training session. All participants were asked to

place completed questionnaires in the plain green envelopes provided and return them via internal mail to a member of the EIP Steering Group who is based in St. Mary's Hospital. It was envisaged that this would lead to a higher return rate than using the public postal service. At regular intervals the assigned member of the Steering Group sent all completed questionnaires received to the evaluation team in bulk. By July 2004 71 completed questionnaires had been returned – an overall response rate of 49 per cent. Table 3.6.1 below records the returns from each training course.

Table 3.6.1 – Training Progress and Questionnaire Returns

Date	Participants N	Questionnaires Returned N	Questionnaires Returned %
30/10/01	7	1	14
14/11/01	10	0	0
12/12/01	14	3	21
08/04/02	12	7	58
29/04/02	14	5	36
20/05/02	17	4	24
20/06/02	8	5	63
18/11/02	7	4	57
21/01/03	7	0	0
21/03/03	8	2	25
28/05/03	8	2	25
29/07/03	13	7	54
03/09/03	8	3	38
06/10/03	6	3	50
10/11/03	7	0	0
28/04/04	10	7	70
14/06/04	7	3	43
Total	***146***	*59 (plus 12 undated returns) = 71 (49 per cent response rate)*	

All participants on the training courses were sent a second questionnaire roughly six months after the initial training to assess their implementation of screening procedures and referral process. Forty-seven questionnaires were returned (32 per cent response rate). A final questionnaire to these same health professionals was distributed in Spring 2004. Disappointingly only 13 were returned.

3.8 Health workers' focus groups

Two focus groups with health workers from the participating hospital departments, organised by the Project Development Officer, were scheduled to take place on the 5th of March 2003. However, these had to be postponed as a result of poor attendance (see Section 3.11.4 below). One focus group, unfortunately with only three staff members, took place in October 2003. The second, with four participants from the A&E department, was held in June 2004.

3.9 EIP staff focus group

On the 17th of September 2002 two members of the evaluation team conducted a focus group in St. Mary's Hospital with the four original members of the EIP team. Unfortunately none of the original staff members now remain. The purpose was to explore the initial implementation of EIP. Topics covered included:

- the 'setting up' of EIP;
- the EIP model;
- working relationships with all other involved parties;
- future plans.

One member of the evaluation team also had ongoing contact with EIP staff on a formal and informal basis, during the database training sessions, in meetings and over the telephone. These contacts have provided opportunities to observe the team at work and in interaction with one another, and for informal discussions about the development of EIP. Interviews were conducted during July 2004 with the then current staff team of two and the Project Development Officer. Information from both the focus group and interviews has been incorporated into the Process Evaluation (see Section 4 below).

3.10 Multi agency telephone interviews

In order to assess the need for, impact and effectiveness of EIP a series of semi-structured interviews were carried out with members of the EIP Steering Group, who represent a wide range of relevant services in the Portsmouth area. These interviews included a discussion of:

- the need for EIP in Portsmouth;
- the location of EIP;
- experience of liaison, working with and referring to EIP;
- plans / suggestions for EIP's future.

Seven of the eight members of the Steering Group were interviewed between the 23rd of January 2003 and the 6th of February 2003. A second round of interviews were undertaken with five of the eight Steering Group members in January 2004. These were followed by final interviews with eight Steering Group members in July 2004.

3.11 Problems and difficulties

This final subsection sets out some of the problems experienced by the evaluation team during the course of undertaking this evaluation.

3.11.1 Delayed implementation

The original planning of the evaluation included an expected start date for EIP of April 2002. However, due to a range of setbacks, largely beyond the control of both the PDO and the evaluation team, the Project's official start date was postponed on a number of occasions and whilst it was officially launched in June 2002, it did not actually go live until mid-August that year. The key reasons for the delay were a financial crisis (see Section 4.1 below) and failure to deliver the Project computer on time. These delays did however, extend the time available for two processes that took longer than originally anticipated: gaining LREC approval and developing the EIP Database.

3.11.2 LREC process

The amount of time that had to be devoted to the application for ethical approval was not anticipated by the evaluation team, who were not aware either that this had not already been given, nor that they would have to take major responsibility for completing the application form and managing the process. This required preparing drafts of all research tools for the evaluation, well in advance of their actual use. The application was submitted on the 22nd of April 2002 and a team member appeared before the

Committee on the 10th of May 2002. A response from the Committee, dated the 17th of May 2002, approved the study but subject to a number of conditions.

A problematic aspect of this process was that, despite clarifications made by the evaluation team both within the application form and at the Committee meeting, the Committee failed to distinguish between CWASU as *external* evaluators of EIP, and the Early Intervention Project itself. This led to the evaluation team member responding to questions from the Committee about the Project, rather than limiting the discussion to the evaluation for which approval was being sought. It was also frustrating to discover that the Committee had not fully consulted either the completed application form or the accompanying drafts of the research instruments, and asked for a range of information, both at the meeting and in their later correspondence, that had already been supplied.

This process took three months from application to approval and required considerable input of time, which had not been factored into the original research tender.

3.11.3 EIP database

The design and development of the EIP Database was undertaken with the assistance of an external consultant. It proved to be more complex than anticipated, but vital to 'get right', since the database was to be a crucial data collection tool for both the project and the evaluation. It proved necessary to create a relatively complex structure in order to capture data on all of the following client categories:

- Those that disclose domestic violence in a participating hospital department(s) on one or more occasions but never access / contact EIP (disclosure only).
- Those that disclose domestic violence in a participating hospital department(s) on one or more occasions and do access / contact EIP on one or more occasions (disclosure and contact).
- Those that never disclose domestic violence in a participating hospital department but do access / contact EIP on one or more occasions (contact only – known to EIP staff as 'walk-in' clients).

In addition the database also had to allow for:

- Clients that disclose domestic violence on more than one occasion and / or contact EIP on more than one occasion who have had more than one perpetrator (violent partner) during the evaluation period.

The original timeline envisaged installing the database in EIP's office in October 2002, following a period of 'beta testing' with data on EIP's first clients. The beta testing meant that EIP staff had time between August and October 2002 to familiarise themselves with the various pro formas and the protocols for their use. However, delivery of the database was delayed following a network problem in London Metropolitan University, where CWASU's offices are based, which corrupted the file containing the most up-to-date version of the database containing the live data. As a result, a significant proportion of the design work had to be redone. A final version of the dedicated User Manual was completed, and the database was installed in the EIP office in November 2002, followed by two days of intensive staff training.

3.11.4 Health workers' focus groups

As mentioned in Section 3.8, the day before the initial two focus groups with health workers were scheduled to take place only one staff member was still available to participate – the other volunteers were either off work due to illness or annual leave, or had other more pressing work-related matters to attend to. Despite the best efforts of both the evaluation team and EIP staff it was impossible to re-

schedule these focus groups until October 2003. Only three staff members were available and only one focus group took place. This did ensure that there was an opportunity to discuss with a small number of hospital staff their experiences of screening and referring to EIP, and to explore with them further some of the key issues that arose from their questionnaire responses. A final focus group, again only with Accident and Emergency staff, took place in June 2004. Unfortunately, despite the efforts of EIP staff, a maternity based group proved impossible to organise.

4. Process Evaluation of the Early Intervention Project

This section is a process evaluation, reflecting on a range of implementation issues, aspects of which are also referred to elsewhere in this report. Data drawn on here includes interviews with the Project Development Officer, Project staff and Steering Group Members.

4.1 Departures from the original EIP model

The evaluation team was informed at the initial meeting with the EIP PDO and members of the Steering Group in November 2001 that EIP was expected to go live in April 2002. However, in January 2002 the evaluation team was notified by the PDO that the local Primary Care Trust had withdrawn all cash funding for EIP as a result of its own financial deficit (although it continues to supply the office and other sundries). Funding had to be sought elsewhere from a variety of sources and was not finally secured until early April 2002. This in turn caused delays in the whole process of obtaining approval for new staff posts, finalising grades and job descriptions, and actual recruitment, which did not take place until June-July 2002. In addition to the delay, the withdrawal of core funding meant that EIP was unable to establish a service with as broad cover as originally envisaged. Instead of a 24 hours a day, seven days a week service employing approximately nine staff, EIP began operation with four staff working seven days a week on 37-hour shifts during daytime hours only. Staffing levels changed substantially throughout the period of the evaluation (see section 4.3.4 below), and the service remains less than originally envisaged.

Funding continues to be an issue for EIP, with a projected short fall over the next two years and funding guaranteed only until 2006/7. Currently, a number of agencies contribute financially to the Project. These are: Portsmouth City Council Crime & Disorder Unit and the Safer Communities Budget. PCC Housing (through a recent commitment by the Homelessness Directorate) funds one full time post which is encouraging. The Government Office for the South East is also offering one year of funding (to be confirmed) and the PDO continues to seek more secure funding for the Project.

Many individuals who are involved with the Project have expressed their understanding, but also their disappointment, that EIP was, and remains unable to operate a 24-hour service. However, EIP workers are confident that referrals that are being picked up by hospital staff outside Project opening hours, and particularly at night, are being passed on to EIP without delay. Typically, EIP workers are being provided with safe contact details for the individual concerned the following morning and are able to follow up the referral immediately.

A further change that had to be made to the original service model was EIP's physical location. Due to space constraints in the A&E Department of Queen Alexandra Hospital (QAH), the project had to be located in the Aftercare ward of the Maternity Department in St. Mary's Hospital. However, staff reported that QAH is very accessible from this location via the special bus service, and they did not feel that they were losing any potential clients as a result of being sited away from A&E. Workers also noted a number of other positive points about the office location, including the fact that they felt very safe within the hospital environment and that it is convenient to a number of key services in the area, including the courts and the police. Given that workers see the vast majority of clients off-site and occasionally in the clients' own homes, they felt that the actual location of the Project office itself was not an issue when it comes to conducting face-to-face work of this nature. There are problems with the size of the office as discussed below (see sections 4.5.1 and 4.5.4 below for information on recent developments).

4.2 Referral rates

In the original EIP Bid Proposal, 100 referrals to EIP per month was cited as a 'conservative estimate'. By July 2004 EIP had recorded details of 349 disclosures and had worked directly with 259 clients, an average of 12 clients per month (over a 22 month period). Clearly referral rates remain lower than originally anticipated. What follows is an outline of a number of factors that may have had an impact on client numbers all of which were noted in both interim reports, and which are supported by data from health professionals, steering group members and service users (reported on in Section 5 below).

- As already noted above, EIP is not the intended 24-hour service.
- EIP's location is too 'low-profile', and therefore does not actively encourage staff to screen.
- EIP is not 'advertised' enough. The Project had to be very selective and careful about where and how it was publicised, given that it was designed to work only with specific hospital departments, and in order to ensure the safety of its workers, and the safety and confidentiality of its clients. However, it has been suggested that this lack of Project 'advertising' contributed to low referral rates.
- Hospital staff are not consistently screening[5]. As noted in the first interim report, it is not uncommon for routine screening practices in health settings to experience 'teething problems' (see for example Mezey and Bewley, 2000). However, despite continuous efforts by EIP workers, EIP management and particular Steering Group members to promote the Project amongst hospital staff and encourage them to screen, it remains the case that not all staff are undertaking their screening duties, whilst amongst those that are it is unclear who they are actually screening, how often, and in what specific circumstances. Indeed, Project workers – who reported an increase in referral rates just before the 2nd Interim Report (January 04) – attributed this to an improvement in police protocols, whilst the number of referrals coming from the participating hospital departments had actually 'dropped-off' during that period. It was also noted that referral rates have not improved as a result of the involvement of a number of other hospital departments that can now refer patients to EIP. However, more recently EIP has established positive links with Occupational Health at both hospitals and the Project has received a number of hospital staff referrals from this particular source, as well as, albeit small numbers, from the mental health team and the Ella Gordon Unit, amongst others. There has also been a slow, but steady, increase in referrals from the maternity department (see Section 5 below) and one of the current Project staff reports that there has been a similar, although lower, increase in referrals from A&E.

4.3 Links with other agencies

As noted in the Introduction (see above) EIP has, from its inception, forged close working relationships with a number of other agencies. These links have continued to grow and the number of external agencies to whom clients are referred has expanded over the period of the evaluation (see Table 5.4.14 below). Referral systems have been developed between the Project and agencies such as Women's Aid and Witness Support. Social Services have increasingly referred clients where there are child protection concerns and EIP staff in these cases, have developed close links with individual social workers. Links with the Housing Department of the Local Authority have proved particularly fruitful and have moved beyond finding alternative accommodation for clients, where necessary. A system has been introduced whereby, for Local Authority Property, the local Housing Department will pay for security measures, including changing locks and if required, installing security lights. Private sector properties are seen by a local Crime Reduction Officer or 'Homecheck' a local organisation providing security measures to local older people, families with children under five, and those who have experienced domestic abuse or racial harassment.

[5] In October 2003 EIP management reported that it is aware that not all staff are consistently screening, but stated that this is a Project goal that is still being worked towards.

Project staff report extremely good relationships with all external agencies and note high levels of co-operation and support.

4.4 The steering group

A steering group, consisting of representatives from the A& E and Maternity Departments and the named lead for Child Protection within the Trust, together with a range of external agencies (Police domestic violence co-ordinator, Victim Support, Royal Marines Welfare and Women's Aid) was formed prior to the Project going 'live'. This group has met at quarterly intervals and reports, from these meetings are fed into the local Domestic Violence Forum. The PDO reports that these meetings have been effective in ensuring that those involved have a 'stake' in the success of the Project and that decisions on changes and/or improvements to the service have agreement from all the agencies. However, there is a concern that there is a large 'cross-over' of representation between the EIP Steering Group and the local Domestic Violence Forum and the PDO is currently investigating a re-structuring of the group. This could take the form of a smaller group consisting of representatives from those agencies providing a non-refuge based support service, with wider issues (including liaison with other agencies) taken to the Domestic Violence Forum. The views of the Steering Group itself are discussed in Section 5.8 below.

4.5 Problems for EIP staff

On-going discussion, contact with and observation of both previous and current EIP staff 'on the job' during the evaluation period has served to highlight a number of difficulties that they faced in performing their roles during the period of the evaluation. These are set out below.

4.5.1 The EIP office

The office was a constant source of complaints from EIP staff. The office was too small to accommodate the original staff team and even when there were only two members of staff in the office at any one time, they were finding it difficult to conduct support telephone calls. The room is so small that when both workers were on the telephone simultaneously, not only were they distracted by each others' voices, clients at the other end of the line could also hear another person's voice in the background during what was supposed to be a confidential phone call. The size of the room also led to high temperatures during the summer. To alleviate this, staff would keep the office door open to benefit, albeit slightly, from the air-conditioning available in the corridor outside. However, this resulted in privacy being compromised and, in some instances, hospital staff and members of the public, walking into the office unannounced. One staff member described the office as "… just so claustrophobic, it's horrendous. It really is horrible."

As a result of these conditions EIP staff rarely used their office as a place to see clients, and typically arranged alternative suitable locations to meet with clients face-to-face, both elsewhere in the hospitals, off-site and sometimes in the clients' own homes. Yet, according to both workers and Project management there had been two larger rooms very close to EIP's current office that had been left unused for quite a long period. However the Trust were unwilling to allow EIP workers to use this space and failed to inform them of what was planned for it in the future. The department has undergone refurbishment in the recent past and hospital services have taken up all the available space.

The inability of the Trust to provide suitable accommodation led to the PDO seeking an alternative location. This has now been found and the main staff team (including the newly appointed Project Leader (see Section 4.5.4 below) will be based in an office in the civic centre. However, to ensure that EIP continues to have a physical link with the Trust, the office at St. Mary's will be retained

and the staff team will rotate between both locations. It is recognised that losing the current St. Mary's office could further lead to a deterioration in the overall recognition of and support for EIP within the Trust.

Lobbying continues to provide a base for EIP in the A&E department and it is hoped that even if this is not possible at present, space may be available when the new hospital building is completed in a few years time.

The poor conditions for the project staff, were also noted as problematic by Steering Group members (see Section 5 below).

4.5.2 Relationships with hospital staff

EIP workers, both past and present, have highlighted discrepancies in the level of support and co-operation that EIP and its staff receive from the two major participating hospital departments. Workers have described A&E staff as supportive of the Project and noted that this department appears to be screening and referring clients on a fairly consistent basis, as well as sharing valuable information with EIP workers where appropriate. Conversely, workers stated that some of the Maternity staff at St. Mary's had been particularly unsupportive of the project. Workers were keen to stress however, that this is *not* the case with regard to *all* Maternity staff, and the Named Nurse for Child Protection from this department was identified as a particular source of ongoing support and advice for workers. To illustrate the above point regarding lack of support and interest, a number of sources gave the example of EIP's first birthday parties: the party organised in St. Mary's was attended by two Maternity staff, whilst the QAH party had over thirty A&E staff attendees. It should be noted however, that the PDO has reported an increase in support from the Maternity department more recently.

Despite some concerns, Project staff, in both focus group and interviews, have always reported that they have good and productive relationships with individual hospital staff, including administrative and support staff although these are with a very small number of people. However, this does not extend to the Trust as an institution. Throughout the period of the evaluation staff reported that they did not feel supported by the Trust itself and that, apart from facilitating entry to the buildings and use of the car park, no effort to make them feel part of the institution has been made. The poor office conditions and Issues to do with pay and grading were major contributing factors to this (see below).

4.5.3 Staff grades

Another problem identified early in the evaluation was that of the EIP staff team's professional grades. Despite protracted negotiations it was impossible to resolve this within the Trust. As a result, as of 1st January 2004, all project staff were transferred to the employ of Portsmouth City Council. This has led to a significant improvement in staff salaries and increased employee support. Agreement was reached with the Trust whereby Project staff retain Trust ID cards, parking and other facilities, enjoyed by Trust employees.

4.5.4 Staff loss / changes

There were major staff changes and losses throughout the period of the evaluation. By the end of the first 15 months (July 02 – September 03) none of the original staff team remained in post. During this period also there were short periods of time when the staff team (excluding the Project Development Officer) stood at two full time and one part time workers. Between September 03 and June 04 staffing stood at two full time workers, with an, albeit short period, where staffing was

reduced to one full time worker. These staff changes undoubtedly caused disruption for the Project overall and had an impact on the level of service provision it was possible to achieve.

A project leader was appointed in July 04 raising the staff team to three full time and a fourth project worker will join in August 04 taking staffing levels back to that applying at the beginning of the project.

Workers who resigned during the first year or so of the project, cited a lack of support for their work, in addition to poor pay and working conditions as their main reasons for leaving. These workers also felt isolated from and excluded or ignored by the Trust. It was noted that various promises made to them regarding an improvement in professional grading and salary came to nothing. They also noted that they felt somewhat 'under-valued' in their roles, that their various skills were not being utilised to their full potential, lack of 'in-house' supervision and that they were not permitted to explore opportunities for work and professional development outside the confines of their specific job descriptions. These factors, in addition to a lack of team-building activities, all contributed to low morale amongst those workers who eventually chose to resign.

