Violence Against Women: A Determinant of Health

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cumberlandlodge.ac.uk/violenceagainstwomen
Violence against women causes physical, sexual, reproductive and mental ill health, but is violence against women sufficiently addressed by mainstream healthcare provision? How can we improve the healthcare services that seek to address this issue in our society? We know that women are more likely to speak to health professionals about their experiences than to report violence directly to the police. This should place public health policy-makers and practitioners at the forefront of an integrated approach to combating violence against women, but what can be done to ensure that this happens in practice?

This Cumberland Lodge Briefing has been produced ahead of a cross-sector conference on ‘Violence Against Women: A Determinant of Health’, taking place at Cumberland Lodge in Windsor Great Park on 6-7 February 2017. It was launched on Friday 25 November 2016 to coincide with the United Nations International Day for the Elimination of Violence against Women.

Find out more about the Cumberland Lodge ‘Violence Against Women: A Determinant of Health’ conference at: cumberlandlodge.ac.uk/violenceagainstwomen.

about Cumberland Lodge

Founded in 1947, Cumberland Lodge in Windsor Great Park is the home of an educational charity with the vision of more peaceful, tolerant and inclusive societies.

The charity tackles social divisions by: equipping and inspiring people to engage in constructive dialogue on issues of social cohesion; challenging silo thinking; and providing a safe space for ‘unsafe’ conversations. It fosters learning and creative thinking through: subsidised student study retreats; conferences and seminars with leading figures from public life; mentoring schemes and scholarships for early career researchers; and educational and cultural workshops and events for schools and the local community.

Cumberland Lodge itself is a 17th century former royal residence, steeped in the nation’s history and set in 5,000 acres of parkland. Its facilities are available to hire throughout the year for residential and non-residential conferences, meetings and special events. The Lodge is noted for its relaxed and welcoming atmosphere, its excellent food and comfortable accommodation, and exceptional quality of service.
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executive summary

Violence against women (VAW) takes many forms. The focus in this report is on those forms identified within chapter two of the 2014 Annual Report of the Chief Medical Officer, including: domestic violence and abuse (DVA); sexual violence; female genital mutilation (FGM); forced marriage; and so-called ‘honour’ based violence.

The term ‘domestic violence and/or abuse’ is used variously, either to refer exclusively to intimate partner violence (IPV) or violence that also encompasses violence against a family member. Given that the evidence base for prevention and intervention is strongest for IPV this is significant when considering how to respond. Definitions which conflate intimate and family violence are confusing since they assume that the dynamics are the same when they are not. Similarly, caution needs to be exercised in relation to estimating prevalence of DVA on the basis of incident-based methodologies which obscure gendered patterns of abuse.

The impact of gender-based violence (GBV) on women’s physical, sexual, reproductive and mental health means that it is a significant public health problem. Abused women use health care services more than non-abused women and identify health care workers as the professionals that they would be most likely to speak to about their experience. Even so, women generally report feeling let down by statutory health care services. Despite the introduction of routine enquiry in maternity services and an acknowledgement of the importance of enquiry in other health care settings, there is little evidence that it is widespread. Instead, women prefer to seek help from and speak more highly of specialist violence against women services that ‘plug the gap’ in mainstream healthcare provision. This highlights that there are two aspects of provision that the statutory sector must provide – those that relate to improved generic statutory services such as health care, and those that are specific to VAW.

Four out of five victims do not report abuse to the police (ONS, 2014)

Even though four out of five victims do not report abuse to the police (ONS, 2014), the focus of the Westminster Government in responding to the issue of violence against women has historically taken the form of a range of criminal justice initiatives. More perpetrators of domestic abuse, rape, sexual offences and child sexual abuse are being prosecuted than ever before, but, at the same time, the proportion of police referrals that lead to successful prosecution has started to fall. Whilst a criminal justice response to violence against women is crucial, victims may not see it as a priority. As such, the women’s sector has argued for a more balanced policy approach to VAW which is less driven by prosecution.

Although the UK has signed the Council of Europe’s Istanbul Convention on preventing and combating violence against women, it is yet to ratify it. In addition, even though the Westminster Government’s strategy to end violence against women and girls (2016-2020) is based on United Nations principles, commentators (see Dustin, 2016) observe that the extent to which VAW is recognised as a human rights issue is limited. For instance, the Government’s anti-human rights rhetoric in the domestic context is seen as inconsistent with the promotion of rights-based approaches internationally. The strategy does not address sexual harassment which is the most pervasive form of VAW, nor does it address links between trafficking, sexual exploitation and prostitution.
A review of the actions which underpin the national VAW strategy (2016-2020) reveals that the Department of Health, NHS England and Public Health England are responsible for delivering Government commitments related to prevention, the provision of services and partnership. Yet, whilst the strategy recognises that NHS staff will be in contact with adult and child victims of abuse across the full range of health services, less attention is paid to similar levels of contact with perpetrators. This serves to under-estimate the potential role that health could play both in supporting perpetrators to address their abusive behaviour and holding them accountable within a coordinated community response to domestic violence.

National Institute for Health and Care Excellence (NICE) guidelines on ‘domestic violence and abuse: multi-agency working’ set out a comprehensive list of evidence-based recommendations for health and social care professionals within the framework provided by the national strategy; however, they have been criticised for failing to adequately cover all the different forms of GBV or to address the needs of particular groups of women. This is crucial to developing appropriate pathways for support.

The NICE guidelines recognise that more needs to be done to develop the evidence base in relation to the effectiveness of health interventions over the short, medium and long term. Whilst studies exploring the longitudinal impact of health interventions and their economic effectiveness remain a gap in the evidence base, progress has been made in relation to the effectiveness of domestic violence interventions which have a positive impact on health.

The 2014 Annual Report of the Chief Medical Officer provides a valuable contribution to the evidence base for health and social care professionals through addressing some of the shortcomings identified in relation to the NICE guidelines. In turn, some of the recommendations for further policy development which are identified within the report have recently been addressed. Other developments such as the 2016 NHS Mandate (recognising the vital role that the NHS can play in tackling domestic violence), the inclusion of domestic violence within the Public Health Outcomes Framework (PHOF) 2013-2016 and the development of a specific domestic violence and abuse Quality Standard by NICE, all represent an opportunity for a step-change in the response of health services.
I. defining violence against women

The United Nations (UN) Declaration (1993) on the Elimination of Violence against Women understands ‘violence against women’ to mean:

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.¹

The term is understood to encompass (but is not limited to) the following:

(a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;

(b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; and

(c) Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.

The definition of violence against women illustrates that gender-based violence (GBV) takes many forms. The following section of the report provides an analysis of those forms identified within chapter two of the Annual Report of the Chief Medical Officer (Mullins & Murphy, 2014). These include: domestic violence and abuse (DVA); sexual violence; female genital mutilation; forced marriage; and so-called ‘honour’-based violence.

a note on definitions

The term ‘domestic violence’ is used variously, either to refer exclusively to intimate partner violence (IPV) or also encompassing violence against a family member, including intergenerational violence such as violence against parents (FRA, 2014).

