

Tackling violence against women – meeting unmet needs

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Key Messages:

- Responding to the scale of the problem is the largest challenge facing health care – further improvements are needed in terms of multi-agency working and information sharing.
- Particular challenges exist around responding to non-recent violence and abuse, non-physical forms of abuse, and working with an ageing population.
- The healthcare system is used by those perpetrating violence and abuse as well as those experiencing it. GPs are particularly likely to come into contact with perpetrators and need training and resources to make appropriate referrals.

Introduction

‘Violence Against Women’ is an umbrella term used to describe ‘any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental 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 As well as domestic violence and abuse, it also includes (but is not limited to) rape and sexual abuse, crimes against women and girls based on notions of ‘honour’, forced marriage, forced prostitution and trafficking, female genital mutilation (FGM), and sexual harassment.

Historically, healthcare responses to violence against women have focused predominantly on domestic violence and abuse. Twenty years ago, in 1998, the Board of Science and Education of the British Medical Association led in the development of healthcare responses to domestic violence in their influential report ‘Domestic violence: a health care issue?’.² This report was crucial in elevating the status of domestic violence amongst healthcare practitioners as well as managers. Today, it is recognised that there are a broad range of forms of violence and abuse against women and that these represent serious, global, public health issues. It is therefore an appropriate time to take stock of unmet needs in tackling violence against women.

Understanding the scale of the problem

Knowing the exact scale of violence against women is difficult due to systemic under-reporting and definitional issues. There are many reasons why women and girls may not report experiences of violence, including: fear of retaliation, feeling their experience is not serious enough, an ongoing relationship with the perpetrator, not recognizing their experiences as abusive, and/or (misplaced) feelings of embarrassment. Women who do not speak English as their first language, women with disabilities, women from minority ethnic communities, and women with insecure immigration status face additional barriers.

In light of the high levels of underreporting of violence against women, victimization surveys are generally viewed as a more reliable source of data. The most accurate data available comes from a European-wide survey, which found that an estimated 13 million women in the EU have experienced physical violence in the course of the previous 12 months (approx. 7% of women aged 18-74).³ Furthermore, 3.7 million women have experienced sexual violence and 9 million women have experienced stalking in the previous 12 months. In the UK, 8% of women had experienced physical and/or sexual violence and 5% of women had been stalked in the previous 12 months. Data from the Femicide Census reveals that violence against women is one of the leading causes of premature death of women.⁴

Data on the extent of forced marriage is even more difficult to gather with accuracy, but The Forced Marriage Unit reported giving advice or support in relation to 1,428 cases of possible forced marriage in 2016 alone.⁵ There is similarly little available data on the extent of Female Genital Mutilation, however the NHS reports 1,971 women attending NHS trusts or GP practices between July and September 2016 where FGM was identified or a procedure for FGM was undertaken.⁶ These figures should all be understood as underestimates.

Research has linked violence against women to a range of physical and mental health problems including depression, emotional distress, and suicidality, as well as injuries, pain and long-term health conditions.⁷ Sexual violence increases risk for a range of physical health problems, including sexually transmitted infections or diseases, vaginal bleeding, urinary tract infection, miscarriage and neonatal death.⁸ Mental health impacts of rape include suicidality, flashbacks, anxiety, depression and panic attacks.⁹ The health impacts of intimate partner violence (IPV) have been most researched and therefore has the strongest evidence base, showing a complex relationship whereby IPV can: a) lead to adverse health effects, b) worsen pre-existing health conditions, or c) lengthen the duration of IPV exposure for women who are depending on partners due to illness or disability.¹⁰ It is important to remember that not all women have equal access to safety and freedom or the resources or ability to leave.

Responding to the scale of the problem is the largest challenge facing health care

The scale of the problem raises different problems depending on the recency of the violence and abuse. Different healthcare responses are needed for someone who is at immediate risk of serious harm or homicide or who has just sustained life threatening physical injuries compared to someone who has experienced years of sexual abuse as a child, has been living in a forced marriage for ten years, or is experiencing long-term post-traumatic stress. To date, there has been more attention placed on acute needs than chronic conditions, however the healthcare burden needs to be recognised as falling heavily across each of these areas. Failing to do so is leaving a huge level of unmet need which weighs heavily on mental health provision and voluntary sector organisations.

Responding to acute needs through multi-agency working

Responding to acute needs includes treating immediate physical injuries, an active involvement in managing risk through liaison with partner organisations and supporting the collection of any forensic medical evidence. It also means dealing with situations that change from being chronic to acute or become acute because of a previous lack of knowledge, for example if a woman who has experienced Type III FGM (narrowing of the vaginal orifice with a covering seal created from the labia minora or majora) goes into labour without previous knowledge of her condition or if a person who has experienced child sexual abuse or exploitation becomes suicidal.