The PDO has acknowledged that the amount of work required to provide 'in-house' supervision was not factored into her role, as project manager, from the beginning. This, and the fact that she was not housed within the hospital alongside Project staff, had a major impact on her ability to provide the level of informal supervision, and access for decision making and problem solving, some of the staff wanted. Formal supervision was structured through monthly one-to-one individual sessions between the PDO and Project staff. Group supervision is provided on a monthly basis, by a hospital-based counsellor. The appointment of a Project Leader based in the same office as the staff will ensure immediate access and on-going supervision in the future.

It should be noted that whilst staff may have perceived a lack of support for professional development, they were offered, and in some cases, took up, a number of opportunities including: a Postgraduate University course; a Counselling course; training of trainers courses and attendance at national conferences.

4.5.5 Overall impacts

It is fair to say that as a result of the above factors in varying combinations, EIP staff, have at times, felt somewhat demoralised and although current staff remained committed to the Project, there is no doubt that there were impacts on the Project's ability to fulfil its objectives. The recent changes, instigated by the EIP Project Development Officer, have been welcomed by the current staff team and should solve the problems outlined above.

4.6 Changes and improvements

The EIP model of service provision has proved to be a dynamic one that is capable of incorporating change when the need has arisen. Documented below are a number of recent positive developments for EIP.

4.6.1 Referral from other sources

As can be seen in Table 5.1.1 below, referrals are now being received from hospital departments other than A&E and Maternity and from sources external to the hospitals.

One of the main referral routes to the Project, until earlier this year, was via the Police. Police officers, responding to incidents of domestic violence, would inform any victim about the Project

and, if agreed, organise a referral. This led to a significant increase in police referrals to the Project, often more than ten per week. There was feedback from the Police Domestic Violence Unit to the PDO that this system had led to a reduction in repeat visits to domestic violence incidents by police officers. However, during the period when there were only two full time project workers a decision was made to prioritise referrals from the Trust, in line with the initial aims of EIP, and from those agencies who are making a financial contribution to the running costs. Police officers, although understanding of the situation, were disappointed that they could no longer make direct referrals. Unfortunately, despite lobbying by individual police officers, it has not been possible for the Hampshire Constabulary to contribute financially to the Project.

The high referral rate from the Police does highlight a gap in provision for victims of domestic violence within the Portsmouth area. There are only two other non-refuge support services available. One is an outreach service with one full time and one part time worker, funded through the Housing Department, to provide a service to clients referred from that department. The other is a support service for current or ex-partners of men attending a violence prevention programme. There are therefore victims of domestic violence, identified by the Police, not currently receiving a service.

4.6.2 An increase in awareness of domestic violence and EIP's profile

EIP workers have noted that hospital staff are far more aware of the issue of domestic violence than they were in the early days of EIP, and are therefore far more likely to identify it during the course of their work. Workers also described how hospital staff have become more accustomed to and comfortable with the PD1 referral forms and are more likely than in the past to complete them, and to do so accurately and in full. One worker stated that PD1 is now coming to be recognised by staff as a 'standard hospital form'.

Over the period of the evaluation a range of measures have been taken to raise the profile of the project, particularly as a result of the some of the views of steering group members and hospital staff that the profile was too low.

These include:

- the publication of an EIP newsletter and its dissemination to all participating hospital departments, as recommended in the first interim report;
- the inclusion of information about EIP in the newsletters of the major participating hospital departments;
- plans for further 'reminder' visits to A&E and Maternity Departments, which will specifically target new staff and those who have returned from the war in Iraq;
- the inclusion of EIP's details in a domestic violence resource pack for every midwife in the Trust, that has been developed by the Midwife with a domestic violence lead, and contains all protocol for screening, responding to and recording disclosures of domestic violence;
- regular invitations to update events for all child protection lead personnel within the Trust.

One EIP worker argued during an interview for the 2nd Interim Report that there is little cause for concern regarding EIP's profile at that time and that, as with most new projects, 'it is merely a matter of time' before it becomes widely recognised. She felt that EIP needed to be in existence for another ten to twelve months for it to become fully instated and appreciated. It would appear that this has proved the case and that the profile has risen amongst hospital staff and external agencies as the referral routes to the Project demonstrates (see Section 5 below).

4.6.3 Ongoing programme of training on handling disclosures of domestic violence

Apart from one five-month gap, the training programme has run either monthly or bi-monthly throughout the period of the evaluation, and these sessions are increasingly attended by staff from agencies outside of the hospitals. There has been a decrease over time in the numbers attending the training sessions (see Section 5.1). The PDO sees this as a natural progression as those staff, particularly from A& E and Maternity with an interest in doing the training, having taken it up in the early stages, with low numbers of new and interested staff attending. Despite the take up from both these departments, the PDO estimates that less than 50 per cent of staff have undertaken the training and there is an argument for it to be made compulsory, supported by some hospital staff (see Section 5.3). Routine screening cannot be embedded within departments where the staff team has differential skills, confidence and understanding in relation to domestic violence, and this almost certainly contributes to the low referral rates. The low take up within these departments has influenced another screening and early intervention project in a hospital setting[6] where training has been made compulsory for all staff.

A recent development has been the mainstreaming of the training within student midwifery training and the incorporation of it within the ongoing development training for midwives. It is hoped that both of these routes will ensure that all midwives working within the Trust will have received the training.

Both the PDO, and some of the responses from the training evaluation questionnaires (see Section 5.1 below), recommend that the current two-and-a-half hour session should be lengthened. The PDO would prefer whole day sessions. Unfortunately, this is unlikely in the near future, as the Trust cannot release staff for this length of time, although the training for student midwives has been extended to a whole day.

It should also be noted that EIP currently pays for the training for hospital staff which reduces the funding available for responding to client need. It could be argued that, alongside the provision of the office, the Trust could invest in the Project through taking on this outgoing.

The PTC was also been successful in extending its reach, and currently runs a slot on handling disclosure in the child protection training for all midwives and the training of every police officer in Portsmouth city.

4.6.4 New EIP posts

The current two full time members of staff, have now been joined by a Project Co-ordinator (as of July 04) another full time project worker is due to start in August 04. One of the advantages of the former post is that it will be at management level grade, and the post holder will take on the role of a Project Leader who will be responsible for the day-to-day management of EIP on-site in the Project office at St. Mary's hospital as well as at the new base in the civic offices. This will mean that workers have the benefit of an individual with management responsibilities in close proximity to them on a full-time basis who can respond to their immediate support and other needs; something which has not been possible until now.

The Homelessness Directorate (via Portsmouth City Council) have provided funding for a project worker post as a result of their recognition of the potential of EIP to support those experiencing domestic violence who want to remain in their own homes, and who could avoid homelessness by being enabled to do so safely. This worker will undertake safety planning with clients and assist

[6] The WORTH Project, based at Worthing Hospital, West Sussex.

with the practicalities of making their homes safe. According to the Project Development Officer, the creation of this post highlights the ongoing high level of support that Portsmouth City Council is providing to EIP.

4.6.5 New service developments

An analysis of the Service User Questionnaires for the first interim report highlighted a number of requests from clients for a more formal counselling service to be offered by EIP. In response to this demand one of the former EIP workers who was also a trained counsellor was planning to provide private counselling on a sessional basis to EIP clients who request this service. Brief focused work was planned for clients who were going through a crisis period, in addition to longer-term, more in-depth support. Unfortunately this staff member experienced a period of sickness and was unable to start the service. As this continues to be a request to the project by clients, EIP now have an agreement from the Government Office for the South East to provide some funding for a counselling service and invitations to tender will be sent shortly to a number of counselling agencies in the area.

One staff member also noted that there has been some discussion within the Project about running a drop-in session for EIP clients and/or possibly some form of group therapy for those who would benefit. Either of these developments may be possible with an increased staff team and permanent Project Leader.

4.6.6 External recognition

Over the period of the evaluation EIP has received positive recognition from a number of external sources.

- EIP was awarded £1,000 by Hugh Marriage, Home Office Director in the South East. With this award EIP was recognised as one of a number of projects providing 'the most significant contribution to reducing violence against women in the South East'.
- EIP has also been included as an example of best practice in the Office of the Deputy Prime Minister's *Reducing B&B Use and Tackling Homelessness – What's Working: A Good Practice Handbook,* that was produced by the Homelessness Directorate and published in August 2003. This contains good practice examples that were reported to the Directorate by councils across England, and EIP is recognised as one such example in the area of 'support and assistance to families experiencing domestic violence'.
- In January 2004 the Project was successful in the Probation 2004 International Community Justice Awards, in the Public Protection Category. They received a cheque for £500 and a glass award, presented by HRH Princess Anne.

Summary

- The failure to acquire the originally promised funding had led to the Project providing a service which is less than originally envisaged;
- The size of the Project office has been a source of continued problems for workers which should be alleviated by the expansion into premises within the Civic Centre;
- There has been a history of staff loss and changes throughout the period of the evaluation. The recent appointment of a Project Leader and the recruitment of another worker takes staffing levels back to that pertaining at the start of the Project;
- Problems with staff grades and pay-scales within the Trust have been solved by transferring staff to the employ of Portsmouth City Council;
- The referral rate is far below that predicted at the start of the Project;

- Although the training has been extensive within the two main participating hospital departments, there continues to be inconsistent screening;
- There has been a recent increase in the Profile of EIP, particularly within other hospital departments and externally. It is hoped that this, together with an increased staff team, will lead to an rise in the number of referrals;
- The Project has received a high level of external recognition.

5. Evaluation Findings

This section sets out the findings from the final analysis of all the data collected by the evaluators. Data collection was scheduled to cease at the end of June 2004. However, some data (such as the third questionnaire to Health Professionals) was not received until the end of July 2004.

5.1 Training evaluation findings

As noted above in Section 3.7, 146 health workers received training on handling disclosures of domestic violence from PTC, 71 of these returned completed Training Evaluation Questionnaires. It should be noted that of the 59 respondents where we know the date they participated in training, 42 per cent (n=25) received this training and the questionnaire *before* EIP went live, and therefore had no direct experience of screening for domestic violence and referring to EIP. The practical application of this training has therefore been explored through the additional data strands of the health staff focus group and the distribution of the Health Professionals Responses questionnaire (see below).

Table 5.1.1 – Respondent's Department

Department	%	N
Accident & Emergency	11	8
Adult Mental Health (self-harm)	1	1
Ante Natal Centre	1	1
Child Health	4	3
Clinical governance	1	1
Contraception and sexual health	1	1
Dermatology	1	1
Discharge Planning	1	1
Fracture clinic	1	1
Gynaecology	3	2
GU Medicine	3	2
HATC*	1	1
Intensive Care Unit	1	1
Maternity	40	29
NSMRC**	3	2
Occupational Health	1	1
Orthopaedics	1	1
Paediatrics	10	7
Royal Marines Welfare	1	1
Service Planning	1	1
Women & Children	3	2
Unknown	4	3
Total	**100**	**71**

* Haslar Accident Treatment Centre
** Nelson substance misuse residential clinic

Table 5.1.1. demonstrates that although the training was targeted initially at staff in the Accident and Emergency and Maternity departments, other staff, both from within and outside the hospital have increasingly attended training. The last two training sessions particularly attracted participants from substance misuse agencies, adult mental health and the Royal Marines.

Overall, respondents gave a positive assessment of the training, as the following findings suggest:

- all bar four thought that it had fulfilled all its objectives;
- the majority understood the procedures to screen for domestic violence;
- No respondents were negative about EIP.

These findings are explored here in more depth. Seventy respondents (99%)[7] agreed that the training objectives were made clear to them at the beginning of the session. Respondents were then asked if the course fulfilled its three main objectives – these are set out below in Table 5.1.2 alongside the responses to each.

Table 5.1.2 – Fulfilment of Training Objectives

Objective	Yes, in full		Yes, partly		No		Missing data	
	N	%	N	%	N	%	N	%
Increase your understanding of domestic violence and its effects	37	52	30	42	2	3	2	3
Help you to develop appropriate responses to patients who disclose domestic violence	39	55	27	38	4	6	1	1
Help you to develop an awareness of services available for patients experiencing domestic violence	51	72	18	26	1	2	1	1

All rows total to n=71 and 100%

Some of the reasons given by respondents (n=9) why, in their view, the training did not fulfil, or only partly fulfilled its objectives included:

- they already knew how to respond to domestic violence;
- the training session was too short and they wanted to know more, especially about EIP;
- not enough information was provided about the different options for people who disclose domestic violence;
- one respondent still felt unsure how to respond to a disclosure of domestic violence where children are involved.

Respondents were then asked if, having completed the course, they understood a range of procedures, which are set out in Table 5.1.3 below alongside the relevant responses.

Table 5.1.3 – Respondent's Understanding of Procedures

Understand Procedure To	Yes		No		Not Sure		Missing data	
	N	%	N	%	N	%	N	%
Ask a patient questions about domestic violence	67	94	-	-	3	4	1	2
Respond to disclosures of domestic violence	59	83	7	10	5	7	-	-
Confidentially record disclosures of domestic violence	60	85	8	11	2	3	1	1

[7] All percentages are rounded to the nearest whole number.

All rows total to n=71 and 100%

While it is evident from the above that the vast majority of respondents felt that they had a clear understanding of the procedures to respond appropriately to domestic violence, it was important to also find out if they actually felt confident enough to use this new knowledge. Respondents' level of confidence with each procedure is set out in Table 5.1.4 below.

Table 5.1.4 – Respondent's Level of Confidence with Procedures

Confident with Procedure To	Very confident		Fairly confident		Not confident		Missing data	
	N	%	N	%	N	%	N	%
Ask a patient questions about domestic violence	14	20	52	73	4	6	1	1
Respond to disclosures of domestic violence	16	22	51	72	2	3	2	3
Confidentially record disclosures of domestic violence	27	38	40	56	3	4	1	2

All rows total to n=71 and 100%

These findings suggest the training had equipped the majority of respondents to both understand the procedures and to use them.

Finally, with regard to these procedures, respondents were asked if they anticipated any problems in using or applying them. Responses are tabulated in Table 5.1.5 below.

Table 5.1.5 – Respondent's Anticipation of Problems with Procedures

Anticipate Problems With	Yes		No		Not Sure		Missing Data	
	N	%	N	%	N	%	N	%
Ask a patient questions about domestic Violence	21 *35*	30 *95*	48 -	68 -	1 *2*	1 *5*	1 -	1 -
Respond to disclosures of domestic Violence	8 *33*	11 *90*	53 *2*	75 *5*	1 *2*	1 *5*	9 -	13 -
Confidentially record disclosures of domestic violence	8 *32*	11 *86*	59 *3*	83 *8*	- *1*	- *3*	4 *1*	6 *3*

All rows total to n=71 and 100%
Numbers and percentages of responses to questionnaires received before 1st Interim Report in italics (37 questionnaires).

Although the numbers are small, those respondents who have received training after EIP went live are much less likely to anticipate problems in applying the procedures than those trained earlier. It may be that these respondents have had some experience of colleagues implementing procedures and this has led to a greater level of confidence.

Just under a third of questionnaire respondents (32 per cent, n=23) noted concerns about all three sets of procedures. The largest group here (43 per cent, n=10) expressed concerns about a range of anticipated practical difficulties such as finding the right place and enough time to ask the question and document disclosures whilst also ensuring the patient's privacy, confidentiality and safety. Adding to the workload of already stressed hospital departments was also noted here. Two of this group were

concerned about how they would be able to arrange asking the question whilst the patent's partner was present.

> *Privacy to ask questions. Our unit may have to look into this.* (Gynaecology – 045)*)*

> *Lack of privacy at times. Lack of time – focussing on giving practical care if child is very sick.* (Child health - 050)

> *On the wards there may be a problem with finding somewhere private to ask such questions, i.e. woman may be in a four-bedded room. (Maternity - 011)*

> *Practical – women always in clinic with partners. (Maternity – 020)*

> *Asking patients about domestic violence, although appropriate to GU clinics may prove to be very time consuming in an already pressurised service.* (GU clinic - 057)

Other concerns, noted by a small minority, included:

- Disclosure may raise child protection issues. (n=3)

> *Children will be involved in the relationship, which will make any disclosures a child protection issue.* (Child health - 050)

> *Concerned regarding immediate disclosure to Social Services if children involved. May nullify any confidence client has in confidential status.* (Occupational health – 054)

- Asking the question may not be as 'straightforward' as the procedures suggest. (n=2)
- Patients may be unwilling to disclose domestic violence. (n=2)
- It may be difficult to gain the confidence of patients so that they feel willing and able to disclose. (n=1)

> *There is potential to upset the client, therefore will impact on the relationship between client and midwife.* (Maternity - 019)

> *I don't think it is as straightforward to put this question to a woman with whom you have not necessarily developed a trusting relationship. (Maternity - 002)*

> *Difficulty with referring disclosure. Trust issues in partner/patient/professional liaison.* (Maternity – 012))

> *Each situation is different and set procedures may not be appropriate. I feel guidelines are more effective.* (Paediatrics - 025)

Additional issues raised by one respondent each were: screening for domestic violence is 'unknown territory'; 'the training was some time ago and they feel the need for a 'refresher''; 'EIP is not a 24 hour service and therefore will not always be able to respond to disclosures' and 'how to handle a disclosure where the patient insists it is done in confidence'.

A total of five respondents expressed unease either with the procedures for recording disclosures of domestic violence (n=3) or how to access information about EIP (n=2).

When asked about EIP itself, 96 per cent (n=68) respondents stated that they understand its functions having completed the training session, and 82 per cent (n=58) believe that it will contribute to better responses to domestic violence. Many were extremely supportive of the Project, and showed a strong awareness of the importance of early intervention, as the following extracts suggest.

> *Having someone on site who is aware of the help available to these women and can help women access, this will be very good – they will then be more likely to disclose domestic violence.* (Maternity – 011)
>
> *It can give immediate help and advice to victims without immediate threat of police involvement.* (Fracture Clinic – 036)
>
> *Knowing where and who to refer to, has been the key for me. Talking to one of the team from EIP has made it all less daunting. The victims deserve help as human beings and they may not be in a position to help themselves.* (A&E - 037)
>
> *Early intervention on any serious issue, especially domestic violence, can prevent, contain, address the matter before it can have far-reaching effects on the abused and the extended family unit long-term.* (Ante Natal Centre - 023)
>
> *I think EIP will be a very good service for the women of Portsmouth, as up until now I don't think we have been very pro-active in identifying and helping women suffering from domestic violence.* (Maternity - 011)
>
> *I'm very positive about this Project. I think this is a long-awaited improvement in services to women.* (Maternity – 035)
>
> *There is immediate help for the sufferer and a safe haven. It would make me feel able to help in a very positive manner.* (HATC - 042)
>
> *It is a first port of call. Women can be contacted when they want, at a convenient time.* (Unknown – 049)
>
> *They are able to support victims and staff.* (Paediatrics - 051)
>
> *Anyone in need of protection from domestic violence will be encouraged to take the first steps in finding help and support.* (Gynaecology - 053)
>
> *Up to date and expert information, advice and general listening time related to domestic violence. Time to give individuals support without direct intervention while they decide what they want.* (Nelson substance misuse residential clinic – 062)

Seventeen per cent (n=12) were unsure or did not think that EIP would contribute to improved responses. Most of these responded in this way because they did not think that patients would be willing to disclose, had reservations about asking the question, had no experience of EIP itself or were concerned about already overstretched health staff.