In the UK, the Government definition of domestic violence applies to both IPV and Adult Family Violence (AFV). AFV is also understood to include female genital mutilation, forced marriage and so-called ‘honour’ based violence.

government definition of domestic violence and abuse

In the UK, the Government definition of domestic violence and abuse (HM Government, 2012) is:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

- Psychological
- Physical
- Sexual
- Financial
- Emotional.

Controlling behaviour
Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour
Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

The conflation of IPV with AFV in the domestic violence definition assumes that their dynamics are the same. However, commentators argue that what is known about IPV draws on research undertaken on men who abuse women in heterosexual relationships and cannot be simply ‘read across’ to relationships with difference generational, sexual or gender circumstances (Kelly & Westmarland, 2014). IPV has long been recognised as an ongoing pattern of behaviour through which one partner uses physical, sexual, psychological and/or financial abuse in order to exert control. The inclusion of ‘controlling and coercive behaviour’ within the Government’s definition of domestic violence was intended to acknowledge this; yet adding ‘a pattern’ of incidents to the ‘any incident’ description (made necessary by the inclusion of forms of violence which are usually single incidents such as FGM and forced marriage) confuses the definition still further (Kelly & Westmarland, 2014).
domestic violence and abuse (DVA)

Police reports of domestic violence and abuse (DVA) have increased year-on-year since 2007/08. In 2014/15 the number of cases recorded reached 943,628 representing a 43% increase (Woodhouse & Dempsey, 2016). Yet it is difficult to ascertain whether this reflects an increase in prevalence or simply reflects improvements made in the recording of DVA offences, alongside an increased willingness of victims to come forward and report (Flatley, 2016). As a consequence, researchers rely on survey data from the Crime Survey for England and Wales (CSEW) which is generally considered to be more reliable (Walby et al., 2015). Two sets of figures are available from the CSEW.

Domestic abuse is defined by the Crime Survey of England & Wales (CSEW) as: ‘non-physical abuse, threats, force, sexual assault or stalking’.

The most recent survey (Flatley, 2016) shows that an estimated 27.1% (4.5 million) of women and 13.2% of men (2.2 million) between the ages of 16 and 59 years have experienced ‘any domestic abuse’ since the age of 16. In 2014-15 alone, 8.2% of women and 4.0% of men disclosed experiencing domestic abuse. The CSEW shows that women are more likely than men to say that they have experienced all forms of abuse asked about. In addition, younger women aged between 16 and 19 (12.6%) and between 20 and 24 (8.9%) are more likely to be victims of any domestic abuse compared with older women aged between 55 and 59 (5.4%).

Yet the headline statistics presented by the CSEW have been criticised for disguising gendered differences in the experience of domestic abuse. This is because the CSEW measures reflect the Government definition of domestic violence which is based on ‘one or more’ discrete acts of domestic abuse experienced in an individual’s lifetime. When IPV is recognised as a pattern of coercive and controlling behaviour then the gendered distribution of victimisation and perpetration is clear.

The methodology used to analyse the CSEW data imposes a ‘cap’ at five incidents. However, when Walby et al. (2015) introduced a new methodology which took account of all violent crimes their findings were significant. According to the CSEW measures, rates of violent crime have been falling since the mid-1990s and trend data suggests that there has been little change in the prevalence of domestic abuse year to year (Britton, 2012 – cited by Myhill, 2015). Yet, using the new methodology, Walby et al. (2015) found that the overall rate of violent crime has actually been increasing. Moreover, domestic violent crime has a different trajectory from other forms of violent crime. Thus, the ‘cap’ imposed by the CSEW serves to disproportionately reduce both the amount of violent crime against women and the amount of violent crime that is domestic. Whilst most violent crime against men is indeed falling, the new methodology reveals that domestic abuse has been rising for women since 2009.

Like Walby et al. (2015), Myhill (2015) has also taken a different approach to the analysis of CSEW data. He argues that there is a qualitative difference between ‘clinical-level’ IPV (see Ehrensaft, Moffitt, & Caspi, 2004 - cited by Myhill, 2015) and abuse which takes place in coercive and controlling contexts. Clinical level IPV is defined simply as abuse which is serious or injurious enough to warrant a medical or other agency response. IPV in the context of coercive control will often involve clinical-level violence, but is not defined by it. Indeed, Stark (2007) argues that that IPV is not a ‘crime of assault’ but a ‘liberty crime’ which creates conditions of un-freedom. Physical and sexual abuse is interwoven with three equally important tactics: control, intimidation and isolation.
Since IPV in this context is ongoing rather than episodic, its unrelenting nature means that victims struggle to exercise autonomy since their ‘space for action’ (Kelly, 2003) is diminished.

In his study, Myhill (2015) selected two variables within the self-completion module of the 2008/09 survey which he believed were closest to aspects of coercive control as it is experienced. Respondents were categorised as having experienced coercive control if they said their partner had done both of the following: ‘repeatedly belittled you to the extent that you felt worthless’ and ‘frightened you, by threatening to hurt you or someone close to you’. Analysis revealed that coercive control was highly gendered, with victims of coercive controlling abuse appearing to be more likely to be women and – consistent with Walby et al. (2015) – to have experienced more than five physical assaults in the past year.

**sexual violence**

The CSEW defines sexual assault as: rape or assault by penetration including attempts (‘serious’) and indecent exposure or unwanted touching (‘less serious’) carried out by any person. In 2014/2015 the CSEW reported that an estimated 2.7% of women had experienced some form of sexual assault in the past year (including attempted offences). This has not significantly changed since the previous survey year (2013/14, 2.2%) although rates have fluctuated over the past ten years (Flatley, 2016).

Young women are again more likely to have been victims of any sexual assault in the last year, with the prevalence of sexual abuse decreasing with age. Around 9.0% of women aged between 16 and 19 were a victim of any sexual abuse in 2014/2015, significantly higher than women aged 25 to 34 (2.2%), 35 to 44 (1.6%), 45 to 54 (1.7%) and aged 55 to 59 (0.6%). The only age group which is not statistically significant when compared with women aged 16 to 19 is women aged 20 to 24 (5.8%).

In over half of serious sexual assaults on women since the age of 16, the offender was a partner or ex-partner in at least one incident.

In over half (57%) of serious sexual assaults on women since the age of 16, the offender was a partner or ex-partner in at least one incident. In contrast, the proportion of less serious sexual assaults experienced by women since the age of 16, where the offender was a partner or ex-partner in at least one incident was lower (25%).

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2 Detailed findings of the self-completion module 2015/16 are planned for release in February 2017: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice.
international comparisons

It is difficult to make international comparisons about the prevalence of DVA since, in practice, definitions vary between studies. There is, however, growing consensus on how best to document exposure to intimate partner and sexual violence (WHO, 2013). The first global systematic review and synthesis of the body of scientific data on the prevalence of two forms of violence against women - violence by an intimate partner (intimate partner violence) and sexual violence by someone other than a partner (non-partner sexual violence) was undertaken by the World Health Organisation (WHO), the London School of Hygiene and Tropical Medicine and the South African Medical Research Council (2013). Compiled in a systematic way, the findings show that, overall, 35% of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence. Most of this violence is intimate partner violence with almost one third (30%) of women worldwide having experienced physical and/or sexual violence by their intimate partner.