While acute needs have arguably been better responded to than chronic needs, there are still a number of improvements that can be made, particularly around multi-agency working and information sharing. Where there is an 'instinct' that something is wrong but no disclosure or direct evidence, it is the piecing together of the multi-agency picture that becomes crucial.

An extreme example of this is the case of Mr X (anonymised in order to protect the identity of his daughters) who was given 25 life sentences in 2008 for the repeated rapes of his two daughters over a 27-year period. The abuse continued into adulthood and the rapes began to result in pregnancies. Between them, they had nineteen pregnancies and nine children (two of which died at birth). A serious case review showed that a number of organisations had information, including the family doctor and medical staff involved in their maternity care, and that there had been missed opportunities to intervene. In total, the family had received input from 28 different agencies over a 35-year period. Some of the family had long term health problems and therefore had a number of healthcare practitioners involved in their lives. The sisters were specifically asked about the paternity of their children on 23

separate occasions, and 7 allegations of incest/sexual abuse were reported to professionals during this time by family members and other professionals. Some of the babies died at birth because of genetic disorders that could only occur when both parents carry a particular genetic abnormality, and two of the seven that lived have severe physical disabilities. The review summarised:

'The Serious Case Review identified that there existed a culture of 'having a quiet word' where informal unwritten information was passed between services sometimes because the professional did not have the understanding or knowledge to escalate the concern, particularly as the belief was that the evidence was either not there to investigate (genetic, DNA) or that the situation had been investigated by the police with no further action required or possible'.¹¹

Domestic Homicide Reviews (DHRs) have also pointed to healthcare, particularly GP surgery staff, as stakeholders that are consistently and actively engaged with victims and perpetrators. Sharp-Jeffs and Kelly argue that those in primary health are in a unique position to identify and respond to people at risk, but that in over half of the cases in their analysis of 32 DHRs GPs had failed to ask victims about domestic violence.¹²

One way in which healthcare practitioners can engage in multi-agency working around acute needs is through the Multi Agency Risk Assessment Conference (MARAC) process. However, research shows that while healthcare practitioners do engage in the conferences, they very rarely refer cases into the MARAC process. Data obtained for this paper (personal communication with SafeLives) shows that little progress has been made in terms of MARAC referrals from health over the last decade: in 2008 just one in fifty referrals was from primary (1.6%) or secondary healthcare (0.4%) and this has now risen to one in twenty-five (2.5% from primary and 1.5% secondary healthcare). Greater awareness and proactive engagement (including referrals) from healthcare with existing MARAC processes is a place where some immediate leaps forward could be made.

Responding to non-recent violence and abuse

The last five years has seen a steep rise in the number of disclosures of non-recent violence and abuse (previously called 'historic' abuse). Cases that have received particular attention, such as the sexual abuse perpetrated over many decades by Jimmy Savile and the related Operation Yewtree investigation, have all led to a greater acknowledgment that abuse is not always reported at the time it happens, and that survivors can live with the effects of abuse for many years or even decades before telling anyone. Sometimes attempts were made at the time to speak out, but those attempts were silenced. This represents a new 'breaking of the silence' on a colossal scale and brings with it both opportunities and challenges.

In terms of opportunities, a new openness, willingness to hear, and reduced stigma associated with being a survivor of non-recent violence or abuse – particularly sexual abuse – can lead to better identification and management of symptoms. The need to respond to the 'root cause' of the problem has been an objective since the cross Government 'Victims of Violence and Abuse Prevention Programme' 2004-2007, but one that is now closer to being realized as it becomes more possible to speak out and be believed.

Armed with the knowledge of the widespread nature of non-recent abuse, there is also the opportunity to think laterally and create changes in key areas of routine and/or women's health. For example: forced penile penetration of the mouth (legally classed as rape since 2005) might make survivors reluctant to engage in dental check-ups; female genital mutilation or forced vaginal penetration by a penis or other object (legally classed as rape since 2005) may make survivors reluctant to engage in sexual health screening such as smear tests, seek help where diagnosis or treatment may involve trans-vaginal scans (e.g. Early Pregnancy Unit scans or IVF); a fear of childbirth linked to a lack of control following sexual abuse may result in a higher level of requests for caesarean sections; a jealous and controlling partner may prevent a woman being able to commence or continue

breastfeeding an infant. For women from ethnic minority groups, there may be additional difficulties for disclosing abuse including a fear or distrust of healthcare providers, language barriers and cultural norms and attitudes.^{13,14}

In terms of challenges, the scale of the problem means that many of those who are now disclosing non-recent sexual abuse are being placed on waiting lists that can be very long. There is not the provision to meet the need within the healthcare system, and the passing on to the historically under-resourced voluntary sector is creating a bottleneck. Therefore, without additional service provision to deal with the scale of the problem, the opportunities to think laterally and to reduce the long-term effects cannot be fully realized.