> *Will women admit to domestic violence just like that? I wouldn't admit it unless possibly at death's door. This is a secretive business.* (Maternity - 009)
>
> *I do not think that it is an easy subject to broach. I do not think this short session was actually enough to give most midwives the skills necessary – unless they know the woman well, have*

her trust. It is so important to build the trust first – that is not possible on a first meeting. (Midwife - 005)

Will we have time to enable women to feel comfortable with disclosure within Maternity Services? (Child Health - 013)

I feel I will have to use the service first to see if it works. (Women & Child health - 039)

Due to staffing levels, the midwives aren't covering basic work relating to obstetrics, so I'm not sure referring women will always happen. (Maternity - 055)

Eighty-six per cent (n=61) respondents anticipated no difficulties in liaising with EIP. However, it is worth noting that of the ten per cent (n=7) that did, all noted that this is because EIP does not offer a 24-hour service with one respondent also noting that they did not know where on the ward information about the project was kept. When asked to comment more generally at the end of the questionnaire, many more respondents made this point, which is clearly a significant concern.

A much needed service, which should have good funding for a 24-hour service. (Service Planning - 014)

We definitely need a 24-hour service within EIP – we are just as busy in A&E early evening / at night as we are in the day. I hope we can continue to have the funding for the EIP. (A&E - 037)

More information should be given on EIP. There should be a 24-hour service for clients suffering from domestic violence (i.e. EIP). (Maternity - 034)

When given the opportunity to comment openly, (taken by 37 respondents) many were very positive about the training, its impact on their knowledge about domestic violence, but also felt that it was too short and called for further sessions.

Training was excellent in time given. However we just skimmed over things because of time constraints. This subject should be taught as a one or two-day course, plus more emphasis put on helping patients disclose and what services are available. I found staff are not too confident in these areas. Apart from that I enjoyed it! (A&E - 029)

I feel that a longer session would be more helpful, to help health professionals come to grips with this enormous and sensitive subjective matter. I felt 2½ hours only gave you a broad view of things. I also found this newfound skill of great benefit to my work in the antenatal area – so more updates and training please – I welcome this initiative. (Ante Natal Centre - 023)

The training was very short. Have completed domestic violence screening training in a different Trust which gave me more confidence / awareness of domestic violence. (Women and Children's Health - 007)

Further training – I find it a lot easier to talk about HIV, Hep B, drugs and sexually transmitted diseases – because I have had much more instruction – not just a couple of hours. (Maternity - 005)

I thought the training was very useful and important and should be repeated so that staff can refresh knowledge and practice case studies etc. (Child health - 050)

> *I was amazed at the numbers quoted to us and about all aspects of domestic violence. It also made me aware how many women I must have come across that were suffering from some form of abuse and I was totally unaware. I will certainly keep my eyes and ears open now.* (Gynaecology - 045)

> *I have not had to deal with clients experiencing domestic violence, i.e. I have not encountered anything to make me suspicious of domestic violence. I imagine dealing with it for the first time could be daunting. Today's session has given me the confidence should I encounter it.* (Dermatology OPD – 060)

> *I think the training was informative in the time given and I was able to take away the practical information about the EIP to pass on to my colleagues. I would like to have had a longer training session in order to cover some of the topics touched on in more depth.* (Nelson substance misuse residential clinic – 062)

> *The training session could have been longer to allow for more discussion and sharing of experiences when dealing with domestic violence. Otherwise very informative*. (Maternity – 070)

> *The training helped me identify and explore issues which may act as a barrier to disclosure. Having the opportunity to share these things with colleagues was instructive*. (Nelson substance misuse agency – 068)

There was only one respondent who were extremely unhappy about the training, reporting that no information on the project itself had been given early in the training session and that both the group work and handouts were "useless".

Other respondents had some more general suggestions to make about healthcare responses to domestic violence.

> *I think training should be given to all healthcare workers working in appropriate areas, as I had never heard of the Early Intervention Project before attending this course. I found the course enlightening and I now know how to approach this difficult area and who I should contact with any concerns I may have.* (Fracture Clinic - 036)

> *This should be part of the Maternity Statutory Training – essential for all to understand. The aims and objectives of the programme need to be more available to get everyone involved.* (Maternity – 033)

> *Does the Trust think this awareness teaching should be included in the mandatory training programme? If not, they should consider It, as this is not a problem for A&E alone to be aware of.* (Clinical Governance – 067)

Summary

- The training is increasingly attracting participants from other departments in the hospital and from external agencies;
- The majority of training participants noted that the training had fulfilled its objectives and provided participants with the skills to screen for and respond to domestic violence;
- Roughly one third of participants raised concerns about practical difficulties in relation to screening, notably lack of privacy and time in busy hospital departments;

- Almost all training participants reported that they understood the services EIP could provide and were supportive of the Project;
- A number of participants recommended expanding the availability of training to include other health professionals.

5.2 Health professionals experiences of screening for and responding to domestic violence

A questionnaire was distributed to hospital staff who had previously undergone training roughly six months later to determine how confident staff were at implementing screening procedures and referral processes. Forty-seven questionnaires were been returned. Of these 15 were from health professionals in the Maternity department, three from Accident and Emergency, two each from the Paediatrics and Gynaecology departments and one each from Intensive Care, Community, Health Promotion and Women and Children's Health. Twenty-one respondents did not record their department. Almost all of these respondents (94%, n=44) had received the 'Handing Disclosure' training, but only 26 had returned a completed training evaluation questionnaire, with seven noting they had never received it.

- Only a small minority of health professionals who answered the question stated that they 'always' ask patients about domestic violence (9%, n=4)– all work in the maternity department and all four noted that they screen 100 per cent of their female patients.
- A further 13 per cent (n=6) 'usually' ask. Forty per cent (n=18) stated that they 'seldom' asked with 38 per cent (n=17) 'never' asking.

Those who only 'seldom' or 'never' asked, gave a range of reasons why they did not routinely screen patients for domestic violence.

- they have not yet identified any suspected cases' or that 'had not been relevant' (n=7);
- they had not received any training or thought their training had been insufficient to equip them to follow the screening procedures (n=3);
- no opportunity to ask clients alone on the labour ward (n=2);
- dealing with incubated patients (n=2);
- not always applicable (n=2);
- not come up in conversation (n=1);
- lack of confidence to deal with any issues that arise (n=1);
- work in a very small unit (n=1);
- feel uncomfortable (n=1);
- as counsellor, not appropriate to raise it – must come from the patient (n=1).

In addition, a small number of respondents are working in roles where patient contact is either nil or negligible. These returns illustrate that procedures for screening are not yet being used routinely and that a number of staff are still uncomfortable or feel unskilled. This latter point was also made by staff during focus group interviews (see Section 5.3)

Apart than the four staff from the maternity department who routinely screen all their female patients, 16 respondents screen between 1 and 85 per cent of female patients. One respondent noted that they screen 15 per cent of their male patients for domestic violence. The largest group screened overall are females suspected of being victims of domestic violence – screened by 20 of the 22 respondents who answered this question. Five respondents screen all women aged over 16 who are not seriously ill and do not have serious mental health problems. Where known, three of these respondents are from the Maternity department, with one working in Gynaecology. In addition five of these respondents also

screen men they suspect are experiencing domestic violence. Here, two respondents work in the A&E department, and one Gynaecology. The departments of the other two respondents are not known. One respondent also screens where they perceive signals suggesting other forms of abuse.

- In contrast to what has been said by service users (see Section 5.5 below) the majority of health professionals (34 per cent, n=16) report that it is they that first bring up the subject of domestic violence.
- A further five respondents note that it is usually the patient.
- 'Someone else', and 'it depends' was noted by two respondents.

Only 24 respondents gave information on when they ask patients. The largest group here (n=12) do not do so, either at triage (only done by 2 respondents) or at first booking/appointment (done by 10 respondents). The 'other time' used by the largest group here varies, with a range of possible times recorded**.** Of these 24 respondents, we have information on their hospital department for 14. The largest group here are from the Maternity Department (n=7) with two each from A&E, Paediatrics, Gynaecology and one from Women and Children's health.

- whenever it feels right/appropriate (n=5);
- when able to see woman on her own (n=3);
- if presentation suggests domestic violence is involved (n=2);
- when have built up trust (n=1);
- during physical examination (n=1);
- during post-miscarriage counselling (n=1).

Again, this suggests that screening procedures are not being routinely followed, although these is some evidence that, of the two participating hospital departments, Maternity and A&E, screening is more likely to occur within the former. It is also interesting that some respondents from other departments, after training, have instigated routine screening. This suggests that the training has provided these respondents with the necessary level of confidence.

- Almost two thirds of respondents who answered the question (64 per cent, n=30 of 44) felt either 'very' (n=7) or 'quite' (n=11) comfortable or 'ok' (n=12) asking patients about domestic violence.
- However, 30 per cent (n=14) felt 'quite' (n=11) or 'very' (n=3) uncomfortable.

Of this latter group, eleven gave a wide range of reasons why they were not comfortable asking the screening questions. These included:

- find it difficult (n=2);
- embarrassment for patient (n=2);
- inexperience (n=2);
- too many other people around (n=1);
- time is a problem (n=1);
- may not be able to deal with patient's reaction (n=1);
- need more training/no training (n=1);
- intrusion into patient's private life (n=1);
- embarrassment for self (n=1);
- invasive (n=1);
- hostile response from patient (n=1)**.**

Confidence levels amongst staff were higher than levels of "comfortableness" with 77 per cent (n=36 of 46 who answered the question) reporting that they were either 'very' (n=8) or 'fairly' (n=28) confident asking patients about domestic violence. Of the seven respondents (of 10) who told us why they were not confident 'lack of training' was cited by three with 'in paediatrics, feel should leave to child psychologist to do it'; 'lack of experience of domestic violence'; 'hostile response from patient' and 'never asked the question' all cited by one respondent respectively. Seventy nine per cent of respondents (n=37) noted that there were specific circumstances that made asking the question difficult. Unsurprisingly, the presence of the suspected perpetrator was cited by 90 per cent (n=35) of these respondents with 'lack of privacy' (59 per cent, n=23) and 'lack of time' (51 per cent, n=20) also noted. Other circumstances that can make it difficult to ask about domestic violence included: 'too many people around'; 'possible aggression' and 'not sure what to do'.

Unsurprisingly given the findings above about confidence and comfortableness, the largest group of respondents (64 per cent, n=30) thought that the training they had received had only partly equipped them to ask about domestic violence. A further six said that it had not equipped them at all. Only nine said it had fully done so. However only seven respondents commented on why the training had not fully equipped them:

- the training was not long enough;
- insufficient information;
- boring;
- just not good training.

One respondent noted that 'they did not agree with the ways of being told to ask' outlined in the training.

Fifteen respondents thought they needed additional help in order to equip them to ask about domestic violence. These included:

- a direct number to refer to;
- laminate card with information on it;
- more training;
- working with/witnessing another professional in that situation first and seeing reactions;
- regular updates and refreshers;
- more practice;
- time;
- privacy;
- more information on services available in Portsmouth;
- resource pack with appropriate forms and telephone numbers always to hand;
- more information from Maternity regarding potential problems;
- posters in wards.

Of the 45 respondents who answered the question, the largest group (66%, n=31) said they had had no disclosures of domestic violence since implementation of the screening protocols. Where known, (16 of 31), the largest group here (n=9) are from the Maternity Department with two from Paediatrics and one each from A&E, Intensive Care, Women & Children's health, Community health and Health promotion. Two disclosures had been received by four respondents (where known, from Maternity), one and three by two respondents respectively (Maternity) and five and seven by one respondent each (Maternity and A&E). Only six respondents thought that the number of disclosures had increased since the introduction of the screening protocols, again where known, the largest group here (n=3) were from Maternity.

- Referral to EIP has become routine as a result of disclosure but other services are also recommended to patients.
- The main referral service here is the child protection section of Social Services, recommended by 12 health professionals.
- Other agencies (noted by one respondent each) included: 'GP'; 'Housing department'; 'Refuge'; 'Relate'; 'Crisis lines'; 'Victim Support' and 'Police'.
- Health professionals here also 'follow-up the patient'; 'arrange to see on a regular basis'; 'offer the support numbers and card'; 'discussion with child protection expert' and 'reassure/listen'.

When disclosures occur this is recorded 'always' (32 per cent, n=15) or 'usually' (9 per cent, n=4). Patient's hospital records are used by the majority of health professionals here, (63 per cent, n=12) with Patient's Details pro forma used by 21 per cent (n=4).

- The majority of respondents (81 per cent, n=35 of 43 who answered the question) are 'very' (n=7) or 'fairly' (n=28) confident about responding to disclosures of domestic violence.

The eight respondents, who said they were not confident, cited:

- lack of training (n=3);
- inexperience (n=2);
- who then to refer onto (n=1);
- not something that happens routinely (n=1);
- confidence will increase with experience (n=1).

Unsurprising again it is the presence of the suspected perpetrator that makes responding to disclosures difficult for health professionals (92 per cent, n=35 of 38 who answered the question). 'Lack of privacy (61 per cent, n=23) and 'lack of time' (47 per cent, n=18) were also again cited here.

- The majority (87 per cent, n=39 of 45 who answered the question) said that the training had fully (n=9) or partly (30) equipped them to respond to disclosures.

Only four respondents said why the training had not equipped them:

- very poor training;
- trainers did not appear confident enough;
- not enough time;
- training a while ago now – need updates.

A quarter of respondents (n=12) said there were other things they needed to help them respond to disclosures. 'Courage'; 'laminated flow chart'; 'more high quality training'; 'constant updating of handling techniques'; 'time'; 'privacy' and 'resource pack to hand' were again cited here.

- According to these respondents, very few patients had been referred to EIP.

In total only 21 referrals had been made. Of these, seven patients had been referred by one respondent, three respondents had referred three patients, two respondents referred two patients and one respondent one patient.

- The referral process was reported as straightforward by all expect one respondent who had made a referral.

- The majority of respondents (79 per cent, n=33 of 42 who answered the question) were well informed about EIP.
- Those who did not think they were well informed wanted more information and time to absorb it.
- Just under three quarters (74 per cent, n=31 of 42 who answered the question) did think that the hospital was the right setting for EIP. A small number (n=4) did note that they thought A&E a more appropriate location that the maternity department.
- Of those who did not think a hospital location was appropriate, a community based service was preferred. One respondent noted that getting to the hospital required a long difficult journey for some patients.
- The profile of EIP was not seen as strong enough amongst hospital staff (61 per cent, n=25 of 41 who answered the question.

There was a very broad range of suggestions as to how the profile could be raised, including:

- regular meetings with ward team/staff (n=6);
- posters on wards for everyone to see (n=5);
- advertising (n=3);
- more training/study (n=2);
- global e-mail to all hospital staff (n=2);
- seminars/open meetings(n=2);
- advertising in The Link (n=2);
- constant reminding to staff (n=2):
- more fliers (n=1);
- road shows (n=1);
- community visits/outreach (n=1);
- section in Cardex to remind staff (n=1);
- more integration (n=1).

- Over half of respondents (57 per cent, n=27) had met EIP workers. One respondent suggested that EIP staff should attend ward/unit meetings.
- Although 94 per cent (n=44) thought EIP is useful to hospital staff only 47 per cent (n=22) though EIP was contributing to a better response to domestic violence.

The reasons given here included:

- give useful information;
- somewhere to refer patients to;
- someone immediately equipped to deal with all the issues involved;
- early help for victims with good advice on options available;
- anything to make staff more aware of domestic violence is a good thing.

Fourteen respondents gave reasons why they were unsure whether EIP was contributing to a better response. These included:

- had no feedback from EIP;
- not enough people aware of it;
- little contact;
- difficult to assess probably;
- not visible;
- never used EIP.

A very long list of suggestions were made to improve the links between hospital staff and EIP. Most of these repeated those made in response to how to raise the profile of EIP within the hospital (see above) with 'regular meetings' being the most popular here.

That EIP is a service welcome by staff is illustrated by these comments:

> *If they help one person, it is one person who has a better life. Maybe even more if children are attached to that person.* (Maternity)
>
> *I just wish this service had been available earlier.* (Unknown)
>
> *It is very useful to be able to refer clients to get appropriate help and support almost immediately.* (Unknown)
>
> *Very helpful, discreet and supportive to clients.* (Unknown)]
>
> *The EIP workers are always approachable and friendly – part of the team!* (Maternity)

In the spring of 2004 a third questionnaire was distributed to all those who had participated on the training. Despite a reminder letter from the PDO, only 13 were returned. As the numbers returned were so low, it is not possible to say whether the information provided is indicative or not of the views and experiences of hospital staff some time after receiving training. It would also appear that at least three of these respondents had attended the most recent training session provided by the PCT.

Responses were received from a member of the: occupational health team; maternity department; adult mental health team; substance misuse team; and a community midwife. A new member of the EIP staff also returned a questionnaire. Unfortunately seven respondents omitted to provide this information. All of these respondents reported that the training had equipped them to ask about domestic violence although one noted that additional training would be useful.

Only two respondents always ask patients about domestic violence with a further three 'usually' asking. Four each either 'seldom' or 'never' ask. There was some indication here that staff working in teams that have on-going contact with patients, such as midwives, mental health, occupational health or substance misuse build relationships with patients which provides possibilities for probing about domestic violence over time.

> *When we have begun to build up a relationship.* (05)[8]
>
> *As client begins to interact*. (11)

Only one respondent here said they were 'quite uncomfortable' asking about or responding to disclosures of domestic violence. Unsurprisingly, the presence of the perpetrator and lack of privacy and/or time were again cited as circumstances that make asking about and responding to disclosures of domestic violence difficult. Where disclosures are received over half of these respondents always record them and the 'patient details pro forma' (n=4) and 'patient's hospital records' (n=5) are used here. Where disclosures were given, over half of respondents would refer to EIP. The concerns here are about access to the Project itself by medical staff based outside of the hospital. Two respondents

[8] As there are only 13 respondents here, and stating which department/team a respondents' comment has come from could lead to identification of an individual, the serial number of the questionnaire has been used as an identifier.

particularly do not think that their department/team have any links with EIP and one said that they 'have no access'. It may be that these respondents are misinformed or do not understand the referral process.

All of those who answered the question thought that the hospital was the right location for the Project, and a presence at QAH was again requested. All though EIP was useful to medical staff, but only six thought the profile was strong enough within the Trust. There was a suggestion here that information about the Project should be on the staff 'intranet' and in the staff newsletter. One respondent noted that the forms about disclosure were not easily accessible to staff in the team.