35% per cent of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence

When these statistics are broken down by WHO region, the lifetime prevalence of physical and/or sexual intimate partner violence among ‘ever-partnered women’ in Europe is 25.4% and the lifetime prevalence of non-partner sexual violence is 5.2%. Taken together, these two measures represent 27.2% of women which is nearly the same as the estimated prevalence of domestic abuse in the UK (although the global study covers a broader age range from 15 to 69).

A survey on violence against women undertaken by the European Union Agency for Fundamental Rights (FRA) found that one in three women (33%) across the European Union has experienced physical and/or sexual violence from a partner or non-partner since the age of 15. This is higher than the regional prevalence estimated globally but also includes women who have never been ‘partnered’. The UK scored over the European Union average at 44% and was ranked alongside France at number 22 out of 28 countries.

When the survey results are looked at alongside the gender equality index for all EU Member States, those States ranked highest in terms of gender equality also tend to have higher prevalence levels of violence against women. It is suggested that where there are greater levels of awareness about VAW at different levels in society, then more women may be willing to disclose their experiences of violence in a survey interview (FRA, 2014).
forced marriage, female genital mutilation and ‘honour’-based violence

Whilst the past decade has seen a rapid growth in the body of research evidence available on the prevalence of intimate partner violence and sexual violence perpetrated by someone other than an intimate partner (WHO, 2013), this is not the case for other forms of violence against women. There are, for instance, no reliable estimates on the extent of forced marriage, female genital mutilation or so-called ‘honour’-based violence in the UK. This section sets out definitions of these terms and presents what prevalence and measured data are known.

forced marriage

Multi-agency statutory guidance for dealing with forced marriage states that a forced marriage is understood to take place when one or both spouses do not consent to the marriage but are coerced into it. Duress can involve physical, psychological, financial, sexual and emotional pressure (HM Government, 2014a:1).

A research report by the National Centre for Social Research (Kazimirski et al., 2009) estimated between 5-8,000 cases of forced marriage in 2008, although this only included victims who approached agencies for help. Of those who did seek help from services, 96% were girls and young women, the vast majority (80%) of whom were 23 and under (Kazimirski et al. 2009). In addition, 97% of those seeking help were identified as Asian young women, 94% of whom were South Asian (Pakistani, 72%; Bangladeshi, 13%; and Indian, 9%). These statistics are reflective of the large and established South Asia Diaspora in the UK. As statutory guidance reminds practitioners, forced marriage is not ‘solely a South-Asian problem’ (HM Government, 2014a: 1-2) and groups of young women from Black African and Caribbean, Middle Eastern, Eastern European and Irish traveller communities may also be affected.

The most recent statistics from the Forced Marriage Unit (FMU) reveal that in 2015 it gave advice or support relating to a possible forced marriage in 1,220 cases (Home Office/FCO, 2016). The FMU also received approximately 350 calls per month. Whilst the majority of cases that the FMU provided support to involved female victims (n=980, 80%), a fifth involved male victims.

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Female Genital Mutilation (FGM)

Female Genital Mutilation is defined in multi-agency statutory guidance as

‘a procedure where the female genital organs are injured or changed and there is no medical reason for this’ (HM Government, 2016b: 8)

The practice of FGM is linked to parts of Africa, the Middle East and Asia, but increased migration has led it to being an issue within Europe, including the UK (Westmarland, 2015). FGM is usually perpetrated against girls shortly after their birth and during childhood or adolescence, but it may also be carried out just before marriage or during a woman’s first pregnancy. In 2015 a study estimated that approximately:

- 60,000 girls aged 0 to 14 were born in England and Wales to mothers who had undergone FGM
- 103,000 women aged 15 to 49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM
- 10,000 girls aged under the age of 15 who have migrated to England and Wales are likely to have undergone FGM (McFarlan & Dorkenoo, 2015)

Several policy developments mean that measured data on FGM can now be collected. Female Genital Mutilation Protection Orders (FGMPOs) came into effect in July 2015 and are intended to safeguard girls who are at risk of FGM at home or abroad, or who are survivors of the practice. In total, there have been 77 applications and 68 orders made since their introduction to the end of June 2016 (MoJ, 2016). Mandatory reporting of FGM was also introduced on 31 October 2015, requiring health and social care professionals and teachers to report ‘known’ cases of FGM in girls aged under-18 to the police. This measure should also increase what is known about the extent of this form of violence.

‘honour’-based violence (HBV)

So-called ‘honour’-based violence (HBV) is difficult to define but is predicated on ‘patriarchal notions of ownership and control of women’s bodies’ (Sen, 2005: 48). Women and girls ‘hold’ family ‘honour’ and are expected to maintain it by following social norms related to restricting their sexual and behavioural autonomy. The role of men and boys is to uphold ‘honour’ through regulating the actions of ‘their girls and women’ (Gill, 2014). Transgression from social norms (whether actual, suspected or potential) results in ‘shame’ – not only for the individual and their family but also community members. As a consequence, attempts may be made to restore ‘honour’ by punishing the individual concerned (Coomaraswamy, 2005). An ‘honour killing’ is the extreme outcome of HBV (Westmarland, 2015).

A recent HMIC report into HBV notes that ‘few forces have taken all necessary steps to ensure that they fully understand the nature and scale of HBV in their areas’ (HMIC, 2015: 11). Indeed, a Freedom of Information Request sent to all 52 police forces across England, Wales, Scotland and Northern Ireland in 2011 resulted in just 39 returns. Between them police had recorded a total of 2,823 incidents. Estimates made in relation to the 13 forces that did not respond suggested around 500 further incidents, meaning an estimated 3,000 incidents of HBV are recorded by the police every year (IKWRO, 2011 cited by Westmarland, 2015). In addition, Home Office statistics estimate that there is around one ‘honour’ based killing every month but acknowledge that the number may be much higher because of the unreported nature of this crime.
2. the impact of violence against women on health

There has been less research on the health effects of exposures to different forms of violence against women (WHO, 2013). What the research literature does reveal, is that violence against women has a broad range of effects – encompassing physical, sexual, reproductive and mental health. Gender-based violence is, therefore, recognised as a significant public health problem due to its physical and psychological impacts.

As is the case with prevalence, much of the research into the health impact of violence against women focuses on intimate partner violence. Women who have been physically or sexually abused by their partners report higher rates of a number of important health problems (WHO, 2013). For example, they are almost twice as likely to experience depression and twice as likely to have an abortion. Diagram one (overleaf) illustrates pathways and health effects of intimate partner violence.

Less data is available on the health effects of non-partner sexual violence, but the evidence which does exist reveals that women who have experienced this form of violence are nearly 2.5 times more likely to have alcohol use disorders and 2.6 times more likely to experience depression or anxiety (WHO, 2013).