Dealing with non-physical forms of abuse

In 2013 the Government definition of domestic violence and abuse changed to include coercive control, and in 2015 a new criminal offence was introduced of 'Controlling or Coercive Behaviour in an Intimate or Family Relationship', punishable by up to five years imprisonment. Coercive control refers to the micro-regulation of the way a woman lives her life¹⁵ – from what she wears, where she can go, what she eats, whether she can work, how she parents, and who she sees. People who are experiencing coercive control describe doubting their own judgement, feeling worthless, having low self-esteem, high levels of stress and anxiety caused by a constant feeling that they are 'walking on eggshells'.

There is a need for health professionals to be more aware of the seriousness of coercive control. Spanish researchers have shown that if health professionals were able to identify this form of violence at an early stage, the long term negative effects on women's health could be minimized but note that research on psychological victimization has tended to receive less attention and be under-researched.¹⁶ They suggest that healthcare professionals should be encouraged to ask about domestic violence where there is no physical or sexual violence, but women report symptoms such as mood swings, crying without reason, irritability, insomnia or permanent fatigue.

Working with an aging population

Older women have been absent from the majority of research, policy and practice developments around violence against women. One of the reasons violence against older women has been invisible is because the problem of violence is not recognized until it becomes 'subsumed under the category of elder abuse'.¹⁷

Violence against older women may be perpetrated inside or outside the family. Some older people may be socially isolated which can increase their risk of abuse whilst at the same time reducing their opportunities for disclosure. Both primary and secondary healthcare practitioners may be the only agencies older people have contact with. In particular, those in community-based healthcare positions who may visit older people in their homes are uniquely placed to be able to identify the signs of abuse and may receive disclosures from older survivors.

It is important that healthcare practitioners are aware of the additional problems age can create for older survivors. It may be more difficult to identify abuse because of health issues associated with aging. For example, physical injuries, bruising or cuts may be associated with trips or falls rather than abuse. Moreover, older people with dementia may find it more difficult to disclose abuse or articulate their experiences and may be more likely to be dismissed or not believed when they do. Generational norms and attitudes may also create difficulties for older women disclosing abuse.

Putting perpetrators into the (healthcare) frame

There has been a tendency to focus on victims/survivors rather than perpetrators of violence against women across all professional and practice sectors, including healthcare. This has long-term implications in terms of the continuation of violence against women – for example one woman may be supported to leave an abusive relationship but if there is no response to the perpetrator then the violence may start again against a new partner. While criminal justice responses to perpetrators are improving, it is still the case that criminal convictions are rare for all forms of violence against women. For example, there have been very few convictions for forced marriage, the rape conviction rate is notoriously low, and there has never been a successful conviction for female genital mutilation (despite a number of UK clinics openly advertising these procedures). Although there is limited research on responding to perpetrators, what does exist suggests healthcare practitioners are ideally situated. For example, research by Hester et al. found that 83% of the convicted domestic violence perpetrators they interviewed had contacted their GP for help.¹⁸ However, GPs often did not know how to respond or made inappropriate referrals. Appropriate referrals for domestic abuse perpetrators are referred to in the NICE quality standard [QS116]¹⁹: 'referral to specialist services for people perpetrating domestic violence or abuse' (Quality statement 4) and research on accredited domestic violence perpetrator programmes in the UK shows encouraging findings.²⁰ However, there is more work to be done on the awareness and availability of such services, and responses to perpetrators of other forms of violence against women is currently even more lacking.

Actions for healthcare professionals

- All healthcare practitioners need to be alert to the impact that violence against women might have on their area of practice.
- Practitioners should be aware of the negative health effects non-physical violence and abuse – particularly 'coercive and controlling behaviour', which is now a criminal offence.
- It is important to remember that not all women have the same access to safety and freedom, or the resources or ability to leave.
- Violence against older women may be more difficult to identify because of health issues associated with ageing, and healthcare practitioners should be alert to the signs of violence against women across the lifespan.
- GPs are particularly likely to come into contact with perpetrators and need to be given the training and resources needed to respond appropriately.

Actions for policy makers

- Focus should continue to be expanded to all forms of violence against women and not solely on domestic violence and abuse.
- Funding arrangements should recognise the resources required for responding to chronic health care needs.
- There is a particular challenge around responding to the scale of non-recent sexual abuse.
- Increased confidence is needed around multi-agency working and information sharing - including referrals into the MARAC process.
- Awareness of violence against older women needs to be increased and ageist assumptions should be challenged through training. General training on violence against women should include older women as case examples.
- More focused attention on perpetrators of violence and abuse is needed.

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