Summary

- Only a small minority of health staff 'always' ask patients about domestic violence. Over three quarters 'seldom' or 'never' ask;
- Some staff were making decisions on 'relevance' before asking screening questions;
- Despite this, the majority say they are 'comfortable' or feel 'ok' about doing so;
- Where domestic violence has been disclosed, hospital staff report that it was they who broached the subject, in contrast to service users, who say that they did so;
- Where disclosure occurs, referral to EIP has become routine;
- EIP was seen as a useful service by these hospital staff
- Hospital staff do not think that the profile of the Project is high enough within the hospitals.

5.3 Hospital staff focus groups

In order to explore hospital staff experience of using the screening protocols and the referral process to EIP a focus group was conducted with hospital staff in October 2003. Unfortunately, only three members of staff, all from the Maternity department attended. It had been hoped that another focus group could be organised within a few months of submission of the 2nd Interim Report in January 2004. Again it proved extremely difficult to organise hospital staff focus groups and only one, with A & E staff, took place in June 2004.

All three maternity staff, taking part in the first focus group, had undergone the training although two acknowledged that it had happened some time ago and refreshers or updates would be useful. Routine screening was seen as something that should be done within the health service and is of benefit to both adults and children.

> *I think it's actually very valuable. I think within the last decade domestic violence, domestic abuse has actually been more acknowledged as a significant impact within families, of emotional abuse, physical and sexual, … so I think asking the question should actually ensure the children's well-being, so a positive outcome. … Too many serious case reviews have actually recognised the fact that domestic violence has made an incredible impact within obviously the death or significant injuries to the woman or the child.* (FG1)

It was reported here that it is not yet routine for community midwives to screen for domestic violence, but that this will happen in the near future. Midwives are to be issued with a resource pack and it is hoped that all will attend the training.

Staff saw 'fear' as the main reason why someone would not disclose domestic violence but 'trust' was also noted here.

> *I think fear plays a huge part. Fear that the perpetrator may find out. If she's only just met you in Accident and Emergency, she may not have built up a trust with you yet. But hopefully by somebody actually asking the question she may come back to you at a later date, if she doesn't feel that she can answer honestly at that point.* (FG1)

Echoing the findings from the Health Professionals Experiences of Screening for and Responding to Domestic Violence questionnaire, the presence of the suspected perpetrator, lack of time and lack of privacy were all seen as impediments to routine screening. It should be noted that both 'lack of time to ask the question' and 'lack of time to sit and listen/discuss' were concerns here. Safety for staff, particularly for those working in the community was raised in this focus group. There was agreement within the group that there were differences for staff working in different situations. Within A&E there may only be one occasion when it is possible to ask the question. Whereas community midwives are working over a period of time with a patient and in those cases asking the question may not need to be done immediately but when trust had been built between the midwife and the patient. This recognises that staff have to balance risk with building trust.

> *It might not be that you follow it all through on the first occasion, you might get a relationship with that person and then ask the pertinent question, but you have a realisation there could be something that is going on. Until you've actually got more of kind of like a feel for the situation, that client knows you, the trust factor is there. So you may not ask that question the first time, you may leave it to the next occasion. It's all about risk and risk management.* (FG1)

> *It becomes increasingly difficult, because I remember then having the husband with the wife and I wanted to ask the question, but couldn't do it, and he was very – it was really difficult. [He spoke for her] all the time. In the end I think I had to ask him to leave. ... But I really felt pressured to think on my feet how am I going to get him out of the room to be able to ask her while she's on her own. I was certain that she'd denied it before*. (FG2)

It was thought that patients being made aware, as they are in relation to HIV, that screening for domestic violence is a routine part of patient assessment, would make it easier both for staff and patients. It could also ensure that the question is asked on multiple, rather than single occasions giving multiple opportunities for disclosure.

> *I think also, as a community midwife you will look after women time and time again, and I think again you're going to have to not assume that things are the same as they were last time. That you have to ask again say "Well can you remember me asking you last time, if we start, it's still routinely part of it, we'd like to ask you again." Because I mean last time round she may not have wanted to disclose, but this time she might want to.* (FG1)

This group of staff did note that there were problems with implementing routine screening within the A& E department due to reorganisation and significant staff changes. Staff changes were also cited as a concern in other departments. Training for new staff and refreshers for existing staff were again mentioned here. It was also though that once a significant number of staff within any department were routinely screening for domestic violence this would impact on new staff and screening would gather momentum and become routine.

It is interesting to note here however, that there were clear differences with the responses between the staff from Maternity and those taking part in the second focus group, all from the A&E department. Whilst one participant here, of four, routinely screened, the others did not. This highlights the necessity of ensuring new staff attend the training, and this group of staff would prefer that attendance was mandatory rather than voluntary as it is currently. None of those who did not routinely screen had undergone the training. They were aware of the Project, and, if they obtained a disclosure of domestic

violence, referred to EIP. The participant who did routinely screen made the point that they have a responsibility to ask the question:

> *I don't think it's our responsibility to talk to them about it at length … I don't think that's an issue, I think if you feel comfortable, that's good, and if I felt comfortable with a certain person then it's good if it's going to help, but I do think it is our responsibility to ask the question whether you feel uncomfortable or not … [patient] shouldn't be denied that service [EIP] because I'm embarrassed or feel awkward about it.* (FG2)

In contrast to the responses from the first focus group, the second did not think that screening had become embedded as a result of either the number of staff who had attended the training, nor the length of the time the Project had been in operation. In fact, the reverse was seen to be the case, with enthusiasm and determination on the part of newly trained staff to implement routine screening waning over time. What was clear however, was that when a patient arrived in the A&E department with injuries known to be the result of a domestic violence incident, or where a disclosure was given/obtained referral to EIP was automatic.

Some medical staff, particularly midwives, had raised the issue of child protection proceedings hampering disclosure. It was noted that whilst some victims may be concerned that disclosing could raise child protection issues equally disclosure could be seen as the first step to protecting any children. Raising the issue of the possible impact of domestic violence on children could also help victims take the first step towards seeking help.

> *It may be an issue that the women feel that they don't want to disclose because of that fear, and then I think that the women that are disclosing are getting to a point where they realise that they have to do something for the safety of their children. And maybe when you're asking the question you need to actually say that one of the reasons for asking the question is because domestic violence has a negative impact on children, and actually children can become at risk, so that hopefully they do start to think about what they're doing and what they're saying.* (FG1)

> *You have to say to them you appreciate their problems and you'll do EIP, but you also have to do the social service referral, and so that's quite hard at building up the trust, because you're – you're trying to show that you care, but then they think you're stitching them up with the social service, so it's hard, so I always offer EIP first, because once you mention social services you can upset them.* (FG2)

It was seen as vitally important to reassure women that involving child protection was not about removing children but about trying to ensure that she and the children are going proper and appropriate support.

These staff members did think that there was general support from medical staff for EIP and for basing it within the hospital. They also thought that the profile of EIP is improving within the hospital and that staff are generally well informed about the services EIP can offer.

> *For me as a nurse I appreciate it 'cause it gives me back-up and support for when I don't know where to go, but more importantly it gives that to the patient as well.* (FG2)

> *You can say that they're completely confidential, they're non-judgemental, they're not from social services, they're not criminal, there's going to be no records held against you, they're there as a support. And I think that's what makes them work, is the fact that they can't be threatening to anybody, can they?* (FG2)

The major recommendation from the second focus group, was for 'refresher' sessions. These would be useful for staff who had undergone the training and could also draw in new staff, particularly as there is a high turn over of staff in the departments and different shift patterns. A 'drop-in' session in the various departments, either over the lunch hour or in the late afternoon was seen as a possibility here. A request was also expressed for some general 'feed-back' from the Project about the outcomes of cases, particularly where patients have benefited from referral to EIP and for information on services, if any, for perpetrators.

> *It's always nice to hear if you've got success stories. Do you know what I mean? 'Cause we don't hear anything, we do our form, and if it's the working hours we might get them up, and then it just vanishes, doesn't it? … So it'd be quite nice to hear some outcomes. Yeah. 'Cause then that makes it more positive to be filling in the forms, as well. If you think that it's doing something.* (FG2)

Summary

- Compulsory training for new staff, 'refresher' sessions and/or drop-ins were recommend by focus group participants;
- Participants who had undergone the training supported routine screening but confirmed that it has not become routine, particularly within A&E;
- Similar barriers to screening identified by hospital staff questionnaire respondents were also noted here: fear, lack of experience, presence of the perpetrator and lack of time and/or privacy;
- All staff who participated were aware of, appreciated and supported the continuation of EIP.

5.4 Database - disclosures and service use

An anonymised version of the EIP database was provided to the evaluators for analysis on the 14th July 2004. The first referral date entered on the database was on 12/08/2002 and the final contact was made on 13/07/2004.

5.4.1 Disclosure and referral

The database contains 349 clients who had disclosed domestic violence. Of the 349 who had disclosed, EIP had had at least one contact with 259, which had resulted in a total of 1,713 separate contacts. Fifty four per cent (n=140) of the 259 clients had disclosed within one of the participating hospital departments and of these 44 per cent (n=113) were identified via screening in Accident and Emergency. Thirty-nine per cent of clients (n=102) had been referred via the police, whilst seven per cent (n=17) had been referred via other sources. All male clients were referred via A&E. Of the clients referred via the police, 29 were also referred to hospital departments. Two of the self-referring clients were also referred to a hospital department. Two of the clients referred via a refuge and the client referred via her GP were also referred to participating hospital departments. In total, two thirds of clients (67 per cent, n=174) had contact with participating hospital departments.

Table 5.4.1 – Referral Route

Referrals	N	%
A&E	113	44
Maternity	21	8
*Other hospital	6	2
GP	1	0

Self	10	4
Police	102	39
**Other	6	2
TOTAL	**259**	**100**

* O&G (3), Critical Care (1), Mental Health Team (1) and Ella Gordon Unit (1)
** EIP (1), Housing (2), Refuge (3)

Over half (54 per cent) of those who disclosed did so in a participating hospital department and most (44 per cent) were identified via screening in A&E. This is a particularly encouraging figure given that EIP is not actually based within or on the same site as this department. A large majority of those who disclosed via one of the hospital departments, 89 (64 per cent) referred themselves to the hospital.

Of the 174 hospital referrals (including 140 direct hospital referrals and 34 subsequently referred to hospital departments) the services of EIP were offered to the clients by hospital staff in 86 per cent (n=150) of cases. Of the 17 cases where it was not offered:

- no reason was given in 15 cases;
- one patient was too ill;
- one patient had left the hospital before she could be offered the service, however she was offered the services of EIP at a later date and requested contact immediately;
- no data available for six cases.

Table 5.4.2 below illustrates patients' responses when asked by hospital staff if they wished to have contact with EIP.

Table 5.4.2 – Patient Response to Offer of Contact with EIP

Whether/When Patient Wants Contact with EIP	N	%
Yes immediately	105	60
Yes at a later time	40	23
Maybe at a later time	0	0
Will contact in own time	1	1
No	2	1
Missing data	26	15
Total	**174**	**100**

At the time of the first interim report, the majority of clients (78%) had heard about the existence of EIP from a member of hospital staff. The report suggested that, over time, it was likely that the other sources mentioned, such as a relative or friend, the police, the refuges, and the local Domestic Violence Helpline would increase as a source of information about EIP, as knowledge spread locally and among specialist services. This has proved to be the case. As of 20th January 2004, the date of the second interim report, 50% of clients (n=92) had heard of EIP via hospital staff (a decrease in percentage terms of 28 per cent). Other sources included: the police (32 per cent, n=60), via relative/friend or a refuge (2 per cent, n=4, respectively) and a domestic violence helpline (n=1). Data is missing for 24 clients.

This pattern has continued with those clients learning about EIP via hospital staff dropping to below half (47 per cent n=123) as of 14th July 2004. The proportion learning about the project via the police has remained relatively static (31 per cent, n=80), as had other sources (friends/relatives n=5, a refuge or housing organisation n=2 respectively, domestic violence helpline or social services n=1 respectively). Data is missing here for 45 clients. With the establishment of the Project in an additional setting (the Civic Centre) and funding being provided by the Homelessness Directorate, it is likely that referral from outside of the Heath Trust is likely to grow.

5.4.2 Demographic data and history of abuse

- Ninety six per cent (n=250) are female[9], three per cent are male (n=8), and there is missing data for one.
- The youngest was 16 years old at the time of disclosure, and the oldest was 68, with 54 per cent (n=140) between the ages of 20 and 39, (data is missing for 45 clients).
- The vast majority are 'White British' in ethnic origin – 65 per cent (n=168), (data is missing for 63 clients).
- Sixty seven per cent (n=173) have children, and of this group 66 per cent (n=115) have more than one child.

No one disclosed that they have experienced violence from a 'new' perpetrator – i.e. someone different from the perpetrator disclosed at a previous contact. However, two young women, still living at home with their family, did disclose experiencing violence from both their brother and their father.

The vast majority of perpetrators were male – 95 per cent (n=246), four per cent (n=11) were female and there was missing data about the gender of the perpetrator in two cases. Of the male perpetrators:

- Fifty nine per cent (n=145) had committed violence against current partners (144 female and 1 male);
- Thirty four per cent (n=84) against female ex-partners;
- There was missing data regarding the relationship of eight male perpetrators.

Of the female perpetrators:

- seven had committed violence against their current male partners;
- two against female ex partners;
- one against current female partner ;
- one against her mother.

Consistent with other research (Walby and Allen, 2004) that demonstrates that ending the relationship does not necessarily end the violence, high levels of post separation violence was recorded amongst these service users (34 per cent where the perpetrator/client relationship is known).

Table 5.4.3 – Relationship of Perpetrator

Relationship	N	%
Current spouse / partner	154	59
Ex spouse / partner	87	34
Other family member(s)	10	4
Missing data	8	3

[9] All percentages are rounded to the nearest whole number.

Total	**259**	**100**

All five of the clients who had made contact with the Project over 50 times said that the perpetrator was either a current or ex male partner or spouse.

It is also worth noting here the fairly broad spread in terms of the length of these violent relationships, as highlighted in Table 5.4.4.

Table 5.4.4 – Length of Relationship

Length of Relationship	N	%
Less than 1 year	14	5
1 – 5 years	91	35
6 – 10 years	41	16
11 – 15 years	20	8
16 – 20 years	18	7
Over 20 years	8	3
Missing data	67	26
Total	**259**	**100**

The EIP Database records a wide range of information about the nature of the violence being experienced by those who disclose. Table 5.4.5 below illustrates the different combinations of violence reported. It is interesting to note that 49 per cent of those who disclosed reported experiencing both physical *and* emotional abuse – a pattern that reflects the reality of domestic violence. However, this table also highlights the rather limited disclosure of sexual violence (reported only by eight per cent, all female).

Table 5.4.5 – Type of Abuse / Violence

Type of Abuse Reported	N	%
Physical and emotional abuse	127	49
Physical abuse only	71	27
Emotional abuse only	31	12
Physical and sexual abuse	5	2
Physical, sexual and emotional abuse	10	4
Sexual abuse only	2	1
Sexual and emotional abuse	4	1
Missing data	9	3
Total	**259**	**100**

Six of the male clients reported physical and emotional abuse and one physical abuse only. Of the 11 female perpetrators, eight were reported to have used physical and emotional abuse, although one was said to have used intimidation through "Standing in very close proximity to client and following her, not

leaving her alone". One was reported to have used physical abuse only and two were reported to have used emotional abuse only.

Of those clients where data was recorded, (n=188), almost two thirds (61%) reported that the violence had happened 'constantly' or 'often'.

Table 5.4.6 – Extent of Abuse / Violence

Extent of Abuse/Violence	N	%
Constant / Often	115	44
Occasional / Once	73	28
Missing data	71	27
Total	**259**	**100**

Of those clients who had reported the frequency of violence (n=111), fifty three per cent (n=59) reported that they had experienced only one or two violent incidents over the previous twelve months with 47 per cent (n=52) reporting more than two violent incidents over that period.

Thirty-four per cent (n=87) stated that they had only attended A&E once over the previous twelve months as a result of the violence with an additional five per cent (n=12) having done so more than once. Table 5.4.7 below demonstrates that the majority, where known, (48 per cent, n=125) of those experiencing violence had done so throughout their relationship.

Table 5.4.7 – History of Abuse / Violence

History of Abuse/Violence	N	%
Throughout	125	48
Recently only	52	20
Unsure	1	0
Missing data	81	31
Total	**259**	**100**

Table 5.4.8 below, brings together the information about police and criminal justice system involvement, and illustrates the process of attrition whereby, although the police were involved in 196 cases (76 per cent of EIP clients) only 17 per cent (n=34) of these resulted in a prosecution.

Table 5.4.8 – Criminal Justice Involvement

Involvement of Criminal Justice System	N	%*
Police ever involved	196	76
Perpetrator ever arrested	65	25
Perpetrator ever prosecuted	34	13

* percentages based on whole sample of 256

Of the 34 where the perpetrator was prosecuted, 33 were male with one female. Fifteen of these 34 perpetrators were reported as being 'often' violent, with 19 reportedly subjecting clients to a history of abuse throughout their relationship.

5.4.3 Service use

As noted in Section 5.4 above EIP had had at least one contact with 259 different clients by the 14th July 2004 – and in total had 1,713 contacts with these clients. Two hundred and seven of the 259 clients made contact with the Project on more than one occasion resulting in 1,406 (82 per cent) repeat contacts. One client made contact with the Project on 78 separate occasions over a 12-month period. However, the average number of contacts per client is skewed by five atypical clients who have had over 50 separate contacts each, amounting to 26 per cent of the total number of contacts. From interviews with Project staff it is clear that cases which: involve clients who need re-housing; and/or where social services are involved due to child protection issues; and/or either the client or the current/ex partner has drug or alcohol problems and where staff may need to liaise with a number of different agencies, can take enormous amounts of time and result in multiple contacts with a client. It is interesting to note that one Project worker estimates that roughly half the client group have a drug and/or alcohol problem and that this rises to three quarters of current/ex partners.[10]

Table 5.4.9 below shows that the more 'typical' EIP client has had between one and seven contacts. Just over half of these clients (54 per cent, n=139) had more than one contact with EIP.

Table 5.4.9 – Number of EIP Contacts per Client

Number of Contacts	N	%
1 – 5	183	71
6 – 10	38	15
11 – 20	24	9
21 – 50	9	3
51 – 60	2	1
Over 60	3	1
Total	**259**	**100**

The strong pro-active approach taken by EIP staff to client support, evidenced by 90% of contacts being initiated by them at the date of the second interim report, has continued. Ninety per cent (n=233) of the 259 contacts to date were initiated by EIP staff. The additional 10 per cent, (n=25), were initiated by the client. Data is missing for one client. EIP staff taking responsibility for initiating contact was appreciated by all service user research participants and echoes findings from evaluations of other advocacy and outreach projects (Kelly and Humphreys, 2001).