Violence against women also has an impact on levels of morbidity and mortality. Analysis of the Adult Psychiatric Morbidity Survey (APMS) in England reveals that a quarter of the population has experienced violence and abuse (Scott et al. 2013). Analysis identified five distinct profiles:

1. Physical violence from a partner
2. Extensive physical violence/coercion from a partner
3. Sexual abuse only as a child
4. Sexual abuse only as an adult
5. Extensive physical violence, sexual abuse as a child/adult.

People in all the groups characterised by experiences of violence and abuse were at least five times more likely than those with little experience to have attempted to take their own life. Group number five were fifteen times more likely to have done so and over half (56%) of people in this group had self-harmed.

Women who have been physically or sexually abused by their partners are almost twice as likely to experience depression, and twice as likely to have an abortion (WHO, 2013)
Figure 1: An approach driven by prosecution (Coy et al. 2008)
women’s use of health services

Given the negative impact of violence on women’s physical and mental health, it is not surprising that abused women use health care services more than non-abused women. In fact, the National Health Service (NHS) spends more time dealing with the impact of VAW than almost any other agency (DoH, 2011). Health services are also often the first point of contact for women who have experienced violence. The CSEW reports that almost a third (32%) of partner abuse victims in England and Wales sought medical assistance due to the abuse. Moreover, victims identify health care workers as the professionals that they would be most likely to speak to about their experience (HM Government, 2016a).

Women access both primary care services (GPs, health visitors, practice nurses, dentists, sexual health clinics, maternity services) and hospital-based services (including Accident and Emergency, hospital and ambulance services). However, it is interesting to note that analysis of domestic homicide reviews suggests that General Practitioners (GP) are identified as the service with which victims most ‘consistently and actively engaged’ (see Neville & Sanders-McDonagh, 2014: 34; Sharp & Kelly, 2016).

Yet despite this engagement, studies suggest that women generally feel let down by health care services. Fourteen focus groups facilitated and led by the Women’s National Commission (WNC) as part of the 2009 Government ‘Task force on the Health Aspects of Violence against Women and Children’ discovered that women wanted health professionals to take more time to identify the root cause of their symptoms rather than respond by prescribing drugs (see also Kelly et al., 2014).

Despite the introduction of routine enquiry in maternity services and an acknowledgement of the importance of enquiry in other health care settings, there is little evidence that it is widespread. Reluctance to ask about abuse has been highlighted in a number of studies. Barriers include not knowing how to ask the question, a lack of confidence in how to respond appropriately to a disclosure, fear of causing distress, and a lack of specialist services to which people can be referred (Scott & McNeish, 2008).

Women generally spoke more highly of the response from specialist violence against women services, explaining that they ‘plugged the gap’ in mainstream healthcare provision. For instance, Sexual Assault Referral Centres (SARCs) provide services needed in the aftermath of rape and Rape Crisis Centres (RCCs) provide support for adults dealing with histories of sexual abuse in childhood and adult rapes that occurred some time ago (Coy et al. 2009). RCCs developed from grassroots activism over thirty years ago to challenge cultures of disbelief and victim blame. Independent Sexual Violence Advisers (ISVAs) are a relatively more recent development and were commissioned by the Home Office in 2005. They are based in specialist women services and provide support to victims of rape and sexual assault.
One of the differences in the approach of specialist women's services is that they have brought the significance of social location into trauma discourse. Burstow (2003: 1305) illustrates what this means by describing how a woman who has previously been raped is fearful about walking down the street. Since the woman lives in a sexist society, violence against women is an ever present danger; social relations in the present contain the same gendered power dynamic that underpinned the rape. In this way her feeling unsafe is not simply the result of her previous experience but an 'attunement to a basic social reality'. Burstow (2003) argues, therefore, that deficit trauma models which focus on the individual are inappropriate since they do not address structural factors which are critical in the creation of trauma.

The women consulted in the WNC focus groups described their ‘ideal’ response to a disclosure as one in which they are: listened to and believed; treated with dignity and respect; and helped to be safe. Women wanted a needs assessment that focused on their emotional well-being to accompany any medical treatment, and information about specialist services that could provide emergency and ongoing support and advocacy and consensual referral to these support services where appropriate (WNC, 2010).

This highlights that there are two aspects of provision that the statutory sector must provide: those that relate to improved generic statutory services such as health care and those that are specific to VAW (Coy et al. 2008). In 2009, research by Coordinated Action Against Domestic Abuse (now SafeLives) concluded that there was a need to strengthen links between generic and specialist health care services. Seven years later the charity published evidence to show how co-locating both aspects of provision is effective. Health professionals working in hospitals reported that the presence of independent domestic violence advocates (IDVAs) that they could refer on to made it more likely that they would ask patients about domestic violence in line with NICE recommendations (see section five below). They also reported greater confidence that identification and referral would result in a meaningful outcome for the victim. Similarly, the Identification and Referral to Improve Safety (IRIS) model, which has recently been implemented in 33 General Practitioner (GP) practices across England, has increased referral levels six-fold after developing local referral pathways for victims and perpetrators (SafeLives, 2016).
3. The policy response to violence against women

The focus of the Government in responding to the issue of violence against women has historically taken the form of a range of criminal justice initiatives (as Figure 2 illustrates, below). The role of ISVAs, SARCs, RCCs and other specialist women’s health services such as FGM clinics have been recognised, but the provision of such services not prioritised.

A criminal justice response to violence against women is, of course, crucial; however, despite a recent increase in reporting, women remain unlikely to report violence to the police, particularly when the violence is committed by someone who is known to them (Flatley, 2016; Walby et al., 2015). As such, the women’s sector has long argued for an approach to Government policy which is driven less by prosecution and which is more balanced. This has been expressed as the ‘Six P’ approach. Perspective and Policy are the necessary foundations and drivers of an integrated approach which gives equal emphasis to Prevention, Provision, Protection and Prosecution.

This section provides a brief summary of the policy approach to violence against women over the past forty years, including an assessment of the current strategy to end violence against women (2016-2020).
criminal justice measures

Analysis of the Government’s response to violence against women up until 2016 reveals four broad phases of activity coinciding with:

1. The 1975 Select Committee Inquiry into violence in marriage
2. The 1992 Select Committee Inquiry into domestic violence

1. The 1975 Select Committee

The 1975 Select Committee inquiry represented Government recognition of the issue of ‘violence in marriage’ for the first time. It led to the introduction of the Domestic Violence and Matrimonial Proceedings Act (1976) and the Domestic Proceedings and Magistrat’s Courts Act (1978). This legislation introduced equal protection to victims whether married or unmarried and included non-molestation and ‘ouster orders’. However, it was not until 1991 that increased public and political awareness of the extent of violence within marriage led to the realisation that rape within this context was the most common form and marital rape was made illegal (Painter, 1989, 1991).

2. The 1992 Select Committee

In 1992 another Select Committee Inquiry explored the issue of domestic violence. A ‘Family Homes and Domestic Violence Bill’ was introduced to Parliament in 1992 but failed to pass. Eventually the Family Law Act (1996) entered onto statute offering protection to a wider range of women, in more situations and for longer periods of time (Matczak et al. 2011). Part IV of the Act set out civil law remedies concerning: the rights of occupation of a non-owning spouse or civil partner; the court’s powers to regulate occupation of family home; the court’s duties to make certain orders; and the court’s powers to grant non-molestation orders. A non-molestation order was also applied to a broader range of people through a new category of associated persons in order to prevent further violence to the applicant or children. Section 45 enables ex-parte orders (Section 45) to be made taking into account the risk of significant harm. Breached orders were made subject to the power of arrest (Section 47).

A year later the Protection from Harassment Act (1997) was introduced to extend both civil and criminal law and introduced provisions to deal with violence outside of the home such as post-separation harassment or violence.

3. The late 1990s

Two events influenced the further development of domestic violence policy in the late 1990s: the need to align UK policies with the strategic objectives agreed in the Beijing Platform for Action (UNWomen, 1995) and the election of the Labour Party to Government (1997) with a manifesto commitment to take forward policy development to combat domestic violence. Living without Fear: An Integrated Approach to Tackling Violence against Women was published in 1999 to guide the overarching policy approach to violence against women; this was superseded by Domestic Violence: A National Report in 2005.
This period saw connections being made across all forms of violence against women (not just domestic violence) including rape and other sexual violence, forced marriage, female genital mutilation and stalking and harassment. For instance, the Home Affairs Select Committee inquiry into Domestic Violence, Forced Marriage and ‘Honour'-Based Violence in 2008 served to widen the focus of the Government's work in this area. This led to Crown Prosecution Service (CPS) developing a Violence Against Women (VAW) strategy. The Government followed suit by publishing a cross-governmental strategy on 25th November 2009 adopting the three-pronged approach to violence against women developed by the Zero Tolerance Campaign (Coy et al., 2008).

Domestic Violence: A National Report continued to develop the criminal justice response to violence against women by introducing new measures such as Specialist Domestic Violence Courts (SDVCs) and Independent Domestic Violence Advisers (IDVAs). New legislation included:

- The **Sexual Offences Act (2003)** – this made changes to sexual crimes laws in England and Wales (and to some extent Northern Ireland), almost completely replacing the Sexual Offences Act (1956). Rape was redefined to include penetration of the mouth. The Act also changed the way in which lack of consent may be proved. Sections 75 and 76 of the Act list circumstances in which lack of consent may be presumed.

- The **Female Genital Mutilation Act (2003)** replaced the Prohibition of Female Circumcision Act (1985). It modernised the offence of FGM and the offence of assisting a girl to carry out FGM on herself while also creating extra-territorial offences to deter people from taking girls abroad for mutilation.

- The **Domestic Violence, Crime and Victims Act (2004)** extended protection offered by civil law to victims of domestic violence by making the breach of a non-molestation order made under Part IV of the Family Law Act 1996 a criminal offence. It also extended the availability of injunctions to same sex couples and to those who, while not living together, have or have had an intimate relationship of significant duration (Section 4). Section 12 of the Act (implemented from September 2009) amended previous legislation relating to restraining orders (section 5 of the Protection from Harassment Act 1997) allowing courts to make restraining orders on conviction or acquittal for any criminal offence based on ‘balance of probability’ evidence if there is a need for an order to protect a person or persons. Protection for victims and witnesses was extended by the introduction (from April 2006) of a statutory Victim’s Code of Practice and a Commissioner for Victims and Witnesses (Section 32). The Act also introduced (from April 2011) statutory multi-agency domestic homicide reviews when anyone over 16 years dies of violence, abuse or neglect from a relative, intimate partner or member of the same household (Section 9).


Soon after the Coalition Government was established in March 2010, the Home Secretary (now Prime Minister) published a new cross-governmental strategy to end violence against women and girls (November 2010). The new strategy reflected the Government’s shift towards localisation and was underpinned by a four pillar approach comprising of: prevention; the provision of services; partnership working; and pursuing perpetrators.
In the five years that the strategy guided the Government’s response to this issue, the Government criminalised a range of offences and made a number of new civil protection measures available. These included:

- **Domestic Violence Protection Orders (DVPOs)** were rolled out across England and Wales from March 2014. Under the DVPO scheme, perpetrators can be banned from returning to their home in the immediate aftermath of the police being called and from having contact with the victim for up to 28 days. The scheme comprises an initial temporary notice (domestic violence protection notice, DVPN), authorised by a senior police officer and issued to the perpetrator, followed by a DVPO that can last from 14 to 28 days, imposed at the magistrates’ court. DVPOs are designed to give victims space and time to access support and consider their options.

- **The DV Disclosure Scheme (DVDS)** was also introduced in March 2014. It allows anyone with concerns about a relationship to obtain information on previous violence committed by the partner and thus make informed choices about their options.

- **The Anti-Social Behaviour, Crime and Policing Act (2014)** criminalised forced marriage (Section 121).

- **Section 73 of the Serious Crime Act 2015** came into force in December 2015 providing for **FGM Protection Orders (FGMPOs)** to be made for the purposes of protecting a girl at risk of FGM or one against whom an FGM offence has been committed. In addition, a new FGM mandatory reporting duty that requires regulated health and social care professionals and teachers to report ‘known’ cases of FGM in under-18s to the police is now in force.

- **Section 76 of the Serious Crime Act 2015** also criminalises patterns of coercive or controlling behaviour where they are perpetrated against an intimate partner or family member.

- **The Modern Slavery Act (2015)** sets out a range of measures on how modern slavery and human trafficking is dealt with.

- **Section 33 of the Criminal Justice and Courts Act 2015** creates an offence of disclosing private sexual photographs or films (‘revenge pornography’) without the consent of an individual who appears in them and with intent to cause that individual distress.

In June 2012 the Government also signed and promised to ratify the **Istanbul Convention** (Council of Europe Convention on Preventing and Combatting Domestic Violence and Violence against Women). This commits Governments to: train professionals in close contact with victims; regularly run awareness-raising campaigns; take steps to include issues such as gender equality and non-violent conflict resolution in interpersonal relationships in teaching material; set up treatment programmes for perpetrators of domestic violence and for sex offenders; work closely with NGOs; and involve the media and the private sector in eradicating gender stereotypes and promoting mutual respect.

In early 2016 the Government said it remained committed to ratifying the Convention but made clear it would not ratify it until the UK complies with all of its articles. At the same time it has also said that the UK already complies with the vast majority of the Convention’s articles through its comprehensive work to protect women and girls (Woodhouse & Dempsey, 2016). It is interesting to note that reference is not made to the Convention in the Government’s new strategy to end violence against women and girls.
the effectiveness of the criminal justice response

The most recent report from the Crown Prosecution Service (CPS, 2016) on its violence against women strategy states that it is ‘prosecuting, and convicting, more defendants of domestic abuse, rape, sexual offences and child sexual abuse than ever before’ (CPS, 2016: 1). In 2015-16 the number of successful prosecutions rose by 11% (n=8,500) from 2014-15.