Eighty-two per cent (n=213) of all contacts took place over the telephone and 17 per cent (n=45) were face-to-face. Data is missing for one client. The high levels of telephone contact may be explained by

[10] There is a growing body of evidence about the links between domestic violence and substance misuse. For more information see: The Stella Project. Separate Issues Shared Solutions. Exploring positive ways of working with domestic violence and substance misuse. Report from the Launch of the Stall Project 2 December 2003. Greater London Domestic Violence Project, May 2003.

the lack of facilities available to EIP staff, during the period of the evaluation, to see clients in person, and the sometimes complex or time-consuming arrangements required to find safe locations to meet with clients both within and away from the hospital sites. However, it should also to be noted that EIP staff report that the difficulties involved in ensuring that conversations conducted on the telephone remain confidential in an extremely small office contributed to staff trying, where possible, to meet clients face to face (see Section 4.3.1).

EIP staff contacted or attempted to contact six individuals who chose not to take up any of the services on offer. Two were un-contactable after repeated attempts, and another did not have any safe contact details. Two felt that they did not need any support at the time. A fifth was 'concerned about a child protection referral'.

Both interim reports indicated that the EIP database collects information about the violence witnessed or directly experienced by any children present in the client's home and that it was significant that this is something that has gone largely unrecorded in some agencies providing services to victims of domestic violence despite the numbers of service users who do have children. Two thirds (67 per cent, n=173) of the 259 clients had children. Twenty-eight per cent (n=48) of this group of clients reported that children had witnessed violence. An additional seven clients, who said they did not have children, also reported that children had witnessed the violence. Fourteen children, all of who had witnessed violence had also experienced violence themselves. Twelve per cent (n=30) female clients disclosed experiencing violence during pregnancy. All but one had experienced physical abuse, eighteen had also experienced emotional abuse and one had experienced physical, emotional and sexual abuse.

However, the non-response rate to these two questions was in the range of seventy per cent. We cannot say with certainty why data collection is so poor on this aspect, but wonder if Project staff, who routinely inform clients of their child protection obligations, are reluctant to ask these specific questions, aware that fear of child protection concerns may deter women from seeking further support.

There is now a large body of evidence about the impact on children of living with domestic violence and the necessity for forms of support designed to respond to their needs (Mullender et.al, 2002). A number of EIP clients, in service user interviews, expressed concerns about the impact of the violence on their children.

The fact that 12 per cent of EIP clients did disclose domestic violence during their pregnancy reinforces the argument made by Hunt and Martin (2001) that maternity staff, and midwives in particular, need to be alert to this possibility. They recommend that all pregnant women are screened for domestic violence and that the question should be asked in a straightforward manner:

> We believe that the simple question 'Have you been hit, slapped, or hurt in anyway in this pregnancy?' is the most appropriate question to ask all women. (pg.137)

Those clients who did take up the services of EIP were asked at each contact about their intentions with regard to their current situation. Clients often reported the same intention more than once or reported a number of different intentions during one contact. As is evident from Table 5.4.10 below, the intention of the majority of clients was quite a basic one – simply to find support. It is also interesting to note that a significant proportion of clients were intending to find a way to leave their violent partner, rather than remain in the relationship.

Table 5.4.10 – Clients' Intentions

Intentions	Intentions N	Intentions %	Clients N	Clients %*

To find support	1,418	48	219	87
To contact EIP	5	0	5	2
To stay separated from perpetrator	521	18	93	37
To leave	113	4	50	20
To get a Protection Order	95	3	42	17
To get perpetrator excluded	114	4	57	23
To keep perpetrator excluded	372	13	85	34
To end the violence	33	1	25	10
To prosecute perpetrator	33	1	14	6
To stay with perpetrator	160	5	69	27
To make contact with perpetrator	7	0	7	3

* based on 251 clients where data available

One of the most interesting findings here is that very few EIP clients, (6 per cent, n=14), intended to pursue a prosecution of the perpetrator.

Table 5.4.11 below details 'need' as identified by clients. A total of 5,373 'needs' were noted by 255 clients – an average of 21 per client. Almost all clients cited 'support' and 'information' as their main needs here (96 per cent and 91 per cent respectively) and in line with the large number of clients who intended to get away from their violent partners (see above), it is perhaps not surprising that such a large number cited safety/protection as one of their needs. It is evident that the vast majority of EIP clients have needs that are ongoing, rather than simply 'one-off', and the type and level of support being provided by EIP staff certainly reflects this.

Table 5.4.11 – Clients' Needs

Stated 'Need'	'Need' N	'Need' %	Clients N	Clients %*
Support	1567	29	244	96
Information	1261	23	232	91
Safety/Protection	688	13	192	75
Housing	436	8	123	48
Legal Action – Civil	356	7	103	40
Financial	253	5	97	38
Custody/Access	276	5	69	27
Legal Action – Criminal	235	4	85	33
Mental Health	159	3	60	23
Physical Health	112	2	57	22
Military issues	2	0	2	1

* based on 255 clients where data available

Services to clients by EIP staff directly reflects the 'needs' identified by them, with 'information' and 'support/listening' the most provided forms (96 per cent and 94 per cent respectively). During the period of the evaluation, 257 clients were provided with 5,150 forms of support from EIP, with many receiving the same type of support more than once. Liaison with other agencies and safety planning continue to be used by a large number of clients. What this table does not properly account for is the referral and accompaniment services provided by EIP that are more fully recorded separately, see Table 5.4.13 below.

Table 5.4.12 – Support Provided

Stated 'Need'	'Need' N	'Need' %	Clients N	Clients %*
Information	1393	27	247	96
Support/Listening	1521	29	241	94
Explanation of Options	1111	22	234	91
Liaison with Agencies	387	7	117	45
Safety Planning	324	6	140	54
Referral	162	3	86	33
Accompaniment	88	2	43	17
Court Accompaniment	91	2	33	13
Advocacy	22	0	16	6

* based on 257 clients where data available

A major strand of the work undertaken by EIP staff was, and remains, referral of clients to other appropriate agencies. Eight hundred and forty two referrals have been made on behalf of 162 clients, an average of five per client. However, it should be noted that this varies widely from one referral for one client to, in one case, 94 referrals on behalf of one client alone. These included referral to: housing authority (n=26); social services (n=16); solicitor (n=10) and the police (n=9), all over a nine-month period. This level of input by EIP staff required by this one client indicates the unpredictable nature of client support.

It is worth noting here that not all of the work undertaken by EIP staff is recorded by the database. Therefore, project staff developed their own record-keeping tools, which give a more complete picture of the work undertaken to support each client. Staff have highlighted, for example, the number of telephone calls they may make that result in no contact with a client (n=330 to date, see Appendix A), and the number of calls they need to make and receive when seeking information for a client, referring them and acting as advocates on their behalf. Staff have kept information about each of these calls – 1559 made or received to date in total – see Appendix A. It is suggested that these, and other similar records that staff keep, are important in terms of being able to accurately quantify all of the work that EIP does. Again, Appendix A illustrates that there are some very 'high use' clients. Although the average number of calls per client is six, 14 clients account for over 20 calls each, and of these, three for over 50 calls each with one of this latter group accounting for 184 calls.

Table 5.4.13 below illustrates the wide variety of agencies clients have been referred to over the course of the evaluation.

Table 5.4.13 - Referrals Made

Agency	Referral N	Referral %	Clients N	Clients %*
Police	91	11	49	30
Solicitor	110	13	42	26
Housing Authority	122	14	40	25
Counsellor	47	6	33	20
Social Services	67	8	24	15
Refuge	71	8	25	15
Benefits Agency	25	3	14	9
GP	20	2	15	9
C.A.B	12	1	10	6

Victim Support	10	1	9	5
Witness Support	8	1	8	5
Local Helpline	7	1	7	4
Women's Aid Helpline	6	1	6	4
Criminal Court	4	0	4	2
Civil Court	2	0	2	1
Family Court	2	0	2	1
Named Nurse Child Protection	2	0	2	1
Mental Health	1	0	1	1
Other**	196	24	78	48

* based on 162 clients where data available
**E.g. community midwife, British Gas, university, passport agency, local rape crisis agency and LEA

Another indication of the level of work undertaken by EIP staff is the accompaniment of clients to other agencies. Table 5.4.14 details the range of agencies involved and that, for some clients, this involves multiple visits.

Table 5.4.14 – Accompaniment to other Agencies

Agency	Clients N	Times N
Solicitor	15	28
Civil Court	12	20
Police	13	16
Family Court	8	15
Housing Authority	9	13
Criminal Court	8	11
Social Services	6	11
Refuge	4	5
Other*	9	14

* This includes: foster carer, GP, train station, psychologist, CAFCASS, women's drop in.

The majority of EIP clients, who were in contact with project staff on more than one occasion (n=207), report that the violence has stopped or decreased. Only 24 clients (12 per cent) reported that violence had increased. These 207 clients account for 1,406 repeat contacts with the project, an average of seven per client, however it should be noted that the number of contacts here ranged from two to over 50. All five clients who had made over 50 contacts each with EIP said that the violence had decreased and then stopped. This demonstrates that the provision of support by the Project greatly contributes to increasing women's safety.

One of the aims of the Project was to reduce repeat visits to A&E as a result of domestic violence related injuries. Of the 113 clients referred by A&E to the Project for this reason, only five made a repeat visit as a consequence of domestic violence after contact with the Project. This represents a repeat victimisation rate of just four per cent. It is impossible to know what the repeat visit rate would have been without the intervention of the Project for this group of clients, however it is likely that at least some of these clients would have sustained further injuries requiring medical attention (Dobash & Dobash, 1985.

Summary

- Just over half of EIP clients were referred from hospital departments, although as noted in Section 4 above, this has dropped to below 50 per cent more recently;
- The overwhelming majority of clients were female, over half aged between 20 and 39 years and were White British. Two thirds have children;
- Forty per cent had been in a relationship for less than five years;
- Ninety five per cent of perpetrators were male;
- Eighty two per cent reported physical violence and for almost two thirds the violence had happened 'constantly' or 'often', for almost half it had happened throughout the relationship;
- Thirty female clients had experienced violence during pregnancy;
- Just over one third of clients had experienced post separation violence;
- The Police had been involved in over three quarters of cases but only a minority (13 per cent) of perpetrators had been subject to a prosecution for a domestic violence related offence;
- The majority of clients (71 per cent) had between one and five contacts with EIP, however five had been in contact more than 50 times, raising concerns about 'heavy need' clients requiring long term support;
- Almost all clients wanted generalised 'support' and 'information';
- There was a very high level of telephone support provided to clients by EIP staff;
- Referral to other agencies continues to be a major strand of the support provided to clients;
- The Project appears to have successfully reduced repeat visits to the A&E department for domestic violence related injuries.

5.5 Service user questionnaire findings

As outlined in Section 3.5 above, the Service User Questionnaire was designed to gather information about clients' experiences and assessments of screening, and using EIP's services. Despite the best efforts of EIP staff only 29 completed questionnaires were returned.

- Less than half of these respondents (n=13) had disclosed within one of the participating hospital departments where screening is being undertaken (n=12 in A&E, n=1 in Maternity).
- Of those attending A&E, almost all (n=11) were doing so because of domestic violence related injuries.

All of these respondents reported that the possibility of domestic violence was raised when they were first seen by a member of the medical staff in the department they were attending. However, it is worth noting that, in response to the question 'During your attendance who *first* brought up (mentioned) the issue of domestic violence?' only three respondents stated that a member of hospital staff had. In eight cases the respondents had first mentioned it themselves, and in one the respondent was accompanied to A&E by an EIP worker, so domestic violence had already been disclosed. One respondent could not remember who had first mentioned domestic violence. It is difficult to know from these few cases whether automatic screening was being undertaken, particularly as the majority here were attending with domestic violence related injuries and were accompanied to A&E by relatives, friends and in one case, the police. Any of these others could have indicated that domestic violence was an issue for these respondents.

- The majority of these respondents thought that they had been listened to (n=12), believed (n=11) and supported (n=11) by the staff member they told about domestic violence.
- One respondent was unsure as to whether she was believed. (1)

The service was very good that I received. (SU12)

Eight respondents said that the staff member had done or said something helpful at this point including:

- that there was help for them;
- that they did not have to do this alone;
- discussed EIP;
- gave advice.

They helped me understand that there's help if I needed it. (SU07)

Put me at ease the whole time and made me understand that there was a lot of help and support for me out there. (SU22)

I have taken seven years of this of my husband, I was advised to think about what to do, so I am divorcing my husband as I can not take anymore beatings from him. (SU21)

They mentioned EIP and asked if I would like to be put in touch with the service. (SU14)

- In general respondents were positive about disclosing domestic violence in this environment – 12 of the 13 stated they were either 'OK' or 'Quite comfortable' with being asked about their experiences by a member of hospital staff.
- Only one respondent said she had felt 'quite uncomfortable' about being asked.

A small number of respondents described how they felt at the time.

I was in shock, my mind was all over the place, but I did feel they were trying to help and I appreciated that a lot. (SU05)

I felt bad but they said "I was not alone in this". (SU12)

I think I found it a little uncomfortable because this was not my first incident of domestic violence. (SU14)

I felt embarrassed at first as I have never had to do this before, but when I started to talk it seemed easy to explain my feelings. (SU21)

- All of the respondents who had disclosed in a hospital department agreed that hospital staff should routinely ask patients about domestic violence 'Usually' (n=7) or 'Always' (n=6).

Reasons provided by some respondents included:

I think a lot of domestic violence gets covered up because of the woman's fear; once they have admitted to someone there's a problem, it may be easier for them to leave their partner with support from outside agencies. (SU06)

Because sometimes people don't like to admit themselves they've been involved in domestic violence. (SU08)

Some people feel they cannot bring it up as they feel alone. (SU12)

Because if women can be offered help and advice then that can only be a good thing. Some women are too afraid to ask for help. (SU14)

I think domestic violence is a common problem that is often covered up. (SU15)

Because you never know, because we can lie very well, so that no one knows. (SU21)

A lot of people feel nothing will happen if they reported their incidences, after talking it through with medical staff I found this wasn't the case. It helped me realise just how caring and understanding people can really be. (SU22)

A lot of people who are getting abused don't know how to ask for help, so I think medical and police should ask the question. (SU27)

- All respondents also agreed that a hospital-based service for anyone experiencing domestic violence is a 'good idea'.

Because unfortunately a lot of people end up in hospital due to domestic violence, and that might be their only opportunity to ask for help. (SU05)

Most people understand hospitals to be a caring and confidential place; women would perhaps associate the same with the EIP because it is hospital-based – the same rules apply. (SU06)

They can make direct referrals from a hospital department. (SU15)

It would make people experiencing this sort of violence realise just how common the problem is. Hopefully more people will feel at ease knowing they have this kind of recognition and support. (SU22)

- Information about EIP was given to all these respondents by medical staff.
- Eleven respondents had been in touch with EIP.
- One respondent stated that they had not as they had experienced no further problems from the perpetrator but that they would contact EIP if these problems recurred.
- One respondent gave no explanation for their lack of contact with EIP.

An additional five respondents had been told about EIP by other members of the medical staff. These were staff in: occupational health (n=2); a midwife; the Ella Gordon Unit and 'maternity' (n=1 each respectively). Other respondents (n=11) had been told about the project by another agency within Portsmouth (n=10), with one respondent being given information by a police service outside of the area. The majority of those referred by another agency had done so via the Police (n=8). Other agencies noted here included: a local refuge; 'Sex Sense' and Social Services.

The main reasons identified by those respondents who gave a reason why they had been in touch with EIP (n=21) were that they needed:

- to talk to someone about what was happening (n=8);
- help to get out of the relationship (n=4);
- general support (n=3);
- advice (n=1);
- to discuss child contact issues (n=1);
- advised to by the police (n=2).

I decided to get in touch with EIP because the midwife said they could give me legal advice and support. (SU02)

*Needed support going to court and wanted to discuss my anxieties about future contact. How I could live with my partner seeing my children and finding where we now liv*e. (SU04)

Because they were willing to listen to me, offer me advice and help but without putting any kind of pressure on me. (SU14)

I needed a really good talk and I needed help. (SU17)

I was encouraged to get in touch because I needed support from an agency who understood emotional and abusive trauma. (SU18)

Because I wanted to know if it was me, if I was going mad or imagining what was happening to me. I needed help. (SU25)

I was under a lot of stress and I needed someone to talk to and offer me professional help. (SU26)

I needed to talk things through to someone unconnected to me and my family. (SU28)

Two respondents noted here that EIP had contacted them.

Of the 29 respondents only ten said they were using EIP services at the point where they completed the questionnaire. The majority of those not doing so (n=19) said that services from EIP were not needed right now as circumstances had changed or they had other forms of support (n=11). Other reasons provided here were: the perpetrator was no longer a threat (n=2); they were trying to cope, not ready yet, trying to save the relationship, able to cope at the moment (n=1 respectively). Two respondents said that EIP had not contacted them recently.

The EIP services most used by respondents and how helpful they found these are detailed table 5.5.1 below.

Table 5.5.1 – EIP Services Used by Questionnaire Respondents

Service	Used by N	Very helpful N	Helpful N
Support/listening	25	22	3
Information	23	18	5
Information about options	17	13	4
Referral to other services	11	11	-
Safety planning	9	8	1
Contact with another service on user's behalf	8	7	1
Accompaniment to another service	7	7	-
Accompaniment to court	6	5	1
Advocacy	6	6	-

Based on 29 respondents

- As the table above illustrates, respondents are extremely positive about EIP itself.
- The support/listening service provided by EIP workers received the most favourable response.

Twenty-six respondents noted how the services they had used had been helpful. These included:

- listening (n=8)

- non-judgmental (n=7)
- ongoing support (n=6)
- generally helpful (n=5)
- being there (n=5)
- information on sources of help (n=4)
- caring/reassuring (n=3)
- being 'not alone' (n=2)
- validation (n=2)

Just knowing that someone was always there to talk and listen. (SU01)

They supported me. They met me when I met my lawyer. They were very helpful and reassuring, just what I needed. (SU05)

I met up for a coffee and I had a chat with someone; it was my chance to unload years of abuse and unhappiness to someone who was willing to listen in a non-judgmental way. (SU06)

Just being able to talk about what happened to someone completely neutral and getting it "off my chest". (SU10)

The court accompaniment has helped me greatly. I feel safer and less intimidated by my ex because EIP staff were with me. (SU15)

They were the only people I talked to who didn't put me on the defensive about my husband. (SU16)

Felt good to get support and information on the things I needed to know about. It helped me knowing I can get the help I needed at certain times during my ordeal. (SU22)

During this time, small things appear overwhelming. There is a lot to consider and the support and help is both practical and impartial. (SU23)

There was a large range of agencies either contacted by EIP staff on behalf of service users, where service users were referred to or to whose offices EIP staff accompanied service users. These included: solicitors (n=5); housing department, refuge, police (n=4 respectively); social services (n=3); victim support, benefits agency, Southern Focus and hospital (n=1 respectively).

Twenty-two respondents noted that an EIP worker had done or said something particularly helpful. The largest group of respondents here (n=7) valued the ongoing support offered by the project. Also noted here were:

- validation (n=5)
- reassurance/understanding (n=4)
- listening/talking (n=4)
- court accompaniment (n=3)
- safe refuge (n=2)
- giving options (n=2)
- advice (n=2)
- physical help with moving house (n=1)
- sorting out an issue with another agency (n=1)
- helping to put things into perspective (n=1)

- confidence to move on (n=1)

They cleared up a misunderstanding with the housing department about my safe house. (SU02)

Yes, just giving me my options and supporting my decision. (SU03)

They identified that I have what I perceive to be a lot of responsibilities I can't walk away from. (SU16)

I found out things I never thought I could do without them telling me. (SU17)

Were always reliable and caring, coming with me to solicitors and court. (SU18)

I had a chat on the phone and at the end of the conversation I found myself having a laugh with the other person which felt quite good. (SU21)

I had lost self confidence and self esteem and she is helping me to regain them. (SU26)

That they would accompany me to court if necessary and sort out a private entrance/room to avoid seeing my ex. (SU28)

They gave me some good advice and are very understanding. (SU29)

Thirteen respondents said they intended to use EIP's services in the future. Unsurprisingly given the findings above, 'talking/listening' was noted by the largest group here (n=5) with 'support' noted by four respondents and 'information/advice' by three. Safety planning, court accompaniment, advice and counselling was also mentioned here. Two respondents hoped they wouldn't need the service in the future but would do so if needed. A small number of respondents (n=5) wanted EIP to be able to provide advice on legal proceedings including criminal cases, divorce, family law and contact proceedings. Other services wanted here were information on mental health law, information on women's health, more help with childcare issues and group work.

- When asked how they felt about EIP's services overall, four stated that they were 'Satisfied' with them, and 24 were 'Very satisfied', (one respondent did not answer this question).

In terms of how EIP might be improved or what other services respondents might like, two respondents thought that EIP should be more widely publicised, particularly amongst General Practitioners. Two stated that they would like EIP to provide more formal counselling services, particularly to help deal with the aftermath of leaving a violent relationship. One would have liked more help with divorce and child contact proceedings and one stated that she would like to receive 'an occasional phone call just to see how I'm doing'. One respondent used this opportunity to call for EIP to be a countrywide service.

Respondents had used a range of other services in relation to domestic violence. Table 5.5.2 below details which services and how helpful respondents had found them.

Table 5.5.2 – Non EIP Services Used by Questionnaire Respondents

Service	Used by	Very Helpful	Helpful	Neither Helpful nor Unhelpful	Unhelpful	Unknown
	N	N	N	N	N	N

Police	12	3	4	1	1	3
Refuge	5	3	1	1	-	-
Housing Department	5	2	2	-	-	1
Solicitor	3	1	1	-	-	1
GP	3	1	1	1	-	-
Southern Focus	3	3	-	-	-	-
Victim Support	2	1	1	-	-	-
Counselling service	2	1	-	1	-	-
Social Services	3	2	-	-	-	1

Based on 16 respondents

There were a range of other services which were used by one respondent respectively: health visitor; Citizens Advice Bureau; Cardiff Women's Safety Unit; Women's Aid Helpline; GU Clinic; Drug helpline; Adolescent mental health team, Family therapy, Anger management; hospital based counsellor and local housing warden. Three respondents also noted that they had used medical services at the hospital. None of these services were reported as being unhelpful.

What both the use of services available within EIP and the range of other services respondents have used demonstrates is the multiple types of support/action that victims of domestic violence need once it has been identified (by them or others) as an issue. As noted both in responses to the questionnaire and in interviews with respondents, the necessity to be in contact with a range of agencies is resented by some victims. As one respondent noted:

> *Please can some of the services offered at the Citizen's Advice Bureau be integral to EIP, i.e. employment law, benefits specialists. The number of external agencies that you need to contact is overwhelming and you establish good, confident relationships with EIP.* (SU23)

Attempting to deal with the emotional impact of domestic violence at the same time as having to handle practical issues is undoubtedly compounded by the necessity to access provision from multiple sources. The ability of EIP to alleviate this to some extent, by liaising with some agencies on service users behalf, was welcomed by all respondents who had used this service.

The question 'What, if anything, would make the most difference for you at the moment?' elicited a very wide range of responses. These ranged from the practical, such as 'help with moving home' or 'recovering possessions' to comments on changes needed in the legal system, such as speeding up divorce proceedings. Ongoing contact with, or use of EIP services was noted here by three respondents, survivors groups by two and another did ask for 'an occasional phone call just to check up'.

It was encouraging to find that 22 respondents (of 27 who answered the question) found completing the questionnaire 'ok/fine/alright' with another finding it 'helpful'. Two respondents found completing the questionnaire 'quite difficult' and another 'traumatic'. One also said they found 'some questions difficult to understand'. The respondents who had found completing the questionnaire 'quite difficult' were still happy to have done so.

These final comments, made by some of the respondents, clearly illustrate the positive impact that EIP has had on their lives.

> *They made me feel supported, that I was doing the right thing. I am very glad EIP is in place because I possibly would have stayed with my now ex otherwise.* (SU05)

> *They were absolutely brilliant to me – and I am very grateful for their care of me.* (SU18)
>
> *What was particularly helpful was the praise offered about the way I was coping with my situation. It gave me strength to carry on with the divorce proceedings.* (SU06)
>
> *Thankfully, I have split from my ex and have been to court. I feel I had the right help at the time and this is almost resolved for me. Thank you – a big thank you.* (SU05)
>
> *I know without EIP I would not have moved on and coped as well as I have – they have been really good.* (SU03)
>
> *Using this service helped me to deal with what had happened to me. My family has also helped but some people are not that lucky to have that support. I was glad that I called this service, as I found it very helpful.* (SU21)

Other respondents used this opportunity to express thanks and to comment on the service overall.

> *Thank you – a very big thank you.* (SU05)
>
> *Everyone involved are caring and good listeners. Excellent Service*. (SU12)
>
> *They were absolutely brilliant to me – and I am very grateful for their care of me.* (SU18)

Summary

- Only a minority of Service User Questionnaire respondents who attended a hospital department reported that they had been asked about domestic violence;
- The majority said that hospital staff had been supportive and believing when told about domestic violence;
- Almost all supported routine screening for domestic violence;
- All respondents welcomed EIP and supported a hospital based service;
- The vast majority (n=25 and n=23 of 29) valued the support/listening and information they had received from EIP and all were positive about the service they had received;
- Respondents use of EIP and the large range of other agencies involved highlights the multiple types of support/action that victims of domestic violence need.

5.6 Service users focus group

A focus group with two service users took place in October 2003. A third anticipated member of the group failed to arrive. A further focus group, planned for early 2004, proved impossible to organise.

One of these two service users had been referred to EIP via hospital staff, the other via the police. Both agreed that having a Hospital based service with important:

> *Domestic violence can quite often mean that you end up in hospital, so the best people – the first people to speak to you are going to be the nurses and the doctors, so I think it's very important that it is based in the hospital, because they do see it.* (FG SU)

There was also agreement that hospital staff should screen for domestic violence and that it is important to probe responses as some patients may be reluctant to disclose in response to the first question asked.

> *I think that question should be posed to people, but I think it should be a question, not an assumption. I see nurses being trained in – or the police trained in – eliciting that information from somebody, so if somebody said "How did you injure your arm?" and you say "Well I was drunk and I fell over." "Where were you drinking?" It's further questioning. "Who were you with?" … You need somebody to say "Did your husband …?" but I think that needs to come from the questioning, not a direct question, "Was your injury a result of domestic violence?" Because most people are going to be defensive, aren't they? Well, most people are embarrassed.* (FG SU)

> *I think it should form part of an assessment tool, so if you're assessing injury, you assess cause of injury. And onto that you might have a few bullet points, like, incidental, road traffic, whatever, domestic violence, and if that information is given by the person, or put them through further questioning. So it's not a direct question. Because I think a lot of people would get very defensive or perhaps not want to be asked about it that way. But there are other signs and symptoms aren't there, like shock. The police said to me "You look shocked, - you're not physically hurt, but you're clearly in a state of shock. What's happened?" So I could've said "Well, there's nothing wrong". But further questioning brought that information out. And I think if somebody had directly asked me that question at an early stage I'd have said "No, no, no, I' fine", like there's just a whole embarrassment about the issue.* (FG SU)

The questions should be asked even though these service users acknowledged that some patients may be offended. There was agreement that the way the question is posed and the tone is vitally important. An explanation of why the question is being asked and that it is asked of every patient at the beginning was also seen as important.

> *If it's asked in the right way, and say "Look, please don't be offended, this would be asked with anybody, including men, a man in the same circumstances, but we need to just clarify is this domestic violence?" I mean, you know, if a person does get offended, and it's said in that sort of a way then, you know, they're that type of person that would be offended being asked any sort of question. I think the majority of people wouldn't, or wouldn't necessarily be offended by it, but I think it's got to be asked. I'd rather it be asked than it's not asked about.* (FG SU)

The pro-active approach used by health workers and by EIP workers was valued by these service users.

> *The referral was made on my behalf, which was useful … because the referral was made on my behalf, the choices and options were still with me. … Let's refer you to this service, not "Oh there's the service up there – go and call them". If it'd been just a question of "Here's a number, give them a call – go and ring them – go home and ring them – I'm sure they'd be able to help you" then you just sort of think "Oh bloody hell, they don't know any of my circumstances" whereas because they were making the referral for you, and they had some information, the person that called me already had some information and so you don't have to start at the very beginning. And I think the point is that if they know that they can contact you.* (FG SU)

> *Like when you are shaken up and embarrassed and feel pretty low, for somebody to take that initiative is nice, it was reassuring. But again it was quite frightening because it was the thought "I've got to face up to the reality of what's happening in my life here, and I don't know if I can," but it's a bit scary, so they phoned back a few days later and they phoned back last week, again, not being pushy, but just enquiring about how I was and what my decisions were.* (FG SU)

Both of these service users had been in contact with EIP although one had not taken up any EIP services immediately. For this service user the most important aspect of the service provided by EIP was the opportunity to access services the future.

> *They phoned again a few days later, just to check I hadn't changed my mind. And they sent me a card as well so that I could use the service in the future if I decided to. So that for me has been the most valuable thing, knowing that, should I decide to use those services, that they're there.* (FG SU)

The other service user found the court accompaniment and liaison with her solicitor an important aspect of the service provided by EIP.

> *I got what I needed, and I have no complaints whatsoever.* (FG SU)

These service users would all recommend EIP to anyone in similar circumstances to themselves.

Summary

- Service User Focus Group participants welcomed and supported EIP and were particularly appreciative of the pro-active approach of the Project;
- There was support for routine screening.

5.7 Service user case studies

These seven case studies are designed to demonstrate the complex needs of service users dealing with domestic violence. Each represents different referral routes, intentions and support needs. In order to ensure confidentiality, EIP reference numbers have not been used and all names changed. All the interviewees were White British and female.

Case Study 1 Yvonne

Age unknown, 2 children
Length of relationship: 1 year 6 months – separated from perpetrator
Physical and emotional abuse, constantly throughout the relationship
No prior police involvement. Contact with a GP and a local refuge prior to referral
Self referred to EIP. Four contacts with EIP. Referred to the Police by EIP.
Intending to stay separated from perpetrator

Yvonne learnt about EIP via a friend who was working for the Trust, and referred herself after a particularly traumatic incident. The initial face to face contact with an EIP worker involved a lengthy visit to the A&E department, during which she discussed her situation and concerns. The latter centred around possible police involvement.

> *It worried me to down the police line, [I thought] no-one's going to believe me, well I mean I had injuries to prove [it] but I just thought well no-one's going to believe the likes of little old me. The discussion was do I or don't I go to the police? Because if I went to the police it might get taken out of my hands, so that was the worry … and I didn't want them to … didn't want a court case as such.*

She notes that the EIP worker was non-judgmental, extremely supportive and spent considerable time outlining what would happen if she reported to the police both at that initial contact and the following day by telephone. The worker offered to, and eventually did, accompany Yvonne to the police Domestic Violence Unit. Being accompanied by someone who could facilitate reporting was particularly appreciated:

> *I found it helpful because I was scared, nervous, anyway, and so it's having somebody to support you, I suppose. Also, when there was things I wasn't quite sure about, she clarified things. I mean she might not've known everything herself anyway, but it's just someone being there to support* you.

Yvonne has nothing but praise for the police response to her situation. An injunction was sought and issued under the Prevention of Harassment Act. The police also gave her a panic phone and telephoned regularly to check that the perpetrator had not found her.

Since gaining the injunction Yvonne has been able to seek and receive help and support from a variety of agencies, including counselling via her GP and treatment for a long-standing domestic violence incident related injury and from friends. In the more recent past she has taken up a part time job and returned to higher education.

This case demonstrates that short, but intensive, intervention by an EIP worker can have extremely positive outcomes. Input from the Project worker was concentrated over a period of a few days. However, once the police became involved and Yvonne felt safe, she was able to access other forms of support and begin to rebuild her life.

There has been no subsequent contact with EIP but Yvonne is extremely grateful for the service they provided.

> *I think it's a really good thing that they do, I really seriously hold my hand up to all of them, 'cause it's definitely a really good service.*

Note: Yvonne discovered, some considerable time after separating from her ex-partner, that he had violently attacked a previous partner.

Case Study 2 Anna

Age unknown, 2 children
Length of relationship: Unknown - separated from perpetrator
Extensive abuse over a long period
Prior CJS and Civil Court involvement, not in Portsmouth area. Short stays at a number of refuges and had received support from a range of agencies outside of Portsmouth
Referred to EIP by local refuge. Three contacts with EIP. Referred to Witness Support.
Intending to stay separated from perpetrator.

Anna had separated from her partner two years before contact with EIP. She had stayed in a number of refuges and then moved over a hundred miles in order to feel safe. She spent a few months in the local refuge in Portsmouth before finding suitable accommodation for herself and her children.

> I was still suffering panic attacks from my husband, whenever I met him (around contact with the children) I was completely in fear, I mean I had to move 150 miles to actually get away. It wasn't the first refuge I'd been in, but the fourth or fifth. Can't remember now. The only way to get away from him was to actually physically move away where he wouldn't find me.

After leaving the refuge, she wanted some support with an impending Family Court hearing, and was surprised to find that there did not appear to be any service that could help other than EIP. In fact the refuge made it clear that they couldn't support Ann and referred her to EIP.

Anna was not a client requiring 'early intervention'. She had separated from the perpetrator, a criminal prosecution had taken place, and civil proceedings regarding access by the perpetrator to the children was ongoing. Anna was quite specific about the type of support she required. She wanted similar support to that she had received at earlier Family Court hearings from an advocacy project in the city she had lived in prior to moving to the Portsmouth area.

> *I mean I was physically sick in the courtroom, I had major panic attacks and lots of times that I went to court I wasn't strong enough to go through myself. [You need] someone that can maybe understand your situation, and be there with you. Like before, they were in court with me, and they were beside my side and they were explaining "This is this, you don't have to do this, this … ", they knew the situation as much as your lawyers and as much as everybody else. So they were extremely supportive and knowledgeable. Well, you can't get that with Witness Support, it isn't the same.*

The EIP worker met with Anna and talked through her situation. Unfortunately EIP were unable to provide the same level of service that Anna had experienced before but they did arrange a referral to Witness Support and ensured that Anna was aware she could contact EIP for support at any time.

Although the court hearings to set up the contact arrangements between the children and their father have concluded, Anna is still involved in on-going procedures with the Child Support Agency as all court orders regarding maintenance for the children have been ignored by her former husband. There has been no subsequent contact with EIP but Anna was very happy with the support she received.

> *It was very good, really productive.*

This case illustrates how EIP is taking on clients who, it could be argued, should be serviced by a community-based outreach and advocacy project.

Case Study 3 Carol

Age 24, 2 children
Length of relationship: 4 years 6 months – separated from perpetrator
Physical, sexual and emotional abuse throughout the relationship
Prior police involvement. Contact with a solicitor prior to referral
Referred to EIP via the Maternity Department. 68 contacts with EIP (almost half face-to face). Referred to Social Services, Benefits Agency, Policy, Housing Authority, Counsellor and several other agencies by EIP
Intending to stay separated from perpetrator

Carol had left the family home whilst pregnant and with a toddler, and was living in temporary accommodation. Both the police and a health visitor informed her about EIP and a referral made by the maternity department on her behalf.

EIP made contact with Carol and provided her with a large amount of telephone and face-to-fact support, liaison with and referral to a number of agencies. This included lobbying the Local Authority to organise permanent housing, accompaniment to court and to access visits between the children and their father. Carol describes how helpful she found her initial contact with EIP.

> *It was just a relief to talk to somebody that understood what I was on about. My ex spent some time telling me that I'd got something wrong with me. That he hadn't done any of the things that he'd done. Just trying to confuse me, and the EIP just helped me with that and helped me understand that what he did was wrong, and that it wasn't my fault that it happened. Because for a couple of months I felt that it was my fault and that I'd been bad.*

Her description of EIP's work with the Local Authority to organise accommodation gives some indication of the input from staff on this case.

> *I was very anxious about getting a house because I had a lot of problems actually getting the place … I was having trouble with the council – they [EIP] just kept giving the council pushes, ringing them up, saying "Look, she's with us, can you do something about it? She's come out of a very bad situation and she needs help" and just kept pushing them. One minute it was off, the next it was on, the council kept changing their mind. But EIP kept ring up the council and speaking to them. They did sort out a deposit for me for the house that I'm in now.*

Although accommodation and financial issues have been dealt with, court hearings about contact between the children and their father are on going. Carol is still frightened of her ex-partner, particularly when she has no choice but to attend a hand-over of her elder child for a contact visit, although she acknowledges that he is unlikely to be physically abusive. Carol understands that she needs more support around the impact of the contact visits on one of the children and that she needs some individual counselling to deal with her own fears. Carol is both full of praise for all of the support she has received from the Project and is relying on them for this in the future.

> *EIP's been very good, she's [staff member] been very supportive and I feel comfortable with her.*

This is an example of a 'high-use' client. At the point of initial contact, Carol was pregnant, caring for a small child, homeless, had no financial resources and was being harassed by her ex-partner. She also had very little accessible informal support. The level of agency liaison, accompaniment and one to one support that EIP staff had to provide is not excessive in these circumstances. However, it is resource intensive and highlights the need for more provision in the Portsmouth area.

Case Study 4 Gwen

Age 51, 2 children
Length of relationship: 4 years – separated from perpetrator
Emotional abuse, recent in the relationship
Prior police involvement – Injunction under Prevention of Harassment Act obtained
Referred to EIP via the police. Five contacts with EIP.
Intending to stay separated from perpetrator

Gwen had been living with her ex-partner for four years when their relationship ended, due to her ex-partner's alcohol and gambling habits. There was no physical or sexual abuse. Gwen ended the relationship, excluded her ex-partner from the family home, started divorce proceedings and attempted to get help to sort out what was a serious financial problem. It was after she started this process that her ex-partner became emotionally abusive, including making serious threats to her, her children from a previous relationship and their property. Gwen reported one serious threat to the police, who referred her to EIP.