- More than 75,000 domestic abuse convictions were secured with a 74.5% conviction rate.
- More than 4,600 defendants were prosecuted for rape offences with convictions being secured in 2,689 of these (57.9%).
- 4,643 child sexual abuse convictions were made with a conviction rate of 74.7%.

Despite increased reporting to the police, there was a fall (3.3%, 4320) in referrals to the CPS for crimes which fall into the VAW ‘subset’ of domestic abuse, rape and sexual offense. In particular, the volume of domestic abuse referrals fell from 122,898 in 2014-15 to 117,882 in 2015-16 (4.1%, 5016), although the proportion of cases charged increased.

Similarly, the volume of referrals from the police of honour based violence related offences (HBV) fell to 216 in 2015-16 from 251 in 2014-15. 145 (67.1%) of these referrals were charged, a fall from 157 in 2014-15. 182 defendants were prosecuted, a fall from 225 last year. 91 defendants were convicted, a fall from 129 in 2014-15. The proportion convicted also fell from 57.3% to 50%. No FGM cases were referred to the CPS for prosecution, reflecting ongoing challenges in obtaining evidence from the victim and their continued engagement with criminal proceedings.

However, the volume of forced marriage referrals from the police rose to 90 in 2015-16 from 82 in 2014-15. 57 (63.3% of these referrals) were charged, the highest volume ever recorded and a rise from 58.5% compared with 2014-15. The volume of prosecutions completed in 2015-16 rose to 53 – a rise from 46 in 2014-15. 60.4% of prosecutions were successful, a fall from 63.0% in 2014-15.
4. government strategy to end violence against women and girls

The Westminster Government’s strategy to End Violence Against Women and Girls (VAWG): 2016-2020 (HM Government, 2016a) builds on the four pillar approach it set out when in Coalition with the Liberal Democrat Party (HM Government, 2010). Whilst the strategy is based on UN principles, the extent to which this is recognised is limited and international commitments have not been fulfilled (Dustin, 2016). As well as the failure to ratify the Istanbul Convention, the Government’s anti-human rights rhetoric in the domestic context is inconsistent with the promotion of rights-based approaches internationally.

The strategy does not address sexual harassment which is the most pervasive form of VAWG; nor does it address links between trafficking, sexual exploitation and prostitution. Whilst it is cross-governmental in scope, the strategy does not enjoy consistent levels of support across all government departments. Indeed, despite the clear mental and physical health issues outlined above and the development of an action plan to improve services for women and child victims of violence in 2010, the Department of Health is often seen as a reluctant partner on VAWG (Dustin, 2016; SafeLives, 2016). Reflecting back on the Taskforce report (2010) looking at the relationship between health and domestic violence (see section two above) SafeLives (2016: 37) notes that ‘it is regrettable that more of the recommendations have not been seen through’.

the role of health

Analysis of the ninety-five actions which underpin the violence against women and girls strategy reveals that the Home Office is responsible for 41 of them in total, reflecting how criminal justice continues to disproportionately drive the Government’s response to this issue. However, after the Home Office, the highest number of actions sits with health. The Department of Health is responsible for nine; NHS England is responsible for five; and Public Health England is responsible for one. This is a positive development since research suggests that when victims do not self-refer to the police, health settings can provide a key route into accessing specialist services (SafeLives, 2016).

Health services feature most strongly within the prevention section of the strategy. It is recognised that the ‘multi-faceted and complex nature of VAWG means that it cannot be addressed by any one agency alone’ (HM Government, 2016a: 11 & 14), and women should be able ‘to disclose experiences of abuse across all public services, including the NHS’. Unlike previous governmental policy, ‘GPs, midwives, health visitors, mental health, drug and alcohol services, sexual health and Accident and Emergency staff’ are all acknowledged as being ‘well-placed’ to detect abuse and direct victims to the most appropriate statutory and non-statutory services (SafeLives, 2016). This includes ensuring that processes already in place are as effective as possible and considering how routine enquiry into domestic abuse within maternity and mental health services can be more firmly embedded. The intention to expand routine enquiry of abuse in childhood and adulthood in a range of targeted services is also noted.
The strategy outlines how the NHS Mandate recognises its role in tackling abuse and violence. It lists a range of interventions through which NHS services can contribute to ending violence against women and girls.

- Health practitioners are trained to identify early signs of abuse and respond appropriately (free online training to improve awareness amongst healthcare professionals based on the NICE guidance on domestic abuse)
- The Identification and Referral to Improve Safety (IRIS) Programme supports GPs to identify and appropriately refer cases on domestic violence and abuse
- Appropriate psychological therapies and mental health interventions for victims and perpetrators are provided through Promoting Recovery in Mental Health (PRIMH) – a project which will provide expert input to safeguarding, clinical and recovery frameworks and contribute to developing strategies to deal with perpetrators of domestic violence
- The FGM prevention programme, in partnership with NHS England, improves the health-based response to FGM and actively supports prevention, including through mandatory reporting requirements

In addition, two of the eight (8) Government commitments on prevention are specifically related to health:

- Make early detection and prevention a priority for the health and public health services and mainstream this into the work of all health professionals (5)
- Work with agencies and local areas to ensure adequate mental health provision for victims and perpetrators of VAWG as well as the development and provision of preventative and harm reduction programmes for perpetrators (6)

Health services are also integrated within outcomes related to the provision of services so that victims, survivors and their families can access the right support at the right time, ensuring fewer victims reach crisis point. The strategy recognises the importance of local areas accessing robust sources of data, evidence and service standards, including health needs. Health commissioners are encouraged to work collaboratively and in a joined up way with local authorities and Police and Crime Commissioners. The strategy introduces the intention to develop a National Statement of Expectations which will provide a supportive framework for such activity. Support specific to health commissioners includes the publication of specialist FGM guidance to ensure that they have the information they need to provide effective services for their local patient populations.

Another area of focus is the challenge providing effective mental health interventions to address domestic and sexual violence and abuse. Clinical Commissioning Groups are expected to ensure that mental health services are included within responses to tackle violence against women. The Government also expects local NHS services to increase the amount they spend on mental health in line with the extra investment of £11.7 billion made nationally. First time access and waiting time targets were also implemented in April 2015.
Two of the six (6) Government commitments made about the provision of services apply to health:

- Support local commissioners to transform service provision through the National Statement of Expectations (2)
- Promote resources available for health and social care professionals to respond to domestic abuse to increase their understanding of domestic violence and abuse and their ability to provide a supportive response to disclosures (3)

Stated outcomes for 2020 in relation to partnership working refer to multiagency arrangements supported by the framework set out in the National Statement of Expectations and rigorous needs assessment considered in line with drug and alcohol services. An example of an effective partnership is the programme developed between Public Health England (PHE) and the University of the West of England (UWE) which is helping to challenge sexual abuse on campus.

One of the seven Government commitments related to partnership working is to help local areas to develop new and more integrated approaches to multi-agency working that support earlier intervention and swifter action to manage the risk from perpetrators and address the needs of their victims and families.