Although the police made a referral on Gwen's behalf, it was her who made the initial contact with EIP, during which a face-to-face meeting was organised. Gwen was extremely grateful for this meeting and describes how helpful it was.

> *[It] has been really helpful, because it's somebody just to talk things through, because you get to the point where you think "I must be imagining this," or "I must be so evil" or "What have I done to deserve this?" You lose your confidence in yourself, you stop believing in yourself, and they actually gave me something back. There's no opinions there was no "Oh you mustn't do this, you must do that, you've got to go here, you've got to go there" – there was none of that. No opinions, it was just listening. It was very useful. It made me feel a lot stronger.*

Gwen did not need any form of liaison with other agencies by EIP on her behalf. They have, however, rung Gwen on a number of occasions and this has been appreciated.

> *They rang me a couple of times. Just for a chat, see how I was, how I'm getting on, what's happening, how do I feel. They have been great.*

Gwen also has a lot of praise for the police and for her solicitor. It was the solicitor to whom Gwen first talked about the threatening phone call and who encouraged her to inform the police, pointing out that what was happening was 'harassment' under the meaning of the Prevention of Harassment Act (PoH). The police attended after the threatening phone call and immediately, with Gwen's cooperation, applied for an injunction under the PoH. The police rang her to confirm that they had served the order and then called intermittently to ensure that there had been no further incidents.

There have been no further incidents of threatening behaviour and the financial problems are in the process of resolution. During her interview, Gwen made it clear that she would contact the Project again if she thought it was necessary and expressed the opinion that all agencies involved had been extremely supportive, understanding and helpful.

> *I was very well looked after.*

This case is an illustration of how, for many victims of domestic violence, simply having someone to talk to, who checks up on them every now and again, can be so helpful and empowering.

Case Study 5 Amy

Age 28, 1 child
Length of relationship: approximately 10 years – separated from perpetrator at initial contact with EIP
Physical abuse, often throughout the relationship
No prior agency involvement
Referred to EIP by A&E Department at the hospital. 36 contacts with EIP (including 5 face-to-face). Referred to a refuge, the police, a counsellor and a number of other agencies by EIP.
Intending to stay in relationship at time of interview

Amy attended the A&E department of the hospital as the result of a domestic violence related injury. Whilst in the department, a nurse asked her about domestic violence. After Amy disclosed what had happened, the nurse encouraged contact with the police and they were called, on her behalf, to the hospital. The department made an automatic referral to EIP. Amy did not go home after this incident and stayed, in the short term, with relatives. EIP made contact with her there and arranged a face-to-face meeting. Amy found that meeting very helpful.

> *She [EIP staff member] was ever so supportive and lovely. Gave me lots of options and told me if I needed anything or any information or any help, I could phone up whenever, it didn't matter.*

At the time of this first contact with EIP Amy did not need referral to other agencies although she was given information about a number of possible sources of help. These were not taken up at the time and other than a few 'check-up' phone calls, Amy had no further contact with EIP. The supportive response from EIP was not reflected, according to Amy, in the response she received from the police.

> *They wanted him (partner) for other things rather than for what'd happened. [After statement and photographs]. They didn't get back in contact with me or anything. They were about as much use as chocolate to be quite honest with you.*

Subsequently, Amy contacted EIP herself for help as her partner's behaviour had deteriorated. This contact resulted in a number of agency referrals, including to refuges. On at least one occasion an EIP staff member accompanied her to a refuge. Amy notes how important it was that she felt able to make contact with EIP herself.

> *They've been great, because they said I could go back if there is a problem, and a lot of people are too embarrassed after the first time, you know, to go back and go "I've done it again, I'm back there". And they've given me phone calls every now and again to see I'm ok and if I need anything don't be embarrassed to go to them if it happens again.*

Amy is still getting a check up call from EIP now and then and is appreciative of this part of the service.

> *I get the odd phone call here and there, just to see how things are going. They've been really, really great.*

This case could be seen as an illustration of a 'high use' client. However, both Amy and her partner had substance misuse issues and Amy sees these as contributing to her partner's behaviour. Both Amy and her partner are now addiction free and hoping to save their relationship. Amy is clear however, that should problems arise again, she would not hesitate to contact EIP for help.

Case Study 6 Bethan

Age unknown, 3 children
Length of relationship: 9 years – separated from perpetrator
Physical and emotional abuse, occasionally throughout the relationship
Prior police involvement.
Self referred to EIP. 33 contacts with EIP (including 6 face-to-face). Referred to the Police, Benefits Agency, Solicitor, Citizens Advice Bureau and locksmith by EIP
Intending to stay separated from perpetrator

Bethan knew of EIP through supporting a colleague who was a client of the Project. It was the first physical assault that prompted contact with EIP, although her ex-partner had been emotionally abusive prior to this incident. The first contacts with EIP helped Bethan to articulate what happened and to think through her options.

> *She [EIP staff member] didn't pass any judgement, it was just listening, reassurance, I couldn't string coherent – you babble, and they somehow were able to put them together to make some sense. Then she just said "What is it you want us to do? We're here, if you want to stay in the situation, try and resolve it, we'll support you; if you want to actually make a break, we'll support you. The sort of practical things we can do for you is changing the locks and organising that," they would've helped me with finding a safe place to go, that was offered. So basically they could support me in finding what I needed to do, whatever I decided I wanted to do.*

The incident happened just before Christmas. EIP gave her a mobile number to contact them, and the name and telephone number of a specialist domestic violence officer, who could also be contacted at any time. During this period, her ex-partner's abusive behaviour significantly increased, including damage to property.

> *I had a mobile number over Christmas, it was a horrendous time. And I just knew there was someone at the end of the phone. I had a raft of numbers, useful numbers, day or night, there was somebody I could get in touch with.*

At this point, Bethan had not decided whether to pursue a prosecution but the possibility of being able to talk through this option, amongst others, was part of the EIP service that was vitally important to her. The assault totally changed Bethan's life. She had a responsible job, had always worked and was used to a secure, reasonable income. Suddenly being the sole carer for three young children meant she had to give this up and face, at least in the short term, living as a benefit claimant. She had no knowledge of the benefits system or what she might be entitled to. Again, EIP proved invaluable.

> *I mean there's all sorts of offices all over town, it seems like an incredible paper mountain that you have to start walking up, and at a time when you're still in shock. What they [EIP] did was they made some useful phone calls, got me in touch with people that could advise me what I might be entitled to. I mean I've got a degree but this is just like completely new territory to me, and its very uncomfortable for someone that's desperately tried to pay her own way in life. It didn't sit well to be doing it. I went in and did my income support, the same with the housing benefit. They read through everything.*

In addition, Bethan was dealing with Social Services to ensure safe contact for the children with their father. As there was on-going harassment, an injunction was taken out under the Prevention of Harassment Act and more recently, divorce proceedings and proceedings in the Family Court regarding contact arrangements have been instigated. Bethan is starting to move forward with her life, including plans to start re-training through evening classes in the Autumn of this year and is clear that this is possible because of the support she has received from friends and family as well as EIP.

This case illustrates the multiple practical and emotional challenges dealing with domestic violence can bring and the variety of support that someone can require.

Case Study 7 Maria

Age 35, 3 children
Length of relationship: 7 years – separated from perpetrator
Physical and emotional abuse, constantly although only commenced recently
Prior involvement with a solicitor and the Police. Prior conviction of perpetrator for assault on a family member. Referred to EIP by the Police. 12 contacts with EIP, all by telephone. Referred to the housing department by EIP.
Intending to stay separated from perpetrator.

Maria contacted the police when her ex-partner committed an extremely serious attack on her, the children and the family home. There had been a series of harassment incidents, some of which involved death threats. The police contacted EIP on Maria's behalf. Maria describes how important the first call from EIP, of several in the first few days following the incident, was for her.

> *I was just a wreck. I needed to talk about it. I was so angry and upset. I did find it a help, because she was saying to me "Well you don't have to go back home, there are options for you," and things like that. I don't know how I would've coped not having anybody. She put me in contact with a solicitor. She also gave me the confidence to know that the council would help me with finding somewhere to live so that I didn't have to return to that property.*

The referral to the solicitor was particularly significant. Maria had already started divorce proceedings and was informing the solicitor of the harassment incidents and had tried to get them to help her obtain an injunction under the Prevention of Harassment Act. The solicitor had not been supportive. The solicitor recommended by EIP proved much more helpful and an injunction was obtained.

Unfortunately, the housing department was only able to provide Maria and the children with hostel accommodation. Maria found this a particularly difficult time and was extremely grateful that, unbeknownst to her, the police had also passed her details to another agency in Portsmouth. She received a call, at the hostel, from someone who at first she thought was another staff member at EIP. This person became Maria's main support.

> *I was moved to a hostel in XX, I was absolutely terrified down there, because I thought if he gets wind that I'm not living at the property, the first thing he's going to think of, "Well she's in a hostel or a safe house or something," XXX is well known as a safe house, and he'll find me down there. I got very, very low again, I basically couldn't even get out of bed. I'd just had enough. I think really and truly if it wasn't for XX, I would've gone down the slippery slope. I was getting to the stage where I just felt suicidal.*

Maria received a check up call from EIP whilst at the hostel, but did not find it helpful because, as she explains, *".. it was general chit-chat which I just didn't really want to hear at the time"*. It is likely that this call took place some while after EIP's first contact because, at the time, EIP were severely under staffed and Maria had forged a relationship with a worker from another agency. EIP scheduled face-to-face meetings, but Maria was unable to make them but has met an EIP staff member on a number of occasions at a support group.

The police are pursuing a prosecution of her ex-partner and Maria is planning to move away from the Portsmouth area.

This case illustrates that the most important thing is that there is someone able to provide immediate and on-going support. Maria had a multitude of needs, including housing, financial, legal as well as emotional support for herself and emotional and practical support for her children. The referral by the Police to two different agencies caused some confusion for Maria at the beginning and it is possible that the non-take up of arranged face-to-face meetings, has been influenced by the obviously extremely good support Maria has received from this other agency.

5.8 Multi agency telephone interview findings

Some of the findings from the three sets of interviews with Steering Group Members during the course of the evaluation have already been incorporated into relevant sections of this Report (see in particular Section 4). A summary of the findings from all of the interviews is provided below.

There was agreement amongst steering group members, at all three interview rounds, that the service provided by EIP was of benefit, highlighted a previous gap in provision and should be continued.

> *The existence of EIP as a new service has highlighted that there has been some very large holes and significant gaps in local and health service responses to DV prior to its establishment. Health workers have not really been engaging with clients on this issue. The Project and its staff are now considered to be a very valuable resource.* (SGM IR1)

> *It's a brilliant avenue where people can get help and learn what availability is out there for them, without even reporting the matter to the police if necessary and I think really when you look at the statistics, the uptake of it, it just speaks for itself really.* (SGM IR2)

> *I think it's already proven in the fairly short while that it's been up and running that it's, you know, been worth its weight in gold really.* (SGM IR2)

> *I really believe that it's necessary and proved itself, I feel it has, and I'd love it to continue.* (SGM IR2)

There was also general agreement that it was important that EIP was based in the hospital. The fact that the hospital is split site, and the actual physical location and facilities are still seen as problematic for EIP workers as noted in both interim reports.

> *[There are] obviously problems that we are a split-site working and it would be nice if obviously if everything was under one roof. That would actually reduce the workers' needs to obviously go between the two client groups, but obviously where they are placed within the trust, but that is well documented and I'm obviously not going to go through that again and there is an issue with that, but that is obviously being looked at within the actual Portsmouth Council for the future. But, as with it being in a hospital, I think it's actually a pro-active move.* (SGM IR2)

> *I think one of the problems is, is that this is a Tri-service site – it's a three hospital site, which I think is a problem in itself because they get referrals from three completely separate units. They are on a different site to us and of course in A&E I think we are one of the biggest referrers to them. So that in itself is a problem. There's a lack of space and privacy and the trust has nowhere for them to go, no private office. So from that perspective there are problems with a hospital site.* (SGM IR2)

> *I think it needs to be based up at A&E..* (SMG IR3)

Liaison with and referral to EIP was seen as unproblematic, and straight forward, by these steering group members. All reported that constructive working relationships had been established, and everyone thought EIP was complementing the services that they themselves are providing – no 'territorial' conflicts or problems were identified in this respect. There as no indication that external agencies, such as Victim Support, were affected by any increase in referrals from EIP. Every respondent stated that they definitely intend to continue working with EIP in the future.

Steering Group Members commented on the high turnover of staff at EIP during the evaluation period and the impact this had, at least in the short term, on working relationships between external agencies and EIP.

> *Working relationships seem to have been very good except as I say continuity of workers there. The girl that's there now I've liaised with about half a dozen times as she's only been in post three months herself. The new employee that's starting, she's worked in support agencies within Portsmouth and again I've known her beforehand. It's good that I do know the workers who are in place, but if you are going to have a fast turnover of staff then obviously you could lose that contact.* (SGM IR2)

There was concern from a small number of steering group members from within the Trust, echoed in comments from the A&E hospital staff focus group, about the paperwork required by EIP for referral of potential clients from hospital departments.

> *There has been one 'bugbear' so far – the amount of paperwork involved – it needs to be made clearer what exactly EIP staff do and do not need to know – i.e. what exactly it is that A&E staff need to collect. This is always a bugbear with A&E staff because of the amount of paperwork that they have to deal with anyway, which can be a real nightmare for them.* (SGM IR1)

> *I think sometimes the paperwork's a bit … it seems to take a long time. I know it doesn't, but when you're busy…* (SGM IR3)

Echoing the aspirations for the Project at the planning stage, Steering Group members lamented the inability of EIP to provide a 24-hour a day, seven-day a week service, and for members who are also hospital staff, the lack of a presence in the A&E department.

> *Certainly, as I say fund it so that there's a larger team, 7 day cover. It would be nice 24 hours a day but even just 7 day cover during normal daylight hours; that would be a good start, but better cover, better funding.* (SGM IR2)

> *I think the service is under-funded because it's not 24 hours a day and we could do with it 7 days a week 24 hours a day and I know they're struggling to keep it operating at all because of funding.* (SGM IR2)

> *I think if there was somebody there that they could call at that time of crisis in the evening, 'cause as I say very often it is in the evenings, or at weekends. I think it would be more helpful, I think more women would seek their help. [Because] it's [referral] not picked up till the next day, you know, the hours and clock's ticking and – and people change their mind.* (SMG IR3)

> *The service needs to be available 24 hours, I would say, definitely, or – well, maybe not 24 hours, but – yeah, probably 24 hours on a call –on an on-call system maybe*. (SMG IR3)

> *I believe it should be based more in our department. I know the thing that stops that is space, there's just nowhere for people to go. I know it's easy to say that you can get the hospital transport up, but sometimes that can take half an hour or so. If you've got somebody that wants advice and help then, half an hour to them if they've got to get back for children or somebody's going to wonder where they are or whatever, is a length of time, really. I mean really it would be ideal if you had somebody down based in Maternity and in A& E. You know, one person in each place.* (SMG IR3)

Steering Group Members welcomed the recent and planned increase in the staff team including the employment of a Project Leader and the expansion of office space despite its location outside of the hospitals. However, there was unease about the long-term stability of the project, particularly in relation to funding.

> *The worry is that the money will run out and they'll have to close and we'll lose something very important and I don't think that that should be the case.* (SGM IR2)

> *It would be nice if the resources could be ring-fenced in a medium-term basis, year to year is, you know, very difficult. It'd be lovely if they could secure funding, shall we say between three and five years?* (SMG IR3)

> *A project like this should be mainstream funded somewhere along the line, so that the service is there, and it's provided, and it's not worrying about one lot of funding, you know, from one year to the next or from one pot of funding from one organisation.* (SMG IR3)

All members of the Steering Group would like to see the service expanded, specifically into other health care settings and with the ability to accept referrals from a range of other agencies as well as self-referrals.

> I *would like a project like EIP to be available and accessible in as many healthcare settings as is possible and appropriate – e.g. in teenage clinics within Paediatric care.* (SGM IR1)

> *I think a medical centre could work quite well, with appropriately favourable GP staff.* (SMG IR3)

> *It'd be great to see [it] into GPs' surgeries and things as well before people actually get to hospital.* (SMG IR3)

> *The ideal thing is that it would be able to take referrals from a lot more organisations, and self-referrals.* (SMG IR3)

The final round of interviews in June 2004 addressed the issue of the Steering Group itself, its composition, timing and usefulness. Whilst all of those who attended the meetings (two members are new in post) found them useful, informative and appreciated the ability to build networks and relationships with other members, there was some concern about erratic attendance and the 'cross-over' between these meetings and that of the Domestic Violence Forum. A suggestion made by a couple of members was for a smaller group focusing on the Project itself, possibly meeting bi-monthly, reporting to the Forum.

> *I think it's quite important to touch base with the coordinator, to keep us updated on how the team's working. You know, even down to fundamentals like the funding and therefore what cover they can offer. That's important, 'cause the staff [hospital] need to know that. And they need to know how to get hold of people and if things change, if processes* change. (SGM IR3)

> *Every time I go, I feel I have gained from it. I've either got a new piece of information or heard some new research or seen how it's developing and what's good for the people who – the service users. … With the other professionals on the steering committee, it's nice to hear their experiences from different forms of work, you know, the midwives, the social worker*s. (SMG IR3)

> *Well sometimes when I go down for the meetings, they're badly attended.* (SMG IR3)

Summary

- Steering Group Members continue to demonstrate strong support for EIP and confirm that it is a service that is needed in Portsmouth.
- The majority fully supported the idea of EIP being based in a hospital setting.
- The majority would prefer that EIP or at least some of its workers, should, if possible, be based in the A& E department.
- Most had liaised with and referred to EIP on a number of occasions and in the vast majority of cases this had been a straightforward and successful process, although there was concern about the amount of paperwork involved.
- All reported a constructive working relationship and saw EIP as complementing the services that they themselves are providing – no 'territorial' conflicts or problems were identified in this respect.
- There was concern about the long-term stability of the Project, particularly in relation to funding.
- Members would like to see the service extended, particularly into other health care settings.
- The Steering Group should continue, but thought should be given to its composition and timing.

6. Conclusions and Recommendations

From the beginning, the Project was unable to fulfil its original intent to provide a 24/7 service, through project workers based in the Accident and Emergency Department of Queen Alexandra Hospital. Hospital staff in that department, steering group members and Project staff all note that such a presence would have greatly enhanced service delivery to clients. Additional operational issues, such as the lack of adequate office space, staff turnover and loss reduced the ability and capacity of the Project could provide during some of the period of this evaluation. Despite this, hospital and external agency staff, who have referred to EIP, were extremely positive about the Project. Referrers, steering group members and clients support the Project and would like to see it expanded. This evaluation was designed to assess the effectiveness of EIP in relation to: introducing routine screening specifically within two hospital departments; reducing repeat victimisation; empowering clients and impact on local services. We address each element in turn.