The pillar related to pursuing perpetrators does not mention health, despite the pillar related to prevention referring to the potential for the Promoting Recovery in Mental Health (PRIMH) Project to contribute to the development of strategies to deal with perpetrators of domestic violence. This is important since analysis of the National Confidential Inquiry (NCI) Into Suicide and Homicide by People with Mental Illness database found that the prevalence of symptoms of mental illness was particularly high among perpetrators of Adult Family Homicide (AFH) with 27% experiencing psychotic symptoms and 7% experiencing symptoms of depression. In addition, perpetrators of Intimate Partner Homicide (IPH) who had symptoms of mental illness were more likely to have depressive symptoms (13%) at the time of the offence (Oram et al. 2013).

Its omission in this section also represents a missed opportunity for the strategy to reinforce the role of health in holding perpetrators accountable as part of the coordinated community response to domestic violence. A recent review of the effectiveness of perpetrator programmes in the UK revealed that just four of 1,100 referrals were made by GPs (n=2) and mental health services (n=2) (Kelly & Westmarland, 2015). In addition, just two of eleven programmes had received funding from health sources.

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3 Of the 251 perpetrators of AFH, a third (n=85) had symptoms of mental illness at the time of the offence.

4 Of the 1,180 IPH perpetrators within the NCI, 20 percent had symptoms of mental illness at the time of the offence.
5. NICE guidelines on domestic violence and abuse: multi-agency working

The National Institute for Health and Care Excellence (NICE) guidelines on ‘Domestic Violence and Abuse: Multi-Agency Working’ (2014) set out a comprehensive list of evidence-based recommendations for health and social care professionals. An assessment of these reveals that they address each of the four pillars which underpin the national violence against women and girls strategy.

**Prevention**

- Create an environment for disclosing domestic violence and abuse (recommendation five)

**Provision of services**

- Plan services based on an assessment of need and service mapping (recommendation one)
- Develop an integrated commissioning strategy (recommendation three)
- Commission integrated care pathways
- Tailor support to meet people’s needs (recommendation eight)
- Help people who find it difficult to access services (recommendation nine)
- Identify and where necessary refer children and young people affected by domestic violence and abuse (recommendation 10)
- Provide specialist domestic violence and abuse services for children and young people (recommendation 11)
- Provide specialist advice, advocacy and support as part of a comprehensive referral pathway (recommendation 12)
- Provide people who experience domestic violence and abuse and have a mental health condition with evidence-based treatment for that condition (recommendation 14)
- Provide specific training for health and social care professionals in how to respond to domestic violence and abuse (recommendation 15)
- GP practices and other agencies should include training on and a referral pathway for domestic violence and abuse (recommendation 16)
- Pre-qualifying training and continuing professional development for health and social care professionals should include domestic violence and abuse (recommendation 17)

**Partnership working**

- Participate in local strategic multi-agency partnership to prevent domestic violence and abuse (recommendation two)
- Adopt clear protocols and methods for information sharing (recommendation seven)

**Pursuing perpetrators**

- Commission and evaluate tailored interventions for people who perpetrate domestic violence and abuse (recommendation 14)
expanding referral pathways

Helpfully the guidelines recognise that the Government definition of domestic violence covers a broad range of behaviours and set out six different ‘forms’ of domestic violence, including: partner abuse among adults; partner abuse among young people; domestic violence and abuse between parents; ‘honour’-based violence and forced marriage; abuse of older people; and abuse of parents by children.

The guidelines have, however, been criticised for failing to adequately cover all these different forms. The report of the Chief Medical Officer identifies that the emphasis is on IPV, reflecting the fact that this is where the evidence base for prevention and intervention is strongest. Another criticism is that the guidelines do not include sexual violence outside of intimate partnerships or highlight links with issues such as trafficking and sexual exploitation or address the needs of particular groups such as asylum-seeking women.

Given that the guidelines recognise violence against women as a gendered issue that takes place within patriarchal structures, it would be helpful if they focused more on framing the different forms of violence as part of a continuum. This would ensure the links and overlaps between them are made. In addition, it would be helpful if an intersectional understanding of GBV was adopted so that gender, race, class and other social characteristics are considered when the particular needs of women are identified. An intersectional approach recognises that women are differently located within hierarchies of power and therefore do not have the same access to and control over resources. This is crucial to developing appropriate pathways to safety. It is also crucial in recognising that some statutory processes designed to offer protection can endanger certain groups of women (Thiara & Gill, 2010). For instance, the information-sharing nature of Multi-Agency Risk Assessment Conferences (MARAC) can pose a risk to women from

health economics

Another area in which the guidelines recognise a lack of evidence is in relation to the effectiveness and cost-effectiveness of health interventions in the medium to long term. It is assumed that, even given conservative assumptions, interventions are likely to be cost effective if they stop the violence and improve the mental health of those concerned. For instance, the recent evaluation of hospital IDVA services (SafeLives, 2016) included an analysis of the potential cost savings. Before accessing IDVA services, the cost of victims using hospital, community and mental health services is £4,500 each year. An annual saving of £2,050 per victim in health service use was estimated, consisting of £2,184 in reduced hospital use and £200 in reduced ambulance use, balanced against rises of £196 in mental health service use, £64 in local surgery use and £74 in alcohol/drug service use. The evaluation notes that the increased use of these latter services is likely to be beneficial to victims, particularly if they have complex needs which have remained unaddressed up until accessing the IDVA service.

An assessment of the evidence base since the guidelines were published suggests that studies exploring the longitudinal impact of health interventions are still outstanding. Yet several studies have been published which might provide a starting point for economic modelling.

5 Use of ‘between’ fails to identify the victim and the perpetrator and implies joint responsibility.
The Adult Psychiatric Morbidity Survey (APMS) demonstrates how left unaddressed, violence can have a significant negative impact on the mental health of victims. A group of individuals was identified who had experienced extensive physical and sexual violence with abuse extending back to childhood. The individuals represented 1 in 25 of the population and 80% were women. Some of the members of this group had been severely beaten by a parent and many had been sexually abused as children. Nearly all the members had also been assaulted by a partner and half had been threatened with death. Most had been raped as an adult too. Over half had a common mental disorder (CMD) such as clinical depression or anxiety making them five times more likely to have a CMD than those with little experience of abuse. In addition there was also a strong link with experiencing more than one disorder. Individuals in this group were about 15 times more likely than those with little experience of violence and abuse to have three or more mental disorders (Scott et al. 2015). The researchers note that the identification of the group of survivors with the poorest outcomes being those with the most extensive experience of abuse as children and adults confirms in an adult population the strong impacts of ‘poly-victimisation’ which Finkelhor (2008) has identified in children and adolescents. This suggests that the compounding effects of different experiences of abuse may continue across the life-course.

A three year study explored how women (n=100) rebuilt their lives after domestic violence. Over half of the women reported a current health condition at the outset of the research and only a quarter were positive about their overall health. Only a small proportion (17%) said that they had been able to manage their health when they lived with the abuser. Although their ability to manage their health increased after leaving, over time the abuse began to take a toll. In fact, women’s use of health services increased over the study period from 36% in Wave Two of data collection to 53% in Wave Four (Kelly et al. 2014).