6.1 Introducing routine screening

Studies of screening projects in health settings consistently find evidence of uneven implementation. Not surprisingly, therefore, similar findings are recorded by this evaluation. Two issues need to be addressed here, firstly whether the training adequately equips staff to implement screening, including the ability to respond appropriately to disclosures, and the level of 'coverage' of the training within targeted departments and secondly, barriers to implementation in everyday practice. Responses from hospital staff who have undergone training demonstrate that, for the majority, the training provided by the PTC provided the skills required to both screen and appropriately respond, although there were requests for 'refreshers' and lengthier sessions. Though very small numbers, the focus groups also highlighted the lack of confidence in asking about and responding to disclosures of domestic violence by non-trained staff.

Problems of 'coverage' within the targeted hospital departments emerged. Training was aimed initially at the A&E and Maternity departments and it is encouraging that the issue of domestic violence has now been mainstreamed into basic midwifery training. In the early stages of the evaluation take-up from both of these departments was relatively high but this has declined over time, whilst participation in the training has increasingly attracted staff from other hospital departments, and non-hospital based health teams. Whilst the latter trend is to be welcomed, it is worrying that the proportion of staff within the A&E department who have undertaken the training is decreasing. Two factors are at play here - turnover of staff and initial take-up of training, attracting interested and concerned staff. A small number of staff, in both their responses to questionnaires and in focus group discussions, raised the question of whether the training should be mandatory for staff within this department, and given that this is where the vast majority of EIP hospital referrals are identified, this should certainly be considered by the Trust and the Project.

The aim of implementing *routine* screening, within both hospital departments, has not been achieved, although it is more mainstreamed in Maternity than within A&E. Only a minority of staff always ask patients about domestic violence and, if the responses to the questionnaires are indicative of all trained staff, over three-quarters seldom or never ask. Importantly, there was some indication that even where staff did implement routine screening following training this 'tails-off' over time. It may be that the physical distance between the Project and the A&E department contributes to the inconsistent level of routine screening there. The same individual and system-level barriers to routine screening identified in previous studies were identified in this evaluation, including discomfort with raising the topic with patients, lack of time and privacy. It is also clear that some staff make decisions about 'relevance'. One example, from a focus group, was whether it was appropriate to ask the screening questions if a patient had attended the department for a non domestic violence related injury, and particularly, if the patient was male. In general staff support routine screening for all women attending the Maternity

department or in contact with community midwives, but question blanket screening elsewhere, particularly within A&E.

The move to mainstreaming in the Maternity department deserves more scrutiny. There are a number of reasons why this may be the case: there is usually on-going contact between staff and patients creating contexts and possibilities raise difficult issues; a growing awareness within the sector that violence may start, or increase, during pregnancy; there is support for screening from the professional body representing staff.

Given that all research, including this evaluation, demonstrates that patients are happy to be asked and are prepared to disclose, the question that needs to be addressed by the Project is whether the aim is to *increase* or *embed* routine screening within A&E. There are three options open to the Project.

- To continue with the present policy of voluntary participation in the training with perhaps more effort placed on recruitment and 'refreshers' together with the current non-mandatory policy of screening implementation. This would continue to leave wide discretion on 'relevance' in relation to individual patients. Take-up of training could not be guaranteed and the wide variation between trained staff in screening rates found in this evaluation would probably persist. However, if EIP continues to expand it referral base outside of the Trust, it may be that this policy would fit with retaining a service to hospital patients whilst becoming a more 'community based' project (see Final Thoughts below).

- To introduce mandatory training for all staff but continue with a non-mandatory policy of screening implementation. This would address the concern about staff skill in undertaking the screening and the 'coverage' issue.

- To introduce mandatory training for all staff linked to mandatory screening. This would address all of the concerns above, however the lessons learnt in earlier studies (see Moracco et al, 2003) suggest that such a policy would be most effective if it included a formal disciplinary process for non-compliance.

6.2 Reducing repeat victimisation

One aim of the project was to reduce the number of repeat visits by victims of domestic violence to the Accident and Emergency department and this has been clearly achieved with a repeat visit rate of only 4 per cent. That this aim was met lends weight to the Project attempting to improve the screening rate within that department and may also support moves to house at least one member of staff in the same premises. There are concerns however about the Project's ability to help reduce repeat visits to the same victim by the Police. During the period when the Police were able to make direct referrals to the Project, there was some indication, from them, that repeat visits had been reduced. It is therefore unfortunate, that due to staff shortages and more recently, to prioritising referrals from agencies providing funding to the Project, that this referral route has been closed. The Project and the Steering Group should consider whether to reverse this policy, particularly in the light of the recent increase in staff at EIP. It could be argued, as the Trust does not contribute financially to the Project, but receives a service, that the same should apply to the Police. The Project would then be targeting the two statutory services most approached by victims of violence.

6.3 Empowering clients

That EIP has achieved its aim of empowering clients is evidenced by all of the data collected about and from clients for this evaluation. The pro-active approach of the Project was welcomed alongside of the provision of non-judgemental support and information about options and other available services. It is

the form and content of interventions that enables clients to make decisions and take actions to change the conditions of their lives. The case studies (see Section 5.7) demonstrate the numerous ways EIP has empowered individual clients. These findings echo those of other evaluations (Domestic Violence Matters, 1999, Domestic Violence Intervention Project, 1998) in relation to specialist services and early pro-active interventions.

There is a concern however, about the, albeit small, number of 'high use' clients. That one client necessitated 184 calls to/from the Project and over 90 referrals to other agencies and with several clients with over 50 calls raises complex issues. Protocols in relation to these high need clients including 'exit-strategies would a few individuals do not absorb a disproportionate amount of resources. Case conferencing might enable a multi-agency approach to better address intractable situations.

6. 4 Impact on other agencies

There was no indication from any of the external agencies that there had been a significant increase in their workload as a result of referral from the Project. In fact, all the external agencies consulted during this evaluation welcomed their links with EIP and were extremely positive in their support for its continuation. The inability of the Project to accept referrals from the police and the negative impact of this on providing support for victims identified by them, and the experience of a number of EIP clients, highlights the lack of provision within the Portsmouth area.

6.5 Final thoughts

A number of factors affect the extent to which EIP can be defined as a 'screening and intervention project within a health setting'. The withdrawal, before the Project went 'live' of any financial support from the Primary Care Trust meant that there was little direct investment from the health sector in the Project from the beginning. Although individual management staff supported EIP, an absence of practical support was evident most graphically illustrated by the Trust's inability to provide suitable premises, staff pay and conditions. This failure needs to be placed in the context of evidence of the necessity for health based responses to domestic violence and that the Trust was receiving a free service, funded by external agencies. Less than half of EIP's clients are the result of hospital referrals. Limited take up during the early period of the evaluation led Project staff to accept referrals from outside the Trust and this, particularly within the Police, led to an expectation that this provision would continue, and disappointment when it did not. The necessity to remove staff from the employ of the Trust and move the Project base to premises external to the hospitals could lead to an increasing 'distance' between EIP and the Trust. The recent input of funding from the Homelessness Directorate and the necessity to raise and possibly secure funding linked to accepting referrals from other sectors can only exacerbate this. There is therefore a potential that EIP will, because of these factors, become a community-based project which may be in tension with its original aims and objectives.

The main recommendation of the evaluation team is that the Project Development Officer, together with the current Steering Group and Trust Management explore these factors in order to decide on a clear trajectory for the Project in the future. There is no doubt that victims of domestic violence in Portsmouth need an advocacy and support service and this is supported by agencies funding posts within EIP. There is also no doubt that all the 'stakeholders' (clients of EIP identified through the participating hospital departments, hospital staff and community medical teams) want the service to continue as a hospital based Project and in fact, there is support for expansion into other health settings. The question is whether EIP continues to expand its 'referral base' outside of the Trust or whether it attempts to return to achieving its original aim as a 'hospital based screening and early intervention project' in a hospital setting. There is not one route that can be suggested, since the progress in Maternity could be replicated in A&E and elsewhere. At the same time other agencies in Portsmouth have demonstrated their willingness to sue EIP's services to the benefit of their clients. It may even be

that this is not an either/or situation, that a twin track strategy can be pursued. Our major concern, however, would be that in the absence of ongoing evaluation and a physical disconnection from the Trust, a period of 'drift' ensues in which structural constraints militate against achieving the formal aims and objectives, whilst other potentials are not developed. The basic challenge remains how EIP is enabled to provide support, advocacy and early intervention services to as many Portsmouth residents as possible.

Bibliography

American College of Emergency Physicians (2003) *Fact Sheet: Domestic Violence*. [Available online at: http://www.acep.org/1,391,0.html].

Bradley, F., Smith, M., Long, J., O'Dowd, T. (2002) 'Reported frequency of domestic violence: cross sectional survey of women attending general practice', *British Medical Journal*, 324: 7332.

Burton, S., Regan, L. and Kelly, L. (1998). *Supporting Women and Challenging Men: Lessons from the Domestic Violence Intervention Project*. Bristol, Policy Press.

Craig, C. (2003) *Domestic Violence and Health Professionals: A Short Study on Women's Experiences*, Belfast: Northern Ireland Women's Aid Federation.

Davidson, L. L., King, V., Garcia, J. and Marchant, S. (2001) 'What role can the health services play?' in Taylor-Browne, J. (ed.), *What Works in Reducing Domestic Violence? A Comprehensive Guide For Professionals*, London: Whiting & Birch, 95-122.

Department of Health, (2000) *Domestic Violence: A Resource Manual for Health Care Professionals*. London: Department of Health.

Department of Health, (1997) O*n the State of the Public Health: The Annual Report of the Chief Medical Officer of the Department of Health for the Year 1996*. London: HMSO.

Dobash, R.E. and Dobash, R.P., (1992) *Women, Violence and Social Change*, London: Routledge

Dobash, R., Dobash R. and Cavanagh, K. (1985), 'The contact between battered women and the social and medical agencies', in Pahl, J. (ed.), *Private Violence and Public Policy: the needs of battered women and the response of the public services*, London: Routledge.

Gerbert, B., Gansky, S. A., Tang, J. W., McPhee, S. J., Carlton, R., Herzig, K., Danley, D. and Caspers, N. (2002) 'Domestic violence compared to other health risks', *American Journal of Preventive Medicine*, 23:2, 82-90.

Humphreys, C. and Thiara, R. (2003) 'Mental Health and Domestic Violence: 'I Call it Symptoms of Abuse'', *British Journal of Social Work*, 33: 209-226.

Hunt, S. C. and Martin, A. M. (2001) *Pregnant Women: Violent Men. What Midwives Need to Know*, Oxford: Butterworth-Heinemann.

Kelly, L. and Humphreys, C. (2001) 'Supporting women and children in their communities: Outreach and advocacy approaches to domestic violence' in Taylor-Browne, J. (ed.), *What Works in Reducing Domestic Violence? A Comprehensive Guide For Professionals*, London: Whiting & Birch, 239-274.

Kelly, L. (1999). *Domestic Violence Matters: An Evaluation of a Demonstration Project*. London, Home Office.

Mezey, G.C., and Bewley, S. (2000) *An Exploration of the Prevalence and Effects of Domestic Violence in Pregnancy*. ESRC.

Mezey, G. C. and Bewley, S. (1997) 'Domestic violence and pregnancy', *British Medical Journal*, 314: 7090.

Moracco, K. E., Runyan, C. W. and Dull, L. (2003) *Violence Against Women: Research Synthesis for Public Health Policymakers*, Washington, DC: National Institute of Justice.

Mullender, A., Hague, G., Imam, U., Kelly, L., Malos E. and Regan, L. (2002) *Children's Perspectives on Domestic Violence,* London: Sage.

NSW Health (2001) *Unless They're Asked: Routine Screening for Domestic Violence in NSW Health*, Sydney: NSW Health Department.

Plichta, S. (1992) 'The effects of woman abuse on health care utilisation and health status: a literature review'. In *Women's Health Issue*, 1992 **2:3**, 154-163.

Queensland Health (2001) *Initiative to Combat the Health Impact of Domestic Violence Against Women: Stage 2 Report*, Queensland Government. [Available online at: http://www.health.qld.gov.au/violence/domestic/dvpubs/Stage2tmcol.PDF.]

Ramsay, J., Richardson, J., Carter, Y. H., Davidson, L. L. and Feder, G. (2002) 'Should health professionals screen women for domestic violence? Systematic review', *British Medical Journal*, 325: 7359.

Rand, M. R. (1997) *Violence-Related Injuries Treated in Hospital Emergency Departments*, Bureau of Justice Statistics Special Report, Washington, DC: US Department of Justice.

Robinson, A. (2003) The *Cardiff Women's Safety Unit: A Multi-Agency Approach to Domestic Violence Final Evaluation Report*, Cardiff: Cardiff University.

Rodriguez, M. A., Bauer, H. M., McLoughlin, , E. and Grumbach, K. (1999) 'Screening and intervention for intimate partner abuse: Practices and Attitudes of Primary Care Physicians', *Journal of the American Medical Association*, 282: 468-474.

Taket, A., Nurse, J., Smith, K., Watson, J., Shakespeare, J., Lavis, V., Cosgrove, K., Mulley, K., Feder, G. (2003) 'Routinely asking women about domestic violence in health settings', *British Medical Journal*, 327: 7416, 676-676.

Walby, S. and Allen, J. (2004) *Domestic violence, sexual assault and stalking: Findings from the British Crime Survey*, Home Office Research Study 276, London: Home Office.

Watts, S., Watson, J., Sethi, D., and McCarthy, C. (2002) *Evaluation of Health Service Interventions in Response to Domestic Violence Against Women in Camden and Islington: Report 2 – Report Following the Implementation in an Accident and Emergency Department and Well Woman Clinic in a London Teaching Hospital*. London: Camden and Islington Health Authority.

Watts, S., Watson, J., Sethi, D., and McCarthy, C. (2000) *Evaluation of Health Service Interventions in Response to Domestic Violence Against Women in Camden and Islington: Report 1 – Interim Report Following the Implementation of Interventions at an Obstetrics and Gynaecology Department in a London Teaching Hospital*. London: Camden and Islington Health Authority

Appendix A EIP Telephone Logs

Calls from/to agencies on service user's behalf

Agency	Calls Made	Calls Received
Solicitor	5	2
Police	22	6
Women's Aid Helpline	0	0
Local Helpline	0	0
Portsmouth Refuge	2	4
Havant Refuge	0	0
Housing Authority	12	7
Benefits Agency	0	0
C.A.B	0	0
Victim Support	1	0
Social Services	11	16
Military Services	0	0
Counsellor	0	0
A&E	6	1
Client (No Contact Call)	330	2
Witness Support	0	0
Midwife	1	3
Child Protection (NHS)	1	0
Client's Friends	1	0
EIP (No Contact Call)	0	0
Primary School	0	0
Other Refuges	15	3
Lea Special Projects	0	0
Haslar Hospital	0	0
CAFCASS	2	1
Gynaecology	0	0
Maternity	2	0
Other Local Services	8	0
Total	**409**	**45**
Total All Calls	**454**	

Number of calls made on to or received from clients:

EIP No:	Calls Made	Calls Rec/d	Total All Calls
16	12	3	15
37	3	0	3
38	27	14	41
39	2	4	6
40	135	49	184
41	2	1	3
42	0	1	1
43	26	14	40
44	0	1	1
45	3	2	5
47	1	1	2
48	13	2	15
50	5	0	5
51	5	3	8
52	0	1	1
53	1	0	1
54	4	2	6
55	4	3	7
56	1	3	4
57	3	1	4
59	0	2	2
60	4	0	4
61	1	0	1
62	4	2	6
64	0	1	1
66	3	0	3
67	2	1	3
68	3	2	5
69	0	1	1
70	2	2	4
71	1	1	2
72	3	1	4
73	1	4	5
74	3	1	4
75	3	2	5
76	1	4	5
77	3	0	3
78	2	2	4
79	3	0	3
81	7	1	8
82	35	13	48
83	2	1	3
84	1	0	1
86	5	1	6
87	6	0	6
88	6	0	6
89	2	1	3
90	1	1	2
91	18	2	20
93	4	0	4
95	3	1	4

96	1	1	2
97	6	2	8
98	5	2	7
99	3	5	8
100	0	3	3
101	0	2	2
102	10	0	10
105	2	0	2
106	3	0	3
107	20	5	25
109	7	1	8
110	10	0	10
111	4	0	4
112	2	0	2
113	8	2	10
114	3	0	3
115	2	1	3
117	62	5	67
118	3	0	3
119	53	4	57
120	1	0	1
121	3	0	3
123	50	10	60
124	1	0	1
125	1	1	2
126	1	0	1
127	1	0	1
128	5	0	5
129	13	1	14
131	2	0	2
132	11	3	14
134	4	0	4
135	3	0	3
136	5	0	5
137	7	0	7
138	9	1	10
139	9	1	10
141	3	0	3
142	23	7	30
145	3	0	3
147	18	1	19
149	1	1	2
150	1	0	1
152	1	0	1
154	4	4	8
155	7	1	8
156	2	0	2
157	1	0	1
158	28	5	32
159	16	0	16
161	12	1	13
162	10	1	11
163	5	0	5
164	4	0	4
165	1	2	3

170	8	1	9
171	19	3	22
172	9	0	9
174	17	0	17
176	4	0	4
194	21	4	25
297	3	0	3
249	7	3	10
298	5	0	5
300	4	1	5
301	9	0	9
304	9	1	10
305	3	1	4
306	5	0	5
308	8	0	8
310	2	0	2
311	5	1	6
312	9	0	9
313	5	0	5
315	14	0	14
316	1	0	1
317	5	0	5
318	4	0	4
319	1	0	1
321	12	0	12
322	11	0	11
323	1	0	1
324	2	0	2
326	2	0	2
327	6	1	7
328	7	0	7
329	5	0	5
331	7	0	7
332	5	0	5
333	9	0	9
334	2	0	2
335	1	0	1
336	7	0	7
337	1	0	1
338	6	0	6
339	1	0	1
340	2	0	2
342	1	0	1
343	3	0	3
346	14	3	17
348	5	2	7
349	1	0	1
351	5	0	5
352	7	0	7
353	17	10	27
354	11	0	11
355	11	0	11
356	4	0	4
357	6	1	7
358	5	0	5

359	11	6	17
360	5	0	5
362	6	0	6
364	5	3	8
367	3	0	3
368	5	0	5
369	10	2	12
370	5	0	5
371	2	0	2
373	3	0	3
374	1	0	1
375	6	0	6
376	3	0	3
377	1	0	1
378	8	0	8
380	5	0	5
381	4	0	4
382	3	0	3
383	5	1	6
Totals	**1291**	**269**	**1559**