![Figure 4: Changes in health management and overall health over time (Kelly et al. 2014)](image)

Figure 4: Changes in health management and overall health over time (Kelly et al. 2014)
Some health issues persisted over the three year period whilst others arose when immediate safety and practical issues (i.e. housing) were less pressing. Another relevant factor was that a number of women experienced post-separation abuse and/or were constantly undertaking ‘safety work’ meaning that stress/anxiety was ongoing.

**progress on recommendations for research: effectiveness of interventions**

Some progress has been made on expanding the evidence base in relation to the effectiveness of certain types of intervention identified within the NICE guidelines, although again, these tend to focus on the short to medium term. For instance, a study on the effectiveness of perpetrator programmes revealed that this intervention can improve the health of women experiencing domestic abuse. In the study, partners of men referred to such programmes were asked whether they had been injured as a result of the violence and abuse they experienced and whether the injury was serious enough to seek/need health care. At baseline, 61% reported injury, of whom most (71%) had sought (or needed) health care. This rate fell to just 2%, 12 months after their partner started a programme (Kelly & Westmarland, 2015).

**monitoring the impact of the guidelines**

The potential impact of the recommendations contained within the guidelines is significant but there are challenges associated with ensuring their implementation. An assessment of the response of health and social care professionals ahead of their introduction revealed that, with the exception of a few PCTs and Mental Health Trusts, there was limited engagement within the issue of violence against women. Similarly, the annual report of the Chief Medical Officer observed that most areas did not have integrated commissioning of DVA services, nor referral pathways between health services and the DVA sector (Mullins & Murphy, 2014) which survivors identify as very important.

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Chapters two and three of the Chief Medical Officer’s report, The Health of the 51%, focus on gender based violence against women and female genital mutilation. They represent a valuable contribution to knowledge for health and social care professionals in that they set out the expanding evidence base on the forms of GBV for which less is known, including: level of need; the related health-impact; and the need to tailor pathways to support. In so doing, they seek to address some of the shortcomings identified in relation to the NICE guidelines.

As well as considering sexual violence and HBV, chapter two makes links to sex work and modern slavery. It also considers groups of women including lesbian and bisexual women, women in prison and women who are asylum seekers and irregular migrants. Some of the suggestions for policy identified by the report are being addressed. For instance:

- Following the introduction of the Modern Slavery Act (2015) the Department of Health updated its e-learning tool for NHS staff on identifying and responding to modern slavery. As part of its health policy research programme, the Department of Health also supported research into optimising identification, referral and care of trafficked people within the NHS. The final report highlights the importance of including information about human trafficking in undergraduate medical training (World Health Organisation/London School of Hygiene and Tropical Medicine/South African Medical Research Council, 2015).

- NHS England has published a commissioning framework for adult and paediatric SARC services which states that it is expected that the SARC will develop and maintain referral pathways and working relationships with relevant third sector services (NHS England, 2015: 10).

- Evaluation of an initiative tackling FGM in the UK explored changing attitudes among diaspora community groups. It found that through workshops decreases in support for FGM could be achieved. When data was disaggregated by gender some important gender-based differences in attitudes towards FGM arose. Men at baseline were often much less supportive of FGM than women, a finding that echoes international research which has shown that even in countries of origin, some men do not approve of FGM but may have few means of opposing the practice. Shifts in attitudes towards FGM allowed the project to reach wider audiences in more public areas (Brown & Porter, 2016).

- A study has explored the most appropriate timing of de-infibulation in pregnancy for those with type three FGM. Women who were not de-infibulated before labour had a significantly greater risk of episiotomy and a prolonged hospital stay of more than 2 days. In addition, when de-infibulation is deferred until labour the risk of morbidity increases (Albert et al., 2015).

Other suggestions for policy may be more challenging to achieve. For instance, the identified need to empower women through economic inclusion is difficult given the historic lack of focus on women’s economic, social and cultural rights and the negative impact that the austerity agenda has had on women (Dustin, 2016).

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7 De-infibulation, is the surgical procedure to open up the closed vagina.
7. conclusion

The Department of Health may previously have been seen as a reluctant partner on VAW. However, 2016 represented a step-change in relation to the strategic importance placed on the role of health services in responding to violence against women. The 2016-20 violence against women and girls strategy, unlike previous governmental policy, recognises the particular importance of integrating domestic violence in health care settings. The 2016 NHS Mandate recognised the vital role that the NHS can play in tackling domestic violence, setting out expectations to ensure it helps identify abuse early and provides or identifies the relevant support. The Public Health Outcomes Framework (PHOF) 2013-2016 contributed to developing practices to integrate domestic violence with healthcare and has been supported by NICE through the development of a specific domestic violence and abuse Quality Standard. What is now vital is the ability of the frontline to deliver the vision of the PHOF as expressed through the four quality statements within the Standard:

1. People presenting to frontline staff with indicators of possible domestic abuse are asked about their experiences in private discussion.
2. People experiencing domestic abuse receive a response from trained staff.
3. People experiencing domestic abuse are offered referral to specialist support services.
4. People who disclose that they are perpetrating domestic abuse are offered referral to specialist support services.
Adult Family Homicide (AFH)
Adult Family Violence (AFV)
Analysis of the Adult Psychiatric Morbidity Survey (APMS)
Chief Medical Officer (CMO)
Common mental disorder (CMD)
Crime Survey of England and Wales (CSEW)
Crown Prosecution Service (CPS)
Domestic violence and abuse (DVA)
Domestic Violence Protection Orders (DVPOs)
DV Disclosure Scheme (DVDS)
European Union Agency for Fundamental Rights (FRA)
Female genital mutilation (FGM)
Female Genital Mutilation Protection Orders (FGMPOs)
Forced Marriage Unit (FMU)
Gender-based violence (GBV)
Her Majesty’s Inspectorate of Constabulary (HMIC)
‘Honour’-based violence (HBV)
Identification and Referral to Improve Safety (IRIS)
Independent Domestic Violence Advocates (IDVAs)
Independent Sexual Violence Advisers (ISVAs)
Intimate Partner Homicide (IPH)
Intimate partner violence (IPV)
Multi-Agency Public Protection Arrangements (MAPPA)
Multi-Agency Risk Assessment Conferences (MARAC)
National Confidential Inquiry (NCI)
National Institute for Health and Care Excellence (NICE)
Non-Governmental Organisations (NGOs)
Office for National Statistics (ONS)
Primary Care Trust (PCT)
Promoting Recovery in Mental Health (PRIMH)
Public Health England (PHE)
Public Health Outcomes Framework (PHOF)
Rape Crisis Centres (RCCs)
Sexual Assault Referral Centres (SARC)
Specialist Domestic Violence Courts (SDVC)
University of West England (UWE)
Violence against women (VAW)
Violence against women and girls (VAWG)
Women’s National Commission (WNC)
World Health Organisation (WHO)